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for Drugs and Drug Addiction

RAPID COMMUNICATION

Drug-related infectious diseases in Europe

Update from the EMCDDA expert network
October 2017



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Coordination and programming of the annual drug-related infectious diseases expert meeting was undertaken by Isabelle Giraudon, Eleni Kalamara, Klaudia Palczak and Dagmar Hedrich for the EMCDDA, together with Erika Duffell, Lara Tivoschi and Andrew Amato from the ECDC, for the Joint EMCDDA-ECDC network meeting held on 16 June 2017 in Lisbon.

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Introduction and objective of this report

This report provides an update on infectious diseases related to drug use in Europe for the period up to June 2017. It provides an overview of the most recent data both on infectious diseases among people who inject drugs in Europe, collected through the EMCDDA drug-related infectious diseases (DRID) indicator ⁽¹⁾, and on the

responses in the area. It includes highlights and new findings discussed during the DRID indicator's annual expert meeting, held in Lisbon on 14-16 June 2017. This event offered a platform for discussion among experts from the 28 EU Member States, Norway and Turkey. EU agency partners and international organisations were also represented ⁽²⁾. The 2017 meeting included a full joint day with the ECDC hepatitis expert network (EMCDDA, 2017a).

At a glance: a summary of key points

Injecting: In Europe, overall, heroin is the most commonly injected illicit drug. In some countries, however, injection of stimulants is common among those who inject drugs. Recent national estimates (from 2009 onwards) of the prevalence of injecting drug use are available for only 16 of the 30 countries reporting to the EMCDDA. The estimates range from less than 1 to more than 9 per 1 000 population aged 15-64. A downward trend can be observed in the proportion of people who inject drugs among those entering specialised drug treatment for heroin-related problems for the first time in their life (from 43 % of heroin users in 2006 to 29 % of heroin users in 2015), but levels of injecting remain high (46 %) among amphetamines users entering drug treatment for the first time in 2015 — although the number of people injecting amphetamines is small and they are concentrated in a few countries.

Hepatitis C virus (HCV): Hepatitis C is the most prevalent blood-borne virus infection among people who inject drugs, with the prevalence of HCV antibodies (i.e. marker of having been infected by the virus) often in excess of 50 %. The majority of those infected will develop chronic infection; however, there are now very effective treatments. These treatments, when provided alongside harm reduction measures, are important for eliminating hepatitis C as a public health threat among people who inject drugs. There are many challenges to delivering the WHO Global Health Sector Strategy for the elimination of viral hepatitis, and monitoring is important to assess progress towards the targets that have been set for hepatitis C. For people who inject drugs or have done so in the past, these challenges include the uptake of diagnostic testing, and unclear referral and care pathways between testing and treatment.

Human immunodeficiency virus (HIV): Europe is seeing a continuing decline in the reported number of new HIV diagnoses attributed to injecting drug use. The 1 233 diagnoses with this risk factor reported in 2015 were the lowest for a decade. Nevertheless, the number of new HIV

diagnoses and the prevalence of HIV among people who inject drugs remain high in a number of countries, particularly Estonia, Latvia and Lithuania. Local HIV outbreaks among marginalised groups of people who inject drugs have recently occurred in Dublin (Ireland), Glasgow (United Kingdom) and Luxembourg.

Outbreaks of other infections: A range of other infections continue to cause outbreaks among people who use drugs. Examples include the recent outbreaks of invasive group A streptococcal infections in the United Kingdom and of hepatitis A in the Czech Republic. There is also an ongoing large outbreak of hepatitis A among men who have sex with men in Europe, and drug use in a sexual context may have been a factor in the development of this outbreak in some countries.

Prisons and hepatitis C: Prisons pose particular challenges to reducing the burden of infectious disease, and those who have been imprisoned report higher levels of lifetime drug use than the general population. There is an elevated risk of transmission of infections associated with imprisonment. Effective interventions for prevention and control of viral hepatitis that are implemented in the community are not always available in prison; where they are, their introduction has typically been later than in the community. Opportunities exist for scaling up hepatitis C prevention, diagnosis and treatment in prisons.

Drug consumption rooms: Drug consumption rooms are professionally supervised healthcare facilities where drugs can be used in a safe, hygienic environment. In Europe, as of June 2017, there were 90 official drug consumption rooms, of which 76 were in six EU countries (31 in the Netherlands, 24 in Germany, 13 in Spain, five in Denmark, two in France and one in Luxembourg), two in Norway and 12 in Switzerland. A number of countries are currently looking to expand their provision, and several others are currently considering the establishment of facilities.

⁽¹⁾ More information of the key indicator is available from www.emcdda.europa.eu/activities/drid.

⁽²⁾ Information on the meeting, including the agenda, presentations and supporting documents, is available at the DRID meeting webpage.

The DRID annual network meetings primarily aim to share and discuss the analysis of national and European data. They also explore new developments, and their implications for actions and policy development. It should be noted that, as this publication is, in part, based on the presentations to the meeting and emerging issues, some of the information presented here is necessarily preliminary.

In addition, this report uses information provided by countries in their 'national DRID updates' in the spring of 2017. It also draws on analysis of the information provided to the EMCDDA by the national focal points and their experts in the 2016 annual reporting exercise, the main findings of which are presented in the European Drug Report 2017 and also available through the Statistical Bulletin (EMCDDA, 2017b; EMCDDA, 2017c).

The multi-indicator data set used in the analysis covers and integrates aspects of the epidemiology (prevalence of injection, prevalence of infections among people who inject drugs, notifications of newly diagnosed infections, risky behaviours, morbidity and outbreaks) and responses (prevention, testing for infections, treatments for addiction and infections, and harm reduction).

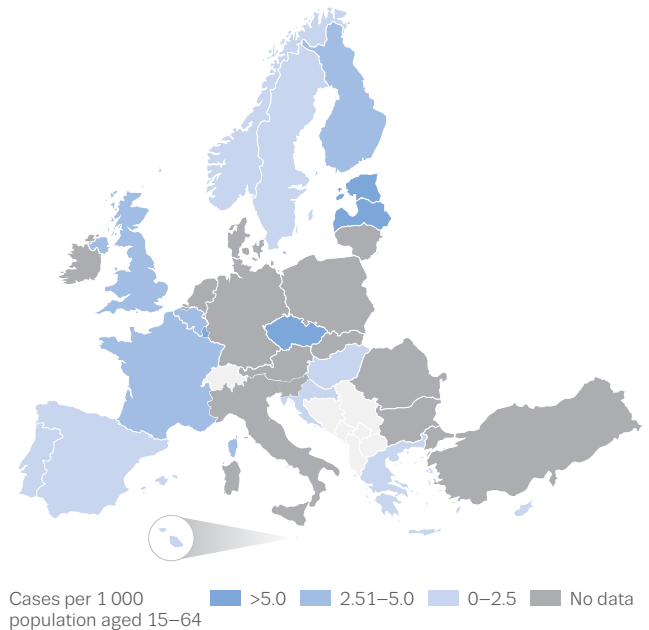
Overview of drug-related infections and risk

This section presents an overview of injecting drug use in Europe, and of the epidemiology and responses to hepatitis C among people who inject drugs. It also provides updates on the epidemiology and responses to other infections, including hepatitis B and HIV, and on recent outbreaks among people who inject drugs in Europe.

Introduction: the extent and nature of injecting drug use in Europe

People who inject drugs are one of the main population groups affected by blood-borne viruses, in particular the hepatitis C and B viruses (HCV and HBV) and human immunodeficiency virus (HIV), as these three viruses can be transmitted through the sharing of syringes, needles and other drug injecting equipment. Recent national estimates (from 2009 onwards) of the prevalence of injecting drug use are available for 16 countries. These range from less than 1 to more than 9 cases per 1 000 population aged 15-64 (Figure 1; Appendix 1). The highest rates are reported from Latvia (9 cases per 1 000 population) and the Czech Republic, Estonia and

FIGURE 1
Estimates of the prevalence of injecting drug use, 2009-15 (most recent data)



NB: Case definition: injecting use of any psychoactive substance not according to medical prescription in the last 12 months (www.emcdda.europa.eu/activities/hrdu). See also Appendix 1.

Source: EMCDDA, 2017c.

Luxembourg (each with around 6 cases per 1 000 population). However, caution is needed in interpreting these data, as the most recent estimate for Latvia is from 2012 and the estimates for Estonia and Luxembourg are from 2009.

Historically, in Europe, the most common route of administration of heroin has been by injection, and, among people who inject drugs, heroin users have been the majority. Information on people entering drug treatment for the first time in their life, however, shows a downward trend in the proportion of those using heroin who report injection as their usual route of drug administration. Over the past 10 years this proportion has fallen from 43 % in 2006 to 29 % in 2015. The second-largest group of people who inject drugs, among those entering drug treatment for the first time, are those whose primary drug is an amphetamine (commonly amphetamine and methamphetamine). Overall, amphetamines users represented 8.4 % of first-time clients in 2015 in the European Union and only a few countries reported significant numbers injecting amphetamine or methamphetamine in their treatment data. However, these data are heavily influenced by the situation in the Czech Republic, which accounted for almost all the first-time clients reporting the injecting of methamphetamine (94 % of the European total).

