



European Monitoring Centre
for Drugs and Drug Addiction

Prevention of infectious diseases among people who inject drugs in some Western Balkan countries

A report based on the Reitox Academy organised on 29–30 October 2013
in Sarajevo, Bosnia and Herzegovina

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The views expressed herein can in no way be taken to reflect the official opinion of the European Union.

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Introduction

Over the past decade the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has expanded and consolidated its cooperation with national drug authorities in Candidate and Potential Candidate Countries to the European Union (CC and PCC) with the ultimate objective of approximating their national drug monitoring systems to the comprehensive European Union (EU) drug monitoring framework. This has been possible thanks to the funding made available to the EMCDDA through the Community Assistance for Reconstruction, Development and Stabilisation (CARDS) funds and the Instrument of Pre-accession assistance (IPA), under which several consecutive projects have been developed since 2008. The project 'Preparation of IPA Beneficiaries for their participation in the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)' (IPA4 funded project, hereinafter in the text 'IPA4') was launched in 2012, and supports CC and PCC in consolidating their drug information systems and producing new, reliable data on the drug situation.

Collection of data on drug-use related infections caused by human immunodeficiency virus (HIV) and hepatitis B and C viruses (HBV and HCV respectively) in EU Member States, and promotion of evidence based responses to minimise drug-related harms are some of the key areas of work at the EMCDDA (see further information in Box). Together with the European Centre for Disease Prevention and Control (ECDC), the EMCDDA has provided assessments and support to EU Member States during recent outbreaks of HIV among people who inject drugs (PWID), namely to [Greece and Romania](#) (EMCDDA/ECDC, 2012). A [joint guidance](#) on Prevention and control of infectious diseases among people who inject drugs (EMCDDA, ECDC, 2011), published by the agencies in 2011 has been instrumental to promote good public health practices that can support effective policies to reduce infections. This guidance has been translated into several EU languages and – using IPA-funding, into Turkish, Bosnian, Croatian, Macedonian, Albanian and Serbian languages, to be accessible to policy planners and staff working in the area in the western Balkan region.

Box

[Drug-related infectious diseases \(DRID\)](#) is EMCDDA key indicator¹, that collects data on the extent of infectious diseases – primarily HIV, hepatitis C and hepatitis B infection – among people who inject drugs (PWID). The data is collected from PWID each calendar year using two main methods. These are: (a) surveys of PWID that include serological testing and (b) the monitoring of routine diagnostic testing for HIV, hepatitis C and hepatitis B infection among PWID. In addition, the EMCDDA monitors also availability of a number of [health and social responses](#) to drug use, including substitution treatment, needle and syringe programmes and other interventions that aim to reduce the negative social and health consequences of drug use in community and prison settings.

In order to support CC and PCC countries to monitor DRID and implement public health responses, the EMCDDA organised, in the framework of the IPA4 project, the Reitox

¹ [One of the five main epidemiological monitoring programmes of the EMCDDA, that collects on-going data on different aspects of the drugs phenomenon. Other key indicators are 'treatment demand', 'drug-related deaths and mortality', 'general population surveys' and 'high-risk drug use'](#)

Academy 'Prevention of infectious diseases among people who inject drugs', which took place in Sarajevo, Bosnia and Herzegovina on 29–30 October 2013.

The Academy was attended by 20 experts from Albania, Bosnia and Herzegovina, Montenegro, Kosovo* ⁽²⁾ and Serbia. In addition, an external expert was invited from Finland, with further participation of the EMCDDA and the Delegation of the European Union to Bosnia and Herzegovina, while a Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) Fund Portfolio Manager for countries in the region attended selected sessions on the second day of the Academy. During the Academy, the participants discussed overall policies and measures to prevent and control infectious diseases and other health consequences related to injecting drug use; availability of epidemiological data relevant for planning and scaling-up health and social responses for the prevention and control of infectious diseases and other health-related consequences among PWID; and explored achievements and gaps, obstacles and opportunities for scaling-up services in their countries.

This report is an output of the Reitox Academy and is based on information gathered in 2012–2013, directly from CC and PCC (see country situation summaries available online at <http://www.emcdda.europa.eu/countries>) and from relevant WHO and UNAIDS databases. This material was complemented by data provided by national experts in their presentations and discussions during the two-day meeting. The experts from the Former Yugoslav Republic of Macedonia did not attend the meeting; therefore data reported for this country represents the information available in the 2011 National Report, the respective Country overviews published on the EMCDDA website or other publicly available data on the topic.

In the last 10 years many international organisations and bilateral donors have supported national efforts to scale-up services for PWID in CC and PCC, in particular we have to acknowledge the efforts of agencies and organisations of the United Nations system, which invest in the development of sustainable health care and disease monitoring systems. The GFATM, which is an independent Swiss Foundation, remains one of the main external funding sources for developing national capacities to deliver evidence based services, such as voluntary counselling and testing, needle and syringe programmes, opioid substitution treatment (OST) and promotion of treatment of hepatitis C infection, for PWID. Since 2003, GFATM signed a total of 13 grants with the CC and PCC in the Western Balkans and more than 117 million USD were committed to support provision of HIV prevention services to vulnerable groups, including PWID. However in most of those countries 2014 and 2015 will be the last years of the GFATM support ([GFATM website](#)), and an exit strategy focusing on sustainability of developed services and their quality is a priority for GFATM activities in the region. Beyond the funding, the GFATM grants have helped to consolidate national expert networks under one coordination mechanism, which has been a driving force behind the service scale-up.

