

TECHNICAL REPORT

HIV and people who inject drugs

Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2018 progress report

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This report of the European Centre for Disease Prevention and Control (ECDC) was coordinated by Teymur Noori and Anastasia Pharris.

This report is one in a series of thematic reports based on information submitted by reporting countries in 2018 on monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS. Other reports in the series can be found on the ECDC website at: <https://ecdc.europa.eu/en/infectious-diseases-public-health/hiv-infection-and-aids/prevention-and-control/monitoring-0>.

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Abbreviations

ART	antiretroviral therapy
BBV	blood-borne viruses
DCR	Drug Consumption Rooms
ECDC	European Centre for Disease Prevention and Control
EU/EEA	European Union/European Economic Area
GAM	Global AIDS Monitoring
HAV	hepatitis A virus
HBV	hepatitis B virus
HCV	hepatitis C virus
MSM	men who have sex with men
NSP	Needle and Syringe Programmes
OST	Opioid Substitution Therapy
PLHIV	People living with HIV
PWID	People who inject drugs
STI	sexually transmitted infection
TESSy	The European Surveillance System
UNAIDS	The Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

Introduction

This report is based on data provided by countries for reporting on the Dublin Declaration [1] and summarises key issues related to HIV and people who inject drugs (PWID) in Europe and Central Asia. It also identifies priority options for action to improve the HIV response for this population.

Methodology

Between January and March 2018, a survey was carried out by the European Centre for Disease Prevention and Control (ECDC) to collect data to monitor implementation of the 2004 Dublin Declaration [1]. The monitoring questionnaire was disseminated to the 53 countries that are part of the WHO European Region, plus Kosovo¹ and Liechtenstein via an online survey. National health authorities were requested to complete the Dublin Declaration survey between mid-February and the end of March 2018.

ECDC further harmonised data collection with UNAIDS and WHO's Regional Office for Europe to ensure compatibility and reduce burden on health authorities. ECDC took responsibility for collecting a core set of Global AIDS Monitoring (GAM) indicators through Dublin Declaration implementation monitoring for EU/EEA Member States, meaning there was no separate GAM reporting for EU/EEA Member States. Non-EU/EEA Member States continued to report to GAM through UNAIDS and were therefore asked to complete a shortened ECDC Dublin Declaration questionnaire, with any GAM questions removed. The data collected through these processes were then combined and included in the analysis for this report.

In May 2018, the information reported by each country was cleaned up and returned for validation. Subsequent notifications of corrections were used to update the information reported. Validation of data collected through the GAM process was conducted by UNAIDS.

The survey contained specific questions in relation to the HIV epidemic among people who inject drugs (PWID) in addition to questions relating to current national prevention interventions, policies and barriers to the public health response to the epidemic.

This report presents the situation among people who inject drugs (PWID), a key group affected by HIV in the WHO European Region. As well as considering the picture for the overall European and Central Asian region, findings are presented by WHO sub-regions (West, Centre, and East). This is the approach used in the joint ECDC/WHO report on HIV/AIDS surveillance in Europe [2], which broadly group areas of Europe and Central Asia by geography and epidemic type, as depicted in Figure 1. In addition, case studies provided by health authorities highlight developments in public health policy and programme implementation, specific to PWID.

The report presents disaggregated data, where available, for PWID for the continuum of HIV care across the region and classifies results according to countries that reported: (a) all four stages², (b) no stages, and (c) at least two consecutive stages of the continuum of care. Findings are compared against the global 90:90:90 targets [3].

Unless otherwise indicated, the data source for all graphs presented is the Dublin Declaration monitoring process for 2018.

Data from the ECDC survey have been supplemented by data from the European Surveillance System (TESSy) for the WHO European Region and from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in relation to EU countries plus Norway and Turkey.

Countries covered by the report are grouped as follows:

West, 24 countries: Andorra, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Liechtenstein, Malta, Monaco, Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland, United Kingdom

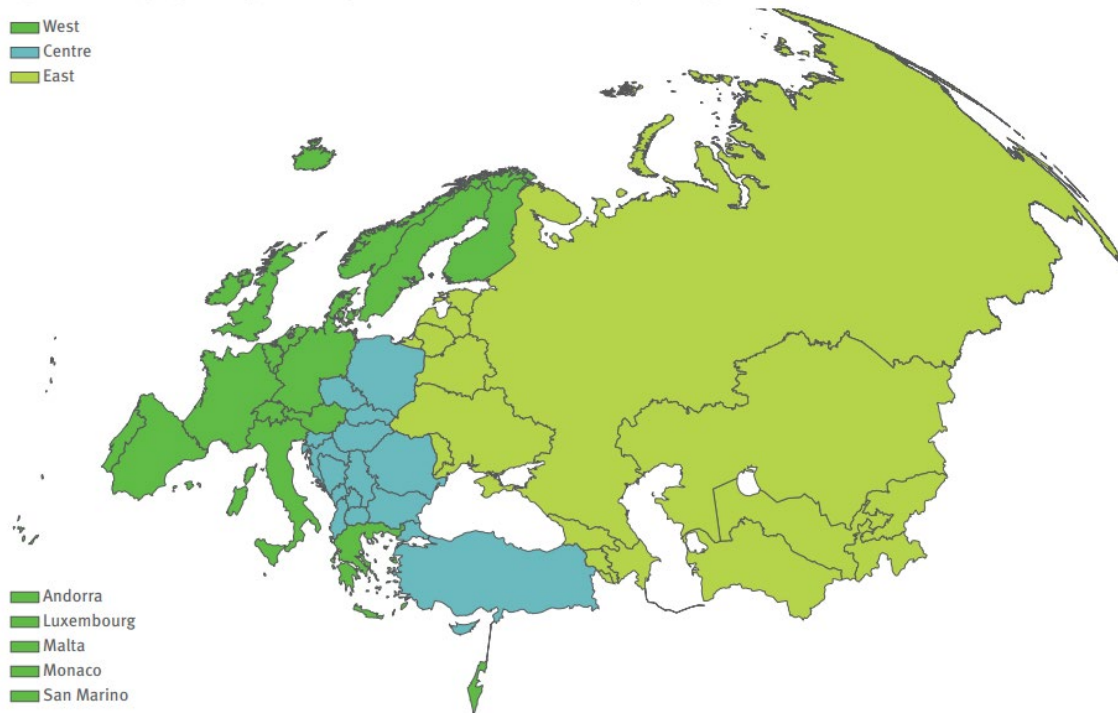
Centre, 16 countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Hungary, Kosovo, North Macedonia, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, Turkey.

East, 15 countries: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan

¹ 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.

² For the four stages of the continuum of care see Table 1 below.

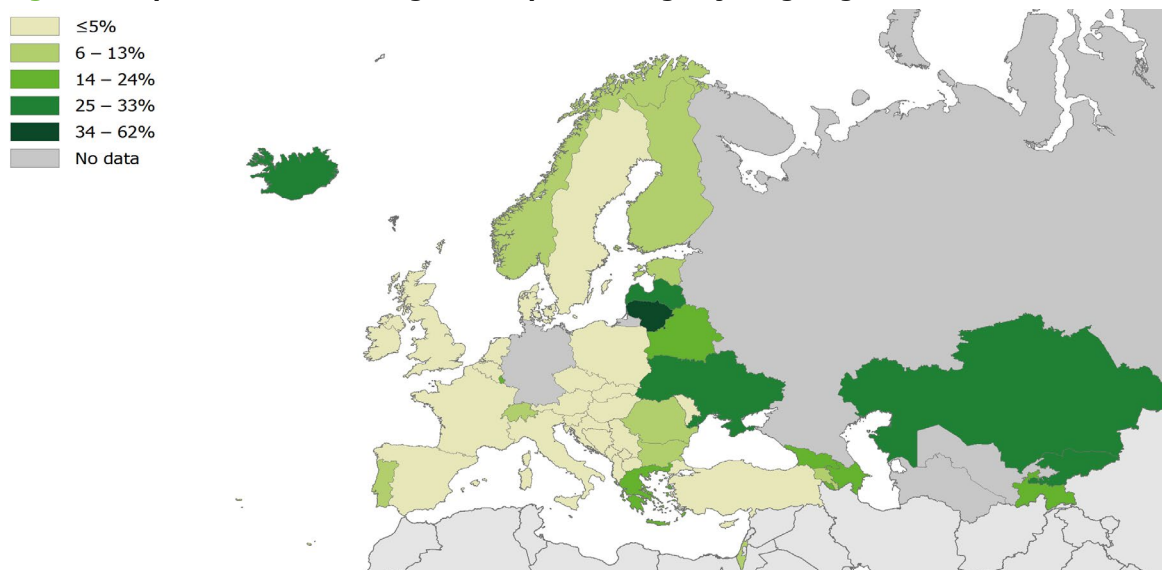
Figure 1. Geographical/epidemiological division of the WHO European Region



Why focus on people who inject drugs?

HIV disproportionately affects people who inject drugs (PWID) on a global basis. HIV and other blood borne viruses can be transmitted through the sharing of injecting equipment including needles, syringes and other paraphernalia. Injecting drug use is a significant mode of HIV transmission in the European Region (Figure 2). In 2017, 13% of all new HIV diagnoses in the European Region were among PWID. The majority of people diagnosed with HIV who had a history of injecting drugs were from the East sub-region, and 24% of the new diagnoses in this sub-region in 2017 were attributed to injecting drug use (compared with 2.7 % in both West and Centre sub-regions). As seen in Figure 2, Kazakhstan, Kyrgyzstan, Iceland, Latvia, Lithuania and Ukraine all reported that over 25% of people newly diagnosed with HIV in 2017 had a history of injecting drugs. There are also significant epidemics in Armenia, Belarus, Georgia, Greece and Tajikistan. While information on transmission mode from Russia is not available, the overall number of new diagnoses in Russia accounted for 65% of all new HIV diagnoses in the European Region in 2017 [2], and injecting drug use is known to be the main route of transmission in that country [4].

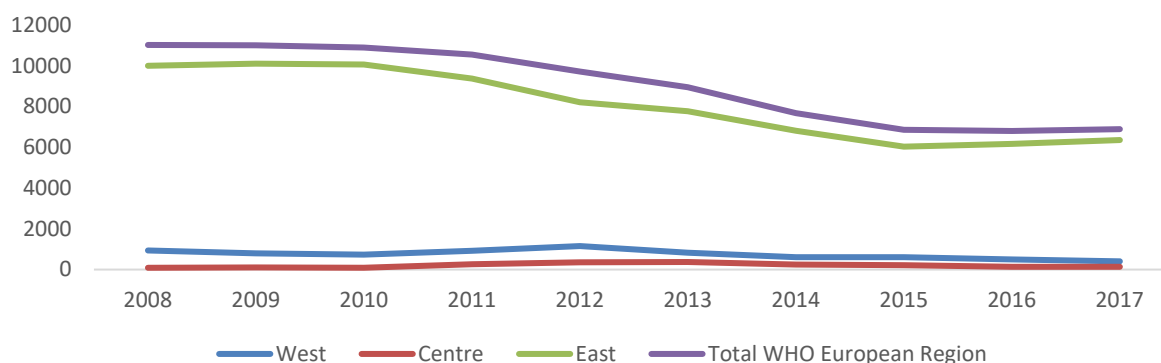
Figure 2. Proportion of new HIV diagnoses acquired through injecting drug use in 2017



Source: ECDC/WHO (2017). HIV/AIDS Surveillance in Europe 2018–2017 data.

Over the past ten years, the number of people diagnosed with HIV who inject drugs declined by 38% (from 11 034 in 2008 to 6 893 in 2017), largely due to decreases in the East sub-region (a fall of 36% from 10 006 to 6 361) and this decline was particularly apparent in the Ukraine and Azerbaijan. Despite this, the East sub-region continues to account for about 92% of all PWID newly diagnosed with HIV in the European Region, a similar proportion to a decade ago. Furthermore, the absence of Russian data means the extent of the current PWID epidemic in the East sub-region is substantially under-documented.

