European Monitoring Centre for Drugs and Drug Addiction

ecdc EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL

MEETING REPORT

Detecting and responding to outbreaks of HIV among people who inject drugs: best practices in HIV prevention and control

Tallinn, 29–30 March 2012

1 Introduction and objectives

A risk assessment performed by the European Centre for Disease Prevention and Control (ECDC) and the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) in 2011 documented an increase in newly detected HIV cases among people who inject drugs in Greece and Romania[1]. It further identified a number of countries as being at risk for potential outbreaks because of: increased HIV incidence or prevalence; increased hepatitis C prevalence (indicating increased injecting risk); recent changes in injecting patterns (with more frequent injecting or increased stimulant injecting); or low coverage of effective prevention services (needle and syringe programmes, opiate substitution treatment).

The increased HIV transmission among people who inject drugs is of concern both because effective prevention measures exist and because HIV can spread very rapidly among injecting populations.

In order to share best practice experiences on monitoring, and responding to the risk of HIV among people who inject drugs, ECDC together with EMCDDA, organised an expert meeting entitled **'Detecting and responding to outbreaks of HIV among people who inject drugs: best practices in HIV prevention and control'** in Tallinn on the 29–30 March 2012 (see agenda in Annex 1).

The key objective of this meeting was to provide a platform for information exchange between countries to support the response to the ongoing HIV outbreaks in Greece and Romania, to prevent the acceleration of HIV infections among people who inject drugs in other countries, and to strengthen the capacity of all participating countries to monitor and prevent HIV infections in this population.

Participants included: national HIV surveillance and prevention contact points; national drug focal points from Bulgaria, Estonia, Greece, Latvia, Lithuania, and Romania (see participant list in Annex 2); experts in the prevention of HIV among injecting drug users (IDUs) from Finland, Portugal, Spain (Catalonia), United

[1] Joint ECDC and EMCDDA rapid risk assessment: HIV in injecting drug users in the EU/EEA, following a reported increase of cases in Greece and Romania. (2012). Available at: http://ecdc.europa.eu/en/publications/Publications/120112_TER_Joint-EMCDDA-and-ECDC-rapid-risk-assessment-HIV-IDU.pdf

Stockholm, May 2012

Kingdom/Scotland and the United States; and representatives from the European Union (EU) civil society forum on HIV.

Ms Normet (Deputy Secretary General on Health, Estonian Ministry of Social Affairs) opened the meeting and welcomed participants on behalf of the Ministry of Social Affairs, Estonia. Participants were also welcomed by ECDC and EMCDDA in continued collaboration to support the reduction of new infections of HIV and hepatitis C (HCV) among people who inject drugs.

Marita van de Laar (ECDC) presented the meeting objectives and tasks which included:

- review of the current situation with respect to the HIV outbreaks among people who inject drugs in Greece and Romania;
- review the epidemiological situation in other EU/European Economic Area (EEA) countries and the potential risk for acceleration of HIV transmission due to coverage of prevention services and changing drug use patterns;
- share experiences in controlling outbreaks among people who inject drugs and review the opportunities and challenges.

