



European Monitoring Centre
for Drugs and Drug Addiction



Meeting Report

Reitox Academy for Baltic countries: Monitoring trends in and responses to drug-related infectious diseases among people who inject drugs 21–22 November 2013, Tallinn

Co-organised and hosted by the Reitox National
Focal Point in Estonia¹

Summary

A joint European Centre for Disease Prevention and Control (ECDC)/European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) risk assessment of human immunodeficiency virus (HIV) transmission among people who inject drugs (PWID) in 30 European Union (EU)/European Economic Area (EEA) countries and Turkey, performed in mid-2013, documented ongoing HIV outbreaks in Greece and Romania, and the potential risk of increased HIV transmission in at least one-third of the countries. When measured against some established thresholds, prevention coverage remains inadequate in at least ten EU/EEA countries (²). The Reitox Academy on 'Monitoring trends in and responses to drug-related infectious diseases among people who inject drugs', organised in Tallinn on 21–22 November 2013, brought together four countries from the Baltic Sea region (Estonia, Latvia, Lithuania and Poland) as part of a series of joint EMCDDA/ECDC events aiming to facilitate the sharing of best practices in monitoring and responding to the risk of HIV transmission among PWID, as a follow-up to the risk assessment.

Common issues of concern in the participating countries were the high levels of stigma and marginalisation attached to drug use and the lack of sustainability of funding for effective measures, hampering the development of a qualified workforce of trained professionals in the drugs field.

Highlights from country presentations and discussions:

(¹) This report summarizes discussions held at the Reitox Academy, jointly organised by the EMCDDA and ECDC. However the views expressed in the report reflect the views of the participating experts and do not necessarily represent the views of EMCDDA and ECDC.

(²) Hedrich, D., Kalamara, E., Sfetcu, O. et al. (2013), 'Human immunodeficiency virus among people who inject drugs: is risk increasing in Europe?' *Eurosurveillance*, 18(48) (www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20648).

Estonia:

- HIV prevalence of 60 % among PWID in Tallinn and North-East Estonia in recent respondent driven sampling studies.
- New national guidance recommends annual HIV testing for the 18- to 49-year-old population attending primary care.
- A move to a web-based database for monitoring needle and syringe programmes (NSPs) will provide added value for policy planning at local and national level.
- Syringe provision is high, but due to legislation defining testing as a medical act , diagnostic testing possibilities do not exist at low threshold services and NSPs which are run by non-governmental organisations (NGOs).
- Coverage of opioid substitution treatment (OST) is not known, as there is no estimate of the size of the opioid using population.

Latvia:

- Prison settings are still extremely significant in HIV transmission — 17.4 % of all new cases registered in 2012 were among prisoners; among those, 61 % of transmissions were reported to be through injecting drug use.
- There has been a large increase in HIV-related mortality.
- Although heterosexual transmission has been the predominant mode since 2008, a recent study suggests that injecting drug use sustains the heterosexual epidemic.
- Geographical expansion of NSP sites is ongoing, but the number of drug users reached by services and the level of syringe provision are very low.
- Despite the expansion of the OST services since 2007, coverage of OST remains among the lowest in Europe.

Lithuania:

- The proportion of injecting drug use-related HIV transmission is decreasing, but still amounts to 39 % (62/160) of all new HIV cases notified in 2012 (in comparison to 96 % in 2002, when an outbreak occurred among prisoners).
- Prisons remain the settings where PWID are most at risk of HIV transmission (30 % of all new HIV cases in 2012); OST is not provided in prisons.
- Against a backdrop of a declining number of NSP sites, the numbers of clients reached has declined since 2010 and the number of syringes given out remains at a low level. There is a lack of OST coverage among PWID in the community.

Poland:

- Since 1985 a total of 5 946 HIV infections (36 % of the total 16 314) have been reported among PWID. Injecting drug use transmission decreased to 1 % in 2012; however, in 60 % of new cases the route of transmission was 'unknown'.
- Rapid testing is preferred by PWID; a dramatic reduction in PWID attending testing has been observed, together with a reduction in the number of NSPs. HIV prevalence among low-threshold clients was 57 % in a study carried out in 2012.
- Despite a supportive national policy framework and existing funding options, the number of harm reduction facilities shows a steady decline; in total only 12 NSPs were operational in the country in 2012, compared to 21 in 2002;
- It is estimated that between 10 % and 20 % of the drug-dependent population receives OST (the estimated number of opioid-dependent users ranges from 10 400 to 19 800).
- A changing profile of problem drug use and a lack of prioritisation of HIV prevention at the local policy making level (districts/cities) have been suggested as possible reasons for the decline of the number of harm reduction facilities.

Conclusions and recommendations:

Participants noted that EMCDDA and ECDC risk assessments, technical support and guidance was important and that the agencies should continue supporting countries in establishing and maintaining programmes to prevent infectious diseases among PWID as a policy priority.

They identified the following areas where further action was needed at national level:

- strengthening multi-sectorial coordination in the HIV response, including at local level;
- monitoring and analysing trends in service provision and being vigilant regarding changes in service funding and provision as well as in the demand for services;
- identifying obstacles to the scaling up of evidence-based interventions, especially diagnostic testing, NSP and OST, and of drug-related health services in prisons.

To tackle these and address specific needs identified in the individual countries with a wider group of national experts and stakeholders, ECDC/EMCDDA country visits were proposed as follow-up.

Background

The rates of newly diagnosed HIV infection among PWID have been steadily decreasing in Europe (EU/EEA) since 2000. However, a risk assessment conducted in EU/EEA countries in November 2011 by the EMCDDA and ECDC documented a significant increase in newly detected HIV cases among PWID in Greece and Romania⁽³⁾. The risk assessment concluded that there was a temporal association between low levels or reduction of provision of prevention services in these two countries and the increase in HIV transmission among PWID. It recommended that there should be an increased focus on prevention measures, such as NSPs and OST, and that further epidemiological investigation should be undertaken to improve understanding and prevent further outbreaks.

A second updated risk assessment was conducted in June 2013⁽⁴⁾. The analysis of the most recent HIV surveillance data (reporting newly diagnosed cases), prevalence estimates, risk and response data indicated that several additional countries have experienced an increase in HIV diagnoses or HIV prevalence among PWID or increases in indicators of HIV risk among PWID. This is of concern, both because effective prevention measures exist and because HIV transmission can spread very rapidly among injecting populations.

In order to share best practice in monitoring and responding to the risk of HIV among PWID, ECDC and EMCDDA organised a series of joint expert meetings (in 2012: Tallinn, Estonia; Lisbon, Portugal and in 2013: Bucharest, Romania). In addition, one day of the 2013 EMCDDA Drug-Related Infectious Diseases (DRID) meeting in Lisbon (18 October) was dedicated to HIV risk assessment.

At the request of Estonia, Latvia, Lithuania and Poland, four countries located in the Baltic Sea region, the present expert meeting was organised in Tallinn on 20–21 November 2013 as a Reitox Academy on 'Monitoring trends in and responses to drug-related infectious diseases among people who inject drugs'. In addition, it served as one of the two joint EMCDDA/ECDC regional follow-up meetings⁽⁵⁾ to the updated risk assessment of 2013 and built on the Lisbon DRID risk assessment day.

The meeting was attended by 16 participants from Reitox national focal points and national HIV surveillance centres in Estonia, Latvia, Lithuania and Poland. One external expert attended (Professor Catharina Matheï, Department of Public Health and Primary Care, Catholic University of Leuven, Belgium) and three technical staff members from the EMCDDA and ECDC (see Annex 2 for a list of participants).

Session 1: Introduction

Katri Abel-Ollo, Head of the Estonian Reitox National Focal Point opened the meeting, welcoming all participants to Tallinn and introducing the objectives of the meeting:

- To review the current epidemiological situation with respect to HIV and hepatitis B and C, and other infections (e.g. tuberculosis), among people who inject drugs.
- To review the current situation with respect to the provision of harm reduction measures aimed at the prevention of infections among PWID.
- To discuss methods and indicators on how drug-related infectious diseases and prevention responses are monitored.
- To follow up on the most recent risk assessment and discussions in the DRID expert meeting and discuss the potential risk for acceleration of HIV transmission due to low coverage of prevention services and/or changing drug use patterns among people who inject drugs.

⁽³⁾EMCDDA/ECDC (2012), 'HIV in injecting drug users in the EU/EEA, following a reported increase of cases in Greece and Romania' (www.emcdda.europa.eu/publications/joint-publications/hiv-in-injecting-drug-users-2011).