Figure 3. New HIV diagnoses among people who inject drugs (PWID) by year of diagnosis and WHO sub-region, 2008–2017



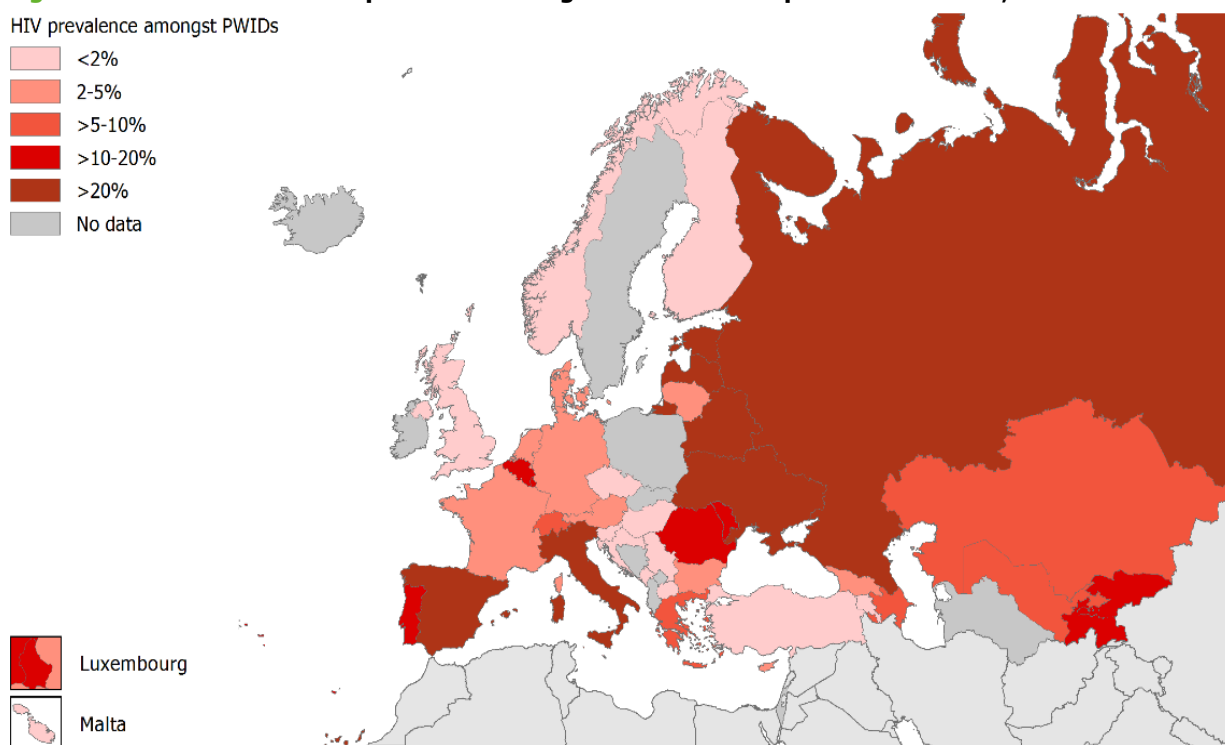
Source: ECDC/WHO (2017). HIV/AIDS Surveillance in Europe 2018 – 2017 data

Prevalence data on HIV among PWID from national and sub-national studies are available from 41 of the 55 countries in the Region (see Figure 4)³. Of the 14 countries which did not provide data, six are in the EU/EEA. Prevalence ranged across the region from 0% reported by North Macedonia, Slovenia and Turkey, to 54% in Estonia. Three countries have a prevalence rate of between 6 and 10% (Azerbaijan, Kazakhstan and Switzerland); seven countries have a prevalence rate of between 11 and 20% (Belgium, Kyrgyzstan, Luxembourg, Moldova, Portugal, Romania and Tajikistan) and seven countries have a prevalence of over 20% (Belarus, Estonia, Italy, Latvia, Russia, Spain and Ukraine).

It should be noted that the accepted definition of a concentrated epidemic is more than 5% HIV prevalence in a key population. On that basis, nineteen countries across the European Region have a concentrated epidemic among PWID - eleven are in the East sub-region, seven in the West and one in the Centre sub-region. Nine of the 19 countries with prevalence above 5% are EU/EEA countries.

It remains vital to implement a full range of prevention and harm reduction measures, as well effective surveillance for this key population. This is the case even for lower prevalence countries since HIV can spread rapidly among PWID. Recent reported outbreaks have occurred in Luxembourg in 2014 [5], Ireland (specifically Dublin) in 2015 [6], the United Kingdom (specifically Glasgow) in 2015 [7], Germany (specifically Bavaria) in 2017 [8], and Lithuania in 2018 [8]. All of these are countries with an estimated HIV prevalence among PWID of <5%.

Figure 4. Available data on HIV prevalence among PWID across Europe and Central Asia, 2011–2017



³ Whilst the majority of the prevalence data reported were published between 2015 and 2017, data from some countries are not recent - Switzerland's data is from 2011; Serbia and Germany's from 2013; and Montenegro, Finland, and Tajikistan's from 2014.

Progress and remaining challenges

Continuum of HIV care

The continuum of HIV care is a conceptual framework that provides a snapshot of critical stages in achieving viral suppression among people living with HIV (PLHIV) [9]. It has become one of the central metrics through which the public health response to HIV is evaluated at the local, national and international level [10]. In 2014, the Joint United Nations Programme on HIV/AIDS (UNAIDS) established the 90-90-90 targets for three of the four stages of the continuum of HIV care, the aim being that by 2020, 90% of all people living with HIV are diagnosed, 90% of those diagnosed receive treatment and 90% of those receiving treatment achieve viral suppression. This translates to a target of 73% viral suppression among all PLHIV. To be able to report on each of the three '90' targets it is necessary to have data for the two relevant consecutive stages of the continuum of care. The definitions for each of the four stages of the continuum of care are provided in Table 1.

Table 1. Consensus definitions for monitoring the continuum of HIV care during Dublin Declaration monitoring 2018

Stage 1: Total estimated number of people living with HIV in the country

The total estimated number should be based on an empirical modelling approach, using the [ECDC HIV Modelling Tool](#)⁴, Spectrum or any other empirical estimate. The estimate should include diagnosed and undiagnosed people.

Stage 2: Number/percentage of above (estimated number of people living with HIV in the country) ever having been diagnosed

The number should include all new HIV or AIDS diagnoses. It should also include those people who are in care and those who have not been linked to care.

Stage 3: Number/percentage of above (estimated number of people living with HIV in the country, ever having been diagnosed) who are currently on antiretroviral treatment

The number should include all people currently on ART, regardless of treatment regimen or treatment interruptions/discontinuation.

Stage 4: Number/percentage of above (estimated number of people living with HIV in the country, ever having been diagnosed or having initiated antiretroviral treatment) who had viral load (VL) ≤ 200 copies/ml at last visit (virally suppressed)⁵

The number should include all those who have ever initiated ART, regardless of regimen or treatment interruptions/discontinuation.

Breaking down the continuum of care by key population allows countries to measure outcomes for groups who are disproportionately affected by HIV. It also means that disparities between key populations that are hidden at the aggregate level can be better understood.

Data for the continuum of care among PWID living with HIV in Europe and Central Asia are limited. In 2018, data about all four stages were reported by seven countries for PWID, one fewer than in 2016 (Figure 5). However, there was some slight improvement in data coverage overall between 2016 and 2018. Between 2016 and 2018, there was an increase in the number of countries reporting data for stages 2, 3 and 4 of the continuum of care for PWID. At least two consecutive stages were reported by 16 countries. There was also a reduction in the number of countries who were unable to report data for any stages of the continuum of care for PWID.

⁴ ECDC Modelling Tool. <http://ecdc.europa.eu/en/healthtopics/aids/Pages/hiv-modelling-tool.aspx>

⁵ A viral load threshold for viral suppression of <200 copies/mL was used to allow for changes over time in the lower detection limits of viral load assays. A threshold of 200 copies/mL for population-level monitoring is consistent with recommendations in a recent systematic review of guidelines produced by IAPAC - www.iapac.org/uploads/JIAPAC-IAPAC-Guidelines-for-Optimizing-the-HIV-Care-Continuum-Supplement-Nov-Dec-2015.pdf and the US Centers for Disease Control and Prevention - www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf

Figure 5. Number of countries reporting data for different stages of the HIV continuum of care for people who inject drugs, Europe and Central Asia, reported in 2016 and 2018

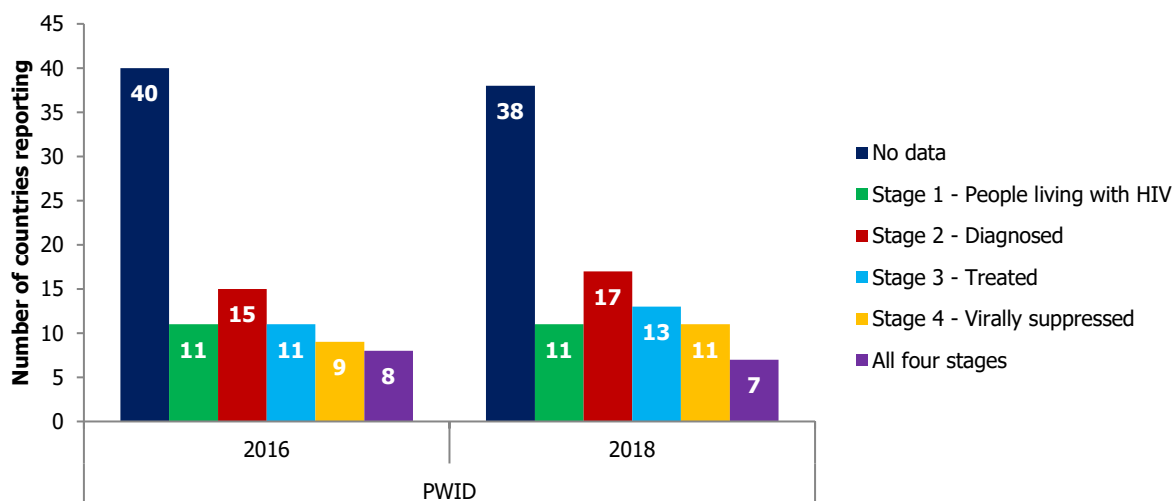


Figure 6 provides more detail for those countries which reported data for PWID across two consecutive stages of the continuum of care and so can report values against the UNAIDS 90-90-90 targets.

Eight countries provided data on the percentage of PWID living with HIV who are aware of their status – the first 90 target. The percentage of estimated PWID living with diagnosed HIV ranged from 75% to 98% (see Figure 6a). This figure is affected not just by testing rates but by incidence and migration, as well as by the accuracy of information on the estimated size of the denominator – stage 1 (i.e. the total number of PWID who are living with HIV). It is worth noting that all eight countries (Figure 6a) who could provide information on the percentage of PWID living with HIV who know their status also had data on the percentage of PWID who had tested in the last 12 months. Moreover, seven of these eight countries had a value of around 50% or significantly higher. The one exception was Azerbaijan which reported 80% of people who inject drugs and living with HIV knowing their status, but only 12.2% of people who inject drugs having tested for HIV in the previous 12 months.

