EVIDENCE BRIEF

People who inject drugs

Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2012 progress report

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Policy implications

- **There is a need to scale up effective HIV prevention programmes for PWID** to levels recommended by ECDC/EMCDDA, especially the provision of sterile injecting equipment and opioid substitution therapy. There is a particular need to scale up such programmes in non-EU/EFTA countries and in EU countries where programme coverage is low.

- **Ensure adequate and sustainable funding to maintain and expand prevention programmes for PWID.** This will require greater domestic commitment and regional financing mechanisms.

- **Take steps to prevent HIV outbreaks among PWID by implementing integrated, effective, high-coverage HIV prevention programmes.** In addition, countries should remain vigilant in order to detect and address HIV outbreaks, requiring surveillance measures which go beyond monitoring national HIV prevalence among PWID.

Overall, HIV prevalence among people who inject drugs (PWID) appears to be stable or declining in the region. However, prevalence remains high in a significant number of countries

In 34 of the 39 countries reporting data on HIV prevalence among PWID in both 2010 and 2012, prevalence was either stable or declining, particularly in many EU/EFTA countries. However, PWID are still a key population at increased risk of HIV in Europe and Central Asia. HIV prevalence of 5% or more among PWID was reported by 19 countries in 2012 (see Figure 1). This includes some EU/EFTA countries, such as France, Greece, Italy, Ireland, Spain and Switzerland in the south and west and Bulgaria, Estonia, Latvia and Poland in the east.

Implementation of effective prevention programmes has enabled many EU/EFTA countries to maintain low or moderate HIV prevalence among PWID

Many EU/EFTA countries have maintained low (<1%) to moderate (1–5%) prevalence among PWID. These countries have been able to control HIV transmission through injecting drug use by implementing large-scale harm reduction programmes. Such programmes have succeeded in distributing more than 100–200 syringes annually to each person who inject drugs and in providing opioid substitution therapy to large numbers (>30–40%) of problem opiate users.

Programme coverage remains low in non-EU/EFTA countries and in a minority of EU countries

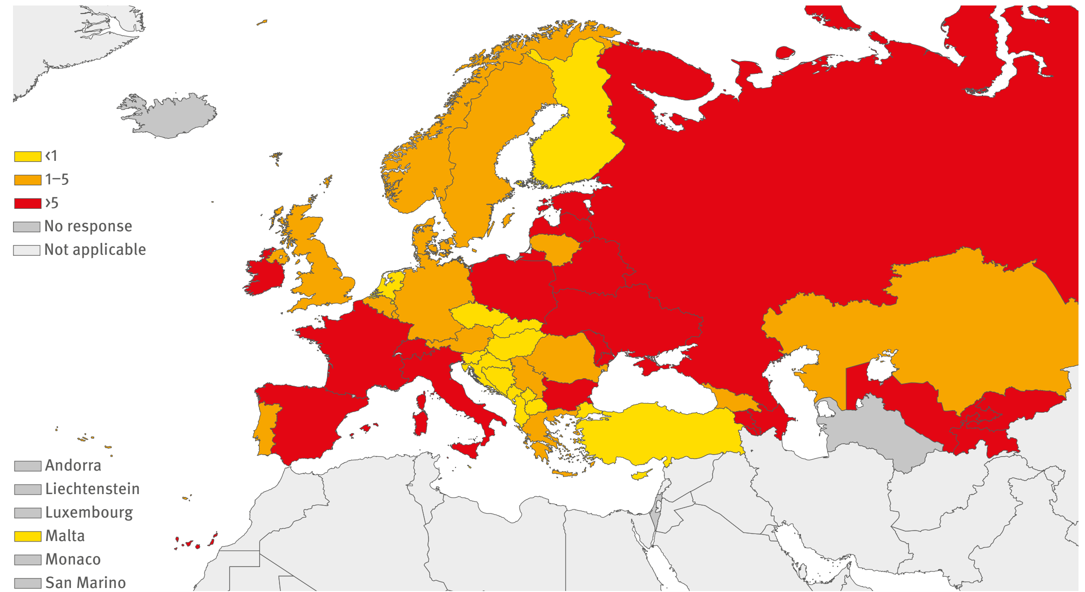
With a few exceptions, coverage of needle and syringe programmes remains low to moderate and coverage of opioid substitution therapy remains very low in countries outside EU/EFTA. In these countries, the introduction of needle and syringe programmes and opioid substitution therapy occurred later than in most EU countries, in some cases requiring external