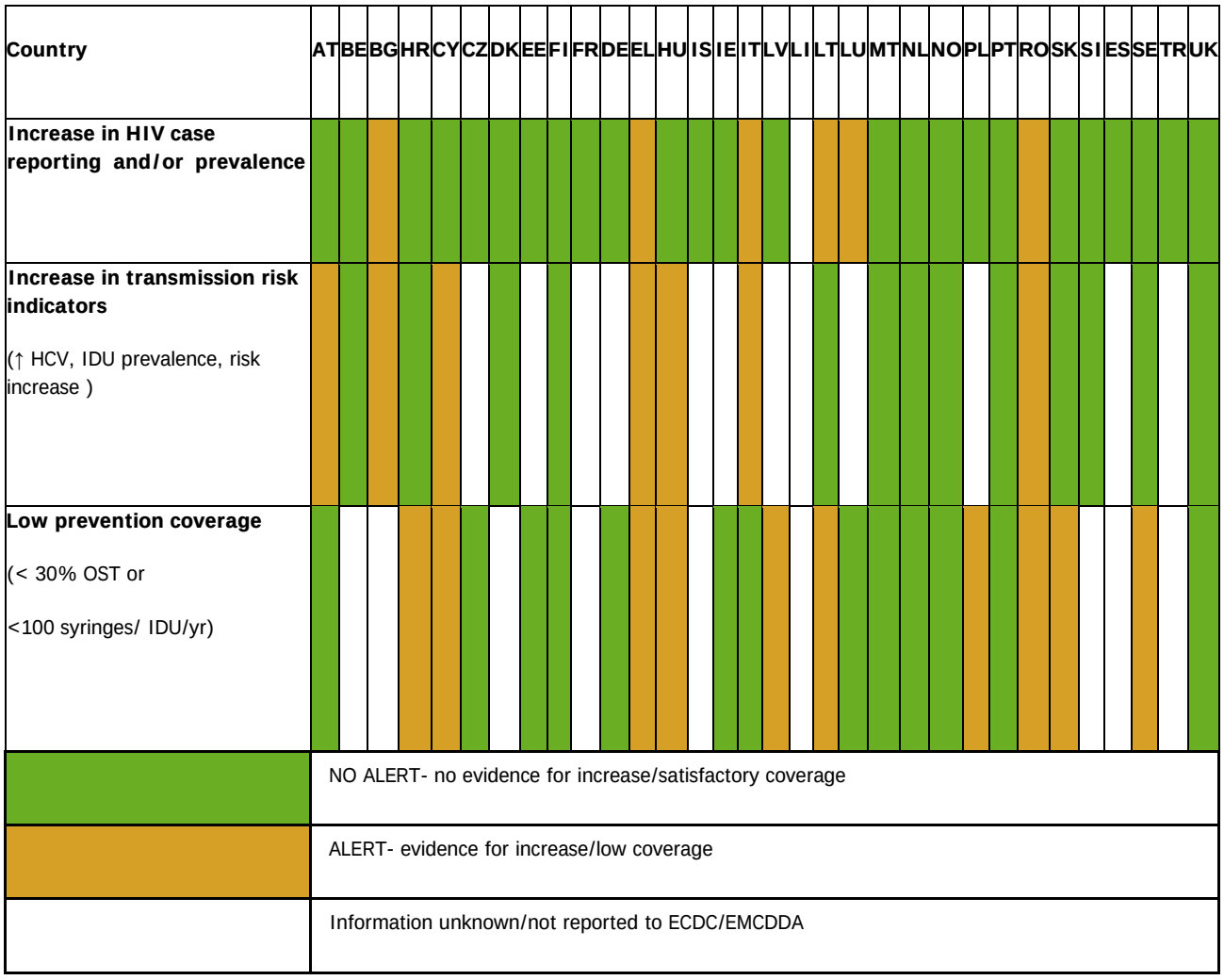
Rapid risk assessment and trends in intervention coverage

The **ECDC-EMCDDA rapid risk assessment** conducted in November 2011 on HIV in injecting drug users in the EU/EEA was presented (Marita van de Laar, ECDC). In this risk assessment, six countries, including Greece and Romania, were determined to have increased HIV prevalence or case reporting rates in 2010–2011 (see Figure 1 below). Countries reported increased injection risk behaviour due to shifting patterns of drug use (four countries) or increased HCV prevalence among IDUs (six countries), indicating increased injection risk. Several countries had low coverage of prevention services such as opiate substitution treatment (coverage of less than 30% in six countries) or syringe coverage (less than 100 syringes/IDU/year in eight countries)[2]. Potential risk factors were identified in 13 countries with several countries having multiple risk factors. The risk assessment concluded that, while most countries in the EU/EEA had low levels of HIV among IDUs, there is a need to keep adequate preventative services on the agenda in challenging economic times. Large increases in HIV among IDUs were observed in Greece and Romania during 2011 and these were associated with low or declining levels of prevention services. It was suggested that prevention services should be scaled-up immediately to prevent further spread of infections. A few other countries with slight increases in HIV among IDUs would benefit from critically reviewing their national prevention programmes.

Dagmar Hedrich (EMCDDA) presented **trends in prevention and intervention coverage** at the EU level, focusing on changes between 2004 and 2010. The number of problem opioid users has been stable over time (1.3 million) and injecting decreased by 40% in this population. Stimulant use has accounted for a larger proportion of the treatment demand over time and methamphetamine use is a problem in some countries. In terms of prevention and response to drug use, there has been a trend towards more evidence-based interventions, including the provision of opiate substitution treatment (OST) and needle and syringe programmes (NSP). Opiate substitution treatment coverage is presently greater than 50% in the EU overall and this should be an aspiration for most countries. One method to facilitate OST scale-up is the provision of OST by general practitioners (GPs). There is an east-west gradient in the provision of this treatment, with provision through GPs not yet introduced in many countries in the eastern part of the EU. Several central- and south-eastern European countries have long waiting times for OST entry. Needle and syringe programmes were introduced within the EU in the late 1980s and early 1990s and now exist in all countries except Turkey. Compared to the year 2003, provision of syringes to injecting drug users through specialist drugs services alone (not including pharmacy sales) had increased more than two-fold (based on a subset of 20 EU countries where data were available). While NSPs are available in most countries, in some countries they are only available in a few regions. However, as many countries lack recent good quality estimates of IDU prevalence, syringe coverage is still difficult to estimate.

[2] These cut-off levels were taken to identify countries with very low coverage, they do not indicate the level of sufficient coverage which is unknown but likely to be much higher.