² This designation is without prejudice to positions on status, and is in line with UNSCR 1244 and the ICJ Opinion on the Kosovo declaration of independence

Key findings

Data from the Bio-behavioural Surveillance Studies suggest that hepatitis B virus (HBV) or hepatitis C virus (HCV) may be increasing among people who inject drugs (PWID) in several CC and PCC of the Western Balkans, suggesting the risk of transmission of blood-borne infections, although for HIV it has not materialised and HIV prevalence rates among this high-risk population remain low.

Drug treatment in the CC and PCC of Western Balkans is mainly provided through publicly funded mental health or psychiatric services and targets opioid users; targeted treatment services for ethnic minorities, women and children are rare.

Despite recent efforts to increase access to Opioid Substitution Treatment (OST) in the public sector and also prisons, the estimated coverage of OST as a percentage of the estimated number of problem opioid users in the country remains low in the region, and ranges between 2.1% (Kosovo*, 2012) and 12.3% (Former Yugoslav Republic of Macedonia, 2011).

Needle and syringe programmes are in place in all the CC and PCC of Western Balkans, and are implemented by non-governmental organisations, with the estimated average number of syringes yearly distributed per injecting drug user through specialised programmes ranging from five in Kosovo(*) and Serbia to 31 in the Former Yugoslav Republic of Macedonia.

In prisons, OST is provided in all Western Balkan CC and PCC, while none of the countries had introduced needle and syringe programmes in a prison setting.

Discussions during the meeting indicate that provision of OST is gradually taken over by national funding sources in majority of the countries, while the needle and syringe programmes largely remain funded by external funds.

Some countries are investing in the provision of treatment of HCV to PWID. By 2013, 98 PWID had received HCV treatment in Montenegro. In some regions of Bosnia and Herzegovina HCV treatment is made available for those who are on OST, while Albania indicated that HCV treatment is not available at all.

Strong international support has assured the presence of a pool of well-trained health professionals working in the fields of prevention, care and monitoring drug-related consequences in the region, and national governments should consider investing further resources in supporting this expertise and further expanding it.

Summary of epidemiological situation

Estimates of the number of people with specific high-risk drug use patterns³ are frequently used to describe the magnitude of problem drug use in a given territory. This information is crucial also for the planning and implementation of responses, as it enables estimating the coverage of services. By end of 2013, all CC and PCC countries in the Western Balkan region, except Kosovo (*), had attempted to estimate problem drug use populations at national or sub-national (Montenegro) levels utilising one or another internationally recognised research method. Available data up to end of 2013 indicates that Albania may have the smallest population of injecting drug users (4 000 to 6 000) (Albania country overview), while in Serbia the estimated population size of injecting drug users is the biggest in the region (more than 30 000) (Baros S. Kovacevic M, 2013). However, one should exercise caution when comparing these figures, as the population sizes of the countries, as well as the methodology for estimation of the high-risk drug use populations, differ. It is also believed that opioids remain the main problem drug in the Western Balkans, and thus problem opioid users constitute a significant part of the high-risk drug use populations in CC and PCC countries.

All CC and PCC countries in the Western Balkan region have implemented Bio-behavioural Surveillance Studies (BioBSS) among PWID. In most countries, several rounds of studies are available since 2006. It is worthwhile to note, that so far the BioBSS were implemented with technical and financial support from various international donors, but at the same time this support has contributed to the enhancement of national experts' knowledge and skills in the field of data collection and analysis. A summary of the available data from the BioBSS suggests that HBV or HCV may be increasing among PWID⁴ in several CC and PCC countries of the Western Balkans, suggesting increasing injecting risks, while HIV prevalence rates among this high-risk population remain low.

Albania

HIV in PWID is low at 0-0.5%, HCV is relatively low at 8-29% in 2008-2011, HBV⁵ is very high (12% in 2005 BioBSS) and increased according to laboratory surveys (2003-2009) (IPH, 2013). The 2011 National report on the drug situation in Albania states that the prevalence of acute HBV has increased over the years and the infection is now more prevalent among PWID compared to the general population (IPH, 2011). (Albania has a high to intermediate prevalence of HBV at more than 8% in general population, universal vaccination programme for new-borns was statutorily established in 1995) (IPH, 2013). BioBSS surveys suggest a recent epidemic of PWID (77% of PWID were injecting for 5 years or less in 2008) (IPH, 2011).

³Up to 2012 the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) defined problem drug use as injecting drug use (IDU) or long duration/regular drug use of opiates, cocaine and/or amphetamines. Ecstasy and cannabis were not included in this category. However, in 2012 a new definition of 'high-risk drug use' was adopted. The new definition includes 'problem drug use', but is broader (mainly in its inclusion of high-risk use of more substances). Details are available [here](#).