financing, lacking political support or encountering public opposition. Coverage of needle and syringe programmes is also low in a small number of EU countries, including those with significant HIV epidemics and those experiencing HIV outbreaks among PWID.

In the absence of HIV programmes for PWID implemented on a sufficient scale, there is a risk of ongoing HIV transmission and of HIV outbreaks

HIV prevalence among PWID is on the increase in some countries. Outbreaks of HIV have been also reported among PWID in other countries (e.g. Greece and Romania) and there are concerns about the risk of further outbreaks in other countries. In these countries, and in countries where injecting drug use continues to be a major driver of HIV epidemics, prevention programmes are less well-established and coverage remains relatively low.

Figure 1: HIV prevalence among PWID in Europe and Central Asia



There are concerns about financing prevention programmes for PWID

A number of countries expressed concerns about their ability to sustain existing programmes and to expand coverage of harm reduction interventions for PWID in view of the current financial crisis and declining external funding. Financing from the Global Fund has been particularly important for many low- and middle-income countries in the region. If such funding comes to an end and is not replaced with an alternative, such as domestic funding, there is a risk that programmes will close or be reduced in scope.

Most countries report moderate (30–60%) to high (>60%) rates of HIV testing among PWID but reported rates of condom use in this population are relatively low

EU/EFTA countries were more likely to report higher levels of HIV testing among PWID. These countries included those with good coverage of needle and syringe programmes and opioid substitution therapy. However, a number of countries reporting high levels of HIV testing among PWID provide more limited HIV services for this population. In most countries across the region, reported condom use at last sex by PWID ranged from 30% to 50%. There is evidence of positive trends in condom use, with a number of countries reporting higher rates of condom use among PWID in 2012 than in 2010.

Antiretroviral therapy is available to PWID in most countries of the region, but there are barriers to accessing treatment

Most respondents from both government and civil society in most countries reported that ART is readily available for PWID. However, some countries identified obstacles to ART access, including the criminalisation of drug use and drug possession, lack of health insurance, and fear of using services.

About this series

The Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia, adopted in 2004, was the first in a series of regional declarations which emphasise HIV as an important political priority for Europe and Central Asia.

Monitoring progress in implementing this declaration began in 2007 with financial support from the German Ministry of Health. This resulted in a publication by the WHO Regional Office for Europe, UNAIDS and civil society organisations in August 2008.

In late 2007, the European Commission requested that ECDC monitor implementation of the declaration on a more systematic basis and ECDC set up an advisory group comprising 15 countries and various international partners, including EMCDDA, UNAIDS, WHO, UNICEF, and produced its first major country-driven, indicator-based progress report in 2010.

In 2012, the process of reporting was further harmonised with EMCDDA, UNAIDS, WHO, UNICEF, as well as with the EU Commission Communication and Action Plan on HIV/AIDS 2009–2013. The objective was to reduce the number of indicators, focus on reporting that was relevant in the European and Central Asian context and minimise the reporting burden for countries by making better use of existing country reported data. Responses were received from 51 of 55 countries (93%).

In this round, instead of producing one overall report, information provided by countries has been analysed to produce ten thematic reports and this series of eight evidence briefs.

Other reports in the series can be found on the ECDC website at www.ecdc.europa.eu under the health topic HIV/AIDS.

978-92-9193-462-1

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DOI: 10.2900/80720