European Monitoring Centre
for Drugs and Drug Addiction

Draft Meeting Report 08/10/2012

EU expert meeting on the EMCDDA key epidemiological indicator Drug Related Infectious Diseases (DRID), EMCDDA, 11-12 October 2011

EMCDDA, October 2012

Table of Contents

Author and acknowledgements

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Meeting Report

EU expert meeting on the EMCDDA key epidemiological indicator Drug Related Infectious Diseases (DRID), EMCDDA, 11-12 October 2011

1. Background

Since 1996 the EMCDDA is annually monitoring 'Drug related infectious diseases' (DRID, mainly HIV and viral hepatitis prevalence) among injecting drug users (IDUs) in the EU, as one of its five 'key epidemiological indicators' of drug use and consequences. This is done using a standard form for the collection of existing data (Standard Table 9 or ST9) through an online data collection system (Fonte). Data can come from seroprevalence surveys among IDUs or from diagnostic testing of IDUs in services.

In 2006, a draft protocol was developed in collaboration with the Greek national focal point, giving more detailed guidance to improve the comparability of primary DRID data collection (sero-behavioural studies) among IDUs in Europe. From this protocol, which included an extended 'example questionnaire', a shortlist of behavioural indicators was proposed for inclusion in ST9, with the purpose of monitoring key behavioural factors and risks for infectious diseases in IDUs (see ST9 part 3). Given the state of low comparability of behavioural indicators between countries, it was decided to keep the 2006 draft protocol draft for a few years in order to pilot and further develop the EMCDDA behavioural indicators, before the protocol would be finalised.

At the 2009 annual DRID expert meeting the finalisation process of these draft tools was started, with a first focus on the behavioural indicators in ST9 part 3, resulting in a list of suggestions for change of these indicators (see 2009 meeting report). These suggestions were fed back during 2010 in an EU-wide consultation of national experts on which they could 'vote' (for results see the expert consultation report, meeting document 3 at the 2011 expert meeting). In 2009 it was also decided not to finalise the original draft protocol, but to convert it into a modular 'toolkit' consisting of multiple more specialised documents ('modules') that could be developed more flexibly and according to need.

In the 2011 meeting the final version of the behavioural indicators ST9 part 3 were reviewed and presented in a first DRID toolkit module 'Behavioural Indicators'. A second module 'Example Questionnaire' was also presented suggesting example formats for actual data collection at national level. The meeting started with a general review session of the ongoing data collection followed by a step by step review of the behavioural indicators.

For more detail see the 2012 DRID meeting documents (available from EMCDDA):

- 3. DRID module 'seroprevalence and behavioural studies in IDUs'
- 4. DRID module 'behavioural indicators'
- 5. DRID module 'example questionnaire'
- 6. Annotated 2006 draft DRID Protocol
- 7. Current pilot version (excel) of ST9 part 3 as used 2006-2011

The 2006 draft protocol and current version of ST9 part 3 are also available at http://www.emcdda.europa.eu/themes/key-indicators/drid).

At the 2011 DRID meeting these discussions were followed on the second day by sessions regarding DRID prevention, the launch of the joint ECDC / EMCDDA prevention guidelines and country examples of DRID and DRID prevention. Presentations of day 2 are available from the EMCDDA, while this report is limited to the discussions on day 1 regarding the DRID modules and behavioural indicators.

2. Meeting objectives

1) To review progress in the ongoing DRID implementation
2) To discuss the general outline and first modules of the DRID toolkit
3) To launch the joint ECDC / EMCDDA DRID prevention guidelines
4) To discuss DRID prevention models and country implementation

3. Meeting agenda

See Annex 3.

4. Summary of main outcomes of the meeting

Day 1

1) DRID data collection is generally going well. Work will concentrate on clarifying geographic coverage of studies as reported to EMCDDA. Ongoing work on XML automated data entry. Some problems with the user-friendliness of ST9 in Fonte still remain.

2) DRID data collection in low threshold centres was seen as highly problematic in some countries. Difficulties include lack of medical staff and regulations that do not permit collecting biological data to non-medical institutions. Ideas on addressing this problem included making a small project on this issue with the countries concerned or writing a selected issue on this topic as well as the possibility of raising the issue at MB meetings.

3) During the current Treatment Demand Indicator (TDI) revision there is the possibility to add a limited number of DRID items to TDI. Three DRID variables that will be included are ‘needle/syringe sharing’, ‘HIV test uptake’, ‘HCV test uptake’.