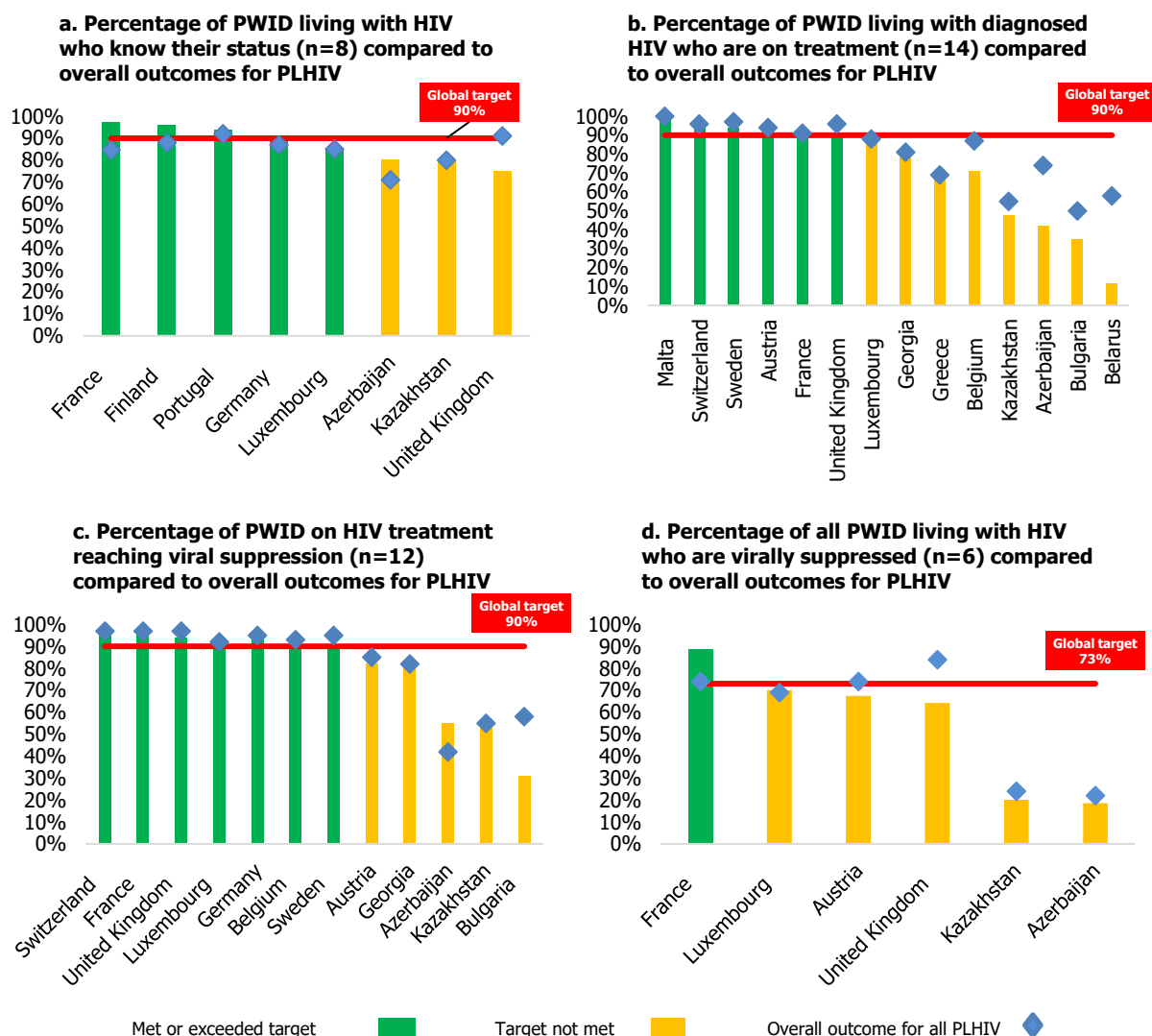
Fourteen countries were able to report the percentage of PWID living with diagnosed HIV who are on treatment in 2018 (Figure 6b) – the second 90 target. Six of the 14 exceeded the UN target of 90% – Malta, Switzerland, Sweden, Austria, France and the United Kingdom. Meanwhile Luxembourg, at 88%, is not far short of the target. However, other countries have some way to go: Georgia, Greece and Belgium had percentages in the 70s, and Kazakhstan and Azerbaijan in the 40s. In the latter two countries, there is clearly important work to be done to improve linkage to and retention in care. However, at least all of the 14 countries have data from which they can identify priorities for their HIV response. It is alarming to see the large number of countries (41/55) which did not report any data for this target.

The same data gap is evident for the percentage of those PWID on treatment who have reached viral suppression (the third 90 target), where again only 12 countries were able to report any data (Figure 6c). Seven countries had met the UN target of 90% - Switzerland, France, United Kingdom, Luxembourg, Germany, Belgium and Sweden. Both Austria and Georgia, at 82%, are making good progress towards the 90% target. However, Azerbaijan (55%), Kazakhstan (53%) and Bulgaria (31%) still have a considerable way to go to reach the UN target and detailed work is needed to understand the reason for these lower percentages.

The ECDC report 'Continuum of HIV Care. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2018 Progress Report' has previously discussed the need to improve data across the continuum of care for PWID. Only six countries (France, Luxembourg, Austria, United Kingdom, Kazakhstan and Azerbaijan) could report data for all four stages to provide an estimate of the percentage of all PWID living with HIV who are virally suppressed against the UN target of 73% (and only one country, France, has met and exceeded this target for PWID – see Figure 6d).

The graphs in Figure 6 also compare outcomes for PWID with those reported by the relevant countries for all people living with HIV (PLHIV). Overall, there are few substantial variations in outcome between PWID and PLHIV in general, apart from diagnosis and viral suppression in the UK; the percentage of those diagnosed on treatment in Belgium, Azerbaijan and Belarus and the percentage of those on treatment who are virally suppressed for Bulgaria. Again, it is unwise to draw general conclusions for the Region from a relatively small number of reporting countries. However, this does demonstrate that it is perfectly possible for outcomes relating to PWID to be as good as those for PLHIV, if resources and targeted services are put in place to address the specific needs of this key population.

Figure 6. Estimates provided for each stage of the continuum of care for PWID living with HIV in Europe and Central Asia compared to national outcomes, reported in 2018⁶



Combination prevention

HIV combination prevention is an approach that brings together single prevention initiatives into a comprehensive programme [11]. Importantly, the specific elements take effect across the life course of HIV infection and encompass primary prevention (preventing people without the virus from acquiring HIV infection), secondary prevention (preventing onward transmission from those living with HIV) and structural tertiary intervention (to improve health-related quality of life of those living with HIV). The interventions implemented will vary depending on the needs of the key population, but it is important that they are implemented at scale and in combination to maximise their benefits.

ECDC and EMCDDA have published guidance (2011) on the prevention and control of infectious diseases among people who inject drugs. The guidance recommends seven key intervention components to address infectious disease, including HIV, among PWID [12]. These are listed in Table 2.

⁶ Austria, Belarus and Israel are excluded from Figure 6a, and Belarus is also excluded from Figure 6c and 6d, due to anomalous results. The number of countries reporting in Figure 6b is larger than the number in Figure 5 reporting data on treatment numbers because two countries, Switzerland and Germany, reported percentages based on cohort data and chose not to provide absolute numbers.

Table 2. Key intervention components

Key intervention components

Injection equipment: provision of, and legal access to, clean drug injection equipment, including sufficient supply of sterile needles and syringes free of charge, as part of a combined multi-component approach, implemented through harm-reduction, counselling and treatment programmes.

Vaccination: hepatitis A and B, tetanus, influenza vaccines, and for HIV-positive individuals in particular, pneumococcal vaccine.

Drug dependence treatment: opioid substitution treatment and other effective forms of drug-dependence treatment.

Testing: voluntary and confidential testing with informed consent for HIV, HCV (HBV for unvaccinated) and other infections, including TB, should be routinely offered and linked to treatment referral.

Infectious disease treatment: antiviral treatment based on clinical indications for those with HIV, HBV or HCV infection. Anti-tuberculosis treatment for active TB cases. TB prophylactic therapy should be considered for latent TB cases. Treatment for other infectious diseases should be offered as clinically indicated.

Health promotion: health promotion focused on safer injecting behaviour; sexual health, including condom use; and disease prevention, testing and treatment.

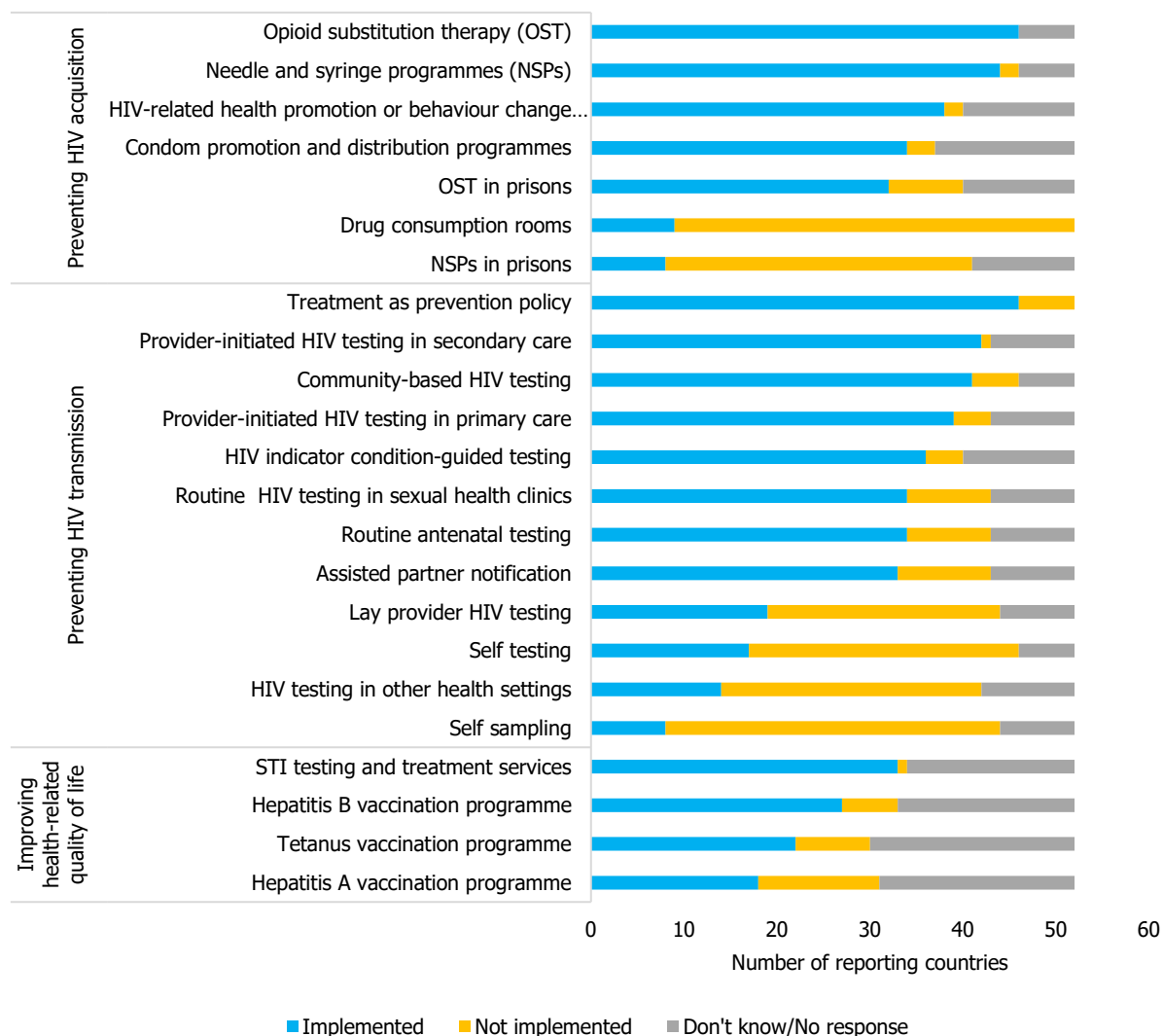
Targeted delivery of services: services should be combined, organised and delivered according to user needs and local conditions. This includes the provision of services through outreach and fixed site settings offering drug treatment, harm reduction, counselling and testing, as well as referrals to general primary health and specialist medical services.

Evidence also indicates that health facilities where drug use is supervised by professional staff and takes place in a clean and safe environment (so-called Drug Consumption Rooms, DCRs) are beneficial for reaching marginalised groups. For those who use them regularly, such facilities are also effective in reducing harm related to injecting drug use, including risk behaviour that enables the transmission of infectious diseases [13]. DCRs have mainly been set up in cities with high levels of concentrated drug use in public spaces, where they form an important part of a comprehensive response in order to reduce health harm and improve public safety.

Countries were asked whether they implemented a range of specified interventions to prevent the transmission of infections among PWID. Responses are shown in Figure 7, where the interventions have been categorised into those with a primary focus on 'preventing HIV acquisition'; those with a secondary prevention element of 'preventing onward HIV transmission'; and those with a broader focus of 'improving health-related quality of life'. Of course many of the interventions which prevent HIV acquisition also contribute towards preventing onward transmission (e.g. condoms and needle and syringe provision), and some also contribute to improving health-related quality of life (e.g. Opioid Substitution Therapy (OST) and Drug Consumption Rooms (DCR) reduce the potential for overdosing and improve engagement with care).

While a significant majority of countries do have a policy to implement key interventions, such as Needle and Syringe Programmes (NSPs) and OST, there is a substantial drop-off in implementation of prevention interventions in prisons for PWID, lower rates of healthcare interventions such as vaccination programmes, and more to do in relation to testing and the sexual health of PWID. A detailed country breakdown can be seen in Annex 1. A more detailed report on combination prevention based on the responses to the 2018 Dublin Declaration reporting process will also be published at a later date.

