



European Monitoring Centre
for Drugs and Drug Addiction



SPECIAL REPORT

Thematic report: People who inject drugs

Monitoring implementation of the Dublin Declaration on
Partnership to Fight HIV/AIDS in Europe and Central Asia:
2014 progress report

ECDC–EMCDDA SPECIAL REPORT

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European Monitoring Centre
for Drugs and Drug Addiction

This report of the European Centre for Disease Prevention and Control (ECDC) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was coordinated by Teymur Noori (ECDC) and Dagmar Hedrich (EMCDDA), with technical support from Andrew J. Amato-Gauci, Anastasia Pharris, César Velasco Muñoz, Lara Tivoschi, Otilia Mårdh, Gianfranco Spiteri, Caroline Daamen, Pierluigi Lopalco, Denis Coulombier, Piotr Kramarz (all ECDC), André Noor and Eleni Kalamara (EMCDDA).

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* This designation is without prejudice to positions on status, and is in line with UNSC 1244 and the ICJ Opinion on the Kosovo Declaration of Independence.

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Abbreviations

ART	Antiretroviral therapy
ECDC	European Centre for Disease Prevention and Control
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EMIS	European men-who-have-sex-with-men internet survey
EU/EEA	European Union/European Economic Area
GARPR	Global AIDS Response Progress Reporting
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
MSM	Men who have sex with men
NGO	Non-governmental organisation
NSP	Needle and syringe programmes
OST	Opioid substitution therapy
PMTCT	Prevention of mother-to-child transmission
PWID	People who inject drugs
STI	Sexually transmitted infection
WHO	World Health Organization

HIV and people who inject drugs

This report, which is based on data provided by countries for reporting on the Dublin Declaration¹, summarises key issues related to HIV and people who inject drugs (PWID) in Europe and Central Asia. It identifies priority options for action to improve the HIV response for this population.

Note on data sources

This report uses the latest data reported by countries, in 2012 or 2014, for four indicators: HIV prevalence, HIV testing, needle and syringe programme coverage, and opioid substitution therapy coverage; additional data were collected by means of a Dublin Declaration questionnaire.

UNAIDS Global AIDS Response Progress Reporting (GARPR) and EMCDDA provided data on HIV prevalence; GARPR provided testing data; EMCDDA collected NSP and OST coverage data for EU/EEA countries; and GARPR provided NSP/OST data for the remaining EU/EEA countries and all non-EU/EEA countries. This report also draws on surveillance data for 2004–2013 reported to ECDC and WHO. It is important to note that some key countries did not report any data, e.g. Russia. The Dublin Declaration questionnaire and data tables are available on the ECDC website².

In recent years, more countries were reporting data on response coverage rates for PWID; this is an important achievement and provides the basis for further improvements in data quality. However, few countries have accurate population size estimates for PWID, and most available data are derived from surveys that are based on variable sample sizes and use different methods. This means there are limited nationally representative data on HIV prevalence, HIV testing, or NSP and OST coverage. In addition, the data quality is too low to make meaningful comparisons over time and across countries, which also implies that conclusions drawn from these data should be interpreted with caution. This report also includes qualitative national information for some issues where quantitative data are missing.

For the first time in 2014, the questionnaire asked for gaps in prevention programmes and information on the scale at which interventions are provided for key populations and the extent of stigma and discrimination they experience. These questions were open to interpretation by respondents; responses, in particular concerning the scale at which interventions are delivered, should be interpreted with caution.

HIV and people who inject drugs: the situation

HIV prevalence is above 5% among PWID in two out of every five EU/EEA countries and more than half of non-EU/EEA countries

Recent national and sub-national data on HIV prevalence rates among PWID are available from 45 countries in the region – 27 EU/EEA and 18 non-EU/EEA countries (Figure 1)³. In the 27 EU/EEA countries⁴, reported prevalence ranges from 0% (based on national data from the Czech Republic, Malta and Slovenia, and sub-national data from Belgium and Hungary) to 62% (based on sub-national data in Estonia). Reported prevalence was above 5% in 11 of the 27 EU/EEA countries that reported data. In the 18 non-EU/EEA countries⁵, reported prevalence ranges from 0% in the former Yugoslav Republic of Macedonia to 20% in Ukraine. Reported prevalence was above 5% in nine of these 18 countries.

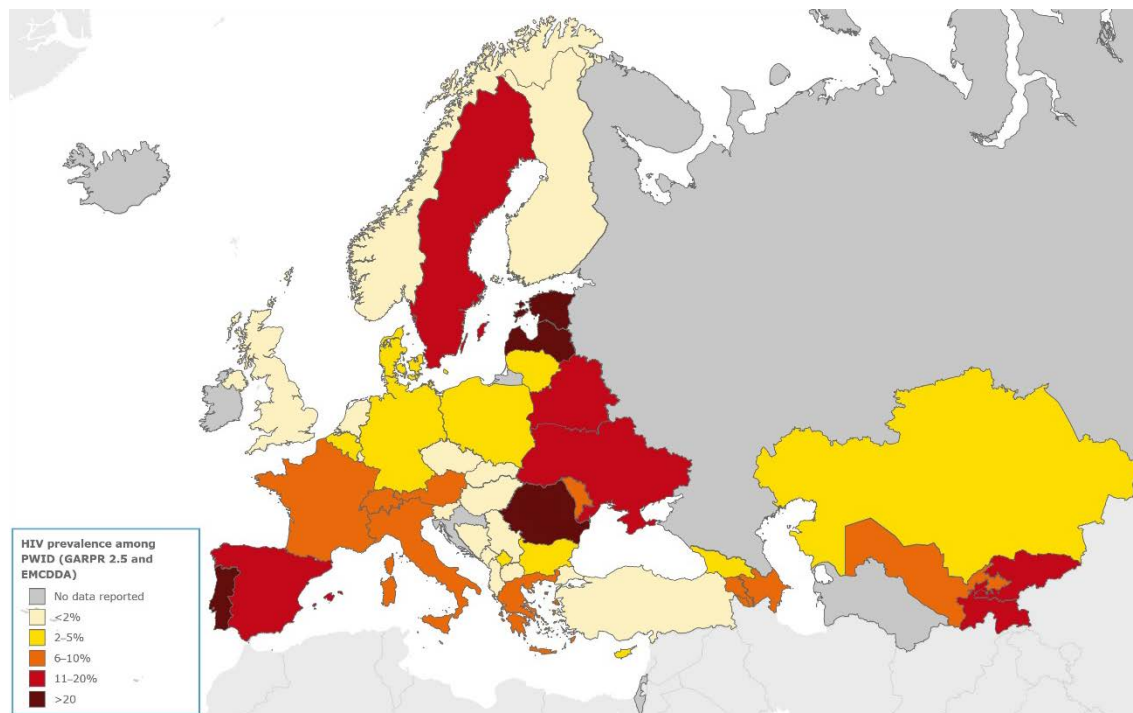
¹ WHO Regional Office for Europe. Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia. [Internet]. 2004 [cited 2015 Jun 1]. Available from: <http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/policy/guiding-policy-documents-and-frameworks-for-whoeuropes-work-on-hiv/dublin-declaration-on-partnership-to-fight-hivaids-in-europe-and-central-asia>

² European Centre for Disease Prevention and Control. Monitoring of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia – Questionnaire. Stockholm: ECDC; 2009. Available from: http://ecdc.europa.eu/en/healthtopics/documents/1009_questionnaire_to_monitor_dublin_declaration.pdf

³ Data reported in 2014 or 2012 for GARPR and the most recent reporting years for EMCDDA.