⁴ Cases of HCV in the Former Yugoslav Republic of Macedonia are increasing in the general population however are still likely related to increasing risks among PWID (HCV is usually related to PWID) suggesting an urgent need for better data and prevention responses

⁵ HBV is a vaccine preventable disease and vaccination of PWID has been found to be effective ([EMCDDA and ECDC, 2011](#))

Bosnia and Herzegovina

Based on data from BioBSS, HIV prevalence rates among PWID are low, at 0.0-2.7% in 2012 (BIH, 2013) (but 35-63% never tested) (Bacak V., 2012); HCV high 12-43% 2012 (in five cities), increasing in BioBSS 2007-2009 but may be declining again in 2009-2012 (Bacak V. et al, 2012), HBV declining but variable (0.0-5.5% 2012) (BIH, 2013).

Montenegro

Based on data from the most recent BioBSS (2011/2012), conducted with support of the United Nations Development Programme, HIV and HBV prevalence rates among PWID are low, at 0.3% and 0% (in a similar study conducted in 2008, HIV prevalence was 0.4% and HBsAg prevalence was 0.0%); however HCV prevalence remains high (at 55% in 2011 and 53.6% in 2008) (Djukovic I., et al, 2013; MoH Montenegro, 2013). Low level of needle sharing is reported among PWID in Montenegro (95% reported using a sterile needle at last injection), while up to 63.4% have a life-time experience in sharing injecting equipment. (UNGASS, 2011, MoH Montenegro, 2013).

Kosovo(*)

Based on data from BioBSS, the HIV prevalence rate is low at 0% in 2011 (Shehu L., Halilaj G, 2013); HCV in two BioBSS increased from 13% in 2006 to 37% in 2011 (GFATM, 2011); HBV shows a strong decline (20% in 2006 to 6% in 2011 from BioBss studies and from 10% for period 2005-08 to 1% in period 2012 among the PWID participating in voluntary counselling and testing (VCT) in Pristina) (Shehu L., Halilaj, G., 2013)⁶; needle sharing appears to be low with 99% reporting to have used a sterile needle at last injection (GFATM, 2011).

The Former Yugoslav Republic of Macedonia⁷

Based on data from BioBSS, HIV prevalence is low among PWID (0% in 2010) (ECDC, 2013) while HCV prevalence is very high (above 80% 2010) (Petrusevska T., 2011), no info on HBV.

Serbia

Based on data from BioBSS, HIV prevalence among PWID in Belgrade is low 4.7% in 2008, 2.4% in 2010 and 1.7% in 2012. HIV prevalence among PWID in Nis was 4.5 % in 2010, while the data from Novi Sad indicate HIV prevalence 0.3% among PWID in 2008, and 0% in 2012. The same studies indicate very high HCV prevalence (58-75 % in 2008) and slightly increasing in 2010 (61-77%) (Baros S., Kovacevic M., 2014), in the context of decline in acute notified cases since 2009 (Kilibarda B., et al, 2011). Available data also indicate a positive trend in safer injecting practices, in 2010, 77% of interviewed PWIDs used a clean needle at last injection, while the 2012 BioBSS study indicates an increase up to 84.7% (Baros S., Kovacevic M., 2013). No data are available on HBV prevalence but there is a slight increase in proportion PWID among acute notified cases. (Kilibarda B., 2011) The most recent BioBSS study was conducted in 2013, but the data were not available for the seminar.

⁶ During 2005–2008, 610 drug users participated in the voluntary testing and counselling program carried by NGO 'Labyrinth', none were HIV positive, 10% tested positive for HBV (60 cases) and 23% for HCV (154 cases). During 2009–2012, 819 PWID were tested for HIV (0 % positive). In 2012 the NGO 'Labyrinth' carried out 152 VCT sessions with PWID in Prishtina, about 36.5 % were infected with HCV and 1 % with HBV.

⁷ data from published and unpublished sources only

Summary on drug treatment

Drug treatment in the Western Balkan region is mostly provided in outpatient settings and appears to be geared primarily towards the needs of individuals with opioid problems. Treatment of drug dependence seems to be primarily the responsibility of mental health specialists. Thus, psychiatry departments in publically funded mental health services are in most countries the main provider of outpatient psychosocial interventions and opioid substitution treatment (Table 1). Besides Serbia, general practitioners are not involved in the provision of drug treatment. According to available information, the availability of targeted treatment services for ethnic minorities, women and children are rare. Similar to outpatient drug treatment, inpatient detoxification or residential treatment is predominantly psychiatry-led and generally takes place in publically funded hospitals (Table 2). Non-hospital based residential treatment is mostly reported in Serbia and Bosnia and Herzegovina and is provided through privately funded therapeutic communities or church-led programmes. Non-governmental organizations are mainly responsible for the provision of harm reduction interventions, such as needle and syringe exchange programmes, voluntary testing and counselling programmes or condom distribution to PWID through low-threshold agencies (drop-in centres) and outreach programmes. In some countries NGOs are also providing structured drug treatment like in Kosovo* (the NGO is registered as a private health care provider). In Albania are NGOs also involved in the provision of OST.

