European Monitoring Centre
for Drugs and Drug Addiction

Chapter 6
Drug-related infectious diseases

Methods and definitions

Drug-related infectious diseases such as HIV and hepatitis B and C are among the most serious health consequences of drug use. They may have the largest economic impact on health care systems of all consequences of drug use, even in countries where HIV prevalence in injecting drug users (IDUs) is low. IDUs are the target group for measuring prevalence of drug-related infections. They are defined as any person who has ever in their lifetime injected a drug for non-medical purposes.

The EMCDDA is systematically monitoring HIV and hepatitis B and C among injecting drug users (prevalence of antibodies, or other specific markers in the case of hepatitis B). This is as a complement to existing notification and case reporting systems that follow trends in counts of cases. National notification data are often unreliable due to under-reporting, biased reporting and large proportions of asymptomatic or chronic cases (hepatitis B/C). In addition, HIV case reporting has not been implemented in some of the countries most affected by AIDS while trends in HIV case reports depend on testing coverage and are not necessarily consistent with trends in measured seroprevalence. Other infections may in the future be added to the EMCDDA monitoring system (e.g. sexually transmitted infections, tuberculosis) while a rapid alert system is being maintained to report outbreaks of serious infections such as tetanus and wound botulism that may be related to infected batches of injectable drugs.

To improve HIV and hepatitis B/C monitoring in IDUs the EMCDDA follows two lines of work:

1. Collecting existing prevalence (HIV and hepatitis B/C) and notification data (hepatitis B/C only, HIV case reports are obtained from EuroHIV in aggregate format using a standard data reporting form) and stimulating increased screening of IDUs and data collection in routine settings such as drug treatment.
2. Stimulating new sero-behavioural studies in injecting drug users, by maintaining an expert network to discuss methods and work towards common protocols.

The EMCDDA has developed draft guidelines for the national focal points to collect the existing prevalence and notification data and it is working on a toolkit or 'framework protocol' for seroprevalence studies. This is based on a draft consensus protocol prepared by an expert network of longitudinal (cohort) studies.

To improve the comparability of prevalence data in IDUs, data are collected and reported on prevalence of HIV and hepatitis in young IDUs (under age 25) and new IDUs (who have injected less than 2 years). These indicators, and especially the data for new IDUs, are more sensitive to changes in incidence than is prevalence in all IDUs. In practice the target group differs slightly between settings: sero-prevalence data from needle exchanges by definition refer to current injectors (defined as having injected in the last 12 months) while data from hepatitis notifications or public health laboratories may be partly based on ex-injectors, so additional methodological data such as service setting are also collected.

The aggregate prevalence data collection through the standard reporting form has been successful. In few years time a general overview could be given of HIV and hepatitis B/C prevalence among IDUs in all EU Member States, going back to 1996 and in part even before. Many countries are able to provide up to date data with national coverage and in many cases there is regional breakdown or data from key regions or cities, often unpublished and recent. For example for HCV, data for 1996 to 2002 have been reported from 63 sources and 111 study sites in 14 countries, including in total 58 time series and 233 prevalence estimates. Similar data are available for HIV and HBV. Several countries are also providing hepatitis B/C notification data for IDUs. These data have proven useful to provide a general overview of the situation, showing regional variation in levels and trends. Although in general they show a stable prevalence of HIV and hepatitis among IDUs, they served to signal some increases in HIV or hepatitis among subgroups of IDUs in some countries.

However, the data are subject to important limitations: the use of varying source-types/settings (drug treatment, low-threshold, prisons etc.) that may result in different biases, in some cases non-adherence to the basic case definition of 'ever-IDUs' that by inclusion of non-IDUs may lead to potentially serious downward bias, small sample sizes and other problems. Improving data quality and comparability proves difficult, as this depends on influencing often well-established data producing systems. Also, to get quality information on trends over time from routine diagnostic data (as opposed to well-defined prevalence studies) it is necessary to understand selection procedures for being tested, and if possible to work towards more standardisation in the criteria for screening IDUs in contact with services.

For more information see http://www.emcdda.eu.int/?nnodeid=1375.

Overview of the data

Listed below are the tables in the bulletin, the supplementary downloadable tables and the associated graphics dealing with drug-related infectious diseases, along with a brief overview. Please note that the associated graphics and the supplementary tables are available only on the statistical bulletin website (http://stats05.emcdda.eu.int).

Tables INF-1 to INF-3 are summary tables by country of the latest results held at EMCDDA, for prevalence of HIV, HCV and HBV infections among injecting drug users, showing the numbers of tests made and the percentage infected, the broader aspects of the study setting, and references to the original reports listed in the section's bibliography, (Tables INF-0 part (i) and INF-0 part (ii)).