⁴ No data were reported by Croatia, Iceland or Ireland.

⁵ No data were reported by Andorra, Israel, Monaco, Russia, San Marino, and Turkmenistan.

Figure 1. Reported HIV prevalence among PWID, 2011–2013⁶

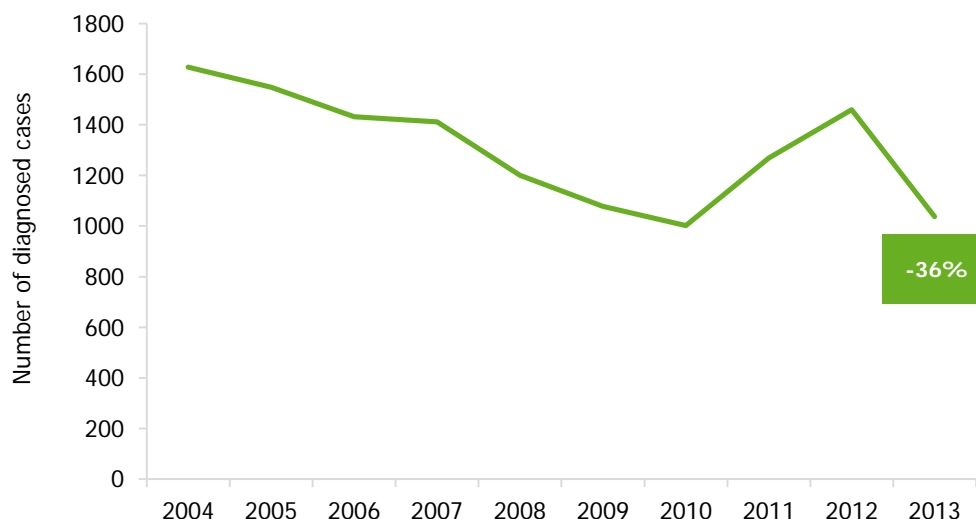
The number of new HIV cases in PWID in the EU/EEA fell by 36% between 2004 and 2013

Surveillance data for 2004–2013⁷, based on 26 EU/EEA countries that consistently reported on mode of transmission during this period⁸, show an overall downward trend in the number of newly-diagnosed HIV cases reported in PWID, rising from 1 628 cases in 2004 to 1 037 in 2013. The increase in reported cases in 2011 and 2012 was due to HIV outbreaks in PWID in Greece and Romania: Greece reported 14 cases in 2004 and 513 in 2012; Romania reported 1 case in 2004 and 170 in 2012.

⁶ Based on data from national and sub-national studies.

⁷ European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2013. Stockholm: ECDC; 2014.

⁸ Excludes Estonia, Italy, Poland and Spain. Data on route of transmission for Estonia and Poland is <50% complete over the period; Italy and Spain expanded surveillance system coverage during this period.

Figure 2. HIV cases among PWID, as reported by EU/EEA countries, 2004–2013⁹

Source: ECDC/WHO. *HIV/AIDS surveillance in Europe 2013*

In most EU/EEA countries, the number of new HIV cases in PWID reported annually has remained stable or decreased over time. In countries reporting few or no cases, including Denmark, Finland, Hungary, the Netherlands, Norway, Slovakia, and Slovenia, there has been little change. There has been a steady decrease in cases reported each year in France, Germany, Ireland, Portugal, and the UK. As noted above, Greece and Romania reported a significant increase in cases in 2011 and 2012, but the number of cases reported by Greece fell to 248 in 2013, as a result of an effective response to the outbreak. The number of cases reported by Bulgaria increased from 7 in 2004 to 74 in 2009 and then decreased to 33 in 2013, most likely as a result of the scaled-up response.

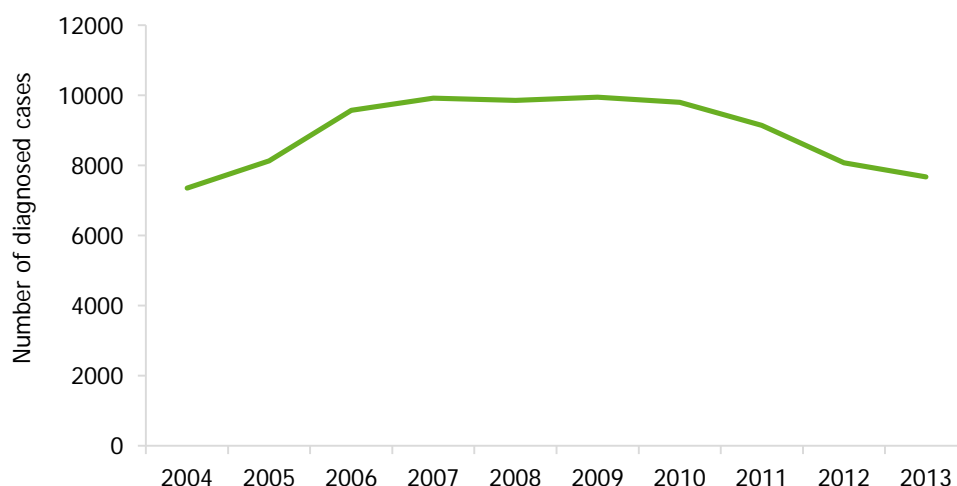
New HIV diagnoses among PWID in non-EU/EEA countries have not declined over the last decade

In non-EU/EEA countries, surveillance data¹⁰ show an increase in the annual number of newly diagnosed HIV cases in PWID reported between 2004 and 2009, from 7 359 to 9 948, followed by a slight decrease between 2010 and 2013 (Figure 3)¹¹. The number of new cases reported by Ukraine, which accounted for the majority of cases reported by non-EU/EEA countries in each year between 2004 and 2013, declined from a peak of 7 127 in 2006 to 5 847 in 2013.

⁹ Excludes Estonia, Italy, Poland and Spain.