Figure 7. Number of European and Central Asian countries implementing selected interventions, 2018



Preventing HIV acquisition

Needle and Syringe Programmes (NSPs)

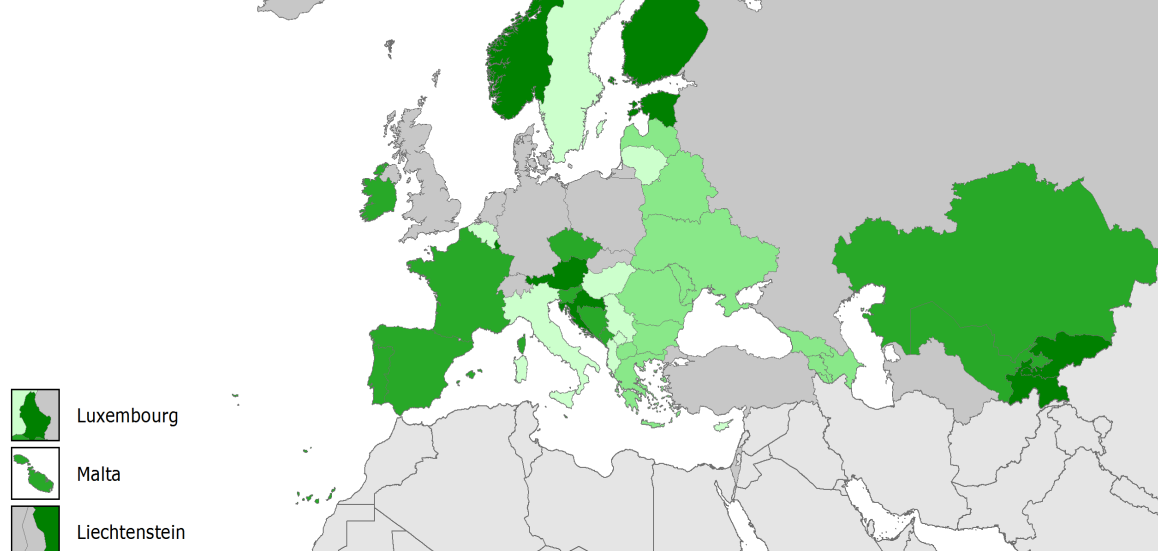
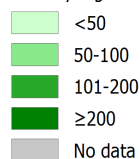
Forty-four of the 52 responding⁷ countries reported that they implemented needle and syringe programmes (NSPs) for PWID. Whilst this suggests a widespread acceptance of this harm reduction measure, it does not offer a realistic picture of coverage and provision. The international standard of acceptable coverage for PWID is at least 200 needles distributed per person per year⁸ [14]. Eleven countries provided no data on the number of syringes distributed per person who injects drugs. Only eight countries in the Region reported meeting this international standard for needle distribution (≥ 200) – Austria, Croatia, Estonia, Finland, Kyrgyzstan, Luxembourg, Norway and Tajikistan (see Figure 8). A further eleven countries reported distribution of between 100 and 200 needles per person per year (Bosnia & Herzegovina, Czech Republic, France, Ireland, Kazakhstan, Malta, Montenegro, Portugal, Slovenia, Spain and Uzbekistan). Only six countries with an HIV prevalence of 11% or over among people who inject drugs also report a distribution of at least 100 needles per person per year, and of those only two are non-EU/EEA countries (Kyrgyzstan and Tajikistan).

⁷ Andorra and Turkey reported that NSPs are not implemented. Iceland responded, 'Don't know'. Five countries – Liechtenstein, Monaco, Russia, Tajikistan and Uzbekistan – did not respond to the question. The three countries which did not respond to the 2018 Dublin Declaration reporting process were Bosnia & Herzegovina, San Marino and Turkmenistan.

⁸ The WHO target to reach by 2020 is 200 sterile needles and syringes provided per person who injects per year, and the target to reach by 2030 is 300.

Figure 8. Available data on number of syringes distributed per person per year, 2018

Nr of syringes distributed per person per year



Source: EMCDDA Statistical Bulletin 2018 and ECDC Dublin Declaration monitoring 2018.

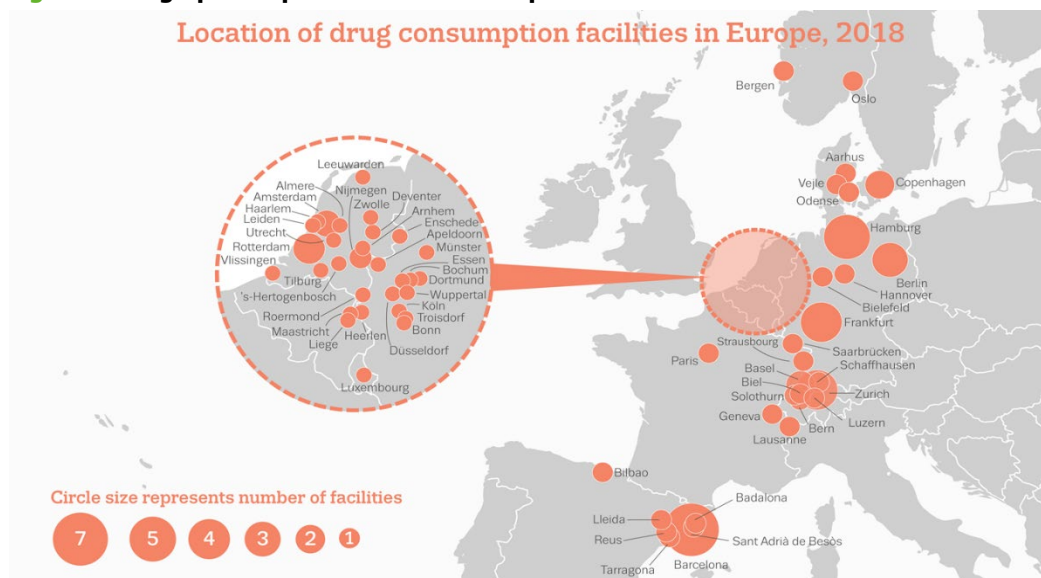
Increasing accessibility to harm reduction

The national health authority in Latvia reports that since January 2017 a new harm reduction mobile unit has been operating in the capital, Riga, and its surrounding neighbourhoods. The mobile unit operates 23 hours per week over four days. It has several employees, including medical, social and outreach workers. The mobile unit provides syringes and needles, condoms, specialist consultations, informative materials for clients, and rapid testing for HIV, hepatitis B and C and syphilis.

Drug Consumption Rooms

Only a few countries report provision of Drug Consumption Rooms (DCRs), despite their documented effectiveness in reducing injecting risk behaviour and overdose morbidity and mortality and in creating opportunities for users to access wider care and support services [13]. In 2018, Belgium, Denmark, France, Germany, Luxembourg, Netherlands, Norway, Spain and Switzerland reported the availability of DCRs (see Figure 9). Ireland reported that funding has now been made available for a DCR, meaning that the establishment of this service can now go ahead. There are, as yet, no DCRs introduced in the Centre and East sub-regions. More countries in Europe, and especially those with high numbers of PWID and high rates of HIV and other health harms, may find it useful to consider opening DCRs as part of a comprehensive response.

Figure 9. Geographical spread of DCRs in Europe



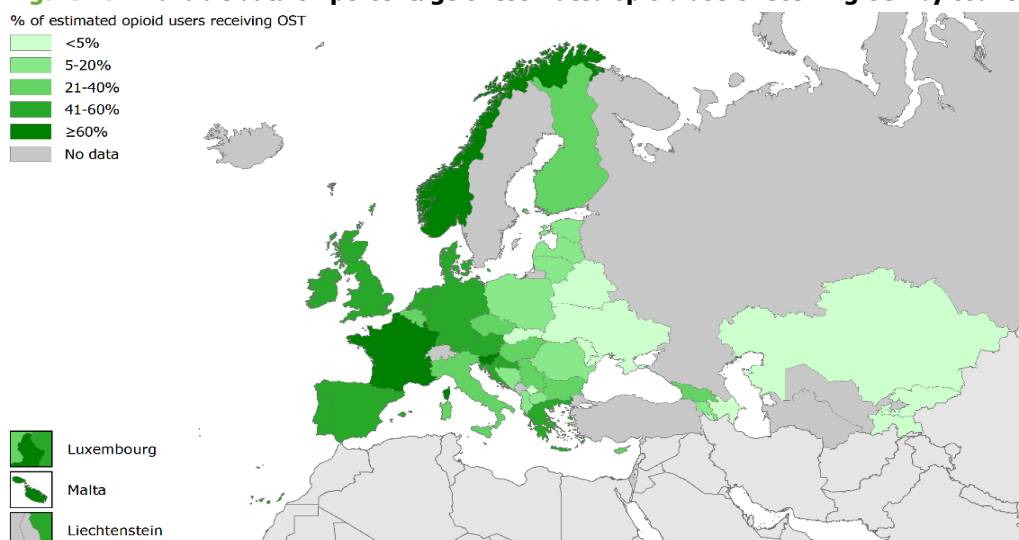
Source: EMCDDA [13]

Opioid Substitution Therapy (OST)

Similarly, for OST, an intervention reported as having been implemented by 46 countries⁹, it is important to look in detail at the percentage of estimated opioid users receiving OST. Thirteen countries had no data on OST coverage. There is a very considerable range in coverage, from 83% in Norway to 0.6% in Kazakhstan. Only five countries (France, Luxembourg, Malta, Norway and Slovenia) reported that over 60% of opioid users were receiving OST. A further 10 countries reported percentages between 40 and 60% (Austria, Croatia, Denmark, Germany, Greece, Ireland, Netherlands, Portugal, Spain and the United Kingdom). It is noteworthy that all countries reporting over 40% of opioid users receiving OST are EU/EEA countries.

In contrast, nine countries reported that less than 5% of opioid users were receiving OST (Azerbaijan, Belarus, Kazakhstan, Kosovo, Kyrgyzstan, Moldova, Slovakia, Tajikistan and Ukraine). With the exception of Slovakia, all these countries are in the East region and are non-EU/EEA countries. Furthermore, many of these countries have high rates of HIV in this key population – with both Belarus and Ukraine having a prevalence rate of over 20% and Kyrgyzstan, Moldova and Tajikistan having prevalence rates between 11 and 20%.

Figure 10. Available data on percentage of estimated opioid users receiving OST by country, 2018



Source: EMCDDA Statistical Bulletin 2018 and ECDC Dublin Declaration monitoring 2018

⁹ Slovakia, Russia and Uzbekistan do not implement OST in the community. Iceland, Liechtenstein, Monaco answered 'Don't know' to this survey question.

Removing legal barriers to OST

In **Germany**, the revision of the Narcotics Prescription Regulation in 2017 allows for more flexible and individualised OST and reduces legal barriers for physicians.

Condom promotion and distribution programmes

Countries were asked to report the percentage of PWID who used condoms the last time they had sex and the coverage of condom programmes among PWID. Condom use can prevent the transmission of HIV and other infections from PWID to their sexual partners. However, 26 countries (half of the responding countries) had no data on condom use at last sexual intercourse – further efforts are needed to collect these data in order to help support the sexual and reproductive health of PWID and their sexual partners. Of the 26 countries who could report data, values ranged from 63.5% in Montenegro to 15.1% in Azerbaijan. It is notable that only a small number of countries from the West sub-region were able to provide data for this indicator.

In terms of condom programme coverage (Figure 11), 13% countries reported low coverage, 33% reported medium coverage, 13% reported high coverage and 6% reported full coverage of condom programmes among PWID. A total of 35% of countries reported either no coverage or 'Don't know/No data'.

It is clear that there is a need to address the sexual health needs of PWID and, to this end, it is important to collect better data on the sexual behaviour and health needs of this key population.

