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▶ Prevention and control of infectious diseases among people who inject drugs.

European Centre for Disease Prevention and Control and European Monitoring Centre for Drugs and Drug Addiction.
Stockholm: European Centre for Disease Prevention and Control, 2011.

European Union drug misuse and disease control agencies have come together to offer guidance on how to prevent injection-related disease spread in Europe. Towards the top of the list are widespread injecting equipment supply and heroin substitute prescribing, but neither chime well with the UK's recovery-focused addiction policies.

This guidance aims to support policy makers in Europe plan adequate, evidence-based, pragmatic, and rationally designed public health responses for the prevention and control of infections among people who inject drugs. Intended readers are national and regional public health planners and decision makers in the fields of infectious diseases, general public health, addiction and mental health care, social services, and drug control.

In part the guidance is based on a systematic 'review of reviews', which together assessed a large number of primary studies on the key interventions, combined with findings from the most recent studies not yet captured by review papers. Primary studies were also analysed when no systematic reviews about the effectiveness of an intervention were available. The guidance also relies on a foundation of core values derived from public health and human rights principles and on expert knowledge and advice on benefits and harms. Best practices as well as user preferences have contributed to the development of the key interventions suggested.

Background

Since the emergence of the HIV epidemic among people who inject drugs in the mid-1980s, many European countries have achieved substantial progress in implementing evidence-based measures to prevent and control infectious diseases among this group. In the 1990s, EU countries started to develop common prevention policies both in the fields of HIV/AIDS and drugs and drug addiction, which included the establishment of EU agencies to monitor the drug situation (the EMCDDA in 1993) and to prevent and control infections (ECDC in 2005). In the past two decades, prevention and treatment

interventions have been expanded and brought to scale. According to reports for the year 2009, more than half of the estimated population of problem opioid users received substitution treatment, and many countries have established needle and syringe programmes with increasing coverage among people who inject drugs. Data from countries with well-established surveillance systems suggest that the number of new HIV infections among people who inject drugs has decreased considerably in most, but not all, EU countries during the last decade.

In the European neighbourhood, injecting drug use remains a major reason for vulnerability to acquiring blood-borne and other infectious diseases, including HIV, hepatitis B and C, tuberculosis, bacterial skin and soft tissue infections, and systemic infections. Estimates of the number of people who inject drugs suggest that there are significant populations at risk of these infections in all European countries. Unaddressed, these infections result in a large burden on European health systems, significant individual suffering, and high treatment costs.

It has been shown that a pragmatic public health prevention approach can have a strong effect on reducing the spread of blood-borne and other infections among people who inject drugs. Prevention is feasible and effective, if properly implemented.

Seven key interventions

On this basis the following seven key intervention components should be applied and, if possible, combined to achieve the maximum prevention effect through synergy:

- *Injection equipment*: Provision of, and legal access to, clean drug injection equipment, including sufficient supply of sterile needles and syringes free of charge, as part of a combined multi-component approach, implemented through harm reduction, counselling and treatment programmes.
- *Vaccination*: Hepatitis A and B, tetanus, influenza vaccines, and, in particular for HIV-positive individuals, pneumococcal vaccine.
- *Drug dependence treatment*: Opioid substitution treatment and other effective forms of drug dependence treatment.
- *Testing*: Voluntary and confidential testing with informed consent for HIV, hepatitis C (and hepatitis B for the unvaccinated) and other infections including tuberculosis should routinely be offered and linked to referral to treatment.
- *Infectious disease treatment*: Antiviral treatment based on clinical indications for those who are infected with HIV, hepatitis C or hepatitis B. Anti-tuberculosis treatment for active tuberculosis cases; tuberculosis prophylactic therapy should be considered for latent cases. Treatment for other infectious diseases should be offered as clinically indicated.
- *Health promotion*: Health promotion focused on: safer injecting; sexual health, including condom use; and disease prevention, testing and treatment.
- *Targeted delivery of services*: Services should be combined and organised and delivered according to user needs and local conditions; this includes the provision of services through outreach and fixed site settings offering drug treatment, harm reduction, counselling and testing, and referrals to general primary health and specialist medical services.

Recent studies and experience from successful prevention programmes document the added value of offering a range of effective intervention measures in the same venues,

and of providing a combination of interventions according to clients' needs, to achieve the maximum effect in preventing infections. A prerequisite to the effective delivery of the key interventions is national and local cooperation, and coordination between sectors. National consensus building and mutually respected objectives are essential when it comes to the successful implementation of interventions. Objectives should be agreed on by actors across all sectors, particularly those who engage with people who inject drugs.

In order to ensure that interventions best serve the population of people who inject drugs, as well as prevent and control infectious diseases, there must be sufficient surveillance of problem drug use and infections on national and sub-national levels. Measures taken should be continuously monitored and evaluated in terms of response, impact, relevance and scale of coverage. Investment in adequate surveillance systems of both drug use and infectious diseases is necessary and cost-effective.

Evidence suggests that higher levels of coverage of needle and syringe programmes and opioid substitution treatment per drug injector are more effective than lower levels of coverage. The goal should be to ensure that the services offered meet local needs and demand. Unmet demand for needle and syringe exchange services or waiting times for drug treatment indicate inefficiency in prevention.

FINDINGS As emphasised by Findings in a major series of reviews on hepatitis C and needle exchange, the featured guidance stresses that "the best way" to curb the spread of HIV and hepatitis C among injectors is high coverage supply of injecting equipment, enough and sufficiently easily available for a fresh set to be used each time. If requiring the return of used equipment stands in the way of this ambition, the guidance says 'requirement' should be watered down to 'encouragement'.

High coverage was also at the heart of recommendations from Britain's National Institute for Health and Clinical Excellence, based partly on a review of the evidence which (as later studies not included in the review reinforced) found that more liberal equipment supply policies most effectively controlled spread of infectious disease. Allied as the featured guidance suggests with high coverage substitute prescribing, high coverage needle exchange has research suggests substantially curbed the spread of hepatitis C among injectors in Britain, a virus which requires particularly complete defences to intercept its transmission.

However, complete coverage in terms of the supply of injecting equipment is very far from the norm in Britain, with the result that at the end of the first decade of the 2000s hepatitis C was spreading more rapidly than in it did in the early 2000s, infecting a quarter of injectors within three years of their starting to inject. However, the pool of injectors in the population available to be infected is declining as drug users turn away from heroin and with it the injecting route, presumably helping make service provision more adequate even if resources are static or declining.

In turn the decline in heroin use and injecting is thought partly due to the greater penetration of effective treatment in recent years, spearheaded by programmes which substitute drugs taken by mouth (methadone and to a lesser extent buprenorphine) for heroin. The dominance of these approaches is however counter to government policy, which now seeks to "ensure that open-ended substitute prescribing in the community is

only used where absolutely necessary" and favours individual recovery from addiction in the form of abstinence, social reintegration and treatment exit.

Such policy is almost diametrically opposed to the characteristics thought to make methadone and allied programmes effective public health tools in the prevention of infection: a widely provided and easily accessible frontline treatment not relegated to the "absolutely necessary" and provided long-term without expecting early or even any termination. An expert group acting on behalf the British government has sought to reconcile this dilemma, allying a recovery orientation with continued long-term methadone prescribing for those who need it, but there are concerns that the public health achievements of recent years will be jeopardised by the new policy focus.

This draft entry is currently subject to consultation and correction by the study authors and other experts.

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