Groups 2 and 5 combined

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We had a lively discussion in this group with a wide diversity in background in relation to DRID problems, experience and possibilities. We focussed on the question what needs improvement and limited the discussion to three topics:

1. Are we capable as a country to collect the data as we are now? Can the EMCDDA be of assistance?
2. What are the questions we want to be answered? Are the EMCDDA and national systems reacting early enough?
3. Are we aware of what happens in other countries and what can be the role of the EMCDDA?

1 Are we capable as a country to collect the data as we are now?
Here we concluded that we are in very different stages of the epidemic, there are differences in access to financial resources, there are issues around data collection and comparability. Below are 5 reasons which play a role in our countries, which explain that countries have different reasons for troubles in collecting the data as requested by the EMCDDA:

1. Issues on methodology
In the Czech Republic a high rate of syphilis was found. But how to interpret this finding? Really more syphilis or better surveillance?
Austria: "We have the nice toolkit, but we don't get started, we have already 3 protocols for a seroprevalence study in Austria, but we still haven't started."
Conclusion from the group: Rather than go into new areas, first get grip on the 3 major DRIDs.

2. Financial issues
Kosovo has info from studies funded by the donor community, whose interest is mainly in HIV monitoring, Kosovo is not capable of monitoring other issues. No reliable data on injecting drug use, no size population estimate.

Also in Slovakia finances for the study is the problem. There is a mismatch of data. There are anonymous DRID data from street work and there are also data from the treatment system. But double counting cannot be excluded. In other words: the number of tests is known, but not the number of patients, maybe they are tested more than once. Another financial issue is that street work uses the not so reliable capillary testing.

3. Political problem
In Lithuania, the surveillance system has been "destroyed" some years ago. Now surveillance (as well as care and harm reduction) is decentralised, resources for

staff and money are lacking. Political commitment is not optimal, esp. from the municipality level, although the national level is not too bad. The questions in this country are largely on practical issues, e.g., how to solve problems like non-insurance for hepatitis B vaccination?

4. Priority
In the "early countries" (Spain, Netherlands) other problems have arisen and injecting of heroin is not the priority anymore.
Spain: epidemic injecting started in the 80s. Now injecting is very low, hard to find IDUs. Both in surveillance and in research injecting is not anymore the focus. Main problem is now other drugs, like cocaine. The focus is broader, on problem drug use, of which injecting may be a small proportion.

5. Comparability
The UK has still a large number of IDUs, but data systems are not consistent over the country (Scotland is different).

Conclusion
We see large differences in the stage of the epidemic and differences in historical ways of coping with the DRID problem. Reality requires different solutions in different countries.

- "Early countries" (UK, NL Spain): funding available, well established systems for data collection, the DRID problem has levelled off.
- "New countries": here IDU is driving the HIV epidemic, IDU is the highest risk factor for HIV. However, in these countries, where the need is highest, systems for data collection are less developed, there are less financial resources available, and other barriers exist (political, expertise).

Can the EMCDDA be of assistance?
1. EMCDDA can change the flow of results, information towards those who collect the data. If you can't show the people who collect the data how their input is used, it will become much more difficult to collect new data. Cooperation all down the line.

2. EMCDDA can provide us with arguments, guidelines for HR measures that we can use for decision makers. EMCDDA can help us with the message: if you find large number of infectious diseases: HR, NSP can help to reduce that.

2. What are the questions we want to be answered?
This question addresses two issues: firstly, what are the basic parameters needed for *MONITORING*, and secondly, are we still monitoring the relevant topics.

The group felt that we are locked in into the problem of heroin, injecting, and the three DRID infections. But the problem is now more complex, with new drugs or new patterns of use in some countries or regions as well as a change in the relevance of injecting, depending on the countries. For some countries the feeling can be that we now do the monitoring but don't know what we are looking for.

What are the problem areas, what is the common area? What is the basic question?

What can the EMCDDA do?

-We have to be more targeted. It was mention that EMCDDA collects many data on DRID, but reporting back is sometimes felt as limited. Sometimes the problem can be the lacking of a plan of analysis. An extended idea seems to be: the more you collect the better. But collect only what you are going to use for output. It could be a problem of not having clear the objectives. Secondly, monitoring is a long process. For monitoring you should not change the objectives and the methodology. If you do not change, you may not be absolutely accurate, but you are at least consistent over time. Monitoring=keep on the line.

-You might need different sources or methodologies to monitor ongoing problems on the one hand and to identify outbreaks on the other hand. What info would we need for that? Info on behaviour, new injectors, new diagnoses….? The answer is complicated. For example, regarding anthrax, the surveillance line should be at a national level. Technical support at a national level could be a role for the EMCDDA. But do not start a new surveillance line at European level.

3. Are we aware of what happens in other countries and what can be the role of the EMCDDA?

We are interested to know what is going on in other countries. The annual report summarises all DRID data but this report is very condensed. The group would appreciate information on the local situations and responses/ projects.

Role for the EMCCDA

In the role of centre where all European information comes together, we hope that the EMCDDA will make this information easily available, e.g., by copying and pasting the DRID sections from the National Reports in one document.