¹⁰ European Centre for Disease Prevention and Control/WHO Regional Office for Europe. *HIV/AIDS surveillance in Europe 2013*. Stockholm: ECDC; 2014.

¹¹ Does not include data for Russia, Turkey, Turkmenistan or Uzbekistan

Figure 3. HIV cases among PWID, as reported by non-EU/EEA countries, 2004–2013

Source: ECDC/WHO⁹

Injecting drug use accounts for a significant proportion of all new HIV diagnoses in non-EU/EEA countries; this is not the case in most EU/EEA countries

In 2013, HIV transmission due to injecting drug use accounted for 16% of newly diagnosed cases reported in the region overall, but for 31% of new cases in the eastern part of Europe¹². In contrast, only 5% of new cases reported by EU/EEA countries in 2013 were due to injecting drug use. However, the proportion is higher in some countries: injecting drug use accounted for more than a quarter of new cases in Greece (31%), Lithuania (35%) and Romania (29%) in 2013.

Rates of late diagnosis among PWID are higher than average in EU/EEA and non-EU/EEA countries¹³

In the EU/EEA in 2013, 47% of all HIV cases were diagnosed late, i.e. with a CD4 cell count <350/mm³¹⁴, but 52% of the cases in PWID were diagnosed late¹⁵ (Figure 4). Nine EU/EEA countries reported late diagnosis in more than half of the cases acquired through injecting drug use (Austria 61%, Belgium 57%, Czech Republic 60%, Greece 75%, Ireland 56%, Italy 61%, Latvia 59%, Portugal 59% and Spain 55%). In non-EU/EEA countries in the same year, 51% of all cases were diagnosed late¹⁶, but 66% of cases in PWID were diagnosed late¹⁷. Five non-EU/EEA countries reported late diagnosis in 60% or more of cases acquired through injecting drug use (Armenia 68%, Azerbaijan 76%, Georgia 79%, Kyrgyzstan 60% and Tajikistan 65%).

¹² Excludes Russia

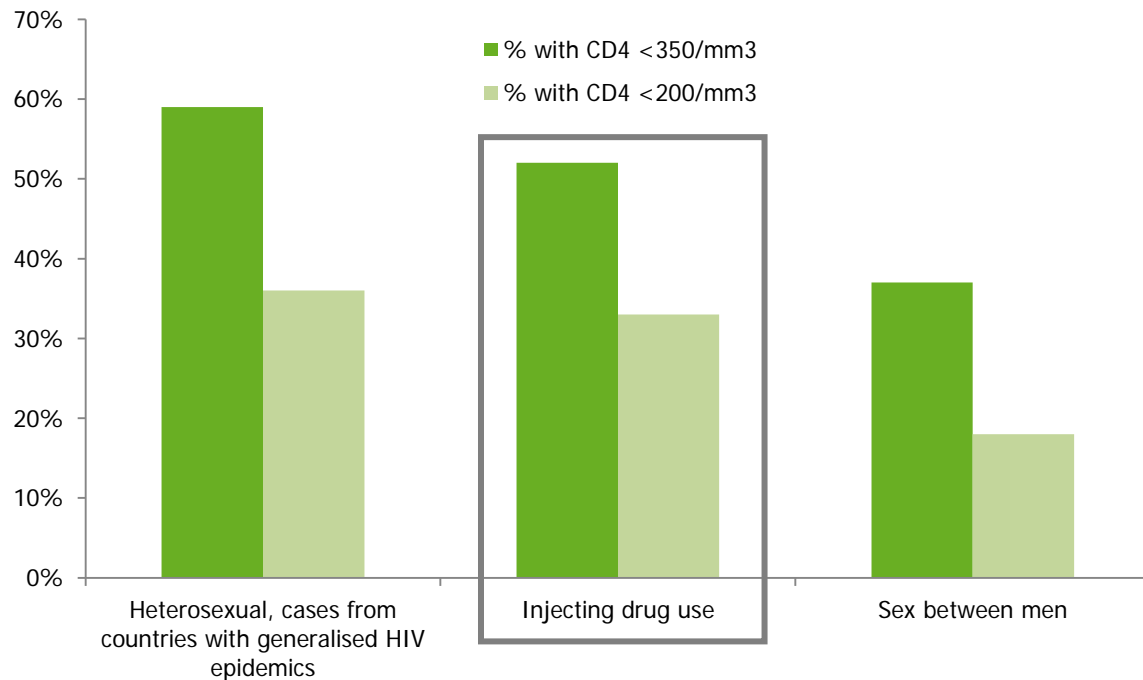
¹³ European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2013. Stockholm: ECDC; 2014.