Figure 11. Percentage of PWID reporting using a condom the last time they had sexual intercourse across Europe and Central Asia (n=26)

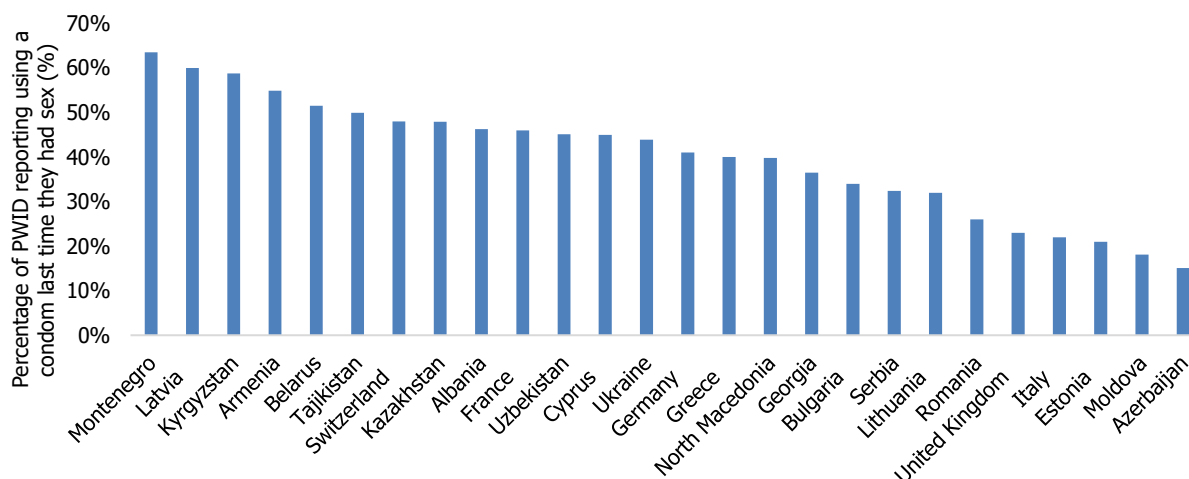
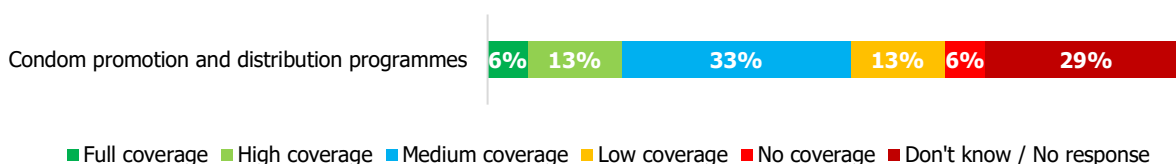


Figure 12. Estimated coverage of condom promotion and distribution programmes for PWID across Europe and Central Asia (n=52)



Harm reduction in prisons

A high percentage of people in prison inject drugs or have done so in the past. Prison offers an opportunity to provide harm reduction and healthcare services to PWID, some of whom may not previously have received such services. Conversely, in the absence of adequate drugs and health services for people who use drugs, the risk of unsafe drug use and the transmission of HIV and other blood-borne viruses (BBV) in prisons is high. In 2018, ECDC and EMCDDA published public health guidance entitled 'Prevention and control of blood-borne viruses in prison settings' [15], which sets out key principles for the provision of health services to prevent BBV transmission in prisons and the evidence base for effective interventions. These interventions include OST, NSPs, condoms and behavioural interventions, HBV vaccination, testing and treatment of HIV and viral hepatitis, and continuity of care.

In this report data on harm reduction in prisons draws on two sources. Data collected by EMCDDA are used for EU countries plus Norway and Turkey. For all other countries, data are drawn from the Dublin Declaration reporting process.

Only five countries across the whole Region implement NSPs in prison (Germany, Kyrgyzstan, Luxembourg, Spain, and Switzerland) (Table 2). This is a far lower number than the 44 countries implementing NSPs in the community. In the ECDC/EMCDDA 2018 guidance there is reference to the principle of 'equivalence of service provision'. The fact that a number of countries do operate NSPs in prison shows that it is possible and can bring health benefits. Other countries in the Region, and especially those with significant HIV epidemics among PWID, should examine the evidence for the value of NSPs in prison and consider implementation.

Table 2. Needle and syringe programmes in prison settings

NSPs in prisons	Countries	
Implemented	5	West: Germany, Luxembourg, Spain, Switzerland East: Kyrgyzstan.
Not implemented	40	West: Andorra, Austria, Belgium, Denmark, Finland, France, Greece, Iceland, Ireland, Israel, Italy, Malta, Netherlands, Norway, Portugal, Sweden, United Kingdom Centre: Albania, Bulgaria, Croatia, Cyprus, Czech Republic, Hungary, North Macedonia, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, Turkey East: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Latvia, Lithuania, Ukraine.
Don't know/no data	7	West: Liechtenstein, Monaco; Centre: Kosovo ¹⁰ ; East: Moldova, Russia, Tajikistan, Uzbekistan.

Source: EMCDDA Statistical Bulletin 2018 and ECDC Dublin Declaration monitoring 2018

Respondents were asked about OST implementation in prison settings (Table 3). Among those countries that have a prevalence of HIV among PWID of 6% and above, the following do not implement OST in prison – Azerbaijan, Kazakhstan, Tajikistan, Belarus, Russia and Ukraine. Russia and Tajikistan do not provide OST in the community either.

Table 3. Opioid substitution therapy in prison settings

OST in prisons	Countries	
Implemented	32	West: Andorra, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Malta, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland; United Kingdom; Centre: Albania, Bulgaria, Croatia, Cyprus, Czech Republic, Hungary, Kosovo ¹¹ , North Macedonia, Poland, Romania, Serbia, Slovakia, Slovenia, Turkey; East: Armenia, Estonia, Georgia, Kyrgyzstan, Latvia, Lithuania, Moldova.
Not implemented	8	West: Iceland, Israel; Centre: Slovakia; East: Azerbaijan, Belarus, Kazakhstan, Russia, Ukraine.
Don't know / No data	12	West: Liechtenstein, Monaco; Centre: Montenegro; East: Tajikistan, Uzbekistan.

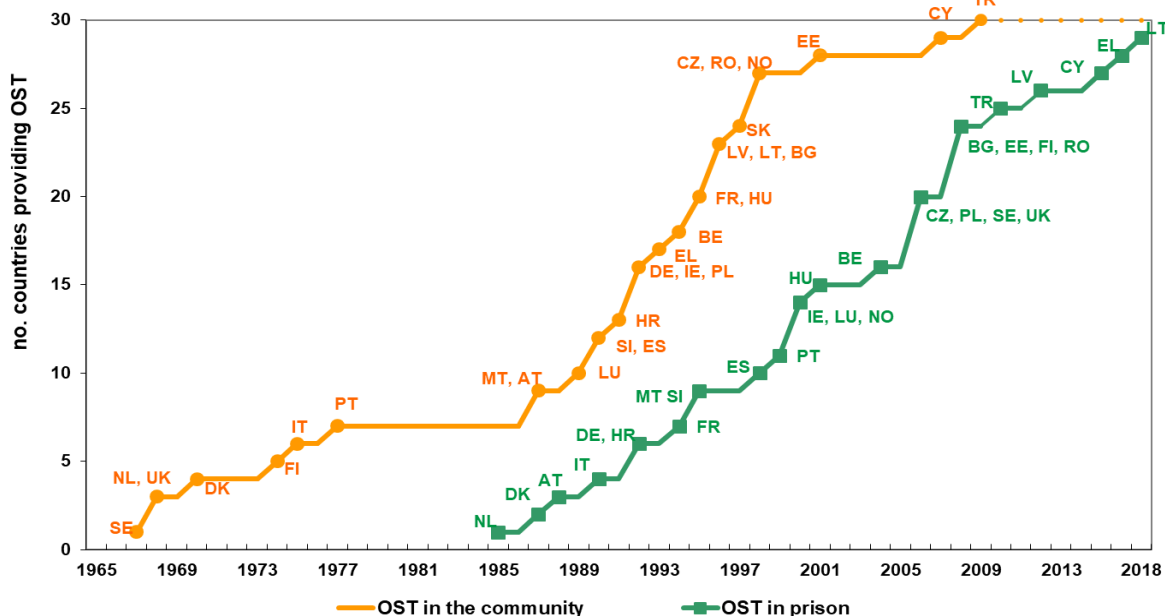
Source: EMCDDA Statistical Bulletin 2018 and ECDC Dublin Declaration monitoring 2018

¹⁰ 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

¹¹ See footnote 12 above.

EMCDDA data indicate that for EMCDDA member countries in recent years, the gap between the availability of OST as a treatment approach for people who use opioids in the community and in prison is slowly closing (Figure 13). Among the 30 EMCDDA member countries (EU-28, plus Norway and Turkey) only Slovakia does not provide the treatment, either in prison settings or in the community. However, the coverage in prison is often low and treatment quality unclear. In four of the 29 countries (Cyprus, Latvia, Lithuania and the Netherlands), OST can only be continued in prison if treatment was started in the community. It is not possible in these four countries to initiate OST in prison.

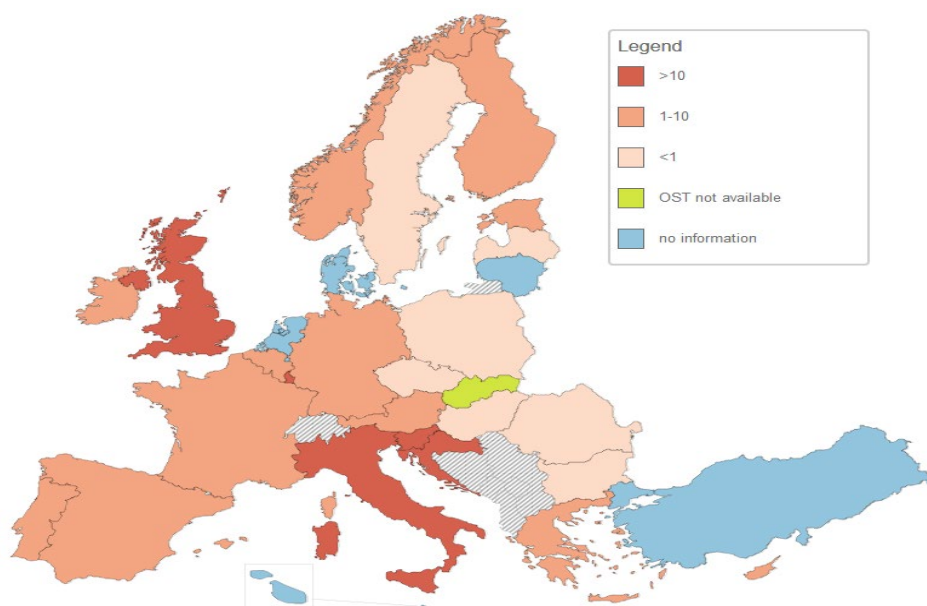
Figure 13. Opioid Substitution Treatment: cumulative number of EU countries introducing OST in community and prison settings



Source: EMCDDA Statistical Bulletin 2018

In terms of coverage, EMCDDA calculates as proxy for the coverage of prison OST the number of prisoners receiving OST per 100 prisoners, using the entire prisoner population as denominator (Figure 14). There are significant differences in this proportion between countries, ranging from more than 10% of all prisoners in Croatia, Italy, Luxembourg, Slovenia and the UK to below 1% in Bulgaria, Czech Republic, Latvia, Hungary, Poland, Romania and Sweden. There are significant challenges to turning policy into practice in prison settings.

Figure 14. Proxy for OST coverage among prisoners in 2017: number of OST patients in prison per 100 prisoners (on a given day)



