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Speech

Speaker	**Alexis Goosdeel, EMCDDA Director**
Title of speech	**HIV, drugs and risk behaviour in Europe – what have we learnt and what are the challenges for the future?**
Occasion	**EU Technical meeting: Fast-track the end of AIDS in the EU — practical evidence-based interventions**
Date	**30.01.2017, Malta**

Dear Minister
Dear Director,
Dear Chair,
Dear Colleagues,
Ladies and Gentlemen,

I would like to thank very much the Maltese Presidency of the EU and ECDC for this invitation to make a presentation on 'HIV, drugs and risk behaviour in Europe'. What I would like to do here today is to share with you some lessons learnt and some reflections on what has been developed over time in Europe. I also want to explain how the EMCDDA can contribute to facing this challenge in the future.

First of all, I would like to remind you that the public health approach, which is commonly considered as one of the two pillars of the European 'balanced approach' on drugs, is not something that has been revealed to us in a matter of days or weeks. **We have learned it the hard way**, with numerous people dying, directly or indirectly, from the heroin epidemics that started at the end of the 70s/early 80s.

The heroin epidemic was characterised by a high number of deaths from overdose in many European cities, and by the exponential spread of HIV, and later of HCV, drug-related infections in most countries. It is important to understand that it is **the nature of the problem that has shaped the approach**, in other words, the problem was a HEALTH PROBLEM.

1. How can we characterise the evolution of the situation?

As shown in the previous presentation on the epidemiological situation, since the early 90s we have observed a long-term decline in new HIV infections attributed to injecting drug use in the EU:

- In 2015, 4% of all HIV diagnoses in the EU were among the transmission group of injecting drug users;
- 2.4 cases per million population of newly reported cases of infections with human immunodeficiency virus can be attributed to injecting drug used compared to 5.2 per million in 2006;
- and also, in 2015, the number of new AIDS cases among this transmission group (479) represented less than a quarter of the number reported in 2006 (1 977).

Praça Europa 1, Cais do Sodré, 1249-289 Lisbon, Portugal
Tel. (351) 211 21 02 00 | Fax (351) 211 21 03 80 | info@emcdda.europa.eu | emcdda.europa.eu

Here are some of the factors that have contributed to this positive development:

- The introduction and scaling up of effective drug treatments (Opioid Substitution Treatment – OST) and direct prevention measures (Needle- and Syringe-exchange Programmes – NSP) in the 90s and 2000s contributed to reduced drug injecting and related risks. Since the early 90s, we have gone from around 30 000 persons in treatment in OST to more than 660 000 in 2015. And our latest data show that a total of 50 million syringes have been distributed (and this excludes large countries such as the UK, Germany and Italy who do not monitor syringe provision nationally – so the real value is likely to be close to 100 million).
- Low-threshold facilities have become a 'bridge' to wider health and survival-oriented services. To date, one in two high-risk opioid users is in effective treatment, and many countries have a wide geographical coverage of syringe provision (but there are still big differences between countries).
- The 'balanced approach', defined as part of the drug policy framework in Europe, clearly identifies the objective of reducing drug-related harm, including injecting-related infections.

2. Why are we talking about drug users at this meeting?

a) The overall trend is positive, but the situation is highly variable within the EU: Regional HIV risk assessment shows imbalances and gaps in prevention coverage — a 'two-speed Europe'. Current HIV notification rates are high (> 10 cases per million) in Baltic countries (Estonia, Latvia and Lithuania) and Luxembourg. HIV prevalence is high (>10%) among People Who Inject Drugs (PWID) in several countries with early epidemics (Spain, Portugal, Germany (local)) and there are increases in Bulgaria, Greece, Latvia and Luxembourg. Countries with low HIV show increases in HCV prevalence = risk behaviours (Hungary).

b) Prevention services do not reach all PWID: PWID have the highest proportion of late diagnosis (58%) compared to other transmission groups = testing is not adequate.

c) New HIV outbreaks linked to new drugs and new risk patterns: Local outbreaks have recently been reported from Luxembourg, Ireland and Scotland; stimulant injection among marginalised drug users are common factors. Cocaine involved in Glasgow and Luxembourg, and new psychoactive substances (NPS) in Dublin, affect highly vulnerable groups. Injecting-related transmission of HIV among small groups of MSM (Men having Sex with Men) documented in many EU cities.

3. What lessons learnt can have an impact on future transmissions?

Injecting drug use remains an important risk factor for acquiring HIV and for the development of AIDS.

Effective responses are known (ECDC–EMCDDA Joint Guidance, 2011):

- Maintain prevention services at high scale (NSP, OST), extend paraphernalia provision to prevent transmission of other infection.
- Reach out to vulnerable groups that are not yet linked to care.
- Optimise delivery of testing: there is scope for the use of community-based, peer-led testing models, and of advanced testing technologies (quick test).
- Treatment as prevention: initiating Antiretroviral Therapy (ART) as soon as diagnosed to reduce the viral load.
- A comprehensive framework to respond to risk of infections is likely to be cost-effective, impacting on reducing risks of other injecting-related infections.
- For example, knowledge of drug markets can also be essential to steer the prevention of new epidemics. NPS.