In Albania, as example, the latest BioBSS study indicates that proportion of PWID in contact with any treatment services during the lifetime has increased in comparison with the earlier studies.

**Table 1. Number of units providing outpatient treatment in the Western Balkan region
(latest available data)**

	Specialised treatment centres	Low-threshold agencies	General practitioners	Treatment units in prisons	Other outpatient unit	OST units	Comments
Albania	1	1 ⁽²⁰¹²⁾	no	yes	no	6 ⁽²⁰¹¹⁾	
Bosnia and Herzegovina	4	10	no	yes	31- FBiH; 28-RS: 1 – Brcko district	6	Other outpatient units: Mental health centres
Former Yugoslav Republic of Macedonia	2	16 NSP sites ⁽²⁰¹¹⁾	no	3	n/a	14	
Kosovo(*)	1	1	no	n.a.	n.a.	5 ⁽²⁰¹³⁾	Other outpatient units: Psychiatry departments of general hospitals
Montenegro	n.a.	5	no	1	18	3 ⁽²⁰¹²⁾	Other outpatient units: Mental health centres or psychiatric units Addiction is treated in public health centres, but data unavailable
Serbia	4	5 ⁽²⁰¹²⁾	Yes (OST), In larger cities	Yes, but no information	Yes, but no information	30 ⁽²⁰¹²⁾	Other outpatient units: general hospitals (Psychiatric departments), primary health care centres.

Notes: FBiH – Federation of Bosnia and Herzegovina; RS – Republica Srsпка; n.a. -information not available

Sources: Country overviews for Albania, The Former Yugoslav Republic of Macedonia, Kosovo*, Montenegro accessed at <http://www.emcdda.europa.eu/publications/country-overviews>; Djukovic I., et al, 2013; Kilibarda B., 2010; BIH, 2013; WHO Harm Reduction Coverage estimate

Table 2. Number of units providing inpatient treatment in the Western Balkan region (latest available data)

	Hospital based residential treatment	Residential drug treatment (non-hospital based)	Therapeutic communities	Prisons	Other inpatient treatment	Comments
Albania	1	n.a.	1	n.a	n.a.	
Bosnia and Herzegovina	3 in FBiH; 1 in RS	n.a.	11	yes	n.a.	
Former Yugoslav Republic of Macedonia	15	n.a.	1	1	n.a.	
Kosovo(*)	1	n.a.	n.a.	9	n.a.	
Montenegro	7	1	1	1	7	Other inpatient units: detoxification units in general hospitals
Serbia	4		Yes, but no information		6 ⁽²⁰¹¹⁾	Other inpatient units: orthodox church programmes

Notes: FBiH – Federation of Bosnia and Herzegovina; RS – Republica Srsпка; n.a. – information not available

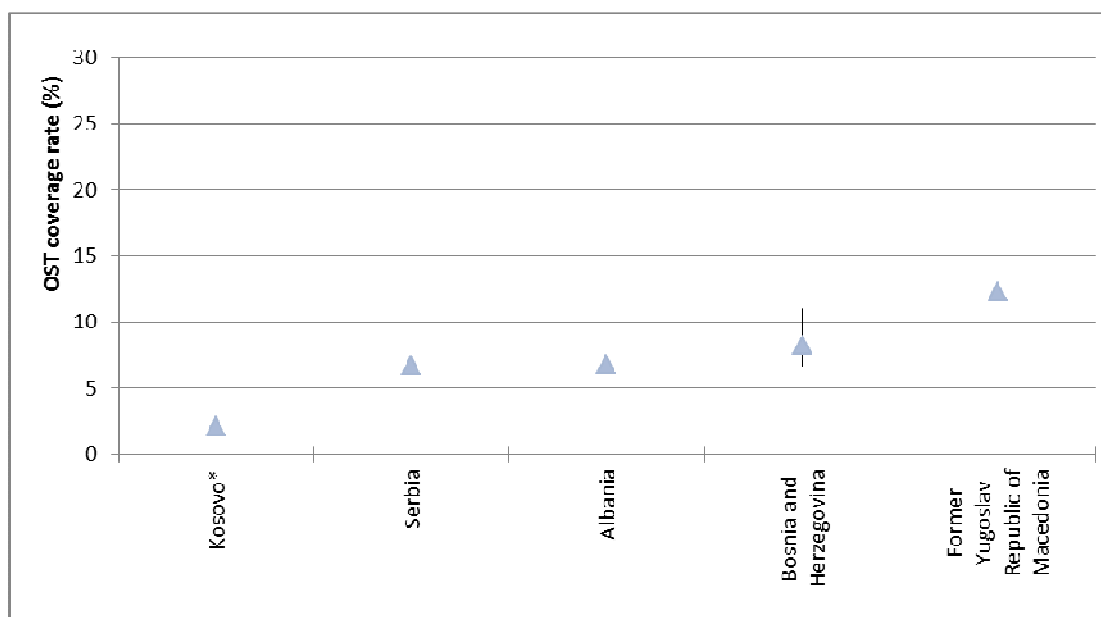
Sources: Country overview Albania, Kosovo*, Montenegro accessed at

<http://www.emcdda.europa.eu/publications/country-overviews>; BIH, 2013; Kilibarda B. et al., 2011; Petrusavska T., 2011; Skipina M., 2011.