The emergence of injecting use of new psychoactive substances, reported in a number of countries, has caused particular concern in recent years (EMCDDA and EUROPOL, 2017). The injection of synthetic cathinones, which are short-acting stimulants, has been associated with increased infection risk and harms, for example, outbreaks of HIV (EMCDDA, 2016a; EMCDDA, 2017b). Timely detection of the use of new and emerging drugs, as well as ongoing monitoring of risky drug use practices (such as injecting and sharing of injecting equipment), and detecting changes in these, is important to reducing and preventing harm.

HCV incidence, prevalence and trends

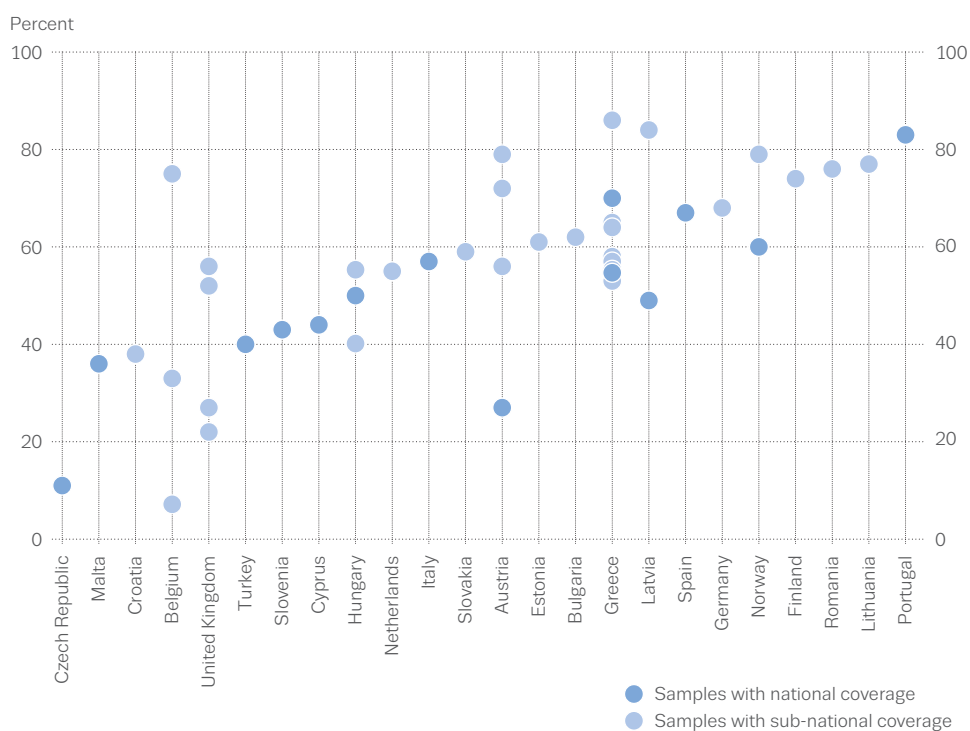
Studies among people who inject drugs conducted in 2014-15 found that the prevalence of antibodies to HCV (anti-HCV) — a marker of present or past infection — was between 16 % and 84 %, with most of the studies with national or subnational data showing levels over 50 % (Figure 2). Recent data (from 2014 or later) on the extent of HCV infection among people who inject drugs are available from 24 countries, and come from a range of study types. Sero-prevalence surveys are reported by 13 countries, seven of which have repeated surveys (Greece, Hungary, Latvia, Slovakia, the United Kingdom, Norway and

Turkey). For 11 countries, the only recent data available on the extent of viral hepatitis is from diagnostic testing; however, 10 of these countries have time trends. This diversity in data sources means that comparisons should be made with caution.

The high prevalence of HCV among people who inject drugs in Europe, and the fact that many of them became infected a long time ago, has a severe impact on the overall health of these populations in Europe. Chronic HCV infection, often worsened by heavy alcohol use, accounts for an increasing number of cases of liver disease, including cirrhosis and liver cancer, and an increasing number of deaths (Stanaway et al., 2016), among an ageing population of people who use or have used drugs by injection.

The incidence of new HCV infections is difficult to estimate directly, as this requires studies that follow up those at risk over time. Incidence can also be estimated through statistical methods from survey data (Léon et al., 2016) and by using biological markers (Page-Shafer et al., 2008; Patel et al., 2016). Alternatively, the extent of recent transmission can be assessed by looking at the prevalence of HCV antibodies among those who have recently started injecting and among younger people who inject drugs (aged 25 years or younger). Infections of individuals in

FIGURE 2
Prevalence of HCV antibodies among people who inject drugs: studies with national and subnational coverage, 2014-15



Source: EMCDDA, 2017b.

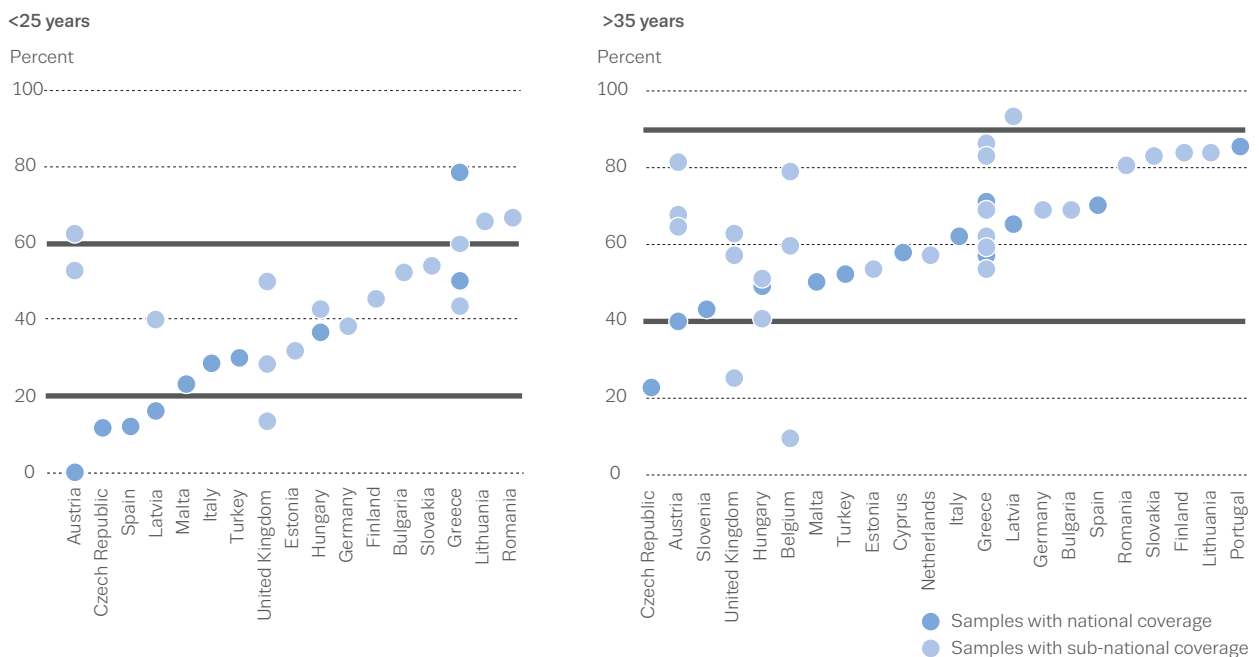
these groups are likely to have occurred recently. There were 25 countries with data available for younger people who inject drugs (2014-15). In many of them, the prevalence in this group is over 20 % (Figure 3; Appendix 2), indicating ongoing transmission.

Most HCV prevalence estimates among younger people who inject drugs are between 20 % and 60 %, whereas most prevalence estimates among older people who inject drugs (those aged 35 years and over) are between 40 % and 80 %, highlighting the accumulation of risk over the years and a high burden of infection among the older groups (Figure 3).

The current monitoring of HCV focuses on the collection of data on HCV antibodies. However, monitoring HCV ribonucleic acid (RNA), a marker of current infection, is now becoming important — see the box on monitoring HCV infection (page 8).

The high level of HCV among those who have injected drugs is mirrored by data on new diagnoses reported to ECDC. In 2015, 34 651 cases of hepatitis C were reported from 28 EU/EEA Member States, a crude rate of 8.6 per 100 000 population (ECDC, 2017a). Although information on the likely route of transmission was available for only approximately 14 % of the HCV diagnoses notified in the European Union during 2015, injecting drug use was the risk reported for 75 % of these newly notified diagnoses. The interpretation of HCV data across countries remains a problem, with ongoing differences in surveillance systems and difficulties in defining reported cases as acute or chronic. With HCV, a largely asymptomatic disease until the late stages, surveillance based on notification data is challenging, with data reflecting testing practices rather than the occurrence of disease.