⁽⁴⁾Hedrich, D., Kalamara, E., Sfetcu, O. et al. (2013), 'Human immunodeficiency virus among people who inject drugs: is risk increasing in Europe?' *Eurosurveillance*, 18(48), p. ii (www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20648).

⁽⁵⁾The 2013 meeting in Bucharest, Romania was held earlier the same week and convened experts from Bulgaria, Cyprus, Greece, Hungary, Malta, Romania and Slovakia, with external experts from Finland, Sweden and the United Kingdom.

- To share best practices in organising and sustaining prevention and care services for injecting drug users, and discuss the role of the Reitox national focal points in advocating for these services.
- To briefly discuss the feasibility of a EMCDDA study assessing the costs of HIV prevention measures and links with the economic situation in the four countries.

She then passed the floor to Otilia Sfetcu (ECDC) and Dagmar Hedrich (EMCDDA), who presented the results of the updated risk assessment of HIV transmission among PWID in 30 EU/EEA countries and Turkey^(6, 7). The aim was to describe HIV transmission, related risk factors, prevalence trend, prevention coverage and also changes in funding in European countries during the period 2010–12. The indicators used were the same as in 2011 risk assessment, namely:

- reported HIV diagnoses among PWID;
- HIV prevalence;
- hepatitis C virus (HCV) prevalence;
- other injecting risk indicators (e.g. increase in injecting drug use, market changes, new substances);
- proportion of opiate users receiving OST;
- number of syringes per PWID per year;
- changes in prevention funding.

The assessment found that 25 countries reported stable or declining rates of newly diagnosed HIV infections among PWID. Trends in HIV transmission among PWID are unclear in Austria, Bulgaria, Estonia and Latvia. Greece and Romania have experienced significant increases in HIV case reports among PWID from 2011; the outbreaks have mostly been centred in capital regions. The rate per 100 000 general population in Romania increased 30-fold from 0.04 in 2010 to 1.1 in 2012; the rate in Greece increased 20-fold from 0.2 to 4.6. While in 2010 Greece and Romania had only accounted for 2.2 % of newly diagnosed cases of HIV among PWID in the EU/EEA, in 2012 they accounted for more than one-third of new cases in this population in the region.

Other findings of the risk assessment included:

- Injecting risk — Increased injecting of stimulants was reported in Hungary and Romania; increased HCV prevalence or HCV prevalence above 50 % among PWID was reported in Belgium (Flemish community), Bulgaria (Sofia), Cyprus, Estonia (Narva), Greece, Italy, Latvia, Romania (Bucharest) and Turkey.
- Prevention coverage — The proportion of problem opiate users in OST was below 20 % in Cyprus, Hungary, Latvia, Lithuania, Poland and Slovakia; NSP coverage was below 100/PWID/year in Belgium, Cyprus, Greece, Hungary, Romania and Slovakia. For syringes given out through NSPs, low coverage is regarded as 100 syringes per person who injects drugs per year (UN target setting guide). Six countries had low NSP coverage, and Turkey does not make syringes available through NSPs.
- Funding — Thirteen countries reported that funding for harm reduction for PWID was insufficient; this included Croatia⁽⁸⁾, Cyprus, the Czech Republic, Estonia, Greece, Hungary, Latvia, Lithuania, Romania and Sweden. Austria and France highlighted insufficient responses in prisons and Germany insufficient NSP coverage in rural areas.

⁽⁶⁾ Croatia, which joined the EU on 1 July 2013, took part in the risk assessment and is included as EU country.

⁽⁷⁾ The results of this risk assessment were published on 28 November 2013 *Eurosurveillance*: <http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20648>.

⁽⁸⁾ Based on reply by National Drug Focal Point, while ECDC HIV surveillance contact point replied that current funding meets needs.

Finally, the risk assessment also highlights the need to monitor changes in patterns of drug use (for example, increased stimulant injecting), and the implications of these changes for HIV prevention, in particular for the scale-up of NSP, and for drug treatment programmes.

The assessment showed that while reports of new HIV diagnoses among PWIDs have been stable or declining in most EU/EEA countries, serious outbreaks in Greece and Romania continued, while economic conditions hindered the provision of effective response coverage. In at least eight other countries, data suggest that substantial populations of PWID have limited access to OST and NSP services and may therefore be vulnerable to future outbreaks. The assessment concluded that prevention efforts should urgently be scaled up.

Figure 1: Indicators of HIV trend, transmission risk and prevention coverage in 31 European countries, 2010-2012

		Table 1: Indicators of HIV trend, transmission risk and prevention coverage in 31 European countries, 2010–2012																														
		AT	BE	BG	HR	CY	CZ	DK	EE	FI	FR	DE	EL	HU	IS	IE	IT	LV	LT	LU	MT	NL	NO	PL	PT	RO	SK	SI	ES	SE	TR	UK
HIV trend																																
HIV case reports/ HIV prevalence studies																																
Transmission risk																																
HCV prevalence, IDU prevalence, changes in injecting risk behaviour																																
OST coverage																																
Percent of estimated problem opiate user population receiving OST: cut-off 30%																																
NSP coverage																																
Number of syringes given out per PWID per year: cut-off 100 syringes																																

		NO ALERT – no evidence for increase in HIV case reports or HIV/HCV prevalence and/or transmission risk and/or low intervention coverage
		CONCERN – sub-national increase in HIV /HCV prevalence and/or transmission risk or consistent but non-significant rise at national level.
		ALERT – evidence for significant increase in HIV case reports or HIV/HCV prevalence and/or increase in transmission risk and/or low intervention coverage.
		Information unknown/not reported to EMCDDA/ECDC.

(Source: Hedrich et al., *Eurosurveillance* 28 November 2013. For further details and information about sources see Supplementary Table available from: www.emcdda.europa.eu/publications/joint-publications/hiv-in-injecting-drug-users/update-2013/supplementary-table).

After the presentation, possible reasons for the HIV outbreaks in Romania and in Greece were discussed. The lack of, or limited access to, prevention and harm reduction services were considered to have considerably increased the risk of HIV transmission. Furthermore, the economic crisis and a related decline in social services were mentioned, exacerbating marginalisation, homelessness, street use and migration especially to urban areas and creating risk environments. However, different factors may affect the situation in the countries. For example, in Romania the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) stopped funding syringe programmes in 2011 and syringe provision fell to almost half the number provided in 2010⁽¹⁰⁾. In Greece, low coverage of services was documented before the outbreak, with just seven syringes distributed per injector per year. In the context of the economic recession and the abandonment of the inner city of Athens by many of its inhabitants, existing open drug scenes became more visible. The prison environment bears additional

⁽⁹⁾ for further detail and information about sources a Supplementary Table can be consulted online; see link below Figure 1

⁽¹⁰⁾ NB: An important, positive change occurred in December 2013 when the GFATM announced that the funding period for Bulgaria and Romania would be extended for three years.

risks for becoming infected as in many countries in Europe, drug-related health services available in the community are not provided to drug dependent prisoners.

Lucas Wiessing then discussed EU level monitoring of drug-related infectious diseases (HIV, viral hepatitis) as part of the EMCDDA drug-related infectious diseases (DRID Indicator) programme. He first gave a wider overview of health and social issues related to PWID and then discussed the objectives of DRID monitoring and recent projects and activities. He emphasized that a core element of successful surveillance/monitoring is building a strong network between stakeholders.

He then discussed the main indicators for monitoring drug-related infectious diseases in Europe. Although there could be different priorities in different countries, central indicators include HIV case reports and HIV/HCV/hepatitis B virus (HBV) prevalence of biological markers. Of particular importance are some key breakdowns (young and new drug injectors) and, more recently, the use of trends in HCV prevalence monitoring as an indicator of HIV risk.

Different indicators provide different pictures, either providing evidence of an infection history (e.g. HBcAb, HCV-Ab) or of ongoing (including acute) infection (HIV, HCV-RNA, HBsAg), whereas some indicators are proxies for the incidence (rate of occurrence) of new infections (e.g. HIV case reports, prevalence of infection in young and new IDUs) and others reflect the overall prevalence (the proportion of the population that is infected). Both prevalence data and case notifications are subject to important limitations, which include under-diagnosis, under-reporting, reporting delay or completeness in risk group (PWID) assignment (case reports / notification data), or representativeness (sample size, geographic coverage), continuity (prevalence data), which should be kept in mind while interpreting the data. While HIV notifications (case reports) are an extremely useful data source, this is less the case for hepatitis notifications where under-diagnosis and under-reporting can be huge and those data may thus not reflect epidemiological rates or even trends. The EMCDDA uses hepatitis notification data mainly to estimate the contribution of IDUs as a transmission group to the spread of hepatitis infection (using the % of IDUs among all cases with known risk factor).