Source: EMCDDA Statistical Bulletin 2018

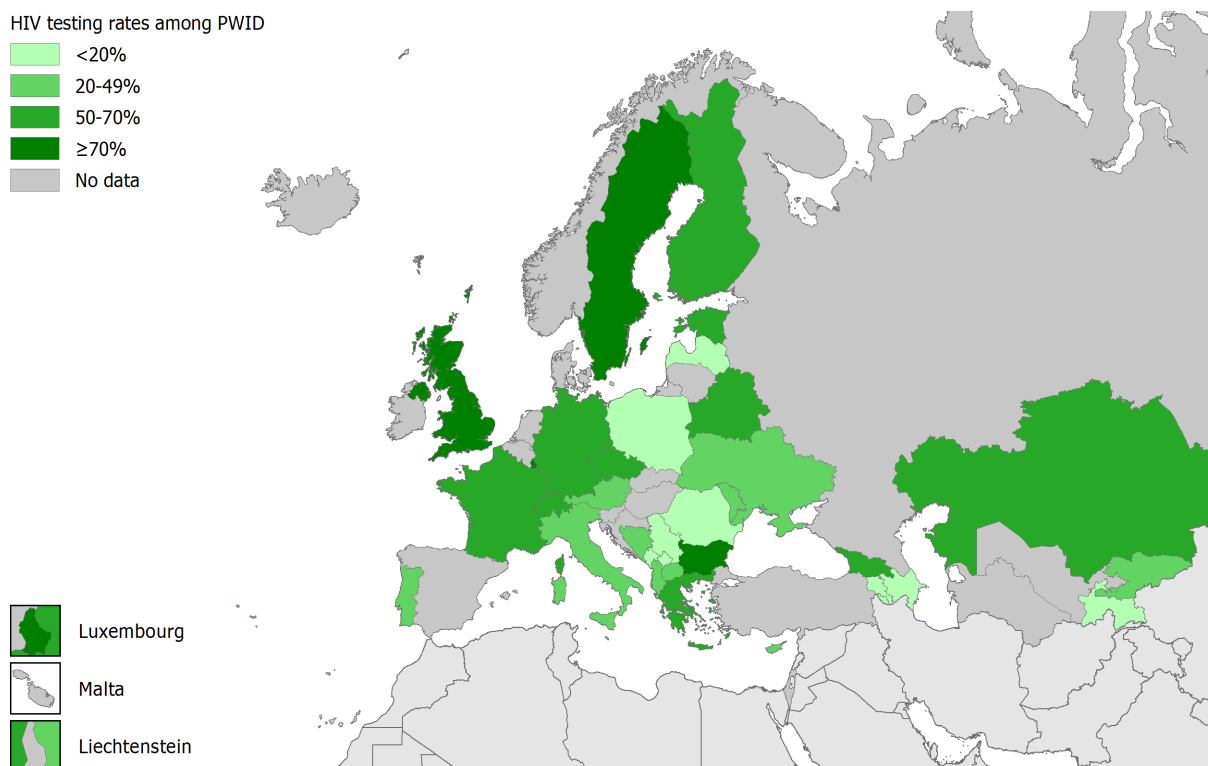
Preventing HIV transmission

Testing guidelines and testing rates

HIV testing is a key intervention to ensure people with HIV are diagnosed as early as possible to benefit from treatment and prevent both morbidity and mortality. It is also a key prevention intervention as diagnosis can support changes in risk behaviour and is the necessary first step in accessing treatment in order to achieve a suppressed viral load and become non-infectious. Of 40 countries with testing guidelines, 31 included content on specific key populations and 25 mentioned PWID. Twenty-eight countries had guidelines which made recommendations on how often key populations should be tested for HIV, with eight countries recommending that PWID should test every six months and 13 countries recommending annual testing, as per ECDC/EMCDDA guidance [12]. Further detail is provided in Annex 2.

Thirty-three countries were able to provide data on PWID testing rates over a 12-month period (see Figure 15). Four countries (Bulgaria, Luxembourg, Sweden and the United Kingdom) reported that over 70% of PWID were tested in the previous 12 months. Ten further countries reported values between 50 and 70%; ten countries reported between 20 and 49%; nine countries reported less than 20%; and 22 countries did not report any data. Furthermore, data reported by three countries were from 2012, 2013 and 2014, respectively. Again, further efforts are needed to survey these populations in many countries to gain a better idea of unmet needs.

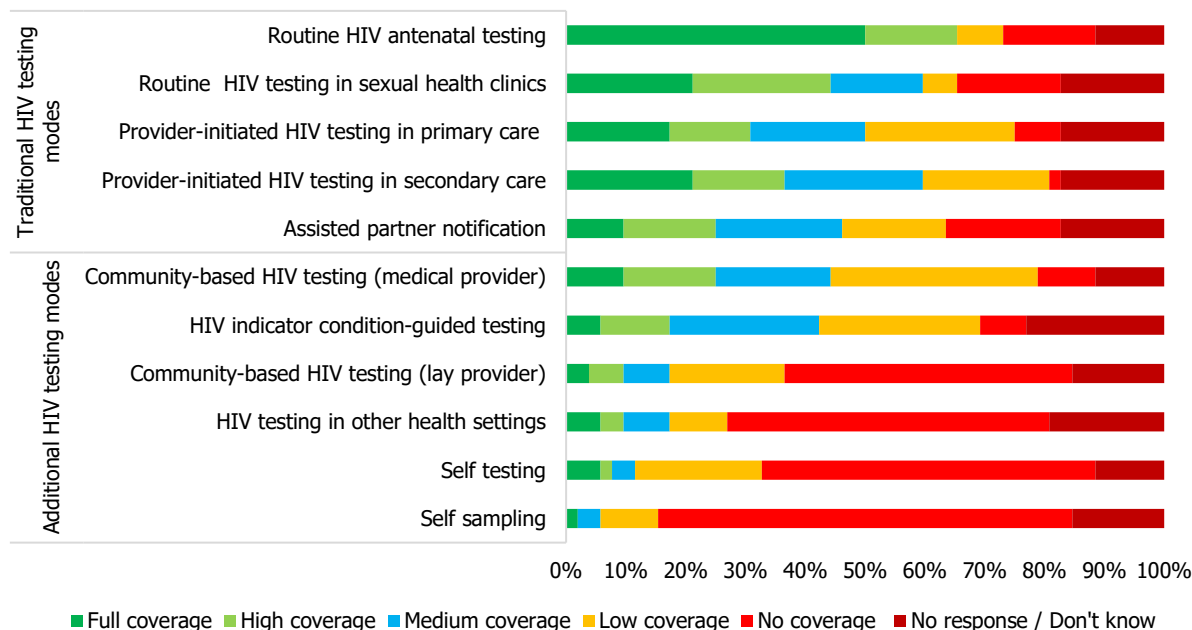
Figure 15. Available data on HIV test uptake (tested in last 12 months) among PWID, 2012–2017



Implementation of different HIV testing modes

It is important to implement a range of HIV testing modes to maximise reach to all populations affected by HIV. Respondents were asked about the degree of coverage in their country for a range of different testing strategies. While the questionnaire did not specifically ask about testing in drug treatment services, there was low coverage reported for testing in 'community' and 'other health settings'. Coverage of provider-initiated testing in primary and secondary care was reported to be higher. While these are settings where PWID might be more likely to be diagnosed, much more needs to be done to extend the reach of such testing interventions.

Figure 16. Level of implementation of different testing modes in Europe and Central Asia, reported in 2018¹²



Increasing HIV testing uptake among PWID

In **Germany**, various approaches are being used to increase testing uptake among PWID. Community-based testing has been expanded and testing is also now being offered in low-threshold drug services. Barriers to testing are being removed, such as the need to return to testing sites to receive test results. This is particularly important as point-of-care testing is increasingly being used. Finally, a testing campaign focusing on drug users aims to normalise routine HIV and hepatitis testing.

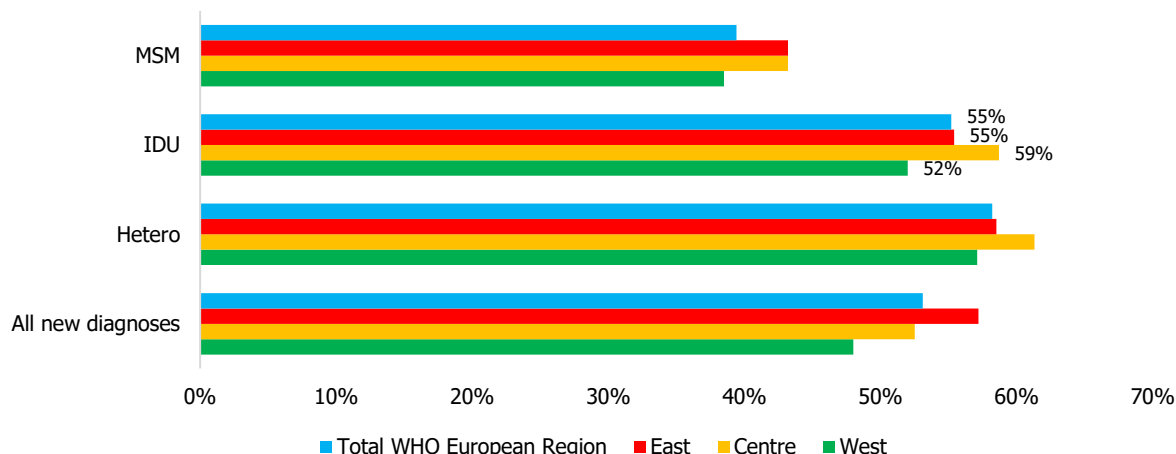
Late HIV diagnoses

HIV testing is vitally important to ensure early diagnosis of people living with HIV so that they can maximise the benefits of HIV treatment. Late diagnosis (defined as diagnosis with a CD4 count of <350/mm³) increases short-term mortality risk, decreases life expectancy and results in greater morbidity. In addition, the earlier people are diagnosed, the sooner they can both adopt safer sex behaviour and become non-infectious once they are receiving effective treatment. Someone diagnosed late will tend to have had HIV for at least three to four years prior to their diagnosis [16]. There is therefore also a significant wider public health benefit to effective HIV testing among people who inject drugs.

Nevertheless, late diagnosis rates remain stubbornly high. For PWID the overall late diagnosis rate across the European Region in 2017 was 55%, with little variation across the three sub-regions [2]. This compares with a 53% late diagnosis rate for all people newly diagnosed with HIV in 2017. Only for the key population of men who have sex with men (MSM) was the late diagnosis rate significantly lower (though still too high) at 39%.

¹² Countries were asked which testing modes were implemented and what level of coverage was implemented. Based on the WHO definition of universal health coverage, full coverage was defined as 'all who need the service can use it, that the service is of sufficient quality to be effective, and that use of the service will not expose the user to financial hardship'. Countries could choose from a scale of coverage, as follows: No coverage: the service is not provided. Low coverage: <30% of the population can use the effective, affordable service. Medium coverage: 30–60% of the population can use the effective, affordable service. High coverage: 61–95% of the population can use the effective, affordable service. Full coverage: 95–100% of the population can use the effective, affordable service.

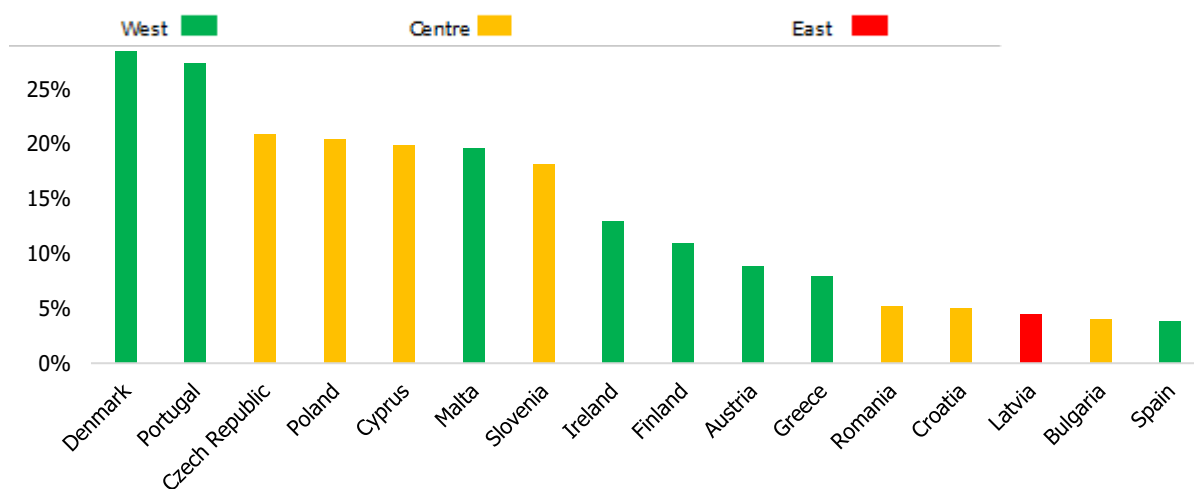
Figure 17. Late diagnosis by exposure route, 2017



Source: ECDC/WHO (2017). HIV/AIDS Surveillance in Europe 2018 – 2017 data

EMCDDA collect data on the percentage of PWID entering drug treatment who report never having been tested for HIV (see Figure 18). ‘Never tested’ rates range from 28% (Denmark) to 4% (Latvia and Bulgaria). There is no clear correlation between EMCDDA data and the Dublin Declaration responses on testing rates in the previous 12 months. Of those countries reporting over 70% testing in the previous 12 months only Bulgaria also provided data to EMCDDA on ‘ever/never’ testing rates for those entering prison – 4% had never tested which confirms the relative effectiveness of Bulgaria’s testing interventions for PWID.