FIGURE 3
Prevalence of hepatitis C infection among people who inject drugs, by age; studies with national and subnational coverage, 2014 to 2015



Source: EMCDDA, 2017c.

NB: The heavy lines in the graphics highlight the differences in the distributions of the two age groups. Studies with sample size of at least 10 are not available for all countries.

Monitoring hepatitis C infection among people who use drugs in the era of direct-acting antivirals

The development of highly effective direct-acting antiviral drugs for HCV infection has resulted in more effective and easily deliverable treatment. As a result, more people are now being successfully treated. This has implications for monitoring HCV infection among people who use drugs. The biological marker of infection that is most commonly used currently in the monitoring of HCV prevalence is antibodies to HCV. As only around a fifth to a quarter of people naturally clear HCV infection, this marker has been a useful proxy for the extent of chronic infection. However, those who are successfully treated remain positive for HCV antibodies even though they are no longer infected. Thus, as the number of people successfully treated increases, this marker will have more limited utility for measuring the extent of current infection. There is a good marker of current infection, which is the presence of HCV RNA; however, testing for this marker is currently less common because it often costs more.

An example of survey development to improve monitoring of HCV prevalence among people who inject drugs was presented at the DRID meeting. The national Unlinked Anonymous Monitoring (UAM) survey of people who inject

drugs in the United Kingdom (excluding Scotland) has recently undergone a number of developments, in part to reflect the impact of new direct-acting antiviral drugs on HCV (Desai, M., DRID meeting, 2017). The recruitment method used in this long-standing system has remained the same, but two changes have been made. Firstly, the survey questionnaire has been revised to better capture data related to access to HCV treatment and care. Secondly, and more significantly, a cost-neutral restructuring of the testing of the samples collected, involving moving to an automated approach, has allowed the introduction of the routine HCV RNA testing of all samples collected in the survey. This will allow not only the ongoing monitoring of the extent of the current HCV infection, but also the monitoring of HCV incident infections by detecting HCV RNA in those without antibodies, which indicates recent infection.

The reporting to EMCDDA of information on HCV RNA prevalence among people who inject drugs is currently an optional data item. Following discussion at the meeting, it was proposed to make reporting this information a core data item, to encourage countries to collect this data.

HCV prevention and treatment

Those currently injecting drugs are thus the main target group for prevention activities, and they and those who have injected in the past are important groups for the provision of treatment for HCV.

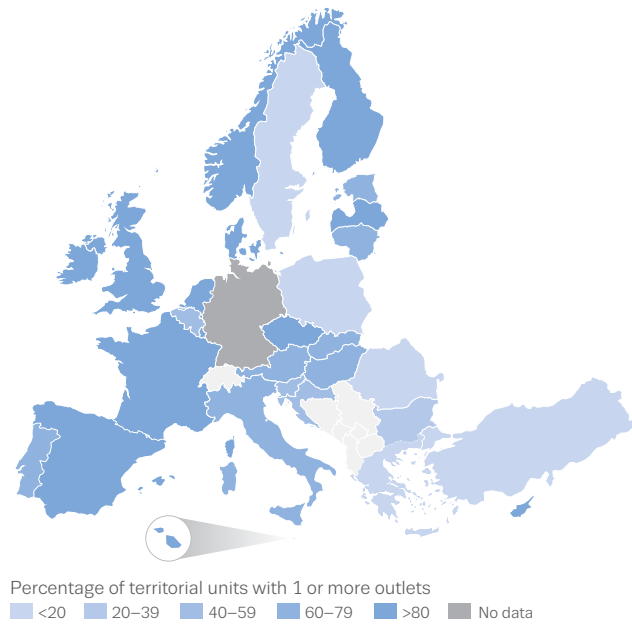
The HCV landscape has changed with the development of a range of very effective direct-acting antiviral drugs (DAAs), which became available in Europe in 2014. Treatment with these drugs can cure HCV infection in almost all those affected (EASL, 2016). However, those who have been cured may remain at risk of liver problems, such as fibrosis, and will still require follow-up. Although many DAAs are available, overall provision is currently low and the scale-up of provision for people who have injected or inject drugs is often slow.

Treating HCV among people who inject drugs on sufficient scale is very likely to have a positive contribution to prevention activities (EMCDDA, 2016b). 'Treatment as prevention', as this approach is called, results from the additive effect of treating HCV among those actively

injecting alongside two established interventions that are known to reduce risk. These interventions are needle and syringe programmes, which aim to ensure that clean, sterile injection equipment is always used, and opioid substitution treatment, prescribing drugs that are taken orally to reduce the frequency of injection. Adequate coverage of these two interventions is important for their effectiveness; however, the available data suggest that the provision of these interventions still remains low in relation to needs in some European countries (Platt et al., 2017).

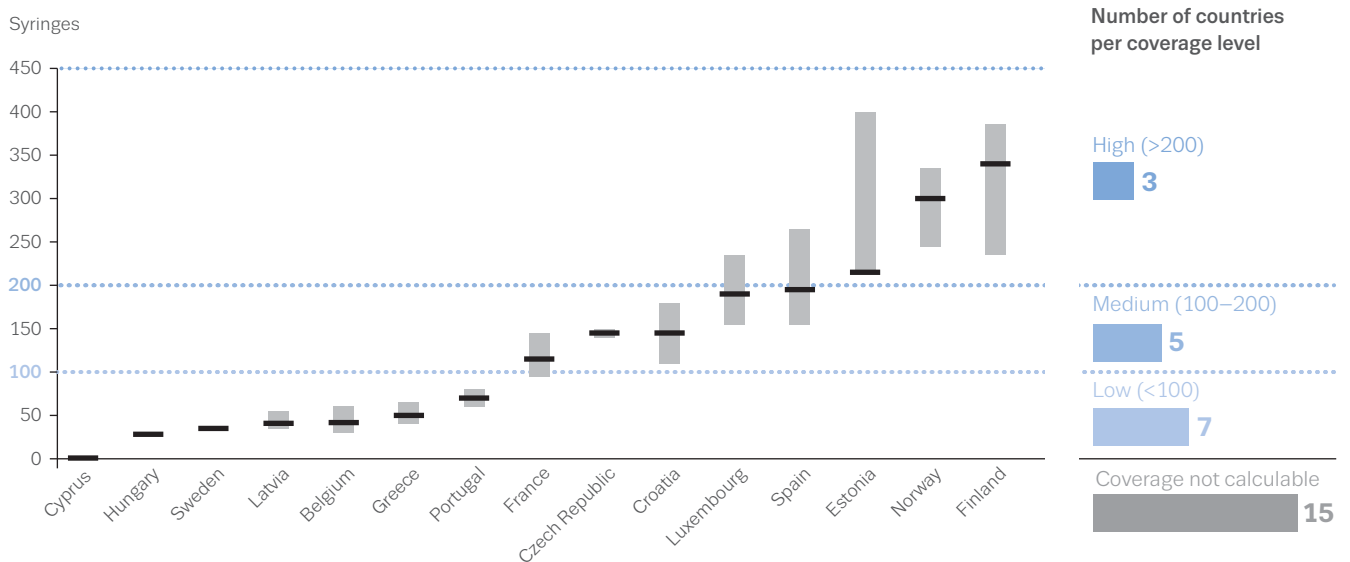
Needle and syringe programmes are available in all European countries (Figure 4), but the geographical spread is poor in a number of countries (Figure 4). National-level data on the estimated coverage of needle and syringe programmes (calculated as the number of syringes distributed from specialised and publicly subsidised programmes annually per person who injects drugs) is available for only 15 countries, with only three of these (Estonia, Finland and Norway) estimating coverage above 200 syringes per person who injects drugs (Figure 5).

FIGURE 4
Availability of specialist needle and syringe programmes in the European Union, Norway and Turkey



NB: Percentage of NUTS-III standardised European territorial units with one or more outlets (NUTS-II for Spain, Italy, Netherlands, Austria). Availability may not be throughout each NUTS, or indicate if coverage within this territory is sufficient.
 Source: (EMCDDA, 2017c).