Recently, the EMCDDA has also started collecting behavioural data, as a complement to biological prevalence monitoring. Examples were shown of these indicators, which include HIV/HCV testing rates, needle/syringe sharing and paraphernalia sharing as 'core' indicators as well as a number of additional and optional indicators⁽¹¹⁾.

To interpret the epidemiological data it is important to combine indicators in a meaningful way. For example, different HIV data sources, HCV trends and intervention coverage can give a good picture of the risk of outbreaks in a country, as was done in the joint EMCDD/ECDC HIV risk assessments. The use of HCV prevalence trends as an indicator of HIV (injecting) risk has been proposed by work carried out in the EMCDDA DRID modelling network (e.g. Vickerman et al. ⁽¹²⁾) and has been confirmed in the recent outbreaks in Greece and Romania, where both HIV outbreaks were preceded by several years of increasing HCV. The importance of other (behavioural) variables was illustrated; for example, in Hungary there is no HIV increase yet but a worrying increase in HCV is observed among stimulant injectors. In Latvia, recent data suggest increases in HIV prevalence among PWID, and at the same time a strong increase in HCV has been observed in earlier years (since 2009), confirming this increase in HIV risk among PWID. Worrying trends in HCV are also observed in Turkey, Malta (where recently three HIV cases were reported for the first time in many years), Cyprus and Bulgaria.

Catharina Matheï (CM) introduced methods and tools for monitoring drug-related infectious diseases. Sampling methods that have been proven useful for PWID include convenience, outreach, time-location, snowball and respondent-driven sampling (RDS).

Time-location sampling uses defined selected time-location units and then selects systematically participants for each unit randomly. It may have a bias if an important site is missing and if a considerable part of the target group cannot be met in public places. Snowball sampling may have bias

⁽¹¹⁾ For more information see DRID toolkit modules available online at: <http://www.emcdda.europa.eu/themes/key-indicators/drid>.

⁽¹²⁾ Vickerman, P., Martin, N., Turner, K. and Hickman, M. (2012), 'Can needle and syringe programmes and opiate substitution therapy achieve substantial reductions in hepatitis C virus prevalence? Model projections for different epidemic settings', *Addiction*, 107(11), pp. 1984–95 (www.ncbi.nlm.nih.gov/pubmed/22564041).

from initial seed selection. Furthermore, it may lead to an over-representation of more cooperative individuals and individuals with large networks. RDS combines snowball sampling with a mathematical model that weighs the sample in order to compensate for the fact that the sample was collected in a non-random way. To reduce non-participation, dual incentives are used. There is a recruitment quota of three to four peers. The method is suitable if the average network size is more than 20 people. Five to six recruitment waves give sufficiently long referral chains so that the sample can be treated as a random sample.

Whereas in a research context the accuracy of the data is vital, in the framework of surveillance a systematic, sustainable routine system of data collection that allows trends to be detected is most important.

After the presentations, the floor was opened for discussion. The participants were particularly interested in receiving further explanations regarding random sampling of services. For example, Poland has a register of harm reduction services providing needle and syringe programmes, and it is possible to use the network for drawing a sample. However, as in this case the target population would only concern the needle/syringe exchange network, conclusions could then only be drawn about clients of this network.

Using the RDS sampling method is appropriate for regional and local studies, and can be particularly helpful in researching outbreaks. CM underlined the importance of selecting the study area. If no harm reduction service providers are available, it may be difficult to get contact with drug users. When harm reduction facilities have been established, it may still take some time to gain clients' trust.

The usefulness of triangulation of data and of using data from different settings (incl. for example police data, data from different treatment settings) was also discussed. Dagmar Hedrich commented that the new EMCDDA treatment data collection strategy involved a 'mapping' of treatment systems at national level to gain an overview of the number and types of providers of drug-related treatment services (including harm reduction facilities) in order to support the planning of health and social responses to drug use. The 'national treatment map' could be used as sampling frame.

Participants discussed whether studies should be limited to current injectors or include ever injectors. It was argued that from the point of view of the burden of disease there is no big difference.

Session 2: Monitoring infectious diseases among PWID: country perspectives

This session was chaired by Lucas Wiessing (EMCDDA) and Catharina Matheï (Belgium) and included updates on the epidemiological situation regarding drug-related infectious diseases from the four countries.

Iwona Wawer from the National AIDS Centre in **Poland** and Artur Malczewski from the National Bureau for Drug Prevention discussed the monitoring of infectious diseases, especially HIV, in their country. The first HIV case was detected in Poland in 1985. Between 1985 and 2012, a total of 16 314 HIV cases were notified, of which 5 946 were reported as linked to injecting drug use. The proportion of new cases linked to this transmission mode has been decreasing over time and is now only 1 % of all reported cases. However, this may not be reliable, as in 60 % of all 852 new HIV case reports in 2012 the route of transmission was not known. Combined with other risk behaviour, injecting drug use may play a role in 11 % of new infections (official data). Among clients of voluntary counselling and testing centres the number of those identified as PWID is decreasing.

Standard protocol for HIV testing is preferred to rapid tests, due to Polish state policy. There has been a substantial reduction in the target group attending the NSP facilities, and the number of facilities has also declined since 2002. Many possible reasons for declining attendance were discussed, including: an increase of clients in drug treatment (OST in particular); a decrease in the PWID population; the price of syringes has decreased; attitudes of pharmacies have changed to be more positive towards PWID; PWID are not attending syringe exchange because they are less aware that HIV is a problem.

In the discussion, the reliability of the data on HIV case reports was scrutinised and participants questioned whether testing sites are client-friendly. There is only a small offer of testing in low-threshold settings, and rapid tests are not the preferred method, as noted above.

There are different data sources for monitoring infectious diseases, and conclusions should be drawn by combining all available data. However, the data are still perceived as a 'puzzle' that is difficult to put together and to draw definite conclusions. The treatment demand indicator (TDI) data collection does not yet cover all treatment centres. The existing data from the TDI pilot project initiated in 2008 seem to document that the use of opioids is in decline. This trend, however, has to be treated with caution as the number of reporting centres varies from year to year, thus in 2009 a total of 23 centres reported the data, while in 2013 the number of reporting centres increased to 50. Data from biennial studies among clients of low-threshold facilities conducted since 2008 provide information about patterns of drug use and HIV prevalence. Mephedrone injecting has doubled among clients of NSPs (from 2010 to 2012). Over half of the respondents reported using amphetamine (52 % in 2012) and almost two-thirds stated that they use opioids (64 % in 2012). These surveys show that the number of *kompot* (Polish home-made heroin) users is also in decline. In 2008 every second user reported using *kompot*, while in 2012 it was reported only by every fifth user. Moreover, the studies indicate HIV prevalence rates of 43 % (2010) and 57 % (2012). However, due to the type of study (self-report, non-random sample) results can not be interpreted as an increasing trend.

Kristi Rütel from the National Institute for Health Development introduced monitoring drug-related infectious diseases in **Estonia**. Infectious diseases surveillance is reported to and organised by the Estonian Health Board. Although, there are no data about PWID, sexually transmitted infections (STIs) in general have been declining. Data on tuberculosis is collected by the Estonian Tuberculosis Registry. HIV surveillance and monitoring is organised through web-based monitoring, with 2 000 infected people registered up to November 2013. New national testing guidance from 2012 stresses the need to recommend testing in primary health settings for everybody aged 18 to 49 in high-risk areas.

The most recent estimate states a figure of 9 000 IDUs for Estonia. Bio-behavioural studies among PWID in Tallinn and in the north-eastern part of Estonia using respondent-driven sampling (2005, 2007, 2009, 2010, 2012) indicated that approximately 90 % of IDUs have been tested for HIV infection and about 60 % were HIV positive. There is no HIV testing on a regular basis in NSPs; however, NSPs are encouraged to remind their clients to undergo testing at least once a year, as stipulated by the Guidance document. In Estonia HIV is more prevalent among males due to the high proportion of HIV positive IDUs who are mainly young men. It was suggested efforts should be made to reach the fraction of IDUs who are never tested. The experts noted improved data on transmission mode and better case finding as reasons for the slightly increasing HIV incidence trend. Other countries questioned the Estonian experts as to how they organise RDS studies, i.e. how blood was transported to labs. Based on this discussion it was suggested that the EMCDDA could look into the possibility of translating protocols and distributing them between countries. Kristi Rütel mentioned that 'last 12 month tested' is not a good indicator for countries with high prevalence, because many infected people do not need to be tested, Lucas Wiessing responded that the EMCDDA has added 'among those who think they are negative' precisely to avoid this problem.