Figure 1. Results from the ECDC-EMCDDA rapid risk assessment



Country situation and response, Greece

An **update on the HIV epidemiological situation in Greece** was given by Foteini Giannou (Hellenic Centre for Disease Control and Prevention). HIV cases increased by 57% from 2010 to 2011, and 65% of this increase was due to cases among IDUs (Table 1). While HIV increased in all age groups between 2010 and 2011, the greatest increase was seen among 15–34 year olds. Greek nationals account for 72.4% of cases notified, and 17.9% are among foreigners (9.6% unknown). Among IDU cases notified, most are among men (82%), 25–44 year olds (80%), Greek nationals (76%), and persons living in Athens (83%). Thus far in 2012, the trend has continued, with 242 HIV cases reported through 27th March, 80 (33%) of them among IDUs.

Table 1. HIV cases and probable route of transmission, Greece, by year of report

	HIV cases by year of report and probable route of HIV transmission					
	Year of report					
	2006	2007	2008	2009	2010	2011
MSM	302 (52.71%)	255 (49.32%)	353 (54.06%)	329 (54.29%)	345 (56.84%)	340 (35.64%)
IDUs	17 (2.97%)	11 (2.13%)	11 (1.68%)	14 (2.31%)	15 (2.47%)	241 (25.26%)
Hetero	160 (27.92%)	136 (26.31%)	155 (23.74%)	114 (18.81%)	113 (18.62%)	148 (15.51%)
Unknown	88 (15.36%)	113 (21.86%)	129 (19.75%)	147 (24.26%)	131 (21.58%)	220 (23.06%)

Avidity testing on 62 specimens from newly detected HIV cases among IDUs in 2011 indicated that 56% had acquired HIV in the five months prior to diagnosis. Prevalence studies conducted in 2011 and 2012 indicated that HIV prevalence has increased and varies between 3–5% among those entering drug treatment and 25% among those tested in mobile units.

Anastasios Fotiou (REITOX focal point) presented additional **epidemiological and behavioural indicators** and highlighted that HCV prevalence rates have been consistently high among IDUs entering treatment during the last decade, particularly in Athens, and that these had increased further from 2008, prior to the HIV outbreak. The percentage of those who are currently entering treatment and are HCV antibody positive are: 50% of those younger than 25 years, 66% between 25–34 years, and 73% of those older than 35 years. Additional data suggest that increases were reported for current injecting, sharing needles and syringes and/or infrequent condom use during recent years, preceding the outbreak. Additional factors that might have contributed to the spread of HIV among IDUs included low coverage of NSP and OST, and deterioration of the physical as well as socio-economic environment of the Athens inner-city area, with high unemployment and frequent police sweep operations (which displaced drug users).

Spyros Bourdoukis (Greek Organisation Against Drugs (OKANA)) presented the **Greek response to scale-up prevention services.** The main response has centered around:

- Scaling up OST (opening 34 new units since August 2011, 20 of which are the greater Athens area, thus creating 2 200 new treatment slots on a national level, 800 of which are in the greater Athens area).
- Expansion of NSP, mainly through the intensification of street outreach through three programmes: i) the 'User Manual' programme which uses local NGOs, street outreach workers and volunteers to perform outreach; ii) the Mobile Unit programme that conducts health promotion, HIV testing, syringes, and

referrals; iii) 'Boule de Neige', which involves street outreach workers who supervise peer supporters to conduct outreach and syringe distribution. In 2010, the estimated number of syringes distributed per IDU/year was 6.7, in 2011 it was 25, and in 2012 it is expected to be 130.
- A switch from high to low dead space syringes
- Condom distribution
- HIV testing of all IDUs entering treatment and mobilising active users to undergo voluntary testing in low threshold or outreach settings
- Providing priority for OST and antiretroviral treatment (ART) for all HIV positive IDUs, and raising the awareness among health care professionals and IDUs as well as the general public.

Issues related to logistics and intervention coverage were discussed. Several experts who had attended the first national coordination meeting in November 2011 (organised by Prof Hatzakis) congratulated Greece on the very rapid scale-up of prevention services, in particular OST, as well as the coordination between HIV prevention and drug control sectors during the last six months.

Country situation and response, Romania

An **update of the HIV epidemiological situation in Romania** was presented by Mariana Madarescu (National Institute of Infectious Diseases 'Prof. Dr. Matei Balş'). In 2011, 619 new HIV cases were reported, mostly among heterosexuals (62%), IDUs (18%) and men who have sex with men (14%). HIV cases increased among men who have sex with men (MSM) in 2011 (86 cases versus 46 in 2010). Among IDUs, the number of HIV cases has increased dramatically: between 3 and 5 in 2007–09, 12 in 2010 and 116 in 2011. Of those HIV cases among IDUs, 44% had a CD4 count below 500 at diagnosis, indicating that the infections are not recent. The majority (80%) of the IDU HIV cases were diagnosed during visits to the infectious disease hospital ward, seeking treatment for other health issues. The majority of new infections are among residents of Bucharest with very low socio-economic status and many have a history of imprisonment.

Adrian Abagiu (Romanian Association Against AIDS and National Institute for Infectious Diseases) and Andrei Botescu (National Agency against Drugs) described a number of **determinants that contributed to the spread of HIV among IDUs in Romania**. The lack of political consistency, with four ministers of health in the past two years, and the lack of an approved HIV prevention strategy has resulted in less effective political decision-making. There was also a temporary dissolution of the National Agency against Drugs (ANA), although it was reinstated in April 2011. Additionally, large sources of external funding for HIV prevention from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and the United States Office on Drugs and Crime (UNODC) finished in 2010 and national funding for HIV prevention has lagged.