FIGURE 5
Coverage of specialised syringe programmes: number of syringes provided per person who injects drugs (estimate)

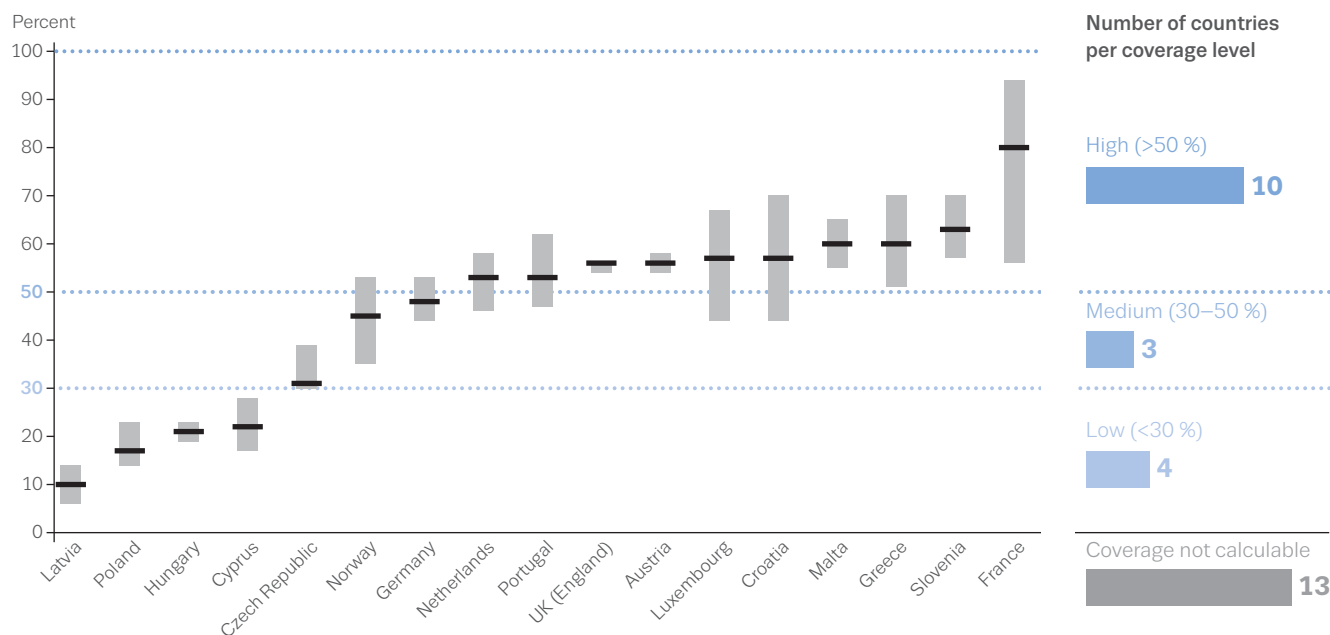


NB: Data displayed as point estimates and uncertainty intervals.
 Source: ST 10 — 2016 data collection and recent injecting drug use estimates (EMCDDA, 2017c).

Oral opioid substitution treatment is effective in reducing the harm from opioid addiction (EMCDDA, n.d.). The coverage of opioid substitution treatment, calculated as the percentage of estimated high-risk opioid users

receiving the treatment, is estimated at over 50 % in 10 of the 17 countries for which estimates of the population of high risk opioid users are available, and less than 30 % in four countries (Figure 6).

FIGURE 6
Coverage of opioid substitution treatment (percentage of estimated high-risk opioid users receiving the intervention)



NB: Data displayed as point estimates and uncertainty intervals.
 Source: EMCDDA, 2017c.

These data indicate a need to improve the coverage of one or both of these interventions in many countries. Data on the number of syringes given out or on the number of people in opioid substitution treatment are available for most countries, but coverage estimates cannot be generated for lack of estimates of the population size to use as a denominator (Appendix 1).

Available data on the extent of access to, and uptake of, treatment for HCV among those who have acquired their infection through injecting drug use is currently limited in Europe. The multistage process from access to diagnostic testing to cure is often referred to as the HCV cascade of care. The EMCDDA, together with the EU Member States, Norway and Turkey, is currently trying to improve data collection for key components of the HCV cascade of care for people who inject drugs. Core data collected by the EMCDDA related to HCV prevalence and prevention are summarised in Appendix 2, and a discussion is ongoing among national experts on how this dataset could be expanded to include markers related to diagnosis, care and treatment. In this context, it should be noted that data on prevention and the continuum of care are important for monitoring progress towards the targets for hepatitis C in the WHO Global Health Sector Strategy for viral hepatitis

(WHO, 2016a) and the regional targets for Europe (Duffell et al., 2017; see below).

Hepatitis C strategies, action plans and indicators

The first ever Global Health Sector Strategy for Viral Hepatitis (2016-21), adopted in May 2016, aims to eliminate viral hepatitis — including hepatitis B and C — as a major public health threat by 2030 (WHO, 2016a). As part of the implementation of this strategy, a European Action Plan was approved in September 2016. This plan is tailored to the specific needs of the WHO European Region (WHO European Office, 2016). These two documents set targets for actions to deliver the ‘elimination’ of hepatitis B and C. The EMCDDA and ECDC are supporting the strategy by assisting countries in the monitoring of its implementation and the achievement of the European regional targets.

Equitable access to hepatitis treatment is one of the progress indicators in the global hepatitis strategy set out by the WHO. In the European Region, the Action Plan for the health sector response to viral hepatitis proposes as one of its milestones for the development of evidence-

based policies in all countries by 2018, the existence of 'a costed and funded national hepatitis plan with clear targets or a viral hepatitis response plan in a broader health strategy or action plan'. In order to support the documentation of progress made towards this milestone, and also to promote the exchange of good practice, the EMCDDA has compiled a list of national hepatitis policy documents (national strategies, action plans and clinical guidelines) from all EU countries plus Norway and Turkey, which are being reviewed with regard to their relevance for inclusion of people who inject drugs.

First results of the analysis of these documents were presented at the meeting (Nielsen, S., DRID 2017), and showed that 13 European countries (Belgium, Denmark, Germany, Spain, Ireland, France, Italy, Netherlands, Slovenia, Finland, Sweden, United Kingdom, Norway) have viral hepatitis strategies. Several of these had been revised or newly developed since the direct-acting treatments for HCV became available in 2014. Five countries (Greece, Latvia, Luxembourg, Poland, Portugal) mentioned being in the process of preparing national hepatitis strategies with the involvement of multiple stakeholders. Among countries which currently do not have a strategy, several recently updated their national clinical treatment guidelines for HCV treatment.

The latest guidelines from the European Association for the Study of the Liver (EASL, 2016) and from the WHO (2016b) recommend prioritising the treatment of people who inject drugs and have HCV, in order to reduce transmission, but the preliminary analysis seems to indicate that few countries implement this.

The example of Portugal, where there is a national treatment register but no national strategy, shows, however, that other approaches, such as clear clinical guidelines in combination with strong political lobbying supported by pharmaceutical firms and civil society involvement, can help to increase treatment access among people who inject drugs.

HBV prevalence and vaccination levels

Hepatitis B virus can be transmitted through injecting drug use; however, unlike for HCV, there is currently an effective and safe vaccine available (ECDC, 2017b). Although most countries now have universal HBV vaccination programmes, these have mostly been introduced in recent decades. As a result, some cohorts of people who inject drugs will not have been vaccinated. The provision of catch-up programmes for these groups is therefore necessary. A few countries have targeted programmes

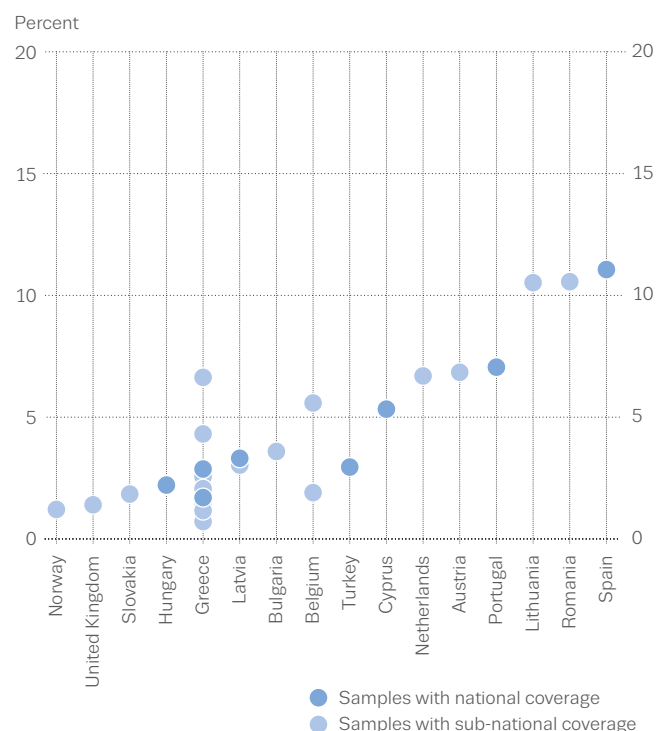
focusing on those at greatest risk, including people who inject drugs. The extent of vaccine uptake among those at risk through drug use is not always well known and is likely to vary from country to country.

Information about the extent of current HBV infection among people who inject drugs (2014-15) is available for 16 EMCDDA countries. In most of them, the prevalence of HBsAg (a marker of chronic carriage of the virus) is under 5 %, although prevalence is higher in national or subnational studies of people who inject drugs from Belgium, Greece, Spain, Lithuania, the Netherlands, Austria, Portugal and Romania (Figure 7).