Figure 18. Percentage of PWID entering drug treatment in 2017 who report having never having been tested for HIV



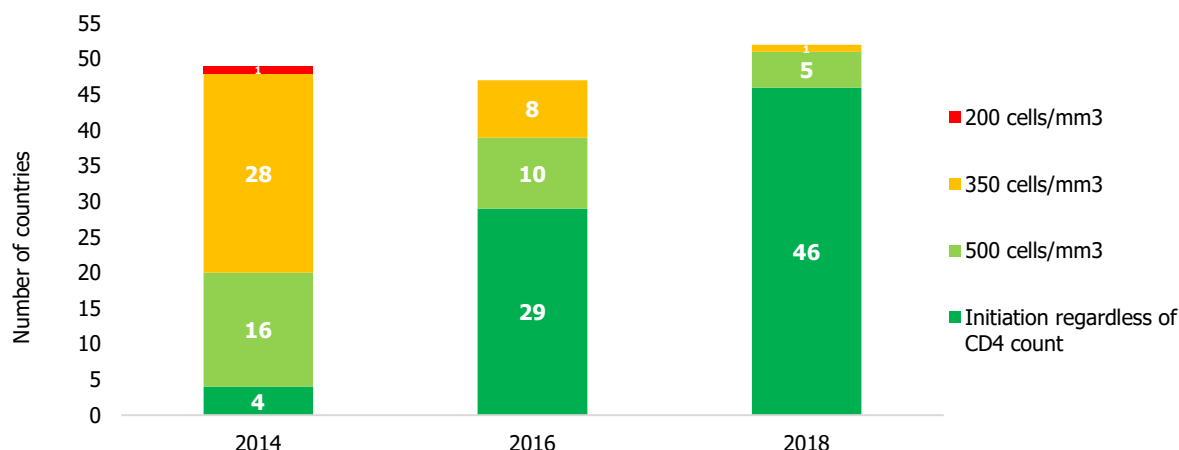
Source: EMCDDA (2018). TDI monitoring system

Treatment guidelines

Ensuring prompt access to HIV treatment not only keeps the person living with HIV healthy, it also eliminates the risk of sexual transmission once the person has reached viral suppression. Since 2014, there has been a significant increase in the number of countries in Europe and Central Asia with guidance advising prompt treatment following diagnosis, regardless of CD4 count. A total of 46 countries have now adopted this advice, in accordance with WHO [17] and EACS [18] clinical guidelines on the use of ART for treating and preventing HIV infection. However, six countries continue to maintain a CD4 threshold for initiating HIV treatment – Azerbaijan, Bosnia & Herzegovina¹³, Latvia, Moldova, Tajikistan and Uzbekistan. Given the significant prevalence of HIV among PWID in some of these countries, implementation of the guidelines on treatment initiation regardless of CD4 count should be considered.

¹³ Although Bosnia & Herzegovina did not officially submit data to the 2018 Dublin Declaration monitoring round, current treatment policy was confirmed via email by the country focal point.

Figure 19. Changing policy on initiation of ART by CD4 count



Whilst the widespread implementation of treatment as prevention policies indicates positive progress, it is less clear whether these policies are being implemented in practice. As Figure 6b in the continuum of care section shows, disaggregated data on treatment coverage among PWID remain limited. Among the small number of countries that did report the percentage of PWID diagnosed who are on treatment, there are a number with low percentages on treatment even though they have a policy of treatment initiation regardless of CD4 count – Greece, Belgium, Kazakhstan, Bulgaria and Belarus. Furthermore, in Figure 6c we can see that in some countries the proportion people on treatment who are virally suppressed is surprisingly low – Azerbaijan, Kazakhstan, Bulgaria – which indicates the reality of treatment provision and access might be more problematic.

Improving adherence to treatment and retention in care among PWID

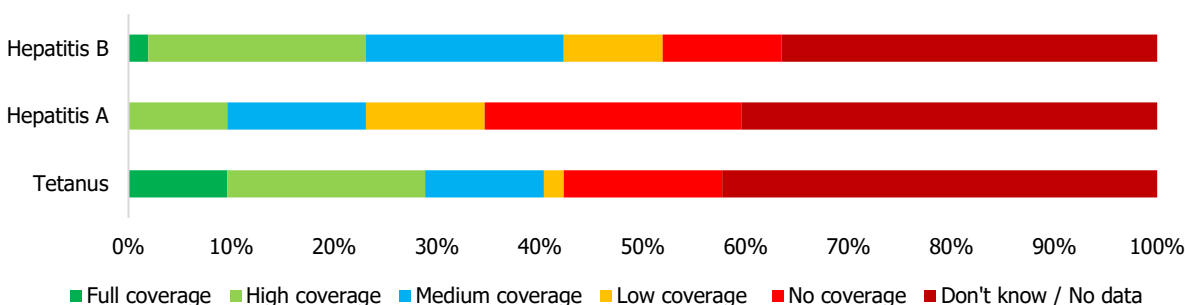
In **Ireland**, one HIV clinic in Dublin has a number of walk-in slots which facilitates 'open appointments' for patients where adherence to treatment and retention in care is a challenge. There is also a consultant-led homeless liaison service with a multi-disciplinary team approach (including keyworkers, outreach, nursing and hostel staff) working to improve retention.

Improving health-related quality of life

Vaccination programmes

Vaccination programmes for PWID are vital in supporting good health and preventing onward transmission, including for those PWID living with HIV. However, data suggest there is much more to do to improve vaccination coverage for PWID. For hepatitis A and tetanus the percentage of countries that report either no coverage or 'Don't know/no data' are 65% and 58%, respectively. The figure is not much better for hepatitis B at 48%.

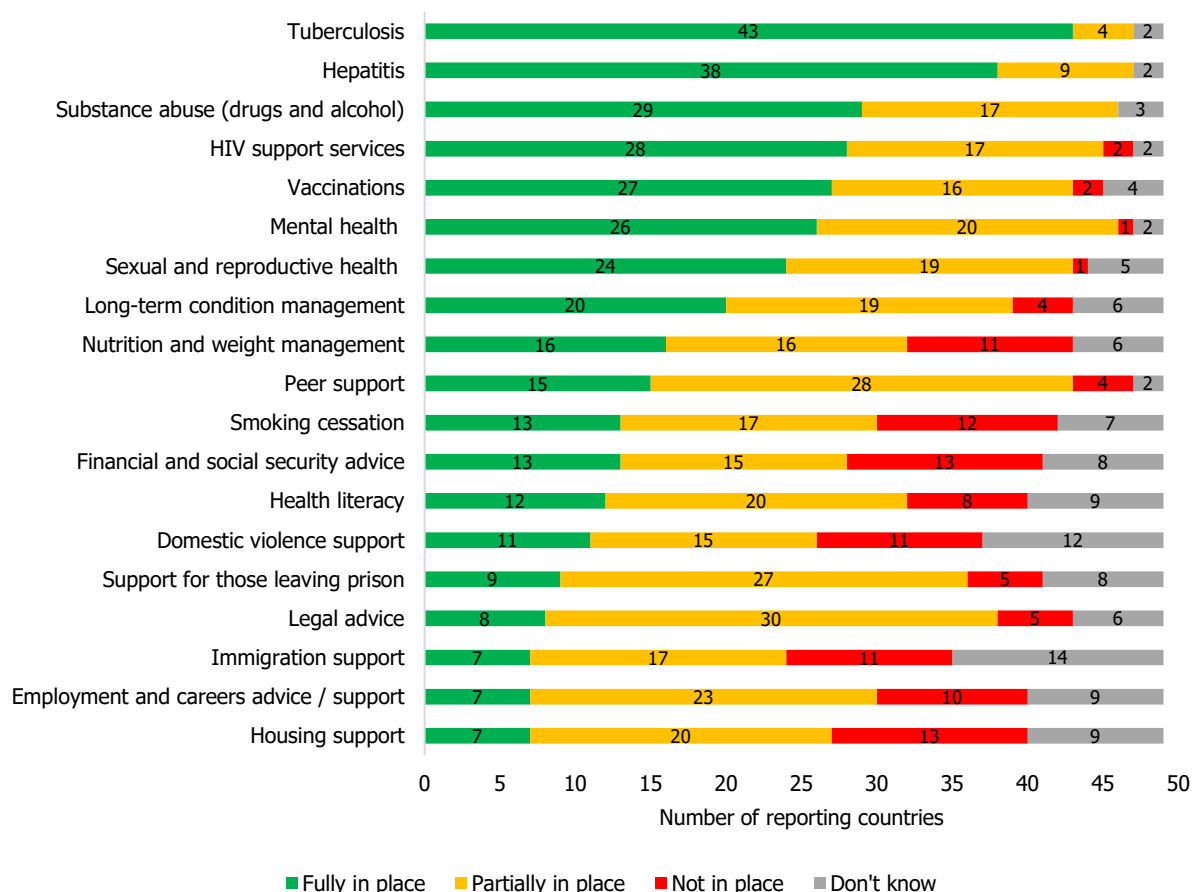
Figure 20. Estimated coverage of HBV, HAV and tetanus vaccination programmes for PWID across Europe and Central Asia (n=52)



Integration of other services into HIV care

The Dublin Declaration questionnaire 2018 asked whether there are systems in place to ensure that PLHIV who are on treatment are linked to other care programmes and services that can improve their general quality of life when living with HIV. Figure 21 indicates that many of the health-related services that are particularly important to PWID living with HIV, such as drugs and alcohol support or hepatitis and TB services, are well integrated into HIV care in a majority of countries. However, services which could have a significant impact on the quality of life of PWID living with HIV, such as housing and legal support, are not well integrated.

Figure 21. Linkage to other support services for people receiving HIV care



Addressing barriers to services

Data on barriers to prevention, testing and treatment in key populations were collected in previous rounds of Dublin Declaration reporting, most recently in 2016 [19]. Barriers have tended to remain constant over time and for PWID these include stigma and discrimination, gaps in prevention programmes (e.g. insufficient NSP coverage, insufficient attention to medical care/BBVs, lack of attention to specific sub-groups of PWID), legal barriers such as criminalisation/punitive legislation, and a failure to deliver treatment at scale [20].

In 2018, 20 countries reported that they had taken action to address barriers to HIV prevention, testing and treatment services which had a direct impact on PWID. Sixteen countries had taken action to remove barriers to prevention services for PWID, eight countries had taken action on barriers to testing, and ten countries had taken action on barriers to treatment for PWID.

Since criminalisation of drug use remains widespread across the European Region [21], it was promising to see a number of countries enacting changes to reduce legal barriers to support for people who inject drugs. Both Malta and Ireland reported actions taking a more public-health focused approach to drug policy, moving away from criminalisation, particularly for minor offences.

Moving towards a public health approach to people who inject drugs

Malta is taking steps to move away from a penal approach to drug policy and towards a more public health focussed approach. In April 2015, the Drug Dependence (Treatment not Imprisonment) Act 2014 came into force. Under this Act, a person found in possession of a small amount of drugs for personal use will be tried in front of the Commissioner of Justice. If found guilty, a fine of EUR 50 to EUR 100 will be imposed for possession of cannabis or EUR 75 to EUR 125 for possession of other drugs. Any offender who commits a second offence within a period of two years will be required to attend the Drug Offenders Rehabilitation Board, where he or she will be assessed for drug dependence and any necessary order issued. Failure to comply with an order may be punishable by a fine or three months in prison. A person found in possession of one cannabis plant for personal use will not be liable to a mandatory prison term. In the case of an offender who commits a limited number of offences as a result of drug dependence, the Court may assume the function of a drug court and refer the offender to the Drug Offenders Rehabilitation Board.

In addition, other actions taken included changes to laws and policies (four countries); increases in funding (four countries); improvements to service delivery (11 countries); improvements in surveillance and monitoring (three countries); increased integration with other health services or support services (four countries); interventions to improve adherence and retention (two countries); interventions to improve education and awareness among health professionals (four countries) and PWID (nine countries); and interventions to reduce stigma and discrimination (two countries). Some of these actions have been included as case studies throughout this report.

With regard to new and emerging barriers to treatment for PWID, Ireland reported that increases in homelessness and unstable accommodation since the previous monitoring round have resulted in patients missing appointments and poor adherence to medication regimes.

Conclusions and priorities for action

PWID continue to be a key population affected by HIV in the European Region. However, the extent of this HIV burden is notably imbalanced across the sub-regions, with the East sub-region, even in the absence of data from Russia, reporting in 2017 that 24.1% of its new HIV diagnoses were among PWID (compared with 2.7% in both other sub-regions).