Access to opioid substitution treatment

Opioid substitution treatment (OST) is listed as a core intervention in the ECDC-EMCDDA guidance on the prevention and control of infectious diseases. A large body of evidence from reviews exists regarding the impact of OST on the incidence of infections as well as of injecting risk behaviours. In the EU 28 (plus Norway and Turkey), it is estimated that 50% of problem opioid users receive OST, although large country differences exist. In the five CC and PCC countries from the Western Balkan region for which data is available, the coverage of OST as a percentage of the estimated number of problem opioid users in the country ranges between 2.1% (Kosovo*, 2012) and 12.3% (Former Yugoslav Republic of Macedonia, 2011) (see Fig 1).

Figure 1. Percentage of problem opiate users receiving opiate substitution treatment (estimate, based data available up to October 2013)



Despite recent efforts to increase access to OST, the calculated OST coverage levels in the 5 countries are worryingly low. With the exception of Bosnia and Herzegovina, the Former Yugoslav Republic of Macedonia and Serbia, who have a longer experience in OST provision, this treatment modality was introduced only more recently in Albania, Montenegro and Kosovo(*) (Table 3). The implementation and expansion of OST within each of these countries generally took place through external funding, mainly the GFTAM and the Soros foundation. Governments have progressively taken over the financing of OST programmes, either partially like in Albania, Bosnia and Herzegovina, Serbia or full financing like in the Former Yugoslav Republic of Macedonia and Montenegro. In Kosovo(*), the funding of OST relies exclusively on external funds. OST with methadone remains the most common form of treatment. For example, in Serbia the rate of methadone clients to buprenorphine clients is estimated at 3 to 1. Only in Serbia are general practitioners entitled to provide OST. Finally OST is available in the prisons of all countries although the number of inmates receiving this treatment is relatively low (e.g. Albania 12 inmates; Montenegro 10 inmates).

Table 3. Year of introduction and total number of clients in opioid substitution treatment

	Year of introduction	Total Number of OST clients	OST medications	OST available in prisons
Albania	2005	473 ⁽²⁰¹¹⁾	Methadone	Yes
Bosnia and Herzegovina	1989 (re-established in 2002)	1 013 ^(11/2012)	Methadone, Buprenorphine	Yes ⁸
Former Yugoslav Republic of Macedonia	1992	1 250 ⁽²⁰¹¹⁾	Methadone, Buprenorphine	Yes
Kosovo(*)	2012	93 ⁽²⁰¹³⁾	Methadone	Yes
Montenegro	2005	94 ⁽²⁰¹⁰⁾	Methadone	Yes
Serbia	Early 80s (Belgrade); 2005 (other cities)	2 045 ⁽²⁰¹²⁾	Methadone, Buprenorphine	Yes

Sources: Country overview Montenegro; Baros S. et al, 2013; BIH, 2013; IPH, 2013; Petrusavska T., 2011; Shehu L., Halilaj G., 2013

⁸ OST in prisons is available in the Federation of Bosnia and Herzegovina since 2014, but not available yet in prisons of Republica Srpska

Preventing infectious diseases among PWID

Drugs users, and particularly those who inject drugs, are at risk of contracting infectious diseases through the sharing of drug use material, and through unprotected sex. Preventing the transmission of HIV, viral hepatitis and other infections is therefore an important objective of national drug policies. For injecting opioid users, some studies suggest that the protective effect of opioid substitution treatment increases when combined with needle and syringe programmes.

In all five countries of the Western Balkan region covered in this report, needle and syringe programmes are available in the community but not in prison settings. The total number of syringes distributed in 2011/2012 through specialised programmes in the five countries is estimated at 615 800 (table 4) and the average number of syringes distributed yearly per injecting drug user through specialised programmes ranged from five in Kosovo(*) and Serbia to 31 in the Former Yugoslav Republic of Macedonia (Figure 2).

Despite the low coverage of PWID accessing clean syringes through specialised programmes, studies have shown relatively high percentages of injecting drug users using sterile equipment in their last injection (Table 5), which may suggest that sterile injecting equipment may be available outside the specialised services or the studies are not representative^{9, 10}. For example, studies from Bosnia and Herzegovina indicate that pharmacies appear to be the most common outlet for PWID to access injecting equipment and condoms. Also in Serbia, syringes can be sold in pharmacies, although the practices of pharmacists are unknown.

Contrary to OST, provision of which is gradually taken over by national funding sources in majority of the countries, needle and syringe programmes largely remain funded by external donors. Only Montenegro reports allocating the Government income from the games of chance revenues to support these harm reduction initiatives¹¹.

Vaccination for hepatitis B is generally provided through statutory national vaccination programmes for the new-born. However, some countries, such as Albania and Serbia have identified people who inject drugs as a special risk group for HBV vaccination.