HIV notifications, prevalence and trends

The transmission of HIV through injecting drug use continues in Europe, especially in eastern countries, even though there are effective public health intervention measures to prevent this. In countries participating in the EMCDDA annual data collection exercise (European Union, Norway and Turkey), transmission of the virus through injecting drug use has declined overall. In 2015, there were only 1 254 cases of newly reported HIV diagnoses attributed to injecting drug use, compared with 2 158 cases in 2012 (EMCDDA, 2017b; ECDC, 2015).

FIGURE 7
HBsAg prevalence among people who inject drugs: studies with national and subnational coverage, 2014-15



NB: Sample sizes below 10 are excluded.
Source: EMCDDA, 2017b.

Over the past decade, the number of newly diagnosed HIV cases attributed to injecting drug use in the European Union plus Norway and Turkey has fallen from 2 260 in 2006 to 1 254 in 2015; with 1 233 diagnoses reported in the European Union during 2015 (EMCDDA, 2017b; ECDC and WHO, 2016). This overall declining trend was interrupted in 2011-12, when a significant increase in new infections occurred as a result of localised outbreaks in Athens and Bucharest. A number of EU countries have much higher than average proportions of HIV diagnoses attributed to injecting drug use, reaching one quarter or more of all the cases reported (where transmission route is known) in Lithuania (34 %, 44 cases), Latvia (32 %, 88 cases), Luxembourg (27 %, 14 cases), and Estonia (25 %, 55 cases) (EMCDDA, 2017b) (see also the section 'Update on HIV outbreaks', below).

Recent estimates (2014-15) of HIV prevalence among people who inject drugs are available for all (EU Member States (excluding Denmark, Ireland, France and Sweden) and for Norway and Turkey. While the prevalence of HIV infection among people who inject drugs is currently below 5 % in most of the countries with data, prevalence levels of 5 % to 10 % are reported from national studies carried out in Greece, Luxembourg and Austria, and from national and subnational studies in Belgium and Germany. Higher HIV prevalences, of more than 10 %, have been reported from studies in Estonia, Greece, Spain, Italy, Latvia, Lithuania, Portugal and Romania.

Outbreaks

Update on HIV outbreaks

Localised outbreaks of HIV among people who inject drugs have been reported in some European countries. A very large outbreak of HIV associated with injecting drug use in Athens (Greece) peaked in 2012 but has now been brought under control. Similarly, following the HIV outbreak in Bucharest (Romania) that occurred in 2011-12, the number of new diagnoses associated with injecting drug use in this country is continuing to decline. There have also been smaller outbreaks reported in Glasgow (United Kingdom) in 2016, Dublin (Ireland) and Luxembourg both in 2015. A number of factors have been associated with these outbreaks, including cocaine use (Glasgow, United Kingdom, and Luxembourg) and homelessness (Glasgow, United Kingdom, and Dublin, Ireland) (EMCDDA, 2016a).

An update on the HIV outbreak among people who inject drugs in Luxembourg was presented at the expert meeting (Devaux, C., DRID meeting, 2017). There had been a marked

increase in numbers of new diagnoses of HIV associated with injecting drug use in 2014, and this was sustained through to 2016. The outbreaks involved two distinct HIV subtypes. One of these was found in a cluster of cases in Luxembourg city and the other was focused in cases reported in the south of the country. Risk analysis identified polydrug use as an important factor, related to a recent increase in cocaine injecting. A range of interventions, including improved outreach for those not in treatment, are being implemented as a response to this development.

Hepatitis outbreaks

Hepatitis C: Outbreaks of HCV among people who inject drugs are probably common, but not often detected, partly because any acute symptoms are usually mild and often go unnoticed. The response to an HCV outbreak in Northern Ireland (United Kingdom) that was detected through the routine diagnostic testing was presented at the expert meeting (Jessop, L., DRID meeting, 2017). Three cases of acute hepatitis C were diagnosed within one week in one town during the summer of 2016; this was very unusual. The cases were all in people who injected drugs and were homeless. In response, the homeless nursing team initiated outreach work to trace contacts and provide information and advice. Twelve contacts were initially identified: four tested positive for HCV and two were known to have chronic infections. A further outbreak case was also identified elsewhere at this time. Two further waves of contact tracing and testing have followed so far. At the time of the DRID meeting (June 2017), 28 positive cases had been identified (eight were women and the mean age of the whole group was 29 years), nine of which were defined as acute, and genetic analysis indicates viruses with three distinct lineages. The acute group had mostly started injecting recently, mainly used heroin, often injected in groups, were commonly injected by others and shared injecting equipment, although not usually needles. Responses included individual and group advice; information posters and leaflets (Figure 8); the promotion of non-injecting routes of administration (advice on smoking heroin and foil provision); extending provision of injecting equipment and sharps packs to hostels; offering hepatitis B vaccination; and referrals for drug treatment assessment. In addition, the frequency of offering diagnostic testing was increased to every three months for those at ongoing risk, and the use of dried blood spot testing was expanded. Those who had, or developed, chronic infection were referred for hepatitis C treatment.

FIGURE 8
Poster and leaflets produced in response to the Northern Ireland hepatitis C outbreak



Source: Jessop, L., DRID meeting, 2017.

Hepatitis A: Outbreaks of hepatitis A among those using drugs or associated with sexual activity continue to be reported, even though an effective vaccine is available. There is currently a large Europe-wide outbreak of hepatitis A among men who have sex with men, in which drug use has played a role in some countries (see section 'Drug use and sexual risks among men who have sex with men', below). Two outbreaks in the Czech Republic were reviewed at the expert meeting: both were among homeless people who use drugs (Janikova, B., DRID meeting, 2017).

In the Karlovy Vary Region in the west of the Czech Republic, there was an outbreak of viral hepatitis A infection from 2014 to July 2016. There were 339 cases reported, with 114 (34 %) in people using drugs who lived in precarious housing and mostly injected methamphetamine. In response, active case finding, targeted outreach prevention and health promotion activities were undertaken.

The second ongoing outbreak was in the South Moravian Region, in the south-east of the Czech Republic. It started towards the end of 2015 and at the time of the DRID meeting, in June 2017, 501 cases had been reported. The cases are mainly in people aged between 24 and 35 years, and either using drugs or without stable housing and employment. Vaccination of over-18s in the general population is recommended in the Czech Republic and is mandatory for specific at-risk groups, such as healthcare professionals (ECDC, 2016a). Targeted vaccination of contacts has been implemented in response to these outbreaks.

Bacterial infections and outbreaks

Drug injection is a risk factor for other infectious diseases, in particular bacterial infection. People who inject drugs are particularly vulnerable to skin and soft tissue infections at injection sites. They are also at risk of infections caused by spore-forming bacteria, such as tetanus and botulism. The spores that these bacteria produce are found in the environment and can contaminate drugs.

Clusters and sporadic cases of wound botulism among people who inject drugs have been reported by several EU countries and Norway over the last two decades (ECDC and EMCDDA, 2015). During 2016, cases of wound botulism among people who inject heroin were reported in Germany (ECDC, 2016b) and in the United Kingdom. More recently an outbreak of an uncommon type of group A streptococcal infection among homeless people, many of whom were injecting drugs, has been reported in the United Kingdom (Bundle et al., 2016).

Infection risks among people who use drugs

Data on the extent of behavioural risks, such as the sharing of injecting equipment and unprotected sexual intercourse, and environmental factors, such as homelessness and imprisonment, can be important for understanding the potential for infections to spread, and for assessing the impact of interventions to reduce risk. The data available on these are limited at European level.

The usefulness of information from behavioural studies was shown in a presentation about the ANRS-Coquelinot sero-prevalence survey undertaken in the Paris region, France, in 2013 (Jauffret-Roustide, M., DRID meeting, 2017; Jauffret-Roustide et al., 2017). This survey recruited 689 people who had snorted or injected drugs and were using specialised services, including harm reduction facilities and addiction treatment centres; of these, 150 were Russian speaking. The Russian speakers were migrants from countries of the former Soviet Union, especially from Georgia (57 %). The hepatitis C prevalence was twice as high among the Russian speakers as among the French speakers (88 % vs 44 %). The Russian speakers were more marginalised and had different behavioural and environmental risk profiles: they were more likely to use heroin and powder cocaine, and less likely to use crack cocaine and prescribed drugs; and they were more likely to have injected drugs in the past month (75 % vs 25 %), but those who had injected were less likely to report syringe sharing (11 % vs 26 %). Overall, the Russian speakers had a higher level of education, but most were unstably housed, with only 10 % living in stable accommodation

compared with half of the French speakers. Marginalisation, environmental factors and language barriers were identified as problems, which had negative impacts on access to services.

Regular bio-behavioural surveys of people who inject have been undertaken using respondent-driven sampling in Estonia. The most recent survey was undertaken in Kohtla-Järve, north-east Estonia, during 2016 (Salekešin, M., DRID meeting, 2017). This was the third survey undertaken in this area; previous comparable surveys were in 2007 and 2012. Behavioural data collected in this survey programme indicate a decline in reported needle and syringe sharing during the preceding 28 days (from 16 % to approx. 1 %) and an increase in the reported uptake of HIV testing (from 72 % to 97 %) over time.