In this context, new drugs emerged on the market in Romania which were initially legally available and, thus, referred to as "legal highs". These are mostly synthetic cannabinoids and cathinones (which have now been regulated and are not legally available since 2011). In 2010, the ANA found that legal highs had surpassed marijuana in reported lifetime use. In 2009, 97% of IDU listed heroin as the main drug of injection and, in 2010, 67% reported heroin and 37% reported amphetamine-type stimulants, mostly synthetic cathinones, as the main drug of injection. Injection of these stimulants was reported to occur on average 6 to 10 times per day.

There are an estimated 18 000 problem drug users in the Bucharest area according to ANA estimates and this number may have increased with the increased use of "legal highs". At the same time, there has been a reduction in the number of needles and syringes distributed from 1.7 million in 2009 to 0.9 million in 2010 and 2011 following the Global Fund phase-out. Response to the HIV outbreak among IDUs has been limited due to lack of finances and lack of a national HIV prevention strategy. In 2011, there was an increase in the number of drug treatment slots for OST when a new centre was opened in Bucharest by the Romanian Association against AIDS (ARAS) and the National Institute for Infectious Diseases. A new needle exchange centre will be opened in 2012 by ANA. The National Agency against Drugs has purchased 160,000 syringes which will be distributed through outreach services; and funding is available to purchase 500 000 more. There are ongoing studies of genotyping and resistance monitoring among a portion of the new IDU cases. Thus far, there has been no national coordination meeting to gather all actors to respond to the problem of HIV among IDUs.

Current country situations

Latvia

Agnese Freimane (Disease Prevention and Control Centre of Latvia) presented that there are an estimated 18 000 problem drug users, mostly in the capital city Riga. The number of new registered HIV cases diagnosed among IDUs has decreased to 88 in 2011, down from >300 cases per year from 2000–2002. Prevalence studies among IDUs have estimated 22–29% HIV prevalence and 58–74% HCV prevalence among IDUs. In low threshold centres, HCV prevalence has increased from 36% to 59% during the last three years. Of the 560 persons receiving ART in Latvia, 44% are IDUs, although many persons are diagnosed when their CD4 is less than 350 and treatment coverage is thought to be low. In 2011, 22% of new HIV cases came from prison settings and from April 1st 2012, the national policy changed so that addiction treatment will also be available in prisons. There are 18 harm reduction service centres in Latvia, mostly in the west of the country, that provide NSP, disinfectants, counselling and testing, but just two where OST and NSP are provided in the same place. Estimated syringes/IDU per year is less than 100.

Lithuania

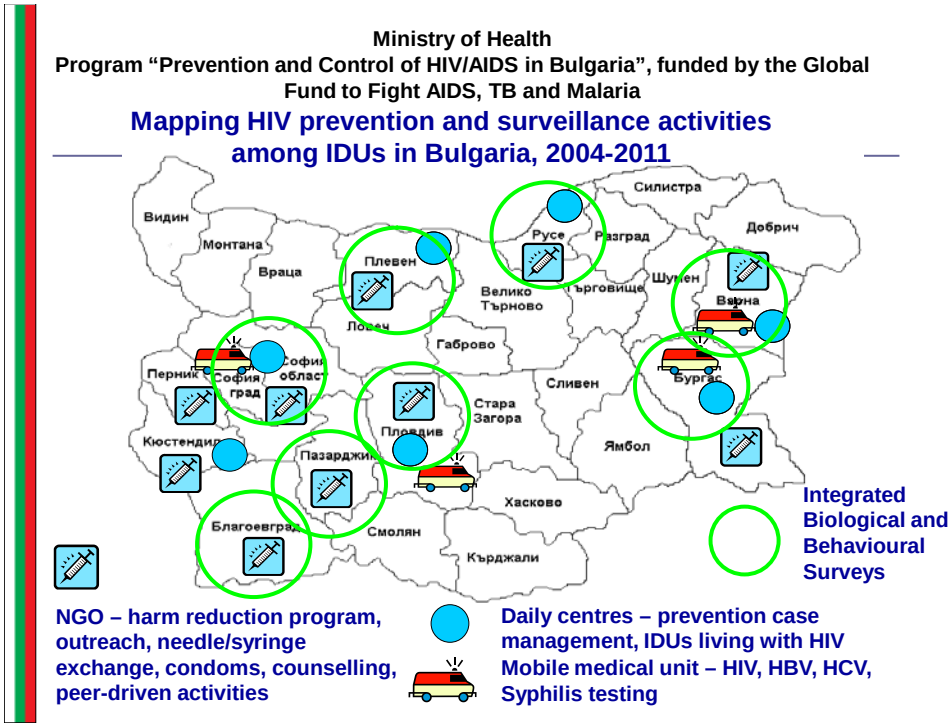
Audrone Astrauskiene (Ministry of Health) and Emilis Subata (Centre for Drugs) showed that IDUs have been the main mode of transmission since 1997, currently constituting 70% of cases (55% of cases are diagnosed in prison). The HIV cases reported among IDUs have remained stable and decreased slightly from 2008 to 2010. Lithuania estimates that there are 6 000 IDUs, mostly males in their early 30s in the capital and large cities. There is an estimated distribution of 45 syringes per IDU per year and a reduction of funding for NSPs between 2006 and 2010 due to the closure of a UNODC grant. Opiate substitution treatment coverage is estimated at 12.7% a doubling between 2006 and 2010. OST and NSP are not available in prisons.