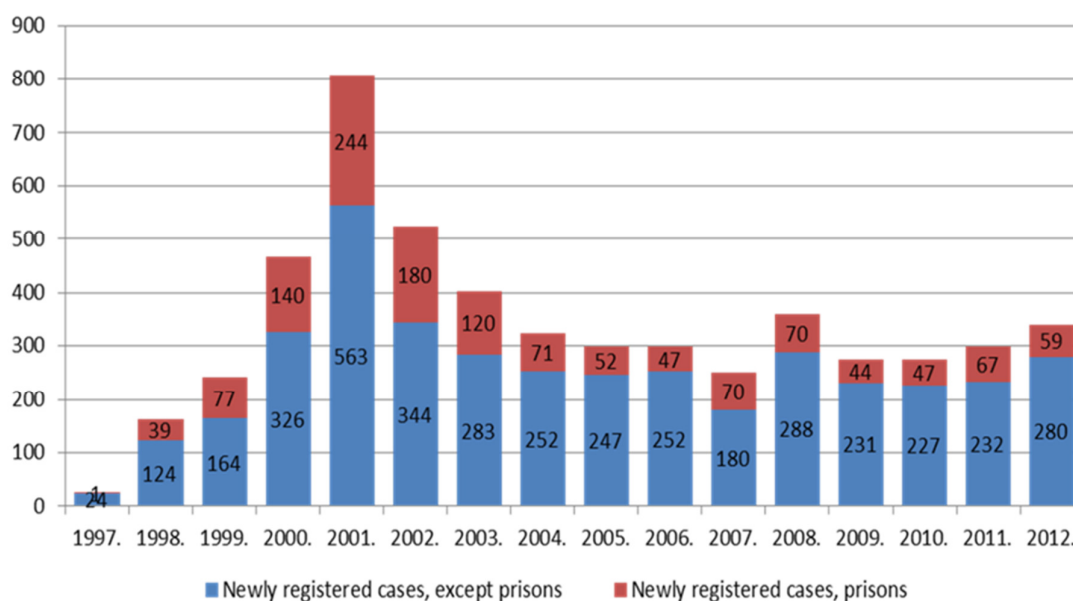
Ernestas Jasaitas, the coordinator of the **Lithuanian** Reitox National Focal Point gave a presentation on monitoring infectious diseases in Lithuania. Between 1988, when the first HIV case was registered in Lithuania and 1 January 2013, a total of 2 060 HIV cases (1 687 men and 373 women) have been diagnosed in the country. A total of 160 HIV cases were registered in 2012, of which 62 were PWID (approximately 39 % of all new cases), a decreasing trend from 96 % in 2002 when a HIV outbreak was detected in a prison setting (Alytus). The 2006–11 UNODC project 'HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania' helped to increase the focus on PWID and to promote harm reduction services in Lithuania. The prison setting remains problematic: most of the new IDU-related cases are diagnosed in prisons; in Alytus prison 20 % of all prisoners are infected with HIV; in two other penitentiaries, the percentages are above 5 %; in the prison hospital around 10 %. Compared to other countries, sentences for drug-related offences in Lithuania are very long. There is a lack of drug-related health services in prisons, and OST is not available. The TDI database shows that 10% of all 2 700 clients entering treatment between January 2012 and November 2013 were HIV positive and 60 % were HCV positive. The majority of people entering treatment (65 %) have injecting as a main route of drug use.

Anda Karnite from the Department of Public Health and Epidemiology at Riga Stradins University in **Latvia** presented the epidemiological data from her country. HIV case reports showed a peak in 2001, which was followed by a decrease until 2009 and a new increase thereafter. The increase in 2001 is assumed to be related to an influx of cheap heroin into the country in 2000; most PWID in Latvia are Russian speaking. Notifications indicating injecting as a route of HIV transmission have dropped since 2001 and were overtaken in 2008 by sexual transmission.

The peak in HIV prevalence among PWID occurred in Latvia at the same time as in Lithuania, while choices of injected drugs vary among the countries. These variations, however, are not static. Thus a study from 2007 indicated that *hanka* (poppy liquid) was a main drug injected by Lithuanian drug users, but in the past five year heroin has become a predominant illicit injected opioid. In Latvia, amphetamine, closely followed by heroin, are the principal injectable drugs, while fentanyl is the main problem drug in Estonia ⁽¹³⁾. A model presented by Graw et al. (2012) ⁽¹⁴⁾ simulated the linkage between heterosexual transmissions and injecting drug use in Latvia, and forecasts that the heterosexual epidemic may be sustained by PWID.

Time-trend analysis of the crude mortality rate among HIV-infected PWID shows a significant increasing tendency for the period 2001–12, i.e. the mortality is increasing by 8.4 % annually ($p=0.007$). Data for this analysis were taken from the national HIV case register. The number of newly notified HIV cases in prisons was found to be considerable (17.4 % of all new cases in 2012, see Figure 2). Among all cases notified in prisons, the transmission route of injecting drug use is the most frequent, representing more than 61 %.

Figure 2: Newly registered HIV cases in penitentiary institutions in Latvia (1997–2012)



Tuberculosis (TB) remains an important health issue among PWID in Latvia. In 2012 a total of 880 new TB cases were reported, of which 57 (6.5 %) were among PWID. For 110 cases dual TB/HIV infection was reported in 2012, and of those 46 were PWID. Among all TB cases, 101 were registered in 2012 as multi-drug resistant TB (MDR-TB), while 26 % of those with dual HIV/TB infectious were reported as MDR-TB (29 cases).

⁽¹³⁾ A study conducted as part of the European Commission co-financed project „Expanding Network for Coordinated and Comprehensive Actions on HIV/AIDS Prevention among IDUs and Bridging Population”. Nr 2005305 (ENCAP).

⁽¹⁴⁾ Graw, F., Leitner, T. and Ribeiro, R. M. (2012), ‘Agent-based and phylogenetic analyses reveal how HIV-1 moves between risk groups: injecting drug users sustain the heterosexual epidemic in Latvia’, *Epidemics*, 4(2), pp. 104–116.

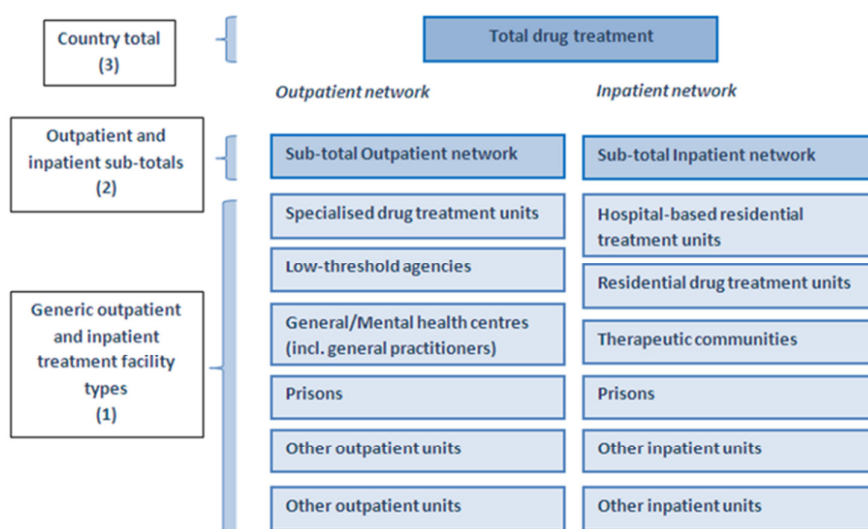
Bio-behavioural studies using respondent-driven sampling conducted in 2007 and 2012 among PWID in Latvia provide an insight into the prevalence of HIV and HCV infection in this group. Thus, HIV prevalence increased from 22.6 % in 2007 to 31.7 % in 2012, while HCV prevalence rose from 74.4 % in 2007 to 82 % in 2012. The PWID cohort study carried out in 2012 (presented by Ildze Redoviča from the Latvian Reitox National Focal Point) with the participation of 514 drug users, of whom 379 were tested for HIV, HCV, HBV and syphilis, reports HIV prevalence of 24.5 % and HCV prevalence of 83.3 %, while 22.7 % tested positive for both HIV and HCV.