¹⁴ Based on data reported to ECDC by 21 countries

¹⁵ Based on data reported to ECDC by 17 countries

¹⁶ Based on data reported to ECDC by 14 countries

¹⁷ Based on data reported to ECDC by 8 countries

Figure 4. Late diagnosis by transmission mode reported by EU/EEA countries, 2013

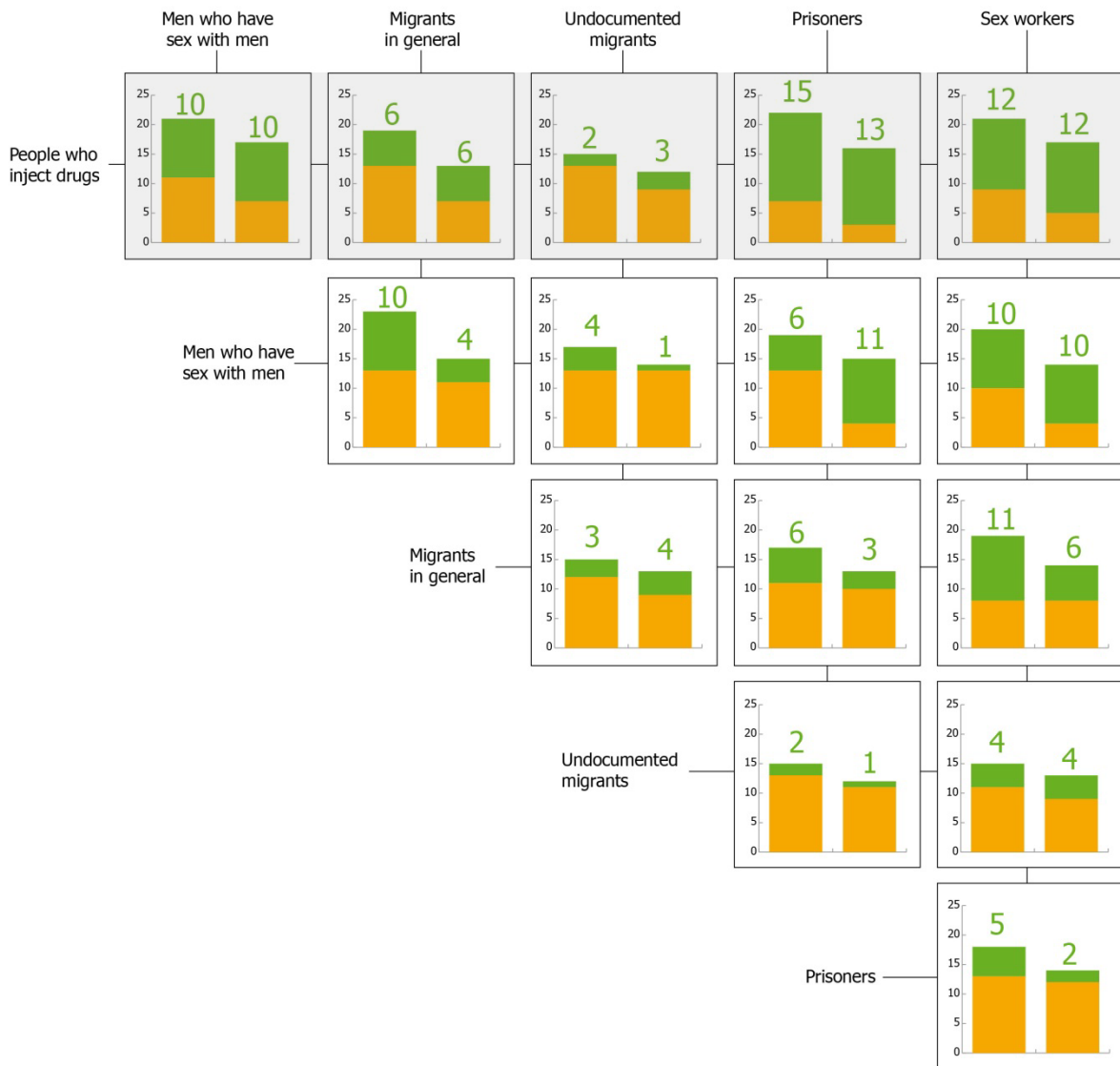
Source: ECDC/WHO¹²

Overlapping risk between PWID and other key populations

Figure 5 shows the number of countries where government respondents report there is evidence of overlapping risk between PWID and other populations (see also Box 1). Most countries reported overlap with prisoners; this is not surprising as many PWID spend time in the prison system. With respect to other key at-risk populations, EU/EEA countries were more likely to report overlap with MSM, and non-EU/EEA countries overlap with sex work. Specific sub-groups of PWID identified as being at increased HIV risk included: sex workers who inject drugs in Bulgaria and Estonia; MSM who inject or use drugs in Hungary, the Netherlands, Spain and the UK; migrants from Eastern Europe or Russian-speaking countries in the Czech Republic, France, Germany, Spain and Sweden; and PWID in prisons in Croatia¹⁸, the Czech Republic and Germany. Kazakhstan and Moldova pointed out the increased HIV risk of sexual partners of PWID.

¹⁸ Vilibic-Cavlek T, Gjenero-Margan I, Retkovic B, Kolaric B, Bisko A, Banozic-Blagus Z, et al. Socio-demographic characteristics and risk behaviours for HIV, hepatitis B and hepatitis C virus infection among Croatian male prisoners. *Int J Prison Health*. 2011 Jan: 28–31.

Figure 5. Number of countries reporting evidence of overlapping risk between PWID and other key populations



Legend:
 Y axis: Number of reporting countries
 Left bar: EU countries
 Right bar: Non-EU countries
 Green: Number of countries reporting evidence of overlapping risk
 Orange: Number of countries reporting no evidence of overlapping risk

Note: Data on PWID shown with grey overlay

Box 1: Evidence of overlapping risk

A sub-national study conducted in Estonia found that 55% of people who inject drugs (PWID) had been in prison at least once in their lifetime and that 55% of them injected drugs while in prison. The same study also found that 29% of PWID had injected drugs during their last imprisonment and 84% had used injecting equipment that someone else had already used.

Ministry of Justice reports show that most prisoners who are HIV-infected have a history of injecting drugs.

A 2011 study on drug use in prisons in Latvia found that 24.5% of prisoners had used heroin at least once in their lives and 41.4% also used amphetamines at least one time.

In Moldova, the 2012 Integrated HIV Bio-Behavioural Surveillance (IBBS) survey among prisoners found that 26.1% had used and 9.5% had injected drugs.

In Ukraine, IBBS data show a significant overlap between PWID and incarceration.

In Norway, national HIV surveillance data indicates that a large proportion of newly infected PWID are migrants.

According to 2013 surveillance data in Sweden, 12 of 14 new HIV cases reported among PWID were foreign-born; 10 of the 12 cases were born in eastern European countries.

Spain's civil society response noted that the number of MSM who inject and use drugs is increasing and that drug use is having an impact on new HIV infections in MSM.

Concerns about MSM and recreational drug use, including injecting, were also highlighted by civil society in the UK, although the overlap between MSM and PWID is still relatively low.

In Hungary, 2010 data from the European men-who-have-sex-with-men internet survey (EMIS) data showed substantial recreational drug use, including injecting drug use, among Hungarian MSM. Other research data show an increase in drug use among this population in the past five years.

In Latvia, 2010 EMIS data showed that 3% of MSM had injected drugs at least once in their lifetime.

In Slovakia, NGO data suggests that there is a significant overlap between PWID and street-based sex workers.

In Latvia, a 2011 survey among sex workers found that in the last 30 days, 32.8% had used heroin, 8.1% had used heroin and amphetamines, and 44.3% had used methamphetamine and amphetamines.

PWID face stigma and discrimination in all parts of the region

Government respondents reported that PWID experience moderate or significant general stigma and discrimination in 33 of 43 countries, and moderate or significant HIV-related stigma and discrimination in 23 of 42 countries. General stigma and discrimination is significant in nine EU/EEA (Austria, the Czech Republic, Denmark, Estonia, Greece, Hungary, Italy, Latvia, and Norway) and six non-EU/EEA countries (Albania, Bosnia and Herzegovina, Georgia, Montenegro, Serbia, and Switzerland). HIV-related stigma and discrimination is significant in four EU/EEA countries (Austria, Estonia, Greece and Iceland) and one non-EU/EEA country (Albania).