Bulgaria

Tsvetana Yakimova (Ministry of Health) showed that HCV prevalence has been high among IDUs (up to 70% according to data from the integrated biological and behavioural surveillance surveys) since 2004 and HIV prevalence has increased from less than 1% in 2005 to about 7% in 2009. The number of reported cases in IDUs has increased steadily between 2004 (7 cases), 2009 (74 cases) and 2010 (56 cases). There is an estimated IDU population size of 20 000. Bulgaria has a grant from the GFTAM which will run through 2014, and which has supported behavioural surveillance and prevention programmes, as well as treatment. Needles distributed per IDU, per year, are estimated at 35–40 (84 per IDU reached). The number of people enrolled in OST programmes supported by state and municipal budgets has been stable for the last few years and is being scaled up with support from the Global Fund. Antiretroviral treatment is free-of-charge and IDU represent 11% of those on ART. Supported by GFATM funds, integrated biological and behavioural surveillance was done among key groups, including IDUs. The key populations' location in relation to prevention service activities are mapped per district (Figure 2).

HIV prevention case management is conducted with IDUs, attempting to keep the client at the centre and ensuring referral and connection to all relevant services. Bulgaria has also focused on prisons, as they estimate that up to 10% of the prison population inject drugs. Needle and syringe programmes are not allowed in prisons due to legislation and OST is allowed only for those who initiate it before entering prison. Testing and health education projects are conducted in all prisons and four detention centres. A pilot project currently being conducted through collaboration between the Ministries of Health and Justice, focuses on peer education in prison in relation to HIV and STI prevention.

Figure 2. Mapping of IDU prevention and surveillance activities



Source: Ministry of Health, Bulgaria

Estonia

Kristi Ruutel (National Institute for Health Development) showed that Estonia is one of the countries in the EU with the highest HIV rate (28 per 100 000 population in 2010). Until recently, the laboratory-based notification of HIV cases through the surveillance system did not allow reports of mode of transmission, but it is estimated that 70% of cases are due to IDU. Capture-recapture studies using three different national databases in 2005 gave an IDU population size estimate of 13 801. Estonia had experienced an IDU-driven HIV outbreak in 2001 (analysis has estimated that most transmission occurred in the late 1990s), when more than 1 400 HIV cases were reported. Estonia has carried out bio-behavioural studies with respondent driven sampling (RDS) in 2005, 2007, 2009 and 2010. HIV prevalence among IDUs in Tallinn has been between 50% and 55% since 2005, with a slight downward trend. Hepatitis C virus antibody positivity among IDUs is estimated at 94% in Tallinn and 78% in Narva. The main drugs of injection are fentanyl, and then amphetamines; poly-drug injection is also common. Most IDU are members of the Russian-speaking ethnic minority group, are male, and are in their 20s and 30s.

The first priority in the national HIV prevention strategy is harm reduction (NSP and OST). Prevention also focuses on HIV testing and related healthcare services, including ART. The prevention services, including harm reduction, were started under the GFATM grant which ended in 2007 and have been continued to be supported by the national budget. Syringe provision was scaled up under the GFATM grant from 2003,and in 2011, 2.1 million syringes were distributed. Since the scale up of NSP, Estonia has measured a slight decrease in HIV incidence and attributes this to the scale-up. Opiate substitution treatment is offered to opiate addicts, but many injectors use other substances and Estonia continues to grapple with effective forms of drug treatment for stimulant addicted persons. HIV testing is offered at OST and testing centres, but not at NSP centres. 20% of IDUs have never been tested and about 40% of all persons living with HIV are diagnosed late. HIV treatment is free for all, but HCV treatment is not. Pilot projects under EU funding are currently evaluating strategies for combined ART and OST provision as well as for tuberculosis and opioid substitution treatments.