Hepatitis C and prisons

Prisons, and other closed settings, pose particular challenges to reducing the burden of infectious disease. In part, this is because they can be high-risk environments for contracting blood-borne infections, compounded by the fact that those entering prison may already have elevated levels of infection.

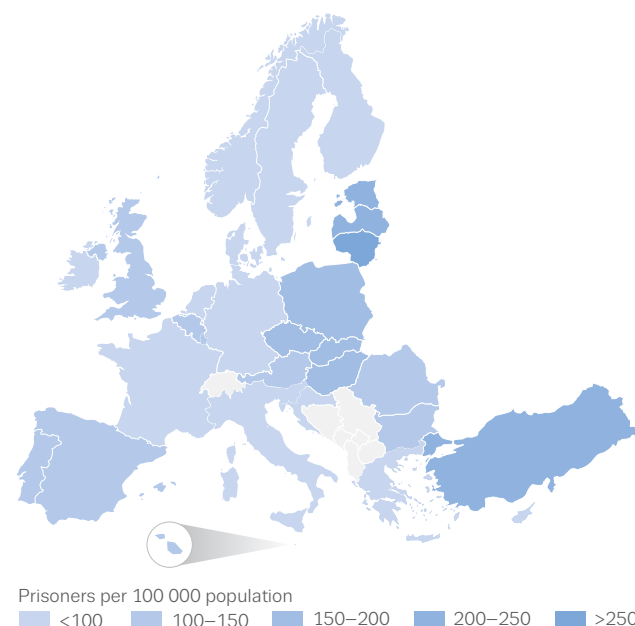
Data indicate that considerable opportunities exist in prisons for the scaling-up of interventions to prevent, diagnose and treat hepatitis C.

The general prison population in Europe (28 EU countries, Norway and Turkey) was around 125 per 100 000 inhabitants, or about 770 000 people imprisoned in Europe on a given day (at 1 September 2015). There is marked variation in the level of imprisonment across the region (Figure 9).

Those who have been imprisoned report higher levels of lifetime drug use than the general population: in the 15 countries reporting to the EMCDDA with data on lifetime use of any illicit drug among prisoners, this ranged from 21 % to 69 % ⁽³⁾. Those imprisoned also report high levels of lifetime injecting drug use. Injecting may also occur in the prison environment, as illustrated by a study conducted among current injectors, in 8 cities in Germany. In this study, of those who had ever been in prison, between 17.8 % in Leipzig and 39.3 % in Berlin reported injecting drugs while incarcerated (Robert Koch Institut, 2016; Wenz, B. 2016).

⁽³⁾ For one of the 15 countries (Croatia), cannabis prevalence was used. Prevalence of cannabis use is therefore a minimum estimate of any illicit drug use in 2015. See Drug use in prison in the 2017 Statistical bulletin.

FIGURE 9
General prison population rates in European countries (EU, Norway and Turkey) at 1 September 2015

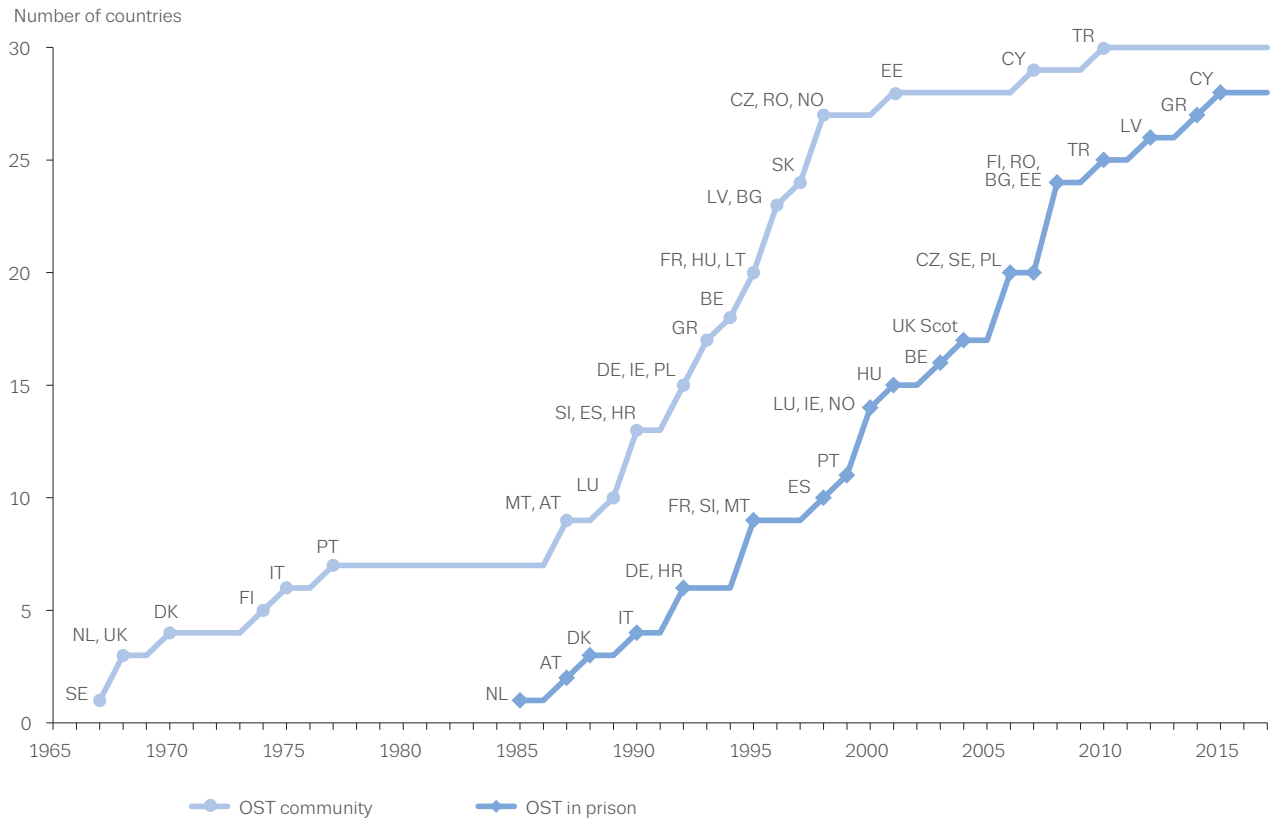


Source: Aebi, 2016.

The available data indicate that the prevalence of hepatitis B and C infection among those imprisoned can be high. Studies of prisoners in 11 European countries reported prevalence estimates between 0.3 % and 25 % for HBsAg and between 4.9 % and 86 % for anti-HCV (ECDC, 2016c). Limited recent data are available on prevalence rates among people who inject drugs, but the available studies have reported prevalences between 12 % and 97 % for anti-HCV (five countries, 2007 to 2013), between 0 % and 0.5 % for HBsAg (two countries, 2009 to 2010) and between 0.2 % and 18 % for HIV (six countries, 2006 to 2015) (EMCDDA, 2017c, INF 111, INF 108).

The provision of drug-related health interventions to reduce drug use related harm and infections in prisons is highly variable between countries. Screening for infections on entry to prison is a standard intervention, although often limited to detection of tuberculosis and HIV infections. Vaccination for hepatitis A and B and treatment of infections are measures recommended for the prevention and control of infections in community settings, but they are less frequently available in prisons; only one in three countries report their existence. Needle and syringe programmes are widely available in the community (see section 'HCV prevention and treatment' above; Figure 4), but are available in prisons in only Spain (17 prisons), Luxembourg (both prisons) and Germany (one prison). In Romanian prisons, needle and syringe programmes have been set up but no use is reported. While prison syringe provision is legally possible in the Portuguese prison system, there are no programmes currently operational.

FIGURE 10
Implementation of opioid substitution treatment in community and prison: cumulative number of 28 EU Member States, Norway and Turkey with opioid substitution treatment in community and prison settings over time



Source: EMCDDA, 2017c.

Opioid substitution treatment is reported to be available in prisons in 26 EU countries (not in Lithuania or Slovakia) as well as in Norway and Turkey. However, in the countries that have introduced opioid substitution treatment in prison, this occurred later than in the community (Figure 10).

Although a range of interventions are available in prisons and are being used, infections continue to occur. An example is the recent outbreak HIV among prisoners in Lithuania during 2016 (Vaitkevičiūtė, I., DRID meeting, 2017). This outbreak occurred in Alytus prison, the second-largest in Lithuania, and has been linked to illicit drug use. There were 38 new HIV diagnoses in the prison during that year, compared with an average of nine a year in the previous four years. There had previously been a large HIV outbreak in the same prison during 2002. In response, a range of measures were introduced in the prison under three broad themes: supply reduction, demand reduction and harm reduction. Lithuania is one of the few countries that does not offer opioid substitution treatment continuation upon imprisonment.