4) The new DRID toolkit module ‘Behavioural Indicators’ was presented and accepted. Some outstanding details are still to be resolved in the advisory group. Formal adoption of the revised ST9-part3 was foreseen at the November 2011 Reitox meeting and Fonte implementation for 2012. (Note this has subsequently been delayed).

5) The second new DRID toolkit module ‘Example Questionnaire’ for primary data collection of ST9-part3 items was well received.

6) A general discussion on the behavioural indicators followed by a step by step review of each of them was done to discuss the final outstanding issues. Decisions taken included:

General:

- Terminology for three priority levels of indicators was accepted: 1) Core 2) Additional and 3) Optional. Here 'Core' means that it is expected these can be implemented in most data providing sources, including routine settings, 'Additional' means these are still important indicators but likely can only be collected in data collection sources that are specialised on drug users, including studies, and 'Optional' that these can be considered as well if there is a specific interest in the country

- Include the UN IDU specific indicators (UNGASS / GARP) as far as possible, if not in the Additional group then at least as Optional. This relates to indicators not commonly collected in Europe (e.g. HIV test uptake knowing test result) or seen as weaker than the current standard (e.g. using clean equipment at last injection was seen as to underestimate risk of infection)

- It was decided to make ST9 parts 2 and 3 more consistent by including indicators that are already used as breakdowns of HIV and hepatitis in part 2 into part 3 (ever in prison, gender, years of injection, primary drug opioids)

- So called 'flexible formats' of questions seem useful where a country has a different recall period than the EMCDDA proposal. This entails asking both recall periods to the respondent in a 'yes/no' format (see module 'Example Questionnaire' for details).

- It was seen as a good idea if EMCDDA would use its data on aHBc and aHBs more specifically to monitor HBV vaccination coverage (this would need a revision of the data collection, they need to be combined).

- For data from RDS studies it is agreed that countries can choose whether to report adjusted or unadjusted prevalences, for consistency with their national figures, but they need to indicate clearly in ST9 part 1 which of the two they are reporting

- It is strongly recommended that countries use translation and backtranslation to check that the agreed wordings of indicators are correctly translated into their language

- It is stressed that for each indicator the rationale should be made very clear, as it results in additional data requests to national partners

- Although the UN system recommends splitting all indicators by age and gender there is insufficient support in the meeting to do this for these indicators, as this would result in a multiplication of data

- After discussing the pros and cons of using means (allows calculating totals, but not useful in skewed distributions) and medians (less easy to interpret) it is decided to use both as optional indicators

With regard to TDI:

- TDI uses last 30 days for frequent behaviours, it was agreed that in practice this is comparable with ‘last 4 weeks’ as adopted by DRID given that recall of past events is not precise anyway

- TDI will include HIV and HCV testing uptake items but will not be able to exclude known positives

- It was noted that TDI uses ‘unstable accommodation and/or homeless’ (as a category of living status in the last 30 days before entering treatment) for the definition of homelessness, which is not fully comparable to the DRID definition which asks about the last 12 months, TDI will not take the indicator out of their protocol as was initially considered.

By indicator (numbering as in DRID module ‘Behavioural Indicators’:

HIV and HCV test uptake indicators

- It is decided to exclude known positives from the HIV (3.1 and 3.2) and HCV (4.1) recent testing uptake indicators if possible. Especially where prevalence is high (HCV) it makes no sense to measure testing uptake in the whole population. Countries should also have the option to provide data where they where not excluded but this should then be indicated

- HIV and HCV test uptake variables should include a category ‘waiting for test result’.

- HBV test uptake or test result should not be asked. It is better to vaccinate without questions and see the serological markers. Similarly it was decided not to include an indicator for hepatitis vaccination as comparability would probably be problematic, as well as very difficult to ask due to complexity of vaccination schemes

Injecting risk indicators

- Using a sterile needle at last injection (5.1) will be kept as Additional, for comparability with the UN indicators, despite that it was noted there are serious weaknesses in this indicator as it underestimates risk

- In the list of primary drugs in the example questionnaire add fentanyl, methamphetamine. TDI asks both primary and secondary drug but that seems too much for DRID

- In the indicator on injecting history (17.1) it was suggested to first ask whether the IDU has had the first injection in the last two years, and only if not then ask age of first injection

- It is decided not to limit indicator on distributive needle sharing (1.3) to HIV positive individuals only but to keep the indicator unchanged

- For the higher category in the number of sex partners (12.1) it is agreed to adopt the UN definition which is ‘more than one partner’

- For the homelessness indicator (21.1) it is agreed to take out the clause that homelessness should have a duration of more than one week, as even incidental one-night homelessness can result in serious social disruption and infection risks.