HIV and PWID: the response

Most countries report that HIV testing and HIV prevention are delivered at scale¹⁹ for PWID, but testing rates and coverage of harm reduction interventions are inadequate in most non-EU/EEA countries and also some EU/EEA countries

Governments in almost all EU/EEA countries stated that HIV testing and HIV prevention programmes for PWID were delivered at scale, although only half of the civil society respondents agreed with this statement. In most non-EU/EEA countries, both government and civil society reported that testing and prevention programmes are delivered at scale for PWID. Despite this, HIV testing rates among PWID are relatively low in some EU/EEA and many non-EU/EEA countries and, as discussed earlier, many PWID are diagnosed late, suggesting that HIV testing

¹⁹ The ECDC questionnaire designed to monitor the implementation of the Dublin Declaration defined 'at scale' as 'at the scale required to meet the needs of the majority of the key population'.

is not delivered at the scale required. Low NSP and OST coverage also indicates that HIV prevention programmes are not being delivered at the scale required in many countries.

Table 1. HIV prevention and testing programmes reported to be delivered at scale for PWID in EU/EEA and non-EU/EEA countries, 2014

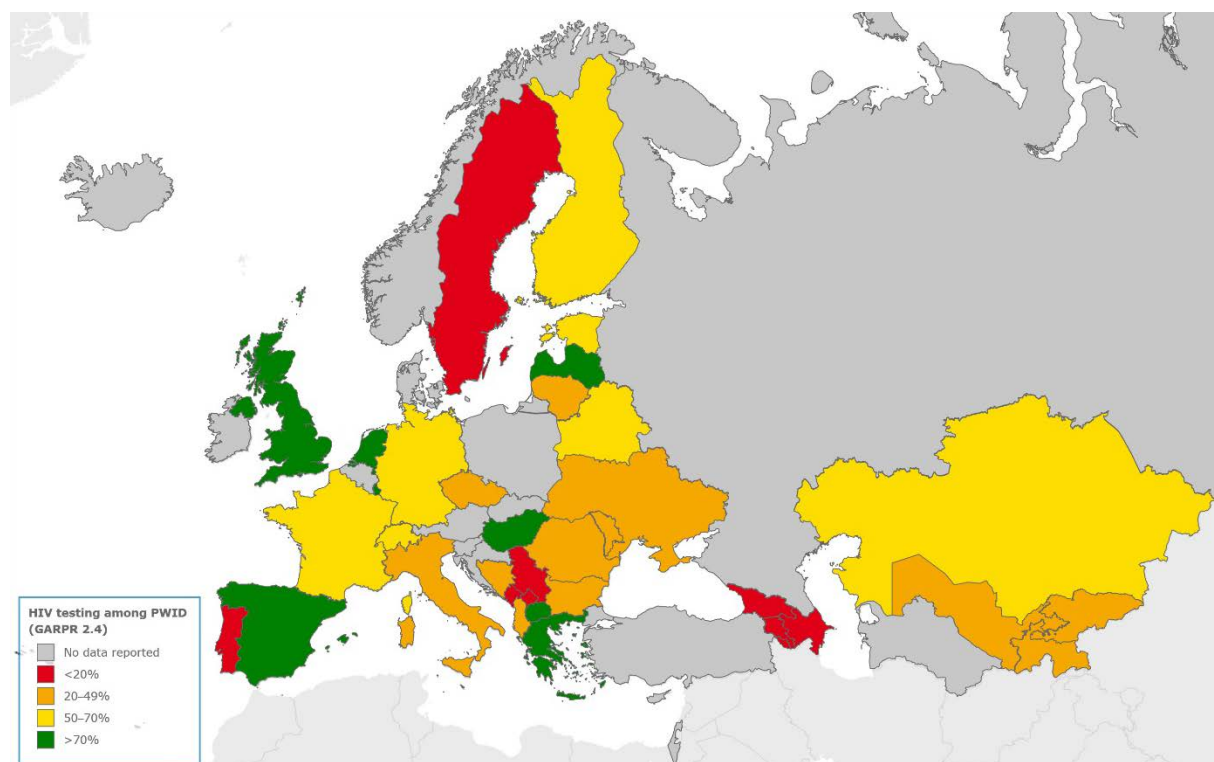
EU/EEA	Are HIV prevention programmes delivered at scale for PWID?		Are HIV testing programmes delivered at scale for PWID?	
	Yes	No	Yes	No
Government	27	3 ²⁰	27	3 ²¹
Civil society	11	11	12	10

Non-EU/EEA	Are HIV prevention programmes delivered at scale for PWID?		Are HIV testing programmes delivered at scale for PWID?	
	Yes	No	Yes	No
Government	17	1 ²²	17	1
Civil society	9	3	11	1

HIV testing rates among PWID are below 50% in one third of EU/EEA countries, and in more than two thirds of non-EU/EEA countries

Recently data²³ on HIV testing among PWID are available from 19 EU/EEA and 17 non-EU/EEA countries. In the EU/EEA, testing rates among PWID range from 6% in Sweden to 100% in Hungary and Latvia²⁴. Four countries reported HIV testing rates above 75% (Spain 89%, Greece 84%, Luxembourg 82%, Malta 81%), six reported rates of between 50% and 75% (UK 75%, Netherlands 74%, France 66%, Finland 63%, Germany 56%, Estonia 51%), and six reported rates below 50% (Bulgaria 48%, Lithuania 45%, Czech Republic 44%, Romania 39%, Italy 30%, Portugal 16%).

Figure 6. Reported HIV testing rates among PWID, 2011–2013



²⁰ EU/EEA countries reporting that HIV prevention programmes for PWID are not delivered at scale: Cyprus, Italy, Sweden.

²¹ EU/EEA countries reporting that HIV testing programmes for PWID are not delivered at scale: Italy, Sweden, Slovenia.

²² Serbia reported that neither prevention nor testing programmes are delivered at scale for PWID.

²³ Data reported in 2014 or 2012.

²⁴ In both countries, surveys of small sample sizes, all of whom were tested for HIV.

In the 17 non-EU/EEA countries, testing rates range from 4% in Azerbaijan to 97% in the former Yugoslav Republic of Macedonia. None of the non EU/EEA countries reported rates above 75%; four reported a rate above 50% (Kazakhstan 67%, Kosovo 58.5%, Belarus 54%, Switzerland 54%); while the remaining countries reported rates below 50% (Moldova 48%, Tajikistan 46%, Kyrgyzstan 43%, Ukraine 43%, Albania 41%, Bosnia and Herzegovina 31%, Uzbekistan 28%, Armenia 20%, Montenegro 20%, Serbia 19%, Georgia 15%).

Two thirds of EU/EEA countries provide more than 100 syringes per PWID per year through NSP, but this number is still too low, particularly in countries where injecting drug use is an important mode of HIV transmission

Recent data²⁵ on the number of NSP-distributed syringes per PWID per year are available from 23 EU/EEA countries (Figure 7). Eight countries report distribution of > 200 syringes per PWID per year; 15 report distribution of > 100 syringes²⁶. Countries reporting low rates include Bulgaria (30), Latvia (33), Greece (53), Lithuania (58) and Poland (78)²⁷.