Knowledge and evidence are not enough

- What we have learnt in past decades: There is a need for more integrated and comprehensive approaches, in which all drug-related health issues would be taken into account. In the early 90s in many countries, for instance, there were separate drug programmes and HIV programmes, with limited or no cooperation.

4. Challenges for the future and the contribution of the EMCDDA to addressing them

Despite positive developments, a combination of low-intervention coverage and changes in drug markets and drug use can challenge the overall decreasing European trend.

Namely:

- We have seen several examples where the appearance of cheap stimulants (including new synthetic substances) on drug markets in European cities can have profound effects on infection risk.
- Highly marginalised groups of opioid users have switched to stimulant use, which increased their risk behaviour.
- Increased risks of infection have been documented among MSM in the context of sex under the influence of potent stimulants.
- Declining drug-related HIV infection rates and reduced prevalence, as well as the evolution of AIDS from an ‘acute’ to a ‘chronic illness’, with the correspondent drop in the associated number of death cases, may be interpreted by decision-makers as ‘problem solved, no need to invest any more’.
- For professionals working in the drugs field, HIV and HCV are often no longer perceived as a priority, partly because of the way the situation has evolved, but also because of a change of generation among professionals (turnover). This means that information, awareness-raising and support for implementing minimum quality criteria and best practices are necessary.
- In this context, infection prevention must address all infections and separating Hepatitis C prevention from HIV prevention efforts may be counterproductive, and even have a negative effect: the high focus on HIV may have delayed action against Hepatitis C in countries with low-level HIV epidemics (an excuse for doing little harm reduction).

5. Conclusion: the contribution of the EMCDDA to a healthier and more secure Europe

In December 2016, the EMCDDA’s Management Board gave its seal of approval on the EMCDDA Strategy 2025, a document which defines an ambitious 10-year direction of travel for our Lisbon-based drugs agency.

The ultimate goal of this journey, and our vision until the year 2025, is **a healthier and a more secure Europe, through better informed drug policy and action**.

To achieve this effectively we must constantly strive to respond to the needs of our key stakeholders, who can be defined as:

- The EU Institutions;
- National decision/policymakers; and
- Professionals working in the drugs field.

In order to achieve our goal to contribute to a healthier Europe, we have identified four strategic objectives:

1. Maintain a state-of-the-art understanding of the extent, patterns and trends in drug use, their impact on public health.

2. Identify new drug-related health threats and support rapid response from the EU and its Member States.

   More generally, threat assessment and rapid reporting are likely to play a greater role in our work, reflecting the dynamic nature of the modern drug problem and the accompanying need for rapid and targeted health responses. Areas of concern here include: new risk behaviours; outbreaks of drug-related infectious diseases or other adverse health events; and new consumption patterns with implications for public health. This work is done in close cooperation with some of our key partners, such as ECDC, for joint risk assessments upon request from EU Member States, for instance.

3. Support interventions to prevent and reduce drug use, drug-related morbidity, mortality and other harms, and support recovery and social reintegration.

   We aim at facilitating the identification and adoption of best practices, and to accompany this with improved understanding of what is necessary for successful implementation in diverse national contexts and settings. Special attention will be given to developing resources in areas where drugs have a significant impact on European public health, such as HIV/hepatitis C prevention and treatment and overdose deaths.

4. Support the development, implementation, monitoring and assessment of policies aimed at addressing the health and social consequences of drug use.

Dear Chair, Ladies and gentlemen,

The main challenge for all of us, if we want to fast-track the end of AIDS in Europe and to deliver even more added value for people living in Europe, is to work together to 'break down the walls' between theory and practice, between drug policy- and infection prevention-frameworks, between science, decision-makers, professionals and clients — not to produce more knowledge and guidelines.

Today, the main obstacle to reaching our objective is the 'atomization' of concepts, issues, populations, policies and fields of intervention, and budgets. This phenomenon has been amplified in Europe, both by the economic crisis and its pressure on national state budgets, and by the various challenges to the European project itself.

We strongly believe that these challenges can only be addressed with more cooperation and less competition, by creating new working methods and partnerships between the different actors I already mentioned, and by giving a clearer priority to the added value of this work for our stakeholders and for EU citizens.

As far as we are concerned, communication with professionals working in the drugs field, researchers, civil society and those affected by the drugs problem is also very important, as our work aims ultimately at reducing the burden of drugs on society and on those who are more vulnerable.

This is how the EMCDDA will support European efforts in this area, and we will do this in close cooperation with our partners and with the Reitox network of national focal points. I am sure that this meeting, and the conference that follows, will make a significant contribution to this endeavour and I wish you good work and cooperation.

Thank you very much.