In response to the elevated risk of infection transmission in prisons, the EMCDDA is collaborating with the ECDC on producing evidence-based public health guidance to provide EU/EEA countries with options for prevention of communicable diseases in prison settings. As part of this work, systematic reviews of the evidence base regarding tuberculosis (ECDC, 2017c) and active case finding are being published; the guidance will ultimately cover a wide range of topic areas, also including vaccination and the prevention of blood-borne infections.

FIGURE 12
Facilities inside the new drug consumption room in Paris



Source: Avril, E., DRID meeting, 2017.

Three European countries are currently considering the possibility of establishing their first drug consumption rooms: Belgium, Ireland and the United Kingdom.

Drug use and sexual risks among men who have sex with men

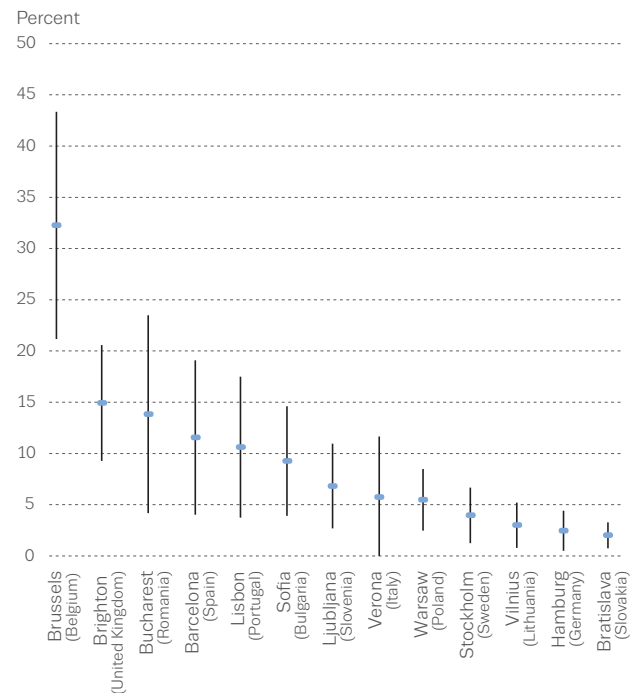
Studies suggest illicit drug use can be more common among some minority groups. Although the reasons for these differences remain unclear, they are likely to be complex. In recent years, there has been concern about drug use among lesbian, gay, bisexual and transgender (LGBT) communities. The emergence of a particular pattern of sexualised drug use — often referred to as ‘chemsex’ or ‘Party and Play’ (PnP) — among some subgroups of men who have sex with men is of concern. Sexualised drug use — that is, drugs being used to enhance or facilitate sex — is not a new phenomenon among LGBT communities or other population groups.

Recent findings on the extent of drug use among men who have sex with men were presented. They were derived from the SIALON II study, which was undertaken in 13 cities across Europe during 2013-14 (Rosińska, M., DRID meeting, 2017; www.sialon.eu/en/). The survey recruited approximately 400 men who have sex with men from the community in each city. The participants completed a behavioural questionnaire and provided a biological sample. The study, unsurprisingly, found that the use of drugs was common. The median level of alcohol use across the cities was 42 % (range of 25-67 %), poppers 13 % (3.8-36 %) and cannabis 5.9 % (1.9-12 %). The use of one or more of the drugs that are commonly used in nightclubs and other ‘party’ settings (i.e. cocaine, amphetamine, ketamine, gamma-hydroxybutyric acid (GHB), mephedrone and 3,4-methylenedioxy-methamphetamine (MDMA)) was reported by 6.8 %



(2.0-15 %; Figure 13). Initial findings from an ongoing analysis of the survey data suggest that those who report using one or more of these ‘party drugs’ may be less likely to use condoms with non-regular partners. These findings corroborate previous ones indicating that levels and patterns of drug use among men who have sex with men vary across Europe and may increase infection risk.

FIGURE 13
‘Party drug’ use prior to or during sex among men who have sex with men in 13 cities: SIALON II study, 2013-14



NB: ‘Party drug’ signifies any of the following: cocaine, amphetamine, ketamine, GHB, mephedrone and MDMA.

Source: Mirandola et al., 2016, Chapter 5.12.

There is a large ongoing multi-country outbreak of hepatitis A in Europe; 1 500 confirmed cases and 2 660 probable or suspected cases had been reported in the European Union to June 2017. These cases are predominantly among men who have sex with men (ECDC, 2017a). The response to the outbreak in Berlin, Germany, was presented (Zimmermann, R., DRID meeting, 2017). There had been 119 hepatitis A cases in Berlin between 16 November 2016 and the date of the meeting. Of these cases, 71 are known to be among men who have sex with men. As part of the outbreak investigation, 44 (including 42 men who have sex with men) were interviewed. The use of gay dating apps and gay venues was common. Overall, 78 % of the men who have sex with men reported alcohol or drug use at sexual contact at least once, with a fifth reporting this at every contact. Of those who reported drug or alcohol use every time or most times, 43 % used both drugs and alcohol, 7 % only drugs and 50 % only alcohol. In response, a range of measures have been taken, including improving access to the hepatitis A vaccination, and information campaigns in German and English on dating apps and in venues (Figure 14).

In Portugal (Duran, D., DRID meeting, 2017), there have been 115 hepatitis A cases reported in 2017 (up to 29 March), 97 % among young men. Molecular analysis of samples from 55 indicate that 53 had strains associated with cases among men who have sex with men in other European countries. Drug use data are not collected with case reports, but available information on drug use among men who have sex with men in Portugal suggests that chemsex is rare.

FIGURE 14
Information materials about hepatitis A targeted at men who have sex with men in Berlin



Source: State Office for Health and Social Affairs Berlin, Germany, DRID meeting, 2017.

Chemsex: definition and possible harms

'Chemsex' is a particular manifestation of sexualised drug use that involves the use of specific drugs as an integral part of, often planned, sexual activity involving multiple partners. The drugs are used to enhance sexual confidence, and to disinhibit and prolong sexual activity and arousal, with crystal meth, GHB/gamma-butyrolactone (GBL), ketamine and mephedrone commonly being used (Bourne et al., 2014). The use of crystal meth can easily become a problem, the use of GHB/GBL and ketamine can be particularly dangerous, and drugs are sometimes injected. Condoms are often not used. Thus this phenomenon can lead to significant harms including the transmission of HIV, HCV and sexually transmitted infections. Although the extent of chemsex remains unclear, its emergence is a concern and has led to closer examination of drug use risks more generally among men who have sex with men.

These data suggest that sexualised drug use may be one of several factors contributing to the current hepatitis A outbreak among men who have sex with men in some of the countries affected. Responding to sexualised drug use and reducing the associated harms, among men who have sex with men or other groups, will require a multidisciplinary approach, in particular collaboration between sexual health, experts on drug use and community groups.

In brief

European Parliament resolution on the European Union's response to HIV/AIDS, tuberculosis and viral hepatitis

In June 2017, the plenary of the European Parliament in Strasbourg adopted a key resolution on the European Union's response to HIV/AIDS, tuberculosis and viral hepatitis. This calls on the European Commission and EU Member States to develop a comprehensive policy framework for addressing these three diseases jointly. The resolution acknowledges the role of injecting drug use as a major driver of the hepatitis C epidemic in the WHO European Region, and the importance of providing comprehensive harm reduction services for people who inject drugs.

Lisbon Addictions 2017

The second European conference on addictive behaviours and dependencies will be held in Lisbon from 24 to 26 October. The event is organised jointly by the Portuguese General-Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD), the journal *Addiction*, the EMCDDA and the International Society of Addiction Journal Editors (ISAJE) (<http://www.lisbonaddictions.eu/>).

Updates on European joint actions and projects

Three major European projects, and a project from Lisbon, had the opportunity to share their work in a 'world café' format during the 2017 DRID/ECDC hepatitis network meeting.

- **HA-REACT** (Joint Action on HIV and Co-infection Prevention and Harm Reduction): The work of HA-REACT is centred on improving the capacity to respond to HIV and co-infection risks, and in particular the provision of harm reduction with a specific focus on people who inject drugs in the European Union. HA-REACT works together with 22 partners from 18 countries. While the focus countries are Hungary, Latvia and Lithuania, activities take place across the European Union (www.hareact.eu/en/about-ha-react).
- **HepCare Europe**: This EU-funded study aims to improve access to HCV testing and treatment among key risk groups, including drug users and homeless people, through outreach to the community and integration of primary and secondary care services (www.ucd.ie/medicine/hepcare/). It works in four sites (Dublin, London, Seville and Bucharest). After one year in Dublin, for example, 547 people using the homeless service had been tested for HCV using point of care testing, and outreach fibro-scanning had successfully been introduced into selected treatment centres.
- **E-DETECT TB**: This is an EU-funded consortium that aims to improve the early detection and case management of tuberculosis in Europe (<https://e-detecttb.eu/>). Its programme of work prioritises people who use drugs, homeless people, prisoners, migrants and those with multi-drug-resistant tuberculosis. Working in partnership with government services, NGOs and affected communities, this project will screen people at risk in Romania and Bulgaria using a mobile X-ray unit equipped with computer-aided diagnostics and on-the-spot molecular tuberculosis testing.
- **In-Mouraria**: Grupo de Ativistas em Tratamentos (GAT) presented this local community-based project. Based in Lisbon, Portugal, it focuses on safer drug use; access to health and social services for people who use drugs or alcohol, including access to treatment; increased

integration of people who use drugs; and tackling stigma and discrimination (<http://www.gatportugal.org/>).