The number of syringes distributed is below the minimum standard in half of the non-EU/EEA countries

Recent data²⁸ on the number of NSP-distributed syringes per PWID per year are available from 16 non-EU/EEA countries (Figure 8). Only two of the 16 countries report distribution of > 200 syringes/PWID/year (Kazakhstan and Kyrgyzstan). Three additional countries report distribution of > 100/PWID/year (Switzerland, Tajikistan and Uzbekistan)²⁹. Countries reporting low numbers include Belarus (37), Moldova (65) and Ukraine (77).

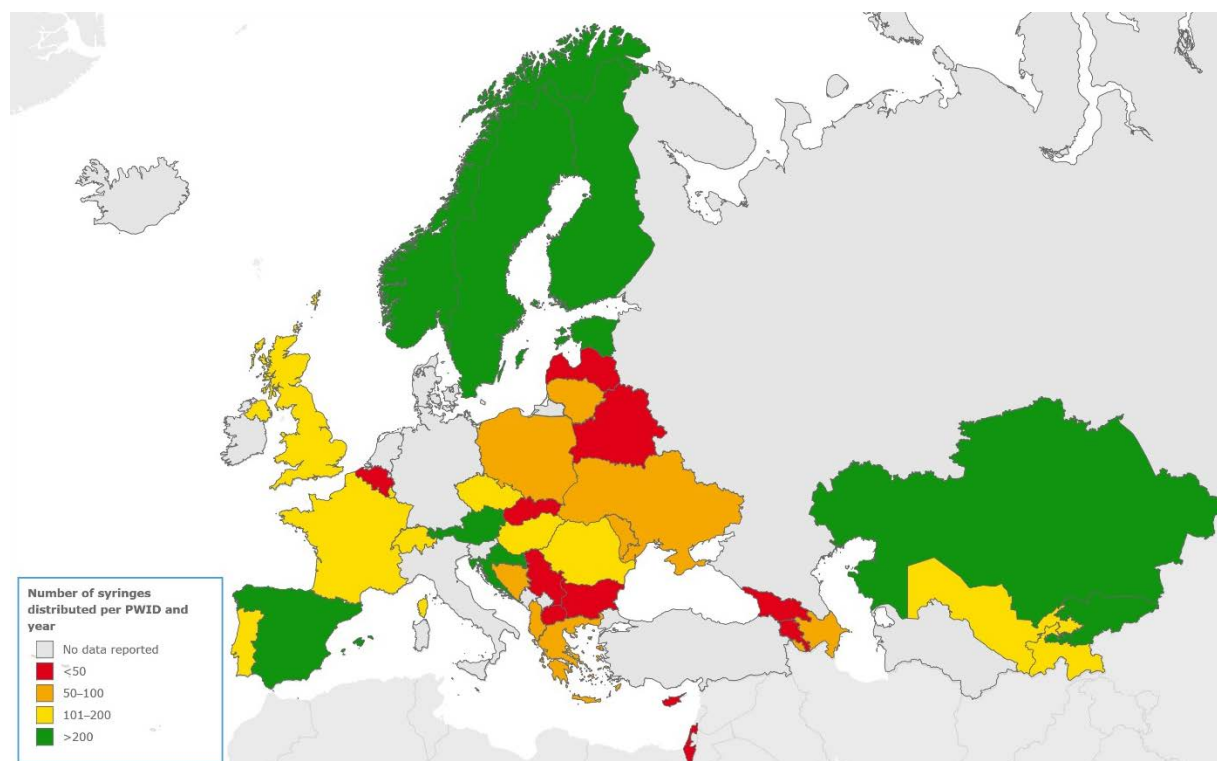
²⁵ Source: EMCDDA 2012 data (unless otherwise stated) reported in 2014 and GARPR data reported in 2012 or 2014. EMCDDA data, where available, is cited for EU/EEA countries rather than GARPR data. See also EMCDDA Statistical Bulletin, available from: <http://www.emcdda.europa.eu/data/2014#displayTable:HSR-5-1>

²⁶ 100 syringes = low coverage, 200 = acceptable coverage. Source: World Health Organization. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision. Geneva: WHO; 2012.

²⁷ The reported number of syringes distributed may be low in countries where most syringes and needles are sold through pharmacies; reported data typically only include syringes distributed for free by NSP, not those sold through pharmacies.

²⁸ EMCDDA reports syringe coverage rates for countries where recent estimates of the PWID population are available. For the reporting year 2012, these rates are available for: Belgium, Croatia, Cyprus, the Czech Republic, Estonia, Finland, Greece, Hungary, Latvia, Luxembourg, Norway and Spain. GARPR data reported in 2012 or 2014 for remaining countries.

²⁹ Number of syringes given out by specialised NSP, excluding pharmacy sales; 100 syringes = low coverage, 200 = acceptable coverage. Source: World Health Organization. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision. Geneva: WHO; 2012. Requirements vary depending on the frequency of injecting; see joint ECDC/EMCDDA guidance (2011) for more detail.

Figure 6. Number of syringes distributed per PWID per year by NSP, 2011–2013

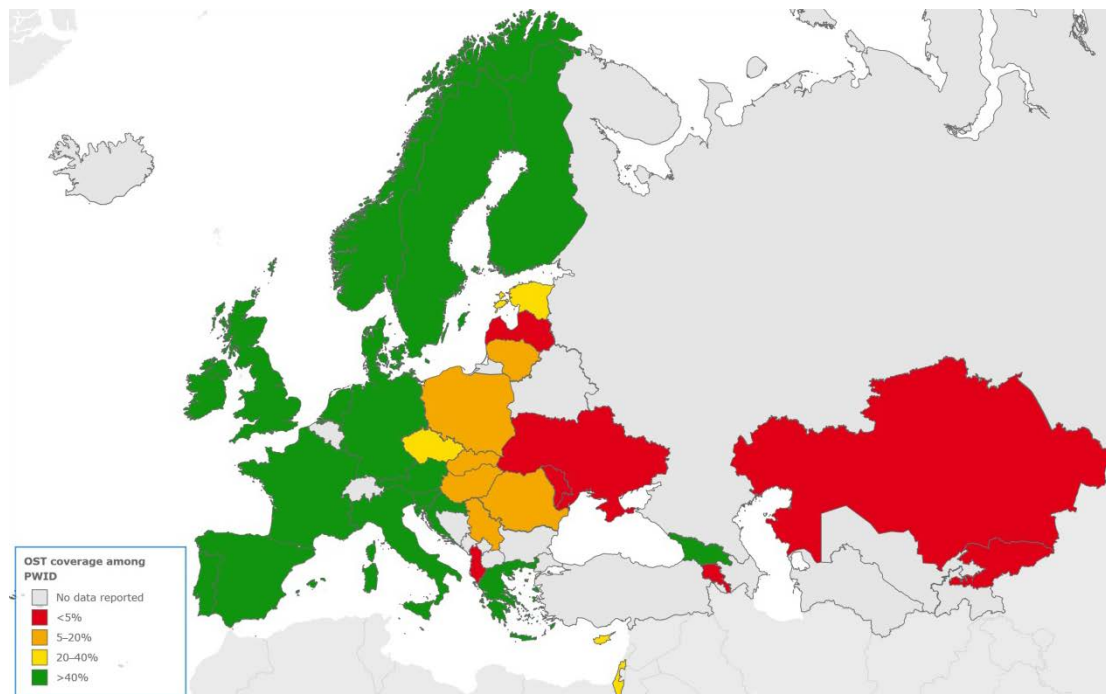
Coverage of opioid substitution therapy is too low in more than half of the EU/EEA countries