Peer-based naloxone programmes to prevent overdose, drug consumption rooms and heroin-assisted treatment are not available in the region.

⁹ The indicator '[Using sterile equipment in their last injection](#)' may underestimate injecting risks

¹⁰ If size of PWID population is overestimated, coverage rates may be underestimated

¹¹ Significant financial funds are allocated from the games of chance revenues and, through public tenders, awarded to non-governmental organisations which implement programmes for prevention, rehabilitation and self-help to addicts, as well as outreach and/or drop-in programmes and/or programmes for reducing damage (harm reduction) caused by drug abuse and/or programmes for populations which are difficult to reach

Table 4. Availability of NSP (latest data available)

	Estimated number of PWID (lower – higher estimate)	NSP Units	Syringes distributed (estimate)	Estimated number of syringes distributed per injecting drug user (lower-higher estimate)
Albania	5 000 (4 000 – 6 000)	4 ⁽²⁰¹¹⁾ 1 ⁽²⁰¹²⁾	36 800 ⁽²⁰¹¹⁾	7 (6 – 9)
Bosnia and Herzegovina	12 500 (9 200 – 15 200)	31	71 951 ⁽²⁰¹¹⁾	6 (5 – 8)
Former Yugoslav Republic of Macedonia	10 200 (7 450 – 14 150)	16	318 485 ⁽²⁰¹¹⁾	31 (23 – 43)
Kosovo(*)	4 000 (3 000 – 5 000)	3	19 900 ⁽²⁰¹¹⁾	5 (4 – 7)
Montenegro	1 283	18	24 822 ⁽²⁰¹¹⁾	19
Serbia	30 383 (12 700 – 48 100)	5	143 864 ⁽²⁰¹²⁾	5 (3 – 11)

Sources: Baros S., Kovacevic M., 2013; Mikik V. et al, 2012; WHO HR coverage estimate; Mikik V., Kuzmanovska G., Memeti S., Report from the behavioural research and assessment of the drug injecting population number in Macedonia, 2010, Skopje, 2012.

Figure 2. Number of syringes provided through specialised programmes per injecting drug user annually (estimate, based data available up to October 2013)

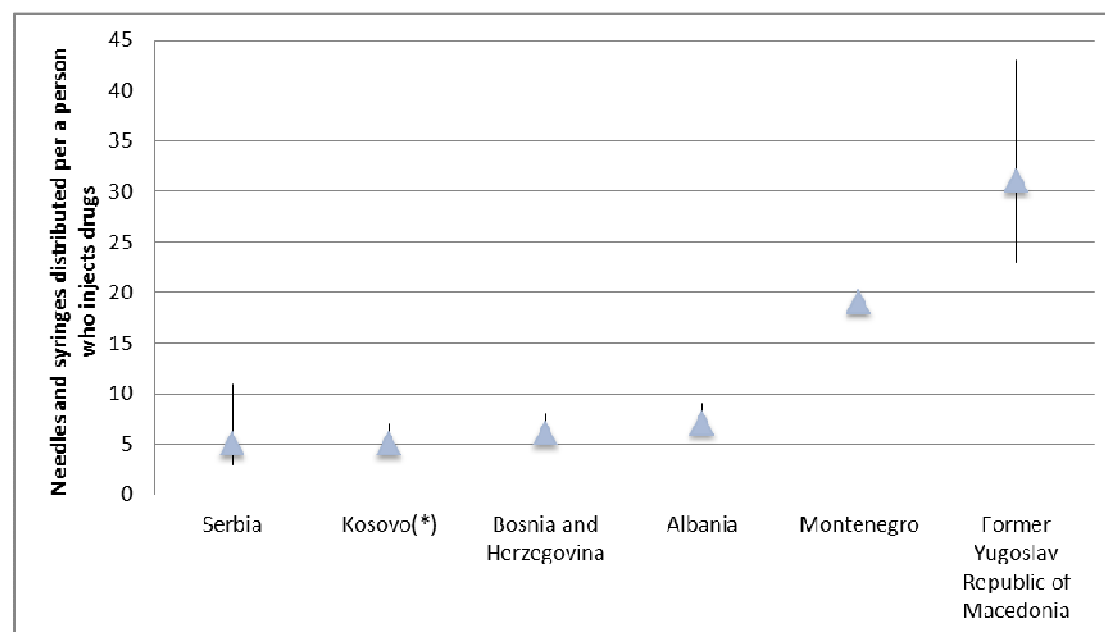


Table 5. Percentage of people who inject drugs who report using sterile injection equipment in the last injection

	Year	Percentage
Albania	2011	75%
Bosnia and Herzegovina	2012	88.5-95.5%
Kosovo*	2011	99.2%
Montenegro	2011	95%
Former Yugoslav Republic of Macedonia	2010	92%
Serbia	2012	84,7% (Belgrade) and 72% (Nis)

Sources: Baros S., Kovacevic M., 2013; BIH, 2013; WHO Harm Reduction Coverage estimates; GFATM, 2011

Testing and treatment of drug-related infectious diseases

Overall, all countries provide free-of-charge voluntary counselling and testing on HIV/AIDS at public health services or through health Insurance funds (Serbia), while testing for HIV/AIDS and other drug-related diseases are also frequently offered by NGO-based needle and syringe programmes.