Day 2

As mentioned above, presentations on responses to DRID, launch of the joint ECDC-EMCDDA guidance and country presentations are available from EMCDDA and on the DRID restricted website.

Final Agenda
EU expert meeting on the EMCDDA key epidemiological indicator Drug Related Infectious Diseases (DRID), EMCDDA, 11-12 October 2011

Venue: EMCDDA, Cais do Sodré, Lisbon

Objectives:
Day 1

- To review progress in the ongoing DRID implementation
- To discuss the general outline and first modules of the DRID toolkit

Day 2

- To launch the joint ECDC / EMCDDA DRID prevention guidelines
- To discuss DRID prevention models and country implementation

Tuesday 11 October - DRID meeting

Chair: Lucas Wiessing

9.00-11.00 Review progress in ongoing DRID implementation

- **Lucas Wiessing** – Introduction
- **Andre Noor and Ricardo Franco** – Progress on Fonte and Standard Table 9 implementation
- **Sandrine Sleiman and Luigi Nisini** – Update on the DRID implementation assessment
- **Linda Montanari** – Update on TDI revision and inclusion of DRID variables
- **Cecile Martel** – EMCDDA DRID support in neighbouring countries
- Discussion on EMCDDA DRID data-collection and neighbouring countries

11.00-11.30 Coffee-break

11.30-13.00 Draft DRID Toolkit outline and first two modules

- **Lucas Wiessing and Luigi Nisini** – Draft Toolkit outline and module “Behavioural indicators”
- **María José Bravo** – Module “Example questionnaire”
- Discussion on draft Toolkit outline and first two modules

13.00-14.00 Lunch

14.00-16.00 Step-by-step review of behavioural indicators

16.00-16.30 Coffee-break

16.30-17.00 Review of indicators continued (if necessary)

17.00-18.00 First ideas for two further modules

- **Magdalena Rosińska** – Draft outline for future module “Serobehavioural studies in IDUs”
- **Catharina Matheï** – Ideas for the future module “General introduction to the DRID toolkit”

18.00-19.30 Reception at EMCDDA premises

Wednesday 12 October – DRID meeting

Chair: Lucas Wiessing

9.00-10.30 Responses to DRID

- **Sharon Hutchinson** – Impact of NSP and OST on the incidence of HCV
- **Patrizia Carrieri** – Opioid substitution treatment for HIV and HCV prevention
- **Maria Prins** – HCV treatment: uptake, effect on burden of disease and potential for reducing HCV transmission

10.30-11.00 Coffee-break

Chairs: Dagmar Hedrich and Mika Salminen

11.00-12.30 Launch of joint ECDC / EMCDDA guidance for DRID prevention

- **Matthew Hickman** – Population impact of interventions to prevent HCV
- **Johan Giesecke** and **Paul Griffiths** – Presentation of the ECDC-EMCDDA guidance: 'Prevention and control of infectious diseases among people who inject drugs'
- Discussion

12.30-14.00 Lunch

Chair: Lucas Wiessing

14.00-15.15 Short country presentations on DRID and DRID prevention

- **Anastasios Fotiou** – An outbreak of HIV among IDUs in Greece, 2011
- **Violeta Bogdanova** – HIV increases among injecting drug users in Bulgaria
- **Svetlana Sidyak** – The monitoring of infectious diseases among IDUs in Ukraine
- **Anna Tarján** – Monitoring HIV and viral hepatitis and related risk behaviours among IDUs in Hungary
- **Vlastimil Nečas** – Testing for HIV and viral hepatitis in community (low-threshold) settings in the Czech Republic

15.15-15.45 Coffee-break

15.45-16.15 Short country presentations continued

- **Esther Croes** – The effectiveness of the Dutch national hepatitis C information campaign for drug users
- **Martin Busch** – HCV and HIV among injecting drug users in Austria – Is there any possibility to say something about trends?

16.15 End of meeting

Annex 2 Participants List

European Monitoring Centre for Drugs and Drug Addiction

EU expert meeting on the EMCDDA key epidemiological indicator Drug Related Infectious Diseases (DRID)
EMCDDA (Lisbon) - 11 & 12 October 2011

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