22 November 2013

Session 3: Harm reduction responses in the EU and core indicators from the joint ECDC/EMCDDA guidance on prevention and control of infections among PWID

This session, chaired by Otilia Stetcu (ECDC) and Dagmar Hedrich (EMCDDA) started with an overview of the core datasets on responses to prevent and control infections among PWID collected at the EMCDDA. The agency uses a number of standardised data collection tools ('standard tables', 'structured questionnaires' and national reports) and analyses the published and grey literature when compiling its reports and datasets to describe the response to the drugs problem in Europe. The presentation was organised according to the data collection tools in the areas of treatment and of harm reduction. Since 2012, when the new EMCDDA strategy to treatment data collection and analysis was adopted, the agency follows a systems-based approach. As a core element of the strategy, the number of treatment units operating in various parts of the national in- and outpatient treatment system and the number of clients receiving treatment services are compiled, using a generic 'map' (see Figure 3).

Figure 3: EMCDDA treatment system map



Furthermore, the strategy foresees the collection of information about the range of available service options (including case management, mental health screening, psychosocial counselling and treatment, as well as outreach and referral services) through a standardised questionnaire or expert ratings.

Regarding measures to prevent and control infectious diseases among PWID (see joint ECDC/EMCDDA guidance on this topic⁽¹⁵⁾), the EMCDDA collects a range of data, including: the number of clients receiving OST, service provider characteristics, substitution medications used and waiting times; types and number of specialised agencies providing syringes to PWID, number of NSP sites and geographical distribution, syringe provision and number of syringe programme clients and contacts; standard paraphernalia available through the needle and syringe programmes; as well as data on HBV vaccination schemes targeting PWID. A tool for improved data collection on drug-related health services in prisons is under development. Otilia Sfetcu added that the ECDC is documenting national HBV immunisation schemes across the EU/EEA (ECDC Technical report, 2010⁽¹⁶⁾) and vaccine schedule online tool⁽¹⁷⁾).

Project: 'HIV outbreaks among PWID in Europe — linking economic, service provision and epidemiological data'

On the second day of the Academy, the feasibility of an EMCDDA project to assess links between economic, service provision and epidemiological data in the context of HIV outbreaks was briefly discussed. National experts reflected on whether data are available to document changes in investment in NSPs and OST between 2005 and 2012.

- **Estonian** experts responded that there hadn't been reductions in the funding of such activities in the period under review, and data collection is feasible. They expressed provisional interest in the project, subject to workload issues.
- In **Latvia**, data about the costs of OST are not collected on a regular basis, and the workload that could be involved for the Latvian Reitox National Focal Point in obtaining them is not clear. Additional guidance on methodology is needed. If funding could be made available for such work, the extraction of the data is considered to be feasible. Data on the cost of syringe purchase are likely to be available at the central level; however, as staff costs for the provision of syringes are covered through municipality budgets, and relevant staff are involved in a range of other and related (health promotion) activities, it may be difficult to distinguish activities or payments directly related to NSP. OST data is available from databases, but could not be obtained quickly.
- In **Lithuania** it is possible to obtain data on OST costs. Regarding syringe/NSP data, further guidance would be needed.
- In Poland, data on expenditures related to OST are available. Furthermore, the National Bureau is the main funder of needle and syringe programmes, so data about the costs could also be obtained. **Poland** would be interested in the project.

Session 4: Prevention of harm among PWID: country perspectives

In this session, national experts shared their perspectives on the status quo and current challenges for harm reduction in the four countries. The session was chaired by Otilia Sfetcu (ECDC) and Dagmar Hedrich (EMCDDA).

Maris Salekešin from the National Institute for Health Development in **Estonia** described the needle and syringe programmes, which are run by NGOs, and the specific data collection system. The first NSP was opened in Estonia in 1997 and to date there are 35 fixed and outreach sites located in or near the capital (Tallinn, Maardu), in Central Estonia (Tapa, Paide) and in North-East Estonia. A syringe exchange database was established in 2007 as a tool for service providers, and it serves routine monitoring purposes at the National Institute for Health Development. While data are currently still exchanged between service providers and the National Institute by email, the aim is to transform the database into a web-based data collection system and to use web-based questionnaires by 2015.

She then presented the most recent data collected through the system. In 2012 a total of 2.2 million syringes were distributed, which translates into 164 syringes distributed per IDU in a year. There were 1 319 new clients and 6 643 repeat clients in 2012. Some 80 % of clients were male, and 85 % were

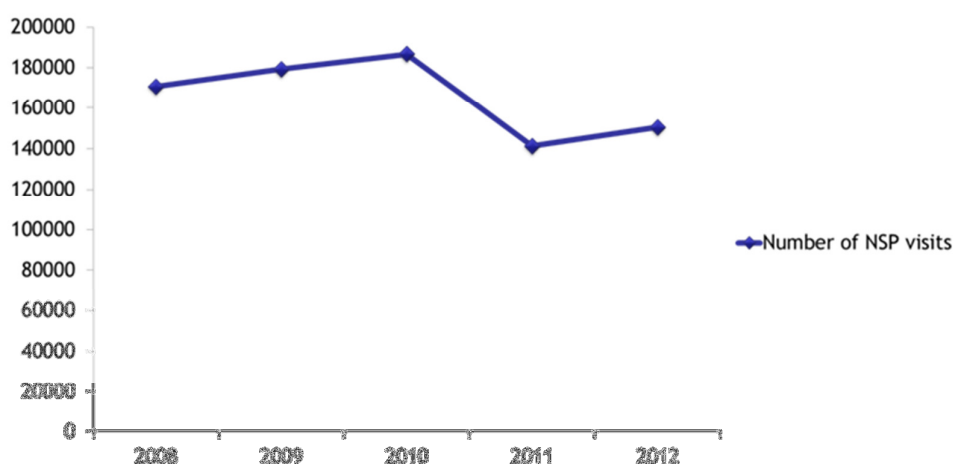
⁽¹⁵⁾ ECDC and EMCDDA guidance. Prevention and control of infectious diseases among people who inject drugs. EMCDDA/ECDC, Stockholm, October 2011. <http://www.emcdda.europa.eu/publications/ecdc-emcdda-guidance>.

⁽¹⁶⁾ European Centre for Disease Prevention and Control (2010), *Surveillance and prevention of hepatitis B and C in Europe*, ECDC, Stockholm.

⁽¹⁷⁾ ECDC Vaccine Schedule (vaccine-schedule.ecdc.europa.eu/Pages/Scheduler.aspx).

Russian speaking. Their mean age was 28 years (range 15–60). The main substance injected was fentanyl, but amphetamines play an increasing role. Client data collected include the length of the injecting career and the date of the latest HIV test. These data show that more than one-third of clients with injecting careers of over three years were last tested more than one year ago. Diagnostic testing cannot be carried out at NSPs because legislation exists that prohibits the delivery of medical services through NGOs. Testing is, however, widely available at specialised centres. As a US charity provided rapid tests to the NGOs free of charge, some NGOs do offer rapid testing at low-threshold facilities. The number of visits to the NSP has dropped from a peak of 180 000 in 2010 (see Figure 4) and it is a challenge to keep services attractive to the target population. She also mentioned a study (using RDS) conducted in 2012 (as part of the TUBIDU⁽¹⁸⁾ project), which showed that 78 % of PWID surveyed obtained their sterile syringes from NSPs and 13 % from pharmacies.

Figure 4: NSP visits in Estonia, 2008–12



Solvita Klavina, Deputy Head of the Unit of Health Promotion Research, Statistics and Health Promotion Department at the Centre for Disease Prevention and Control in **Latvia** and Anda Karnite presented information on how NSPs are organised in their country and what level of harm reduction service coverage has been achieved. The first NSP was established in Riga in 1997; outreach workers became involved in local syringe distribution in 1999, and in 2000 NSPs were extended to two further cities. External funds enabled the opening of eight further sites in 2002. Currently there are 18 NSP sites in 15 Latvian cities (see Figure 5), two of which are new sites opened in 2013 and two are due to be opened in 2014.

The national coordination level (the Centre for Disease Prevention and Control of Latvia) provides methodological guidance, training, data analyses and procurement of prevention materials, while the municipalities are responsible for staffing the NSP sites. The regional UNODC project 'HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania' (www.unodc.org/balticstates/en/about/index.html), implemented between 2006–11, helped to set up web-based data collection from the NSP sites (reporting had previously been done on paper-based forms). Data is owned by the Centre for Disease Prevention and Control of Latvia. The database captures items made available by NSPs in addition to syringes, including disinfectants, condoms and counselling, and rapid tests for HIV, HBV, HCV and syphilis. This electronic database contains complete data about the services provided to clients since 2012.