Given the high and increasing prevalence of HCV, some countries are investing in the provision of HCV treatment to PWID. The Montenegro Health Insurance Fund covers HCV treatment to all those diagnosed with HCV infection. However, drug users are only eligible to receive treatment if they prove 12 months abstinence. By 2013, 98 PWID had received HCV treatment in Montenegro, and for 56 clients sustained virological response had been achieved. The Health insurance Fund covers HCV treatment to PWID with HCV diagnosis based on clinical criteria, however it is available only to those who have health insurance. In some regions of Bosnia and Herzegovina HCV treatment is made available for those who are on OST, while Albania indicated that HCV treatment is not available at all.

Achievements and challenges

Countries in the region have made significant investments into surveillance and monitoring activities of drug-related infectious diseases, and a good overview about epidemiological situation with DRID can be obtained from regular surveillance and also from special studies.

There is, however, an opinion that regular surveillance systems may underreport HIV/AIDS in high-risk groups, including among people who inject drugs, due to the stigma attached to drug use behaviour. Despite this, in most countries the situation on HIV still seems to be relatively good (i.e. low notification rates and prevalence) but the burden of other drug-related blood-borne infections seems to be higher, with hepatitis B and C found the percent- or tens of percentages among PWID. This suggests that the risks of transmission exist although for HIV they have not materialized. This is a situation which is reminiscent of the situations in Northern Europe before the turn of the millennium (Finland, Estonia, Latvia), the Russian Federation and more lately, Greece and Romania. In all of these countries, HIV eventually caused outbreaks when sufficient prevention was not present.

In the participating countries significant, but varying, achievements have been reached in the provision of preventive, supportive and other health services targeted at PWID. Several forms of harm reduction and treatment services are available, while it is difficult to objectively assess if the levels of coverage and volume are sufficient to have a real and sustained prevention effect. Based on the reported figures, this remains uncertain, although the situation is clearly variable and some countries have a better coverage than others. Montenegro is investing in provision of HCV treatment to PWID, while in Albania such treatment is not available at all. Across the region, prisons remain a setting where implementation of harm-reduction interventions fall behind the achievements reached in a public sector, and it is believed that women drug users are among those least reached by the existing service networks.

The countries in the region have built significant knowledge bases in implementing harm reduction and other services for PWID. OST provision has been scaled-up mainly in cooperation with and assistance from the GFTAM and other external funders. Introduction of the OST in Albania and Kosovo* are the most remarkable recent achievements.

Most of the countries have their national drug strategies and also sectorial HIV/AIDS prevention plans, and some are starting reform of the mental health area with a view to expanding access to drug treatment, although these efforts might be hampered by lack of appropriate national treatment guidance, a rigid legal and regulatory framework, and in some countries – slow decision making processes. In several countries preparatory steps have been taken by governments to gradually take over service provision, while needle and syringe programmes are vulnerable and their sustainability are under threat. This knowledge base can be built on and expanded to cover real long term needs if the resources and governmental support are provided. At the same time, the experts expressed a feeling that drug-related matters, and harm-reduction in particular, are not among the high-priority actions, and that decisions in the field are based on political preferences rather on objective and reliable data.

The fact that the HIV situation is still fairly good should be seen as a very significant opportunity for a cost effective prevention effort, as a lack of investment at this time could easily lead to rapidly expanding outbreaks and very high future treatment costs for society. Paradoxically, low HIV prevalence may create an obstacle for prevention, as it might be more difficult to convince governments to spend on prevention if there does not seem to be a problem at the moment. However, prevention should be seen as an investment for the future

which will pay itself back through savings on treatment and through the productivity of the population.

Examining the EMCDDA/ECDC recommendations on key preventive interventions, it is not clear that all recommendations are fully met in the region. Provision of services is differently executed in the different countries. This is not unusual for situations where new ways of working are slowly adapted, but over time it would be important to professionalize services so that they can be maintained on a long-term basis and achieve a sustainable funding base. Moreover, international support has assured that there is a pool of well-trained health professionals. The provision of harm reduction services and other services for PWID must at some point become permanently funded by governments (be it local or national), for the services to become sustainable. Furthermore, permanent cooperative arrangements must be established between NGOs, clinical professionals in multiple specialty areas (i.e. addiction medicine, mental health and infectious diseases) and social services for responses to become truly effective. Still furthermore, arrangements on rules of conduct between health/social sector and the law enforcement must be established if efforts are not to become counterproductive on either side.

Way forward

Sustainability is a key issue to ensure effectiveness of prevention and harm reduction services. In the region, scaling-up of services has been supported by international actors such as the GFATM and United Nations agencies, such as UNODC, which are now gradually handing-over service provision and monitoring systems to national governments. This process requires coordinated and well negotiated exit strategies to ensure that the knowledge and expertise built is not lost, and initiatives are continued.