There is encouraging evidence of a decline in new HIV diagnoses among PWID in some countries, especially Ukraine and Azerbaijan, but also in Estonia, Portugal, Austria and Spain. However, this decline is not observed across the whole Region. It will be important to identify and share the reasons for this encouraging trend and implement shared learning. There is, of course, already a very strong evidence base for what works in reducing HIV transmission among this population. Most importantly, a comprehensive package of harm reduction measures needs to be implemented. The 2018 Dublin Declaration monitoring survey found that only eight countries have achieved the 2020 minimum target set by WHO's Regional Office for Europe for availability of clean injecting equipment for PWID. It is hardly surprising, given such inadequate provision, that HIV and other BBVs continue to be transmitted. Similarly, we know that OST reduces heroin use and injecting, and supports people in moving into structured treatment and wide-ranging support for a variety of needs. Whilst 42 countries stated they had a policy of providing OST to PWID, most countries, if they had data at all, reported relatively low percentages of PWID on OST. Although it is necessary to have the right policies in place, this on its own is insufficient. Resources, services and monitoring need to be provided to ensure that as many PWID as possible can and do access such prevention measures. There is a proven synergistic effect of combining harm reduction at scale (NSPs and OST) with effective treatment of infections (e.g. ART for HIV).

Whilst NSPs and OST are the most commonly cited elements to harm reduction, there are other important measures which should be combined with these to reduce harm, such as HIV transmission. The evidence suggests not enough is being done to support safer sex in this population, and there is more to do on wider healthcare including STI testing and treatment, and vaccination programmes. Far greater efforts need to be made to overcome the barriers to healthcare access experienced by PWID, and there should be monitoring of, and targets to reduce, rates of morbidity and mortality in this population.

It is encouraging to see the gap in OST provision in prisons across Europe slowly closing, especially in EMCDDA member countries. However, policies do not always determine the level of provision of services, and the rates of prisoners receiving the treatment vary widely across the Region. Even if policies are now in place to provide OST to people during their time in prison, coverage needs to be significantly improved.

Data collection in relation to HIV care for PWID remains poor across Europe, with only seven countries being able to report on all four stages of the continuum of care. There was relatively little progress in data collection on the continuum of care for PWID between 2016 and 2018. This report also makes it clear that insufficient surveillance and data collection is not confined to the stages of the continuum of care. For example, there are similar gaps and deficiencies across Europe in relation to coverage of harm reduction measures. There are countries in all three sub-regions which need to improve data collection. Where the proportion of PWID among all people living with diagnosed HIV is relatively low there is an even greater risk that overall data for the population of people living with HIV can disguise, in the absence of disaggregated data, significant health inequalities experienced by PWID.

Priority options for action

Strengthen prevention programmes for PWID

- All countries which have not yet reached the international standard of >200 clean syringes distributed per PWID per year should consider developing and implementing a plan to do so, to meet WHO targets.
- Greater efforts need to be made to ensure that opioid users can easily access effective treatment, such as OST, especially in the East sub-region. All countries should be aiming in the short- to medium-term to meet WHO's 40% target for the Region, and countries which have already met this target should consider adopting more ambitious targets.
- Cities in the European Region that have not as yet introduced Drug Consumption Rooms (DCRs) should review the international evidence for their effectiveness, consider whether they can meet needs among PWID in their locality, and consider piloting/introducing DCRs when the evidence suggests they can help reduce HIV transmission and other harming behaviour on a local scale.
- The quality, accessibility and acceptability of condom promotion and distribution programmes for PWID should be reviewed in order to increase condom uptake and usage.

- In accordance with ECDC/EMCDA guidance, comprehensive harm reduction interventions should be implemented in prisons to reduce health harms arising from injecting drug use and more support provided to people in accessing treatment and care, including OST. All countries should consider making OST available for PWID in prison, both for initiation and continuation of treatment.
- All countries should consider reviewing barriers to PWID accessing HIV prevention, testing, treatment and care, and consider, in light of national and international recommended best practices, measures to remove those barriers. In addition to the measures identified above, they should consider interventions against stigma and discrimination, reviews of punitive laws affecting PWID, enhanced testing efforts (for example in drug treatment services and community settings), and improved treatment for the health needs of PWID, such as testing for other BBVs.
- Infectious disease testing, treatment and care for PWID should ideally be integrated, along with vaccination programmes, into wider healthcare and health promotion.

Improve surveillance, research and data collection

- More and better data on PWID need to be collected, especially for all stages of the continuum of care – this should be considered as a priority for all countries in the European Region.
- Other data that would be very useful to collect across Europe include new diagnoses and prevalence data for PWID, the percentage of PWID who have tested in the last 12 months, uptake of all key prevention/harm reduction interventions, prison-specific data, health outcomes for PWID, adherence/retention in treatment (especially in the East sub-region), and epidemiological data on transmission among sexual partners of PWID.
- The views of PWID and service users on the availability, accessibility and quality of services could be regularly collected and published, and ideally the survey process should be co-produced with PWID to be acceptable to and trusted by them.
- Assumptions on coverage and service delivery for PWID could be compared against other relevant data sources and civil society perspectives to improve accuracy.

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Annex 1. Combination Prevention for PWID

NSP – Needle and Syringe Programmes

NSPP – Needle and Syringe Programmes in Prisons

OST – Opioid Substitution Therapy

OSTP - Opioid Substitution Therapy in Prisons

DCR – Drug Consumption Rooms

C – Condom promotion and distribution programmes

BC – HIV-related health promotion or behaviour change programmes

TV – Tetanus vaccination programme

CBT – Community-based HIV testing (medical provider)

SS – Self sampling

ST – Self testing

LPT – Community-based HIV testing (lay provider)

AT – Routine antenatal testing

RSH – Routine HIV testing in sexual health clinics

PIPC – Provider-initiated HIV testing in primary care

STITT – STI testing and treatment

PISC - Provider-initiated HIV testing in secondary care

TOS – HIV testing in other settings

PN – Assisted partner notification

ICT – HIV indicator condition-guided testing

TASP – Treatment as Prevention

HAV – Hepatitis A vaccination programme

HBV – Hepatitis B vaccination programme

Implemented with high to full coverage

Implemented with low to medium coverage

Not implemented

Don't know / No response

WHO Region	Country	NSP	NSPP ¹⁴	OST ¹⁵	OSIP ¹⁶	DCR ¹⁷	C	BC	CBT	SS	ST	LPT	AT	RSH	PIPC	PISC	TOS	PN	ICT	TASP	HAV	HBV	TV	STITT	
West	Andorra	Red	Red	Green	Green	Red	Red	Red	Grey	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
	Austria	Green	Red	Green	Green	Red	Red	Red	Green	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
	Belgium	Green	Red	Green	Green	Red	Red	Red	Green	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
	Denmark	Green	Red	Green	Green	Red	Red	Red	Green	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
	Finland	Yellow	Red	Yellow	Green	Red	Red	Red	Yellow	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
	France	Green	Red	Green	Green	Red	Red	Red	Green	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
	Germany	Green	Red	Green	Green	Red	Red	Red	Green	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
	Greece	Yellow	Red	Green	Green	Red	Red	Red	Yellow	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
	Iceland	Grey	Red	Grey	Red	Red	Red	Red	Grey	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
	Ireland	Green	Red	Green	Green	Red	Red	Red	Green	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
	Israel	Green	Red	Green	Green	Red	Red	Red	Green	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
	Italy	Yellow	Red	Green	Green	Red	Red	Red	Yellow	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
	Liechtenstein	Grey	Red	Grey	Red	Red	Red	Red	Grey	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
	Luxembourg	Green	Red	Green	Green	Red	Red	Red	Green	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
	Malta	Green	Red	Green	Green	Red	Red	Red	Green	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red

¹⁴ For EU countries plus Norway and Turkey, EMCDDA data were used to determine whether NSPs are available in prisons.

¹⁵ EMCDDA report that OST is available in the community in Sweden and Turkey. No information is available on coverage.

¹⁶ Response categories for whether OST is available in prisons only included the option of yes (categorised as green) or no (categorised as red). Data for EU countries plus Norway and Turkey are from EMCDDA and for other countries are from the Dublin Declaration reporting process.

¹⁷ Response categories for whether DCRs are implemented only included the option of yes (categorised as green) or no (categorised as red). This data was provided by EMCDDA.

WHO Region	Country	NSP	NSPP ¹⁴	OST ¹⁵	OSIP ¹⁶	DCR ¹⁷	C	BC	CBT	SS	ST	LPT	AT	RSH	PIPC	PISC	TOS	PN	ICT	TASP	HAV	HBV	TV	STIT		
West	Monaco																									
	Netherlands																									
	Norway																									
	Portugal																									
	Spain																									
	Sweden																									
	Switzerland																									
	United Kingdom																									
Centre	Albania																									
	Bulgaria																									
	Croatia																									
	Cyprus																									
	Czech Republic																									
	Hungary																									
	Kosovo																									
	North Macedonia																									
	Montenegro																									
	Poland																									
	Romania																									
	Serbia																									
	Slovakia																									
	Slovenia																									
	Turkey																									
	East	Armenia																								
Azerbaijan																										
Belarus																										
Estonia																										
Georgia																										
Kazakhstan																										
Kyrgyzstan																										
Latvia																										
Lithuania																										
Moldova																										
Russia																										
Tajikistan																										
Ukraine																										
Uzbekistan																										

Annex 2. Testing guidelines

WHO sub-region	Country	Are there any national policies or guidelines in your country that cover HIV testing interventions and strategies?	Do the guidelines have content on specific key populations?	Do they mention PWID?	Do the guidelines make recommendations on how often key populations should be tested for HIV?	Do they mention PWID?
West	Andorra	No				
	Austria	Yes	No		No	
	Belgium	No				
	Denmark	Yes	Yes	Yes	Yes	No
	Finland	Yes	No		No	
	France	Yes	Yes	Yes	Yes	Yes - once a year
	Greece	Yes	Yes	Yes	Yes	Yes - every 6 months
	Iceland	No				
	Ireland	No				
	Israel	Yes	Yes	Yes	No	
	Italy	Yes	Yes	Yes	Yes	Yes - every 6 months
	Liechtenstein					
	Luxembourg	Yes	Yes	Yes	Yes	Yes - once a year
	Malta	Yes	Yes	Yes	Yes	Yes - every 6 months
	Monaco	No response				
	Netherlands	Yes	Yes	No	Yes	No
	Norway	Yes	Yes		Yes	No
	Portugal	Yes	Yes	Yes	Yes	Yes - once a year
	Spain	Yes	Yes	Yes	Yes	Yes - once a year
Sweden	Yes	Yes	Yes	No		

WHO sub-region	Country	Are there any national policies or guidelines in your country that cover HIV testing interventions and strategies?	Do the guidelines have content on specific key populations?	Do they mention PWID?	Do the guidelines make recommendations on how often key populations should be tested for HIV?	Do they mention PWID?
	Switzerland	Yes	Yes	Yes	No	
	United Kingdom	Yes	Yes	Yes	Yes	Yes - once a year
	Germany	Yes	Yes	Yes	Yes	Yes - once a year
Centre	Albania	Yes	No		No	
	Bulgaria	Yes	Yes	No	Yes	Yes - once a year
	Croatia	Yes	Yes	Yes	No	
	Cyprus	No				
	Czech Republic	Yes	No		No	
	Hungary	Yes	No		No	
	Kosovo	Yes	Yes	Yes	Yes	Yes - every 6 months
	North Macedonia	Yes	Yes	Yes	Yes	Yes - every 6 months
	Montenegro	No				
	Romania	Yes	Yes	Yes	Yes	Yes - once a year
	Serbia	Yes	Yes	No	No	
	Slovakia	No				
	Slovenia	Yes	Yes	Yes	Yes	Yes - once a year
	Turkey	Yes	No		No	
	Poland	Yes	Yes	No	Yes	No
East	Armenia	Yes	No		Yes	No
	Azerbaijan	Yes	Yes	Yes	Yes	Yes - once a year
	Belarus	Yes	Yes	Yes	Yes	Yes - every 6 months
	Estonia	Yes	Yes	Yes	Yes	Yes - once a year

WHO sub-region	Country	Are there any national policies or guidelines in your country that cover HIV testing interventions and strategies?	Do the guidelines have content on specific key populations?	Do they mention PWID?	Do the guidelines make recommendations on how often key populations should be tested for HIV?	Do they mention PWID?
	Georgia	Yes	No		No	
	Kazakhstan	Yes	Yes	Yes	Yes	Yes - once a year
	Kyrgyzstan	Yes	Yes	Yes	Yes	Yes - every 6 months
	Latvia	No				
	Lithuania	Yes	Yes	Yes	Yes	Yes - once a year
	Moldova	Yes	Yes	Yes	Yes	Yes - every 6 months
	Russia	No response				
	Tajikistan	Yes	No		Yes	No
	Ukraine	Yes	Yes	No	Yes	No
	Uzbekistan	No response				

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