In the supplementary tables, Tables INF-4 to INF-6 report information on newly diagnosed or notified HIV, HCV and HBV cases respectively, giving medium-term historical data on the number of reported cases. Table INF-4 gives additionally the rate per million population for HIV infection and Tables INF-5 and INF-6 give the IDU percentage among the cases that have information on the presumed transmission category.

A small number of countries report incidence data for HCV from follow-up studies of IDUs at a city level. Table INF-7 reports the number of IDUs followed, the number of sero-conversions, follow-up time, the incidence rate per 100 person-years and a reference to the source study in the section's bibliography, Table INF-0 part (ii).

Fuller information on which the summaries above are based as well as prevalence rates among younger injectors and new injectors can be found among the supplementary downloadable tables: Table INF-8 to Table INF-10 for HIV; Table INF-11 to Table INF-13 for HCV; and Tables INF-14 and Table INF-15 for HBV current infection prevalence and HBV antibodies prevalence, respectively.

Summary points

AIDS and HIV infection

- AIDS incidence rates among IDUs are available for all EU members and show strong declines in the 'old' EU member countries, although there are increases in some of the 'newer' members.
- The decline in AIDS incidence in the late 1990s is generally thought to be not only the result of reduced transmission, but also due to the introduction in 1996 of highly active antiretroviral treatments (HAART) that delay or prevent the development of AIDS. Estimates of the coverage of highly active antiretroviral treatment made by WHO-Euro suggest that in the EU and most of Central Europe over 75 % of persons in need of treatment have access to HAART. However in most countries of Eastern Europe and in the Baltic states coverage is estimated to be at best 'poor'. Coverage estimates specific to IDUs are not available, but studies show that IDUs are often at higher risk for inadequate access to HAART than people infected by other routes. Reference: WHO Regional Office for Europe Health for all database, www.euro.who.int/hfadb (accessed 8 March 2005) (Figure INF-24, Figure INF-25).
- A lack of decline or a late decline among IDUs can indicate a lack of coverage or late introduction of these treatments for IDUs or continued high transmission of HIV among IDUs.
- AIDS incidence in IDUs in affected countries peaked in the early 1990s: in some countries somewhat later. Few countries have evidence of recently increasing AIDS incidence for IDUs.
- AIDS incidence data show that IDUs have been the most important transmission group for HIV and AIDS until 2002, when AIDS incidence due to heterosexual transmission became the largest category (Figure INF-1, Figure INF-2).
- Rates in the general population of newly diagnosed HIV

cases who are IDUs have strongly increased in the Baltic states, but have remained low in other EU countries.

- Data on newly diagnosed cases of HIV infection shows high peaks of HIV transmission as recently as 2001 in some EU Member States and elsewhere in Eastern Europe, (see Annual report 2005, HIV/AIDS in the EU and Eastern Europe).
- Some of the highest rates of newly diagnosed cases, reaching peak rates of 108 cases per 100 000, were recorded in 2001.
- While in the 'old' EU members rates have stayed constant at about 5 cases per 100 000 per year (although this is likely an underestimation as data are not available from the most affected countries) rates in the five Central Asian Republics have recently increased to a similar level (Figure INF-11).
- Seroprevalence data are an important complementary source of information to HIV case reports. HIV seroprevalence data, mostly from studies of IDUs in drug treatment, suggests that long-term the prevalence of HIV among IDUs has decreased in the most affected countries but has in most cases stabilised since the mid-1990s.
- Since 1997/8 however some new increases are seen in the available national level seroprevalence data.
- In 2002 and 2003, the HIV prevalence among IDUs shows wide variation in regional studies both within and between countries, ranging from 0 % in some of the newer members to a high of over 30 %, with several studies reporting prevalence in excess of 20 %. Recent local data are though not available from some of the most affected countries and areas.
- Some very small-scale local studies among young IDUs (aged <25) and new injectors (injecting less than 2 years) found high prevalence of HIV infection (greater than 20 %), suggesting recent transmission of HIV. Data for young or new injectors also, though, is lacking from several countries and regions which have a high prevalence overall, making it more difficult to evaluate the extent of recent transmission (Figure INF-3, Figure INF-4, Figure INF-5).

Hepatitis B and C infections

- HCV prevalence among IDUs (mostly among IDUs in drug treatment) is in general extremely high but shows wide variation within and between countries, ranging from 10 % in some national data to 97 % in one QQ regional study.
- National data are missing for many countries and in others data relate to problem drug users, not restricted to injectors, and may thus underestimate prevalence among IDUs. Even so, data for 2001 to 2003 show high prevalence in several national samples.
- Data on local/regional HCV prevalence levels are also unavailable for several countries, but high regional or local prevalence levels (exceeding 60 %) among IDUs have been found for 2001 to 2003 in studies in some countries. Lower prevalence (less than