⁽¹⁸⁾TUBIDU is an acronym for the project 'Empowering the public health system and civil society to fight the tuberculosis epidemic among vulnerable groups'. The project is co-funded by the Executive Agency for Health and Consumers (EAHC) and its activities include: drawing up an overview of the situation and scope of the problem in selected countries; capacity building among public health, health care and civil society professionals; and the development of quality guidelines and models for community based organisations working with vulnerable groups, including PWID. The project ends in 2014 (www.tai.ee/tubidu).

Figure 5: Geographical location of NSP sites in Latvia



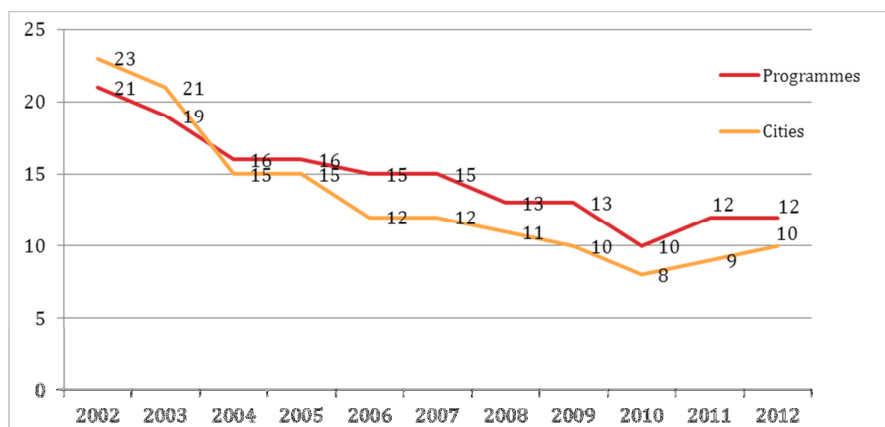
In 2012 the total number of syringes distributed was 311 188, showing some decline from the 338 473 syringes given out in the previous year and probably related to the ending of a UNODC-funded project. Applying this number to the estimated total of problem drug users of 13 141, of which ~90 % are injectors, results in a rate of 24 syringes per PWID for 2012, which represents low coverage. In 2012 only 2 261 individual clients used the NSPs and the services face a challenge in attracting more users. It is estimated that half of all PWID live in the capital city, Riga. The current average number of clients per NSP site is as low as 130 and there are on average only 160 contacts at each NSP site per month. During the discussions it was suggested that extending outreach work might help. Another challenge is unemployment among clients — finding a job is an important goal for the clients and they would need more substantial social support.

OST provision in Latvia has significantly increased, from 134 clients in 2007 to 355 clients in 2012 — mainly due to the efforts of the UNODC project — but the coverage rates of 2–3 % of the total estimated population of dependent opioid users remains among the lowest in Europe. Methadone maintenance programmes are available in 10 cities. Buprenorphine is available in five cities. One option to increase coverage would be to open new OST centres, or to use mobile facilities, if legislation allows this. In order to convince decision-makers of the need to increase the coverage of OST and follow evidence-based and best practices in the European region, a country mission by the EU agencies ECDC and EMCDDA was seen as an important and even urgent next step, considering the dramatically increasing mortality rates observed among PWID in Latvia.

Artur Malczewski from the National Bureau for Drug Prevention of **Poland** presented an overview of harm reduction in Poland, focusing on trends in syringe provision. There are currently 38 harm reduction programmes in the country (including 12 NSPs), and the number of NSPs is declining. While the National Bureau is co-funding these services, however, decisions about whether or not to implement these services are based on local drug strategies. The local drug strategies have to be implemented in a decentralised way by each of the 2 500 communities/jurisdictions across Poland based on the local situation, but guided by the national Drugs Strategy and by drug laws. The national level is supportive of harm reduction. For example, every year, the Bureau organises a conference for harm reduction programmes to exchange information and listen to feedback and new ideas.

Poland was among the first European countries to establish syringe exchange in Europe — the first programme started in 1989, operated by the NGO Monar. By 1993 a total of 360 000 syringes were reported to have been given out. Twenty-one NSP sites were operational when official monitoring began in 2002. A continuous decline in the number of NSP sites and syringes has been documented since 2003 (see Figure 6, which shows the data reported by the Polish Reitox National Focal Point to the EMCDDA). The latest data show that NSP sites exist in 10 Polish cities, and in 2012 they gave 98 000 syringes to 1 528 individual clients. With a new estimated total number of 7 170 PWID (confidence interval: 4 000–10 000), this translates into an average of 14 syringes per PWID in 2012.

Figure 6: Number of needle and syringe programmes and number of cities with needle and syringe programmes in Poland in 2002–12



Source: National report on the drug situation, Polish Reitox National Focal Point, 2013

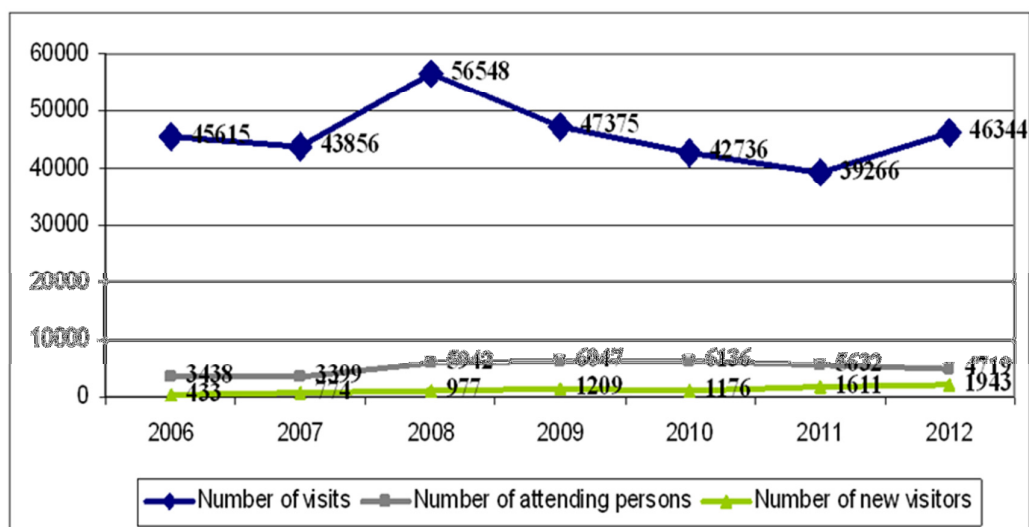
To explain this strongly declining trend, which is also reflected in a decreasing number of syringes given out in Poland, a number of different reasons were discussed. It is considered that the decline could reflect a decrease in demand, due to less injecting drug use; or it could be due to the fact that open drug scenes have disappeared as the use of mobile phones has changed patterns of drug dealing. This allows drug users to remain much less visible (and thus they are less willing to identify themselves as drug users by frequenting harm reduction programmes). This lack of visibility of drug users makes it more difficult for drug workers to operate. It is also assumed that the main source for syringes in Poland is the pharmacy. Finally, syringe programmes may not be attractive to drug users as they do not provide comprehensive services, and there are no referral links to other facilities. The experts also mentioned a lack of support for harm reduction policies among local authorities because the perceived HIV threat has reduced, and the NSPs are competing for the same grant funding as abstinence-oriented activities (on average EUR 20 million annually from the local governments). Taking into account the fact that the NGOs providing NSP frequently also provide treatment programmes, for which it is much easier to receive financial support from the National Health Fund, they may have less interest in competing for the additional funds that would allow them to provide the NSPs.

The need to analyse the decline of syringe provision in Poland in more detail was one of the conclusions of the meeting. As OST coverage in Poland is low, similar to Latvia, there may be a potential risk of an HIV epidemic. It is more difficult to argue in favour of prevention services when there is no direct perceived risk or even an outbreak. As HIV incidence has gone down it is difficult to maintain harm reduction programmes and to stress their importance.

Emilis Subata from the Vilnius Centre for Addictive Disorders, **Lithuania**, presented the country's harm reduction system. The first NSP was established in 1997 but the legal basis for harm reduction services was only created in July 2006 with the Ministry of Health (MoH) Order No. V-584 'On the approval of implementation procedures for drug and psychotropic substance harm reduction programmes' (recently reconfirmed in August 2012 by Order V-793 'On the approval of implementation procedures of low threshold services' (LTS)). The defined goals of LTS are a reduction of drug use, of the risks of transmission of infectious diseases, drug overdoses and deaths; and of negative health, social, economic and legal consequences. The following services are required to be provided: syringe/needle exchange, provision of disinfectants, condoms; information and counselling; personal hygiene services, provision of wound dressing; and rapid HIV testing. The LTS are also involved in management of waste injecting equipment and take part in information collection and reporting. NSP staff include social workers, health care specialists and trained outreach workers.