Common issues identified with respect to the country situations:

- Economic issues as a threat to continued or scaled-up service provision: This was described as an issue in Greece, Estonia, Romania and is expected in Bulgaria after the termination of the GFATM grant in 2014. It was stressed that the provision of syringes, for example, is cheap, but that it should be part of a more comprehensive prevention package which is more expensive. Economic issues were also mentioned as a barrier to ongoing or comprehensive bio-behavioural surveillance among IDUs.
- HIV among IDUs is concentrated in minority groups and in larger cities: In Romania, Roma populations are reportedly disproportionately affected; in Bulgaria the Roma population is affected in some regions where overlapping risk behaviours are observed; in Estonia, Latvia and Lithuania the Russian-speaking minority is affected; in Greece, immigrants are implicated in the outbreak, but only comprise 15% of HIV cases notified. In all settings, there may be an overlap between IDU and sex work, but this is not well documented in any setting.
- Coverage of intervention services is lower than the EU average in all settings, except for NSP in Estonia, which has been scaled up over the past nine years. One barrier to the scale-up of OST in most of the countries present is the inability (due to legislation) for OST to be prescribed via a general practitioner.
- Prisons are a part of the response and present a challenge for prevention work. Legislation inhibits OST and/or NSP in prison in several countries. Some countries allow only the continuation of OST and do not allow people to begin OST in prison.
- Changing drug use patterns or increasing stimulant use appear to contribute to high spread in Romania, Estonia, Greece.

Expert presentations

Sam Friedman (National Development and Research Institutes, New York, US) presented on **IDU network factors and implications for prevention interventions,** focusing on looking at HIV transmission in the context of larger political and economic events. This can lead to disruption of economic and service provision processes and structures, population displacement, and changes in social ideas and norms which can, concretely, be manifested in cutbacks in social and health services, disrupted life patterns, changed social relationships of gender, unemployment, increased drug use, and sex work. At the community level, it is important to understand how HIV is transmitted through networks and it is key to understand how both injecting and sexual networks interact. Infection 'chains' and networks can also be used for interventions, to find people who are infected, test them, start them on treatment and prevent them from infecting others. Tracing and finding recent infections is of particular importance given the very high viral load in that phase and the much higher risk of infecting others. In Ukraine, this is being piloted through tracing of the sexual and injecting partners and venues, to try to find those who might have recently been exposed to HIV and/or might be at risk of exposure.

Angelos Hatzakis (Athens University Medical School) presented a project on **molecular epidemiology of the ongoing HIV-1 outbreak in Greece**, which provides information about the time of infection, phylogeographic analysis, case linking, and potential founders of the outbreak. Using this, they were able to see warning signs that a new HIV sequence, linking several cases, was introduced in mid-2010 in Greece (while the case notifications alerted an increase in Feb–March 2011). Analysis of additional cases indicates that a large proportion of the HIV sequences among diagnosed IDUs fall within phylogenetic clusters, suggesting an ongoing outbreak. Among IDUs, 5% of infections in 1998–2009 were clustered; in 2010, 50% were clustered; in 2011, 97% were clustered. This suggests that most users in Greece prior to 2010 were probably infected through sexual transmission whereas the outbreak is due to injection transmission. The phylogeographic and potential founder analyses were informative for directing prevention campaigns targeted at affected populations.

The seek-test-treat-retain intervention project (STTR) is currently being started in the greater Athens area with the aim of decreasing HIV/AIDS transmission among IDUs. Through respondent driven sampling, they will try to identify IDUs and increase testing as well as provide prevention and treatment services. Secondary aims include estimating the HIV prevalence among IDUs, to describe phylogenetic and social networks, and to examine the quality and provision of HIV prevention services. The estimated sample size is 7 000 persons, which nears the IDU size estimate for the greater Athens area.

These presentations were followed by discussion on the importance of understanding and documenting the 'anatomy and physiology' of the IDU transmission dynamics, and that this understanding could be achieved through targeted bio-behavioural surveillance combined with networks studies involving molecular analysis. The feasibility of this was discussed and Hatzakis stressed that much of this information is already being collected, and that the molecular sequencing need not be performed on the entire sample of new cases detected.

Next steps, action items and conclusions

In small working groups countries briefly assessed the main strengths and weaknesses of national HIV prevention and response and, from this, identified the most important priority actions needed to further prevent and address HIV (and HCV) infections among IDUs. These priority actions are listed below by country as a result of small working group sessions. It is important to note that they may not be listed in priority order or represent all relevant or needed actions for all countries. During the working groups, ECDC and EMCDDA discussed possible indicators and actions for follow-up and support of countries in monitoring and responding to HIV among IDUs and these are also listed below.

Four general actions were determined:

- Countries and ECDC/EMCDDA would collaborate on the priority action items
- Countries would liaise with each other directly and request support and/or technical assistance in achieving their priority actions from ECDC and EMCDDA.
- A second meeting would be held, most likely in October 2012 during the EMCDDA annual expert meeting on drug related infectious diseases (DRID), to follow-up on progress toward the priority actions
- Countries would report on some indicators regarding HIV and HCV and response among IDUs during 2012 to follow the situation more closely (Annex 3).

Two priority actions were determined:

- Monitor the ongoing situation of HIV cases, HIV prevalence, HCV prevalence, injection risk behaviour and/or changes in drug use patterns, and prevention intervention coverage
- Continue and improve close collaboration between sectors (HIV surveillance, prevention, drug services, civil society and NGOs) to better monitor and improve the response to the prevention of HIV among IDUs, if possible including regular national level meetings with all stakeholders.