Data on OST coverage is available from 27 EU/EEA countries. Reported coverage varies considerably, ranging from 3% in Latvia to 81% in Spain. Eighteen of the 27 countries report coverage above 40%; in five countries it is below 20%. Relatively low OST coverage in countries that report high rates of HIV among PWID is a concern. These countries include Estonia, Latvia, Lithuania, Poland and Romania.

OST coverage is far lower in non-EU/EEA countries than in the EU/EEA

Only nine non-EU/EEA countries reported data on OST coverage in 2012 or 2014. In six of these countries, coverage is below 20% (Figure 9).

Figure 7. Opioid substitution coverage among PWID, 2011–2013³⁰



How EMCDDA calculates NSP and OST coverage

The number of clients who receive OST and the number of syringes distributed to PWID by specialised NSP are extracted by EMCDDA National Focal Points who have access to national registries. These data are routinely reported to 'Fonte', EMCDDA's online data collection and retrieval system. NSP coverage is calculated by dividing the number of syringes given out in a given year by the estimated* number of PWID. Syringe data include free or subsidised provision of the injecting equipment at fixed or mobile NSP sites (including pharmacies), but do not include the sale of syringes at pharmacies. OST coverage is calculated by dividing the number of reported OST clients by the estimated number of problem opioid users, again using recent* estimates of the number of opiate-dependent problem opioid users.

* Estimate less than five years old

³⁰ Source: OST coverage is calculated by dividing the number of reported OST treatment clients by the estimated number of problem opioid users, using recent (less than 5 years old) estimates of the opiate dependent population. For the reporting year 2012, EMCDDA provides these rates for all EU/EEA countries except Denmark, Estonia, Portugal, Romania and Sweden. For these countries, GARPR data reported in 2012 or 2014 have been used.

More than half of countries in the region report gaps in prevention programmes for PWID

Government respondents in 13 of 28 EU/EEA countries stated that there are gaps in their prevention services for PWID (Bulgaria, Croatia, the Czech Republic, Denmark, Estonia, France, Germany, Greece, Iceland, Italy, Latvia, Romania and Sweden). In 11 of 17 non-EU/EEA countries, government respondents reported that there are gaps in prevention services for PWID (Albania, Azerbaijan, Belarus, Georgia, Kazakhstan, Kosovo, Kyrgyzstan, Moldova, Serbia, Tajikistan and Ukraine).

Box 2: Gaps in HIV prevention programmes for PWID

- Insufficient national NSP coverage in Croatia, Estonia, Georgia, Greece, Kosovo, Latvia, Moldova, Romania, Sweden and Ukraine.
- Insufficient provision of syringes through pharmacies in Moldova.
- Lack of attention to drug-related infectious diseases such as viral hepatitis in Germany and Italy.
- Lack of attention to the different needs of subgroups of PWID, i.e. users of opiates and stimulants in Moldova, younger drug users in Greece and Moldova.
- Insufficient medical care for PWID in Ukraine.

Source: 2014 Dublin Declaration questionnaire

The main reasons given for these gaps are: legal and political (e.g. restrictive laws and policies, lack of political support for NSP); financial (e.g. insufficient or decreasing funding in some EU/EEA countries, sustainability of funding in countries that have so far relied on external financing in non-EU/EEA countries); and capacity (e.g. long waiting lists for OST, limited human resources and high workload of physicians providing OST, lack of specialised staff, negative attitudes of staff, poor quality of OST services, lack of incentives for health services or medical practitioners to provide OST).

The legal and policy context is widely reported to be supportive of HIV testing and prevention programmes for PWID, but laws and policies are still a barrier in some countries

Government respondents in 28 EU/EEA and 17 non-EU/EEA countries stated that they have national policies or laws on NSP which are relevant, effective, implemented and enforced³¹; 27 EU/EEA and 16 non-EU/EEA countries stated the same for national policies or laws on OST³²; 26 EU/EEA and 17 non-EU/EEA countries stated the same for national policies or laws on the availability of, and access to, free and anonymous HIV testing for PWID³³.

Three EU/EEA government respondents cited policies and laws which acted as barriers, particularly for HIV prevention interventions. Denmark and Estonia referred to laws limiting NSP in prisons, and Sweden commented that, by law, only people aged 20 years or older can receive sterile needles and syringes. Civil society respondents from ten EU/EEA countries reported that laws and policies make it difficult to reach PWID with prevention interventions or discourage uptake of services; in many countries, civil society pointed out that the criminalisation of drug users, drug use or drug possession acted as a barrier.

Non-EU/EEA government respondents in Belarus, Moldova, Serbia and Switzerland reported that various laws and policies, specifically those related to the criminalisation of drug use, present intervention barriers. Serbia noted that only health facilities could provide HIV testing and Switzerland highlighted the fact that HIV testing was not free. Civil society in Belarus, Georgia, Moldova, Montenegro, Serbia and Tajikistan reported that punitive drug legislation hinders HIV prevention for PWID.

³¹ Only Italy and Turkey stated that they have no national policies or laws on NSP. Note: EMCDDA reports that Italy offers NSP.

³² Only Turkey and Uzbekistan stated that they have no national policies or laws on OST. Note: EMCDDA reports that OST is being implemented in Turkey.

³³ Only Turkey declared that it has no national policies or laws on free and anonymous HIV testing for PWID.

Most countries report that HIV treatment, care and support are delivered at scale for PWID; although most PWID do not experience difficulty accessing treatment, access is a problem in some countries

Government respondents in 28 EU/EEA and 18 non-EU/EEA countries stated that they have national policies or laws on the availability of, and access to, HIV treatment and care services for PWID and that they are implemented and enforced. This is consistent with responses concerning delivery of treatment, care and support at scale for PWID.