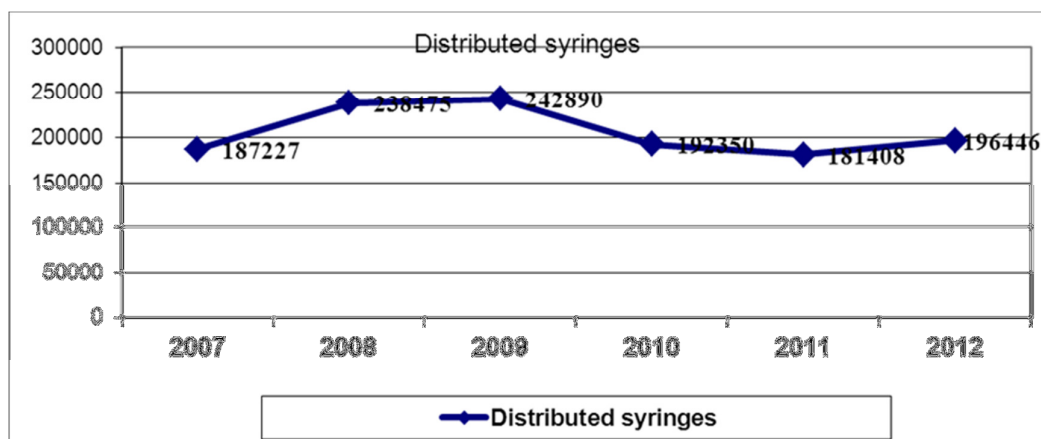
By 2008 the number of NSP sites had increased to 14, but they decreased thereafter and by 2012 there were 11 programmes, distributed over 8 cities, including mobile programmes in Vilnius and Klaipeda. Available funding is limited and comes mainly from municipalities. While previously the maximum number of syringes that could be given to clients was fixed, this has now changed and is more flexible. Between 2006 and 2010 the number of individual clients visiting the NSPs increased, but has significantly declined by 23 % since then, from 6 136 in 2010 to 4 719 in 2012 (see Figure 7).

Figure 7: Visits, new clients and total number of clients at NSPs in Lithuania (2006–12)



A decline in the number of distributed syringes was noted between 2009 and 2011; the latest data (2012) show a small increase, however (see Figure 8). Using the latest available problem drug user (PDU) estimate, which is for the year 2007 (5 458 PDU; 4 912 or 90 % of whom are PWID), and applying this (now out of date) estimate to the 196 446 syringes given out in 2012, results in an average number of 40 syringes per PWID.

Figure 8: Syringes distributed at harm reduction programmes in Lithuania (2007–12)



The use of rapid testing has increased over the last three years; more than 4 000 rapid HIV tests were carried out at LTS in 2012. As in Estonia, these tests are provided by a US-based charity free of charge. Again similar to the Estonia situation, only institutions with a medical licence can offer diagnostic testing; however, in Lithuania some NGOs have concluded formal agreements with medical institutions that enable them to officially provide infectious diseases testing.

In Lithuania methadone maintenance is funded by state health budgets and is available at 19 sites in 13 municipalities (four specialised centres for dependence diseases and 15 primary health care (PHC) facilities). Medical supplies (methadone and urine/saliva drug tests) are funded through the State Patient Fund (Program for Treatment of Dependence Disorders 2009–13); the treatment is administered by staff from the regional Centres for Addictive Disorders. Buprenorphine maintenance treatment is not covered by this health insurance; the medication is mainly used for detoxification. For all clients in treatment, yearly HIV, HCV and syphilis testing is required, which is paid by the State Patient Fund. On 31 December 2012 a total of 4 664 opioid dependent patients were registered and the coverage of the estimated number of dependent opioid users is estimated to be 10 %.

A mobile clinic for methadone and NSP has operated in Vilnius since 2010 at four sites, including a Roma settlement and the railway station, servicing 40 to 50 clients. Rapid tests and counselling services are also offered. The reason for introducing mobile services was a need to reduce the numbers of a problematic client group that were congregating around a main OST site and to prevent negative reactions from the community as well as drug dealing around this location.

In conclusion, syringe provision in Lithuania, which was started in those municipalities where problem drug use first appeared and expanded during the UNODC project (2006–11), has decreased somewhat in the past couple of years, but seems to have maintained a certain level. Funding is unstable, and it is difficult for harm reduction to compete with other types of prevention programmes. It was questioned whether the figures showing a decrease in HIV incidence during recent years are reliable. According to available data, HIV is decreasing among IDUs, but new cases continue to appear in prisons and the transmission route has changed towards sexual transmission.

Rapid tests (Catharina Matheï)

At the request of the participants, Catharina Matheï gave an additional presentation on rapid tests on the second meeting day. She explained the main ways to evaluate the accuracy of rapid tests. Concepts of sensitivity, specificity, and positive and negative predictive value were explained. As one key aspect to consider, she stressed the importance of being aware that positive predictive value is affected by prevalence, and if infection prevalence is very low the proportion of false positives will increase.

She presented the results of a meta-analysis comparing the diagnostic accuracy of a rapid HIV antibody based point-of-care test (OraQuick® Advance Rapid HIV-1/2, OraSure Technologies Inc, PA, USA) when used with oral versus blood-based specimens in adults. It was shown that, especially in low prevalence populations, oral-based specimens are less reliable. Finally, she presented a study in which the OraQuick® HCV Rapid Antibody Test for the detection of antibodies to HCV was evaluated, which can be used with oral fluid or fingerstick blood specimens in addition to serum, plasma and venous blood sample types. Overall sensitivities were virtually identical for venous blood, fingerstick blood, serum and plasma (99.7–99.9 %). Observed sensitivity was, however, slightly lower for oral fluid at 98.1 % though the upper CI (99.0 %) was equal to the lower CI for venous blood and fingerstick blood.

Session 5: Challenges to monitoring and service provision

In the final session, national experts defined priority actions for their countries in the response to HIV. Estonian, Latvian and Lithuanian experts started from a priority lists defined 18 months ago at the expert meeting in Tallinn ⁽¹⁹⁾. Since Poland had not been involved in the 2012 meeting, priority actions for this country were drawn up from scratch.

The updated priorities/actors involved are as follows:

Estonia:

1. Develop integrated services (prevention and treatment) for risk groups (collaboration between NGOs and health care), meeting the needs of different types of PWID (opioid vs. stimulant injectors), ensure the continuum of care (Ministry of Social Affairs (MoSA), National Institute of Health Development (NIHD), professional societies, health insurance).
2. Improve the coverage (including geographical) and quality of syringe exchange and OST (MoSA).
3. Improve the surveillance system for risk groups (PWID, men who have sex with men, sex workers) and passive surveillance and monitoring of the services (harm reduction), and improve the involvement of community (based organisations) in surveillance. New estimates for size of risk groups (MoSA, Health Board, NIHD).
4. Ensure sustainability of funding, long-term strategy vs. project-based approach. Continuous and sufficient financing and development of human resources (Government, MoSA) is needed.

Latvia:

1. Improve HIV testing (Ministry of Health (MoH), Centre for Disease Prevention and Control of Latvia (CDPC), local governments, NGOs).
2. Enhance understanding among policymakers and those responsible for the implementation of HIV prevention strategy (to organise a national level meeting, to share this meeting report).
3. Improve collaboration between organisations and sectors dealing with HIV and drug use related issues (NGOs, MoH, CDPC, private sector).
4. Improve healthcare workers' attitudes toward PWID (re-prioritise, target obstetricians/gynaecologists, support antenatal screening of pregnant injecting drug users), provide women friendly services.
5. Improve access and uptake of harm reduction services by considering confidentiality, location and other organisational aspects of services (MoH, CDPC).
6. Improve OST coverage by including OST in harm reduction centres — integrate services (MoH).
7. Ensure free NSP and condom provision in prisons (MoH, CDPC, Ministry of Justice, prison administration).
8. Plan and carry out epidemiological measurement outside Riga, especially in areas with high HIV and HCV infection (MoH, CDPC).
9. ECDC/EMCDDA country visit.