Country specific actions were listed:

Greece

- Continue to expand and sustain expansion of syringe provision to improve coverage
- Continue to expand and sustain expansion of OST to improve coverage
- Enhance further HIV surveillance and expand screening (e.g. STTR programme)
- Increase behavioural surveillance to better target and evaluate interventions
- Better attention to accessing NSP, testing, OST, treatment
- Further raise public awareness
- Expand HBV vaccination to ‘active’ users
- Active participation of IDUs in prevention and response efforts

Romania

- Organise a national coordination meeting, including all relevant stakeholders and actors within Romania and international experts
- Approve the national HIV prevention strategy (Ministry of Health)
- Improve harm reduction services: OST coverage and NSP coverage
- Plan and carry out behavioural surveillance (including HIV surveillance) to better target and evaluate interventions
- Apply for international funding to support NSP and other prevention programmes
- Improve syringe sales at pharmacies
- Increase HIV screening among IDUs
- Identify and apply effective treatment for stimulant-dependent persons
- Work on defining the population (size) of opiate users

Bulgaria

- Sustain and scale up prevention interventions implemented by the network of NGOs (Ministry of Health and local government)
- Ensure that prevention activities implemented by NGOs continue to be supported (Ministry of Health and local government)
- Consider how to generate prevention funding through non-government sources (NGOs)
- Introduce OST and NSP in prisons (Ministry of Justice, Ministry of Health)
- Support IDUs to organise themselves to perform advocacy (NGOs, Ministry of Health)
- Provide hepatitis C treatment of IDUs in OST (National Health Insurance Fund)

Latvia

- Improve HIV testing (Ministry of Health, NGO)
- Improve collaboration between sectors dealing with HIV and IDUs (NGO, Ministry of Health, private sector)
- Plan and carry out epidemiological measurement outside Riga, especially in areas with high HIV and HCV infection (Ministry of Health)
- Improve access and uptake of harm reduction services by considering confidentiality and placement of services (Ministry of Health)
- Improve OST coverage by providing OST in harm reduction centres (service integration) (Ministry of Health)
- Address and improve health care worker attitudes toward IDUs
- Promote HIV, HBV and HCV-related services in prisons
- Consider the number of individuals, including IDUs, who are on ART to improve treatment coverage

Lithuania

- Improve HIV testing (Ministry of Health)
- Improve surveillance capacity through an exchange programme between Estonia and Lithuania (ECDC-EMCDDA; Ministry of Health, academia)
- Start to provide OST in prison (Ministry of Justice, Ministry of Health)
- Improve collaboration between the Ministry of Health and NGOs to ensure better coordination and service provision (Ministry of Health and coalition of NGOs)
- Improve coverage of OST and syringe exchange (Ministry of Health, municipalities)
- Report and analyse CD4 cell counts in new HIV cases with surveillance data
- Improve street-based surveillance to closely monitor the situation
- Consider the number of individuals, including IDUs, who are on ART to improve treatment coverage

Estonia

- Improve the risk-group based (IDU, MSM, sex workers) surveillance system and passive surveillance and monitoring of the services (harm reduction), and improve involvement of community -based organisations in surveillance. New estimates for size of risk groups (Ministry of Social Affairs, health board, NIHD)
- Develop integrated services (prevention and treatment) for risk groups (collaboration between NGOs and health care), meeting the needs of different types of IDUs (opioid vs stimulant injectors), ensuring the continuum of care (Ministry of Social Affairs, NIHD, professional societies, Health Insurance)
- Improve the coverage (including geographical) and quality of syringe exchange and OST (Ministry of Social Affairs) (through allowing non-psychiatrists with necessary training to prescribe OST)
- Exchange with Lithuania on OST programmes (NIHD, professional societies)
- Continuous and sufficient financing and development of human resources (Government)

ECDC and EMCDDA

- Support countries and an EU-wide understanding of the situation through ongoing monitoring of the situation during 2012 (numbers of HIV cases among IDU, HIV prevalence, HCV prevalence, injection risk behaviour, changes in drug use patterns, and prevention intervention coverage).
- Update the EU-wide risk assessment of HIV among IDU by the end of 2012
- Provide technical support as requested by countries with the following items identified during the meeting:
  - support Romania in their national coordination meeting or, if requested, through a country visit
  - support countries in need of behavioural surveillance support among IDUs through the ECDC behavioural surveillance project and the EMCDDA DRID programme.
  - support Romania with technical input regarding the involvement of GPs in the provision of OST (EMCDDA)
  - support Greece in providing technical support to the STTR study
  - support Romania in collating evidence and technical advice regarding drug consumption rooms (EMCDDA)
  - support twinning information exchange and/or visits on issues of bilateral country interest/need
- Organise a second meeting, most probably in October 2012 during the EMCDDA DRID meeting, to continue to monitor the situation and further support country response.
- Finalise and disseminate translated language versions of the IDU guidance in brief
- Liaise with other international actors, including the European Commission, the Joint United Nations Programme on HIV/AIDS(UNAIDS), and the World Health Organization to maximise support to countries in preventing and responding to HIV among IDUs
- Consider the role of molecular sequencing and avidity testing (in conjunction with the analysis of behaviours and networks) in acting as early warnings for clusters of HIV transmission and outbreaks (among IDUs and other key population groups).