The participants in the meeting discussed and proposed the following actions to ensure that PWID across the region continue to receive effective infectious disease prevention services.

Sustainability

- Need to motivate translation of a political commitment into financial commitment to sustain provision of low threshold services developed by the non-governmental sector (NSPs, outreach, testing)
- Share best practice and explore national and local funding models for low threshold service at regional, European and also international level with an emphasis to most 'vulnerable' services
- Utilise the 'cost-effectiveness' concept as an argument for investing in services for high-risk populations

Raising awareness

- Continue, with help from the external bodies, raising the visibility of the situation and work carried out in the region
- Continue to support countries (e.g. national coordinators or future focal points) with data and information exchange; and also build their capacity on how to use this information for policy advocacy at national level

Scaling-up services (including prisons)

- Review legislation which limits scaling-up services in prisons and encourage adoption of legislative frameworks which promote diversification of service providers; access to services; client-oriented approaches and facilitate integration among different services
- Benchmarking and policies-reinforcing provision of needle and syringe programmes (for example, adapting policies which put local authorities in charge of this function)
- Follow nationwide coherent implementation of the legislative and policy documents
- Invest in monitoring and evaluation of service quality and, if this does not exist, adapt quality control frameworks in the form of minimum standards
- Continue to train professionals involved in service provision
- Continue scaling up services in the community
- Introduce or expand services for people who inject drugs in prisons

Strengthening service and epidemiological monitoring

- Highlight the links between high rates of HCV and potential for HIV outbreaks and other infections as a motivator to scale-up and sustain the provision of prevention services
- Discuss the feasibility to continue BioBSS studies after the GFATM and other international actors withdraw their funding

- Widen the range of estimates beyond the injecting drug use populations
- Encourage a monitoring system that reduces double counting and underestimates
- Stress the importance of monitoring epidemiology and responses for service planning and the impact of responses (facility surveys); also encourage a data system which has permanent data collection which is combined by ad-hoc studies
- Stress the importance of expert networks for data collection and meaningful analysis, evidence and decision making
- Continue to invest in the creation of national drug data collection networks, and national drug observatories in particular, and strengthen cooperation with EMCDDA

Reducing stigma

- Train and educate professionals and also clients of services
- Review alternative strategies and communication methods at national levels (such as a newsletter)
- Encourage the creation of drug users and parent associations, and involve them in decision making
- Identify 'opinion leaders' and have them advocate for harm reduction approaches

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Annex 1: List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
BioBSS	Bio-behavioural Surveillance Studies
CARDS	Community Assistance for Reconstruction, Development and Stabilisation
CC and PCC	Candidate and Potential Candidate Countries to the European Union
DRID	Drug-related infectious diseases
ECDC	European Centre for Disease Prevention and Control
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
FBiH	Federation of Bosnia and Herzegovina
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	Hepatitis B virus
HBsAg	The surface antigen of the hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
IPA	Instrument for Pre-accession
NGO	Non-governmental organisation
NSP	Needle and syringe programme
OST	Opioid substitution treatment
PWID	People who inject drugs
RS	The Republika Srpska, one of two entities in Bosnia and Herzegovina
UNODC	United Nations Office on Drugs and Crime
USD	United States dollar
VCT	Voluntary counselling and testing
WHO	World Health Organisation

Annex 2: List of definitions

General practitioners are medical doctors in private practice providing drug treatment.

Hospital based residential treatment - specialist medical, psychiatric and/or psychosocial treatment services that address drug dependency, carried out in hospitals (often psychiatric hospitals or psychiatric wards in general hospitals).

Low threshold facilities are settings that facilitate drugs users' access to health and social services, in particular those that help to prevent and reduce health-related harm associated with drug use. To encourage drug users to enter into contact, the use of these services typically requires little bureaucracy, often no payment, and is not conditional upon being or becoming drug-free. They target current users, 'hard-to-reach' and high-risk groups among drug users and experimental users.

Opioid substitution treatment – treatment of drug dependence by prescription of a substitute drug (agonist and antagonist) for which cross-dependence and cross-tolerance exists, with the goal of reducing or eliminating the use of a particular substance.

Residential drug treatment (non-hospital based) - treatment environments in which drug-dependent individuals live together and follow a programme of counselling or therapy in order to achieve social and psychological change. A range of the theoretical approaches, including family, psychodynamic, cognitive-behavioural therapy, medical or 12-step approaches may underpin residential treatment programmes.

Specialised drug treatment centres comprise public or private, governmental or nongovernmental facilities, which specialise in, and whose primary focus is, the treatment of drug dependence on an outpatient basis.

Therapeutic communities - typically are a drug-free environment in which drug-dependent individuals live together in an organised and structured way in order to promote social and psychological change. The central philosophy is that residents are active participants in their own and each other's treatment and that responsibility for the daily running of the community is shared among residents and staff members

Treatment units in prisons are facilities (dedicated physical space) inside prisons where qualified socio-medical staff (external or internal to the prison, but employed or delegated by the prison health administration) deliver treatment services to prison inmates.