In the EU/EEA, government respondents in 29 of 30 countries stated that HIV treatment is delivered at scale for PWID; 27 of 30 countries stated the same for HIV care and support. Only Italy declared that HIV treatment programmes are not delivered at scale for PWID. Estonia, Italy and Lithuania stated that HIV care and support programmes are not delivered at scale. Civil society respondents were less positive. In Estonia, civil society commented that HIV treatment services were not oriented to the needs of PWID. Slovakia pointed out that people without health insurance found it difficult to access treatment. Spain noted reluctance to prescribe ART for PWID due to lack of support services to ensure adherence. Government respondents in three countries (Estonia, Greece and Spain) reported that PWID have difficulty accessing treatment, care and support. Civil society reported that PWID experience difficulties in nine countries (the Czech Republic, Estonia, Greece, Hungary, Lithuania, Portugal, Slovakia, Spain and Sweden).

Table 2. HIV treatment, care and support programmes reported to be delivered at scale for PWID in EU/EEA and non-EU/EEA countries, 2014

EU countries	Are HIV treatment programmes delivered at scale for PWID?		Are HIV care and support programmes delivered at scale for PWID?	
	Yes	No	Yes	No
Government	29	1	27	3
Civil society	17	5	11	11

Non-EU/EEA countries	Are HIV treatment programmes delivered at scale for PWID?		Are HIV care and support programmes delivered at scale for PWID?	
	Yes	No	Yes	No
Government	16	2	15	3
Civil society	11	1	6	6

In non-EU/EEA countries, the majority of government respondents, with the exception of Serbia and Ukraine, and the majority of civil society respondents, with the exception of Ukraine, report that HIV treatment programmes for PWID are delivered at scale. Most governments, with the exception of Albania, Moldova and Serbia, also report that HIV care and support for PWID is delivered at scale, but only half of the civil society respondents share this view. No government respondents reported that PWID have difficulties in accessing HIV treatment, care and support; civil society respondents from two countries (Montenegro and Tajikistan) report that PWID face difficulties.

Conclusions

The number of HIV infections acquired through injecting drug use is declining or stable in most EU/EEA countries; PWID represented only 5% of all new cases reported in the EU/EEA in 2013. The number of newly-diagnosed cases of HIV reported among PWID is far higher in non-EU/EEA countries; almost one third of new infections in the eastern part of the region in 2013 were acquired through injecting drug use.

In many countries, there is evidence of an overlap between PWID and prisoners and, to a lesser extent, between PWID and other at risk populations including sex workers, MSM and migrants. This emphasises the need for comprehensive prevention programmes that address multiple risk factors for PWID and other key populations who also inject drugs. In addition, there is some evidence of the low uptake among pregnant women who inject drugs of services aimed at the prevention of mother-to-child transmission; late presentation is also more likely among pregnant women who inject drugs, suggesting that targeted interventions are required for this subgroup of women.

Harm reduction activities such as needle and syringe programmes and opioid substitution therapy are proven interventions for HIV prevention for PWID. However, NSP and OST coverage is low in most non-EU/EEA countries, as well as in some EU/EEA countries where injecting drug use is an important mode of HIV transmission³⁴. Despite

³⁴ Relatively few countries are implementing a full the range of interventions as recommended by ECDC and EMCDDA: European Centre for Disease Prevention and Control and European Monitoring Centre for Drugs and Drug Addiction. Prevention and control

the decline in reported HIV cases among PWID in the EU/EEA and in some non-EU/EEA countries, recent HIV outbreaks in Greece and Romania highlight the importance of sustained investment to maintain or scale up interventions in all countries where PWID may be at risk of HIV infection. There is also a need to address policy and legal barriers which hamper the introduction or expansion of harm reduction programmes. Criminalising drug users and drug use has a negative impact on the provision and uptake of HIV prevention interventions.

Reported data suggest that rates of HIV testing in PWID are low in a number of EU/EEA countries where injecting drug use is an important mode of HIV transmission, e.g. Estonia, Lithuania, Italy and Portugal, and in most non-EU/EEA countries³⁵. Rates of testing also appear to be relatively low in some countries that state that HIV testing programmes are delivered at scale. This suggests that HIV testing programmes are not being delivered at scale, or are failing to reach a sizeable proportion of PWID, or that there are other factors that prevent uptake of testing by this population. The situation is more positive concerning HIV treatment, which is reported to be available for PWID across the region, although treatment coverage is inadequate in a number of non-EU/EEA countries, and some countries report that PWID experience difficulties in accessing treatment.

Priority options for action

Strengthen prevention programmes for PWID

- Advocate for greater political commitment to harm reduction interventions for PWID.
- Scale up NSP in countries where coverage is currently low.
- Scale up OST coverage across Europe, in particular in non-EU/EEA countries.
- Promote increased access to, and uptake of, HIV testing among PWID to reach the undiagnosed and reduce late diagnosis; community-based approaches should be used.
- Develop and implement targeted approaches to reach sex workers, migrants and MSM who inject drugs, and provide comprehensive interventions to prevent HIV transmission through unsafe drug use and unsafe sex.
- Consider reviewing or revising laws that criminalise drug use and drug-related activities and hinder HIV prevention and outreach work.
- Reduce stigma and discrimination towards PWID, particularly in healthcare settings.
- Provide comprehensive prevention, screening and treatment programmes that address other drug-related diseases, such as HCV.

Improve data on HIV and drug-related infectious diseases among PWID

- Enhance monitoring of HIV incidence and prevalence among PWID, in particular in countries where there is a risk of ongoing HIV transmission or of HIV outbreaks in this population.
- Improve availability of population size estimates for people who inject drugs and problem opioid users in order to provide a basis for calculating intervention coverage.
- Collect data on overlapping risk between PWID and other at risk populations, including MSM, sex workers, and migrants; also collect data on the risk of contracting HIV for sexual partners of PWID.
- Improve the availability and quality of data on HIV testing and late diagnosis among PWID.
- Improve qualitative data on factors that limit uptake of services by PWID, including the extent to which stigma and discrimination plays a role.
- Improve the availability and quality of epidemiological and behavioural data through joint funding, capacity building and harmonised data collection tools.

Ensure that there is adequate funding for HIV surveillance and HIV prevention programmes for PWID

- Increase investments in epidemiological and behavioural surveillance.
- Sustain funding for HIV prevention interventions for PWID in countries where programmes have been dependent on external sources of funding.
- Consider establishing regional financing mechanisms for HIV prevention programmes for PWID in low- and middle-income countries in the region.

of infectious diseases among people who inject drugs. Stockholm: ECDC; 2011.

³⁵ Some caution is required in interpreting data on this indicator, which monitors HIV testing in the last 12 months because a proportion of PWID will already know that they are HIV positive and will therefore not get tested.

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