The meeting was closed by thanking all of the participants from the countries, the invited experts, and each other for the very fruitful collaboration and valuable input from all persons present. It was agreed that a meeting report would be circulated to all participants for comments and finalised and published by ECDC and EMCDDA.

Annex 1: Agenda

March 29 2012	
	Morning session- Chairs: Marita van de Laar, ECDC and Lucas Wiessing, EMCDDA
9:30–9:45	Welcome and introductions: Estonia, ECDC, EMCDDA
9:45–10:00	Rapid risk assessment on HIV among people who inject drugs in Greece and Romania (Marita van de Laar, ECDC)
10.00–10.15	Current trends in intervention coverage (Dagmar Hedrich, EMCDDA)
10:15–11:00	Overview of current country situation and responses: Greece
11:00–11:30	Coffee break
11:30–12:15	Overview of current country situation and responses: Romania
12:00–12:30	Discussion: ongoing outbreaks and responses
12:30–13:30	Lunch
13:30–15:00	**Afternoon session-** Chairs: David Goldberg and Dagmar Hedrich Overview of current country situations: Latvia, Lithuania, Bulgaria, Estonia (15 minute presentations each with time for discussion)
15:00–15:30	Coffee break
15:30–17:30	Country overview and discussion, continued
19:00	ECDC hosted dinner
March 30 2012	
	Morning session- Chairs: Marita van de Laar and Kristi Ruutel
9:00–9:15	Quick recap of day 1 and revised agenda for day 2
9:15–9:45	IDU network factors and implications for prevention interventions (Sam Friedman)
9:45–10:15	A Seek-Test-Treat-Retain (STTR) Intervention to Decrease HIV/AIDS Transmission among IDU in Athens metropolitan area (Angelos Hatzakis)
10:15–10:30	Coffee break
10:30–11:30	Discussion in small groups Group A: Greece, Romania, Mika, Sam, David, Group B: Latvia, Lithuania, Bulgaria, Estonia, Xavier, Luis Group C: ECDC, EMCDDA, Vivian
	Final session - Chairs: Marita van de Laar, ECDC and Lucas Wiessing, EMCDDA
11:30–12:45	Feedback to the plenary on group work; discussion of the items for action and follow up and the way forward
12:45–13:00	Meeting closing

Annex 2: List of participants

Country/Organisation	Participant
Bulgaria	Tsvetana Yakimova
Bulgaria	Violeta Bogdanova
Catalonia	Francisco Xavier Majó Roca
Civil Society Forum	Luis Mendao
Greece	Foteini Giannou
Greece	Anastasios Fotiou
Greece	Spiros Bourdoukis
Greece	Angelos Hatzakis
Greece	Meni Malloiri
England	Vivian Hope
Estonia	Merilin Mäesalu
Estonia	Aljona Kurbatova
Estonia	Kristi Ruutel
Estonia	Katri Abel-Ollo
Estonia	Ave Talu
Finland	Mika Salminen
Latvia	Agnese Freimane
Lithuania	Emilis Subata
Lithuania	Audrone Astrauskiene
Scotland	David Goldberg
Romania	Marian Ursan
Romania	Andrei Botescu
Romania	Adrian Abagiu
Romania	Mariana Mardarescu
USA	Sam Friedman
KIT Amsterdam (Observer)	Pauline Oosterhoff
EMCDDA	Dagmar Hedrich
EMCDDA	Lucas Wiessing
ECDC	Anastasia Pharris
ECDC	Marita van de Laar
ECDC	Otilia Sfetcu

Annex 3: EU communication strategy and monitoring

ECDC and the EMCDDA aim to collaborate to support countries in their response and to achieve an EU-wide understanding of the current situation through: monitoring numbers of HIV cases among IDUs; HIV prevalence; HCV prevalence; injection risk behaviour; changes in drug use patterns; and prevention intervention coverage. This data will facilitate towards:

- Enabling a rapid response and support to countries with ongoing outbreaks;
- Monitoring for increases in risk factors or actual cases reported in countries at risk for future outbreaks
- Promoting communication and information exchange between HIV surveillance and drug services sectors at national and EU levels.

The following strategy was proposed and agreed upon by meeting participants:

- Disseminate the meeting report to the ECDC network for HIV and the EMCDDA national focal point /DRID network;
- Inform both networks that the risk assessment for the EU will be repeated by the end of 2012;
- Present and agree on the indicators used for monitoring the situation of HIV among IDUs in countries with ongoing outbreaks and in other EU countries (ECDC and EMCDDA to propose indicators to country contact points in follow-up to the Tallinn meeting)
- Agree on the frequency of monitoring, taking account of the indicators collected through the EMCDDA annual reporting mechanism.