Lithuania:

1. Improve testing (Ministry of Health (MoH)).
2. Improve coverage of OST and syringe exchange (MoH, municipalities).
3. Start to provide OST in prison (Ministry of Justice (MoJ), MoH) (obstacles: lack of staff and MoJ has limited resources).
4. Improve collaboration between MoH and NGOs to ensure better coordination and service provision (MoH and coalition of NGOs). Start making concrete plans — project with Norwegian funding to increase advocacy will start; national level meeting could be organised in 2014.
5. ECDC/EMCDDA country visit.

⁽¹⁹⁾ 'Detecting and responding to outbreaks of HIV among people who inject drugs: best practices in HIV prevention and control', held on 29–30 March 2012 in Tallinn (ecdc.europa.eu/en/publications/publications/mer-idu-outbreaks.pdf).

Poland:

1. Identify, describe and understand the causes of the decreasing trends in response, especially NSP (National Bureau for Drug Prevention (NBDP)).
2. Think about how to promote harm reduction programmes (NBDP, National AIDS Centre (NAC)).
3. Find possibilities for financial support for prevention (regional levels, from local administration) (NBDP, municipalities, provincial experts on drug information system).
4. Scale-up testing; identify best strategies to increase testing among IDUs (NBDP).
5. Strengthening and empowerment of harm reduction services network (forum for communication — conference, enforce coordination, partnership) (NBDP).
6. Improve surveillance, monitoring of HIV, hepatitis and other infectious diseases among IDUs, behavioural studies (NBDP, NAC).

The main issues for experts from all four countries were the need to reintroduce HIV as an important issue among policymakers; and to stress the importance of monitoring to control the situation and guide investments in service provision. It was acknowledged that arguing for harm reduction interventions is more difficult when HIV is low or decreasing. Participants recognised the value of NGOs in the implementation of infectious diseases prevention and their fragile financial existence, and saw a need to strengthen NGOs and harm reduction networks. It was argued that there must be a move away from project-based funding to sustainable harm reduction service provision as an integrated part of the mainstream healthcare system.

They acknowledge the value of sharing best practices and of collaboration between countries and with the EMCDDA and the ECDC. The agencies can play an important role in supporting policymakers to apply evidence-based measures. Participants underlined the need for a better understanding of HIV surveillance data/trends by combining them with further data from research among drug user populations, and it was proposed that the next meetings should put more emphasis on analysing and interpreting available data. Models from other countries on how to analyse datasets in an integrated way for policy making would be welcome.

Part of the final discussion focused on the high level of stigma facing drug users in the countries, which also affects staff. In conclusion, it was stressed that people working on harm reduction should be better equipped to face resistance, know how to stand up for their work and clients and understand how to deal with these negative perceptions. Participants discussed whether national workshops for harm reduction sector could help.

Lack of funding or a need for sustained funding were common topics. As follow-up, information materials and the presentation given by the representative of EurohealthNet at the Bucharest meeting (18–19 November 2013) will be made available to the participants.

The ECDC and EMCDDA expressed their gratitude to the Estonian Reitox National Focal Point for hosting the meeting. Maris Salekešin (Estonian Reitox National Focal Point) closed the meeting by thanking the head of the Lithuanian Reitox National Focal Point for his initiative in suggesting a regional Reitox Academy on the topic of infectious diseases and all participants for their contributions.

Acknowledgments: [Sigrid Vorobjov](#) provided meeting notes for the preparation of this report.

Annex 1: Agenda

21 November 2013

Monitoring drug-related infectious diseases

9.00–10.30	Welcome and introduction by Estonian Reitox National Focal Point
Chair:	
Estonian Reitox National Focal Point	
	<i>Tour de table</i>
	Setting the scene — Results of the updated HIV risk assessment, 2013. Dagmar Hedrich, EMCDDA and Otilia Sfetcu, ECDC
	Questions and answers
	Monitoring drug-related infectious diseases in Europe. Lucas Wiessing, EMCDDA
	DRID methods and toolkit. Catharina Matheï, Belgium
10.30–11.00	Break
11.00–12.30	Monitoring infectious diseases among people who use drugs: country perspectives
Chairs: Lucas Wiessing and Catharina Matheï	<ul style="list-style-type: none"> Estonia — Presentation and discussion. Kristi Rüütel, National Institute for Health Development Poland — Presentation and discussion. Artur Malczewski, Polish Reitox National Focal Point
12.30–13.30	Lunch break
13.30–15.30	Monitoring infectious diseases among people who use drugs: country perspectives (continued)
Chairs: Lucas Wiessing and Catharina Matheï	<ul style="list-style-type: none"> Lithuania — Presentation and discussion. Ernestas Jasaitis, Lithuanian Reitox National Focal Point Latvia — Presentation and discussion. Anda Karnite, Riga Stradins University and Ildze Redovica, Centre for Disease Prevention and Control
15.30–16.00	Break
16.00–16.55	Open discussion
Chairs: Lucas Wiessing and Catharina Matheï	
16.55–17.00	Closure of the day. Lucas Wiessing, EMCDDA

22 November 2013**Prevention of and response to drug-related infectious diseases**

09.00–09.45	Harm reduction responses in the EU and core indicators from joint ECDC and EMCDDA guidance on prevention and control of infectious diseases among people who inject drugs. Dagmar Hedrich and Otilia Sfetcu
Chairs: Dagmar Hedrich and Otilia Sfetcu	Feasibility of assessing links between the economic situation, service provision and epidemiology (follow-up to discussions at DRID meeting). Dagmar Hedrich
	Discussion
09.45–11.00	Prevention of harm among people who use drugs: country perspectives
Chairs: Dagmar Hedrich and Otilia Sfetcu	<ul style="list-style-type: none"> • Estonia — Presentation and discussion. Maris Salekešin, Estonian Reitox National Focal Point • Latvia — Presentation and discussion. Anda Karnite
11.00–11.15	Break
11.15–12.30	Prevention of harm among people who use drugs: country perspectives continued
Chairs: Dagmar Hedrich and Otilia Sfetcu	<ul style="list-style-type: none"> • Poland — Presentation and discussion. Artur Malczewski • Lithuania — Presentation and discussion. Emilis Subata, Vilnius Centre for Addictive Disorders
12.30–13.30	Lunch break
13.30–15.00	Workshop: challenges to monitoring and service provision
Chairs: Dagmar Hedrich and Otilia Sfetcu	<ul style="list-style-type: none"> • Open discussion on challenges and ways forward (feedback on presentations)
15.00–15.30	Conclusions: round table among all participants
Chairs: EMCDDA and ECDC	

Annex 2: List of participants

Country	Name	Institution
Estonia	Katri Abel-Ollo	National Institute for Health Development Head of Estonian Reitox National Focal Point
	Maris Salekešin	National Institute for Health Development Infectious Diseases and Drug Monitoring Department
	Sigrid Vorobjov	National Institute for Health Development Infectious Diseases and Drug Monitoring Department
	Kristi Rüütel	National Institute for Health Development Infectious Diseases and Drug Monitoring Department
	Natalia Kerbo	Health Board Estonia
	Jevgenia Epštein	Health Board Estonia
	Kuulo Kutsar	Health Board Estonia
	Ave Talu	University of Tartu
Latvia	Anda Karnite	Rigas Stradina University National DRID expert
	Sarlote Konova	Centre for Disease Control and Prevention National HIV Register
	Ildze Redovica	Centre for Disease Control and Prevention Latvian Reitox National Focal Point
	Solvita Klavina	Centre for Disease Control and Prevention HPP Network Coordinator
Lithuania	Emilis Subata	Vilnius Centre for Addictive Disorders, Director
	Ernestas Jasaitis	Drug Control Department of the Government of the Republic of Lithuania/Drug, Tobacco and Alcohol Control Department Head of Lithuanian Reitox National Focal Point
Poland	Iwona Wawer	National AIDS Centre, ECDC contact point
	Artur Malczewski	National Bureau for Drug Prevention; Head of Polish Reitox National Focal Point
Belgium	Catharina Matheï	Professor, Department of Public Health and Primary Care,

		KU Leuven
ECDC	Otilia Sfetcu	Surveillance and Response Support Unit HIV, STI and hepatitis programme Otilia.Sfetcu@ecdc.europa.eu
EMCDDA	Lucas Wiessing	Prevalence, Consequences and Data Management Unit Principal Scientist, Infectious Diseases And Modelling Lucas.Wiessing@emcdda.europa.eu
	Dagmar Hedrich	Interventions, Best Practice and Scientific Partners Unit Head of Health and Social Responses Sector Dagmar.Hedrich@emcdda.europa.eu