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Appendixes

Appendix 1

Estimates of the prevalence of injecting drug use (rate per 1 000 population aged 15-64), last study available

Country	Year	Injecting drug use prevalence (per 1 000 population aged 15-64)			Estimated number of users		
		Central	Lower	Upper	Central estimate	Lower bound	Upper bound
Belgium	2015	3.28	2.32	4.61	23 828	16 841	33 517
Czech Republic	2015	6.25	6.12	6.38	43 900	43 000	44 800
Estonia	2009	5.89	4.29	10.8	5 362	3 906	9 837
Greece	2015	0.77	0.6	1.02	5 397	4 225	7 129
Spain	2014	0.24	0.18	0.31	7 578	5 634	9 522
France	2014	2.59	2.1	3.2	105 000	85 300	130 000
Croatia	2015	2.21	1.79	2.87	6 344	5 147	8 255
Cyprus	2015	0.42	0.3	0.67	198	141	316
Latvia	2012	9.22	7.34	11.68	12 573	10 003	15 914
Luxembourg	2009	5.68	4.5	6.85	1 907	1 524	2 301
Hungary	2015	0.98			6 707		
Portugal	2012	2.2	1.94	2.46	14 426	12 732	16 101
Finland	2012	4.6	4.1	6.7	15 611	13 770	22 665
Sweden	2008-11	1.31			8 021		
United Kingdom	2004-11	3	2.87	3.22	122 894	117 370	131 869
Norway	2014	2.47	2.2	2.98	8 393	7 459	10 141

NB: The estimates are based on several sources and statistical methods (e.g. capture-recapture, mortality multiplier) and not only on treatment data. They may underestimate the prevalence of injection, as some substances may not appear in the sources used (e.g. these estimates will not include image and performance enhancing drugs). Caution is required when comparing countries. More information is available from <http://www.emcdda.europa.eu/activities/hrdu>. Source: EMCDDA, 2017b.

Appendix 2

Hepatitis C situation among people who inject drugs in 28 European countries, Norway and Turkey: prevalence and prevention

Indicator	Prevalence of anti-HCV (whole samples)				Prevalence of HCV RNA: positive (viraemic)				Prevalence of HCV infection in young people (age <25 years) who inject drugs (subsets of the samples) (proxy for incidence)				Prevalence of HCV infection in new injecting drug users (%) (subsets of the samples) (proxy for incidence)				Size of target population (people who inject drugs estimate)		Syringes per estimated injector per year: EMCDDA method (programme monitoring)		Estimated % of problem opioid users receiving opioid substitution treatment		
	Number tested	National samples	Subnational samples	Availability of data	Number tested	National samples	Subnational samples	Number tested	National samples	Subnational samples	Number tested	National samples	Subnational samples	Number tested	National samples	Subnational samples	Mid-estimate number	Mid-estimate range	PDU and syringe availability	Percentage			
EMCDDA-related indicators and data sources	DRID																				PDU		POU and clients in opioid substitution treatment
Data-type																							
Belgium	463	:	70-75.2	Yes	23		10-38.5	26		9.1-60.0			23 828 (16 841-33 517)	3.28 (2.32-4.61)	43								
Bulgaria	698	:	61.6	Old data	86		52.3	29		55.2			:	:									
Czech Republic	2 008	15.7	:	NR	318	12		88	8			43 900 (43 000-44 800)	6.25 (6.12-6.38)	146						31			
Denmark	223	52.5	:	NR									:	:									
Germany	2 077	:	36.9-73.0	Yes	135		5.7-50.0	72		0-36.4			:	:						48			
Estonia	349	:	61.3	NR	24		33.3	13		23.1			5 362 (3 906-9 837)	5.89 (4.29-10.8)	217								
Ireland	200	41.5	:	NR	44	9.1		28	3.6				:	:						46			
Greece	920	54.82-69.6	52.7-85.6	Yes	65	50-79	44.4-60.0	71	29.4-50.0	28.5-50.0			5 397 (4 225-7 129)	0.77 (0.6-1.02)	50					60			
Spain	3 668	66.6	:	NR	50	12		26	42.3				7 578 (5 634-9 522)	0.24 (0.18-0.31)	196					>50			
France	901	:	63.8	NR	58		10	32		7.5			105 000 (85 300-130 000)	2.59 (2.1-3.2)	117					80			
Croatia	817	:	38.3	NR									6 344 (5 147-8 255)	2.21 (1.79-2.87)	146					57			
Italy	9 080	57.3	:	NR	334	28.7							:	:									
Cyprus	52	44.2	:	NR	12	50		11	27.3				198 (141-316)	0.42 (0.3-0.67)	1					22			

Indicator	Prevalence of anti-HCV (whole samples)		Prevalence of HCV RNA: positive (viraemic)		Prevalence of HCV infection in young people (age <25 years) who inject drugs (subsets of the samples) (proxy for incidence)		Prevalence of HCV infection in new (injecting less than 2 years) injecting drug users (%) (subsets of the samples) (proxy for incidence)			Size of target population who inject drugs estimate		Syringes per estimated injector per year: EMCDDA method (programme monitoring)	Estimated % of problem opioid users receiving opioid substitution treatment	
	Number tested	National samples	Subnational samples	Availability of data	Number tested	National samples	Subnational samples	Number tested	National samples	Subnational samples	Mid-estimate number			Mid-estimate range
EMCDDA-related indicators and data sources	DRID													
Data-type	Number tested	National samples	Subnational samples	Availability of data	Number tested	National samples	Subnational samples	Number tested	National samples	Subnational samples	Mid-estimate number	Mid-estimate range	PDU and syringe availability	POU and clients in opioid substitution treatment
Latvia	990	48.6	84.2	NR	160	16.5	40	23	34.8		12 573 (10 003-15 914)	9.22 (7.34-11.68)	42	10
Lithuania	200	:	77	Old data	24		66.7				:	:		13
Luxembourg	238	:	73.5	NR							1 907 (1 524-2 301)	5.68 (4.5-6.85)	190	57
Hungary	559	49.7	40.5-55.3	NR	71	36.6	33.3-43.5	29	31	25.0-60.0	6 707 (-)	0.98 (-)	28	21
Malta	182	35.7	:	NR	13	23.1					:	:		60
Netherlands	20	:	55	Yes							:	:		53
Austria	416	26.8	56.5-79.1	Yes	43	0	53.3-62.5	24		41.7	:	:		56
Poland	184	:	44.3-72.4	NR	28		17.6-54.5	19		21.1	:	:		17
Portugal	333	83.5	:	NR	10	60		15	53.3		14 426 (12 732-16 101)	2.2 (1.94-2.46)	70	53
Romania	522	:	75.7	NR	83		67.5	20		45	:	:		
Slovenia	89	42.7	:	NR	15	13.3		13	15.4		:	:		63
Slovakia	58	:	58.6	NR	11		54.6	12		16.7	:	:		8
Finland	569	:	74.02	NR	82		46.3	15		6.7	15 611 (13 770-22 665)	4.6 (4.1-6.7)	340	
Sweden	62	:	96.8	NR	18		27.8	16		25	8 021 (-)	1.38 (-)	35	
United Kingdom	5 352	:	27.5-57.5	NR	240		13.3-50.0	335		25.2-31.2	122 894 (117 370-131 869)	3 (2.87-3.22)		56
Turkey	2 926	39.8		NR	1 173	30.1		222	24.3		:	:	0	
Norway	7 298	60.2	78.9	NR							8 393 (7 459-10 141)	2.47 (2.2-2.98)	298	45

NR, Not reported.

Source: Reports of the national focal points through EMCDDA standard tables ST9 (DRID), ST10 (syringe availability) and ST24 (availability and access to treatment/number of clients in opioid substitution treatment); EMCDDA, 2017b; Updates provided by the experts: Prevalence survey among clients of a drug consumption room in Luxembourg, 2016-17 (Devaux, C., DRID meeting, 2017).

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About this publication

Rapid communications bring you the latest findings and discussions in key areas in the drugs field. This report provides an update on infectious diseases related to injecting drug use in Europe. It covers both the EMCDDA Drug-related infectious diseases indicator, which collects data on the situation, and the responses in the area. The report is based on the indicator's annual expert meeting, held in Lisbon in June 2017, which brought together national experts from the 28 EU Member States, Norway, Turkey, European neighbourhood countries and partner organisations.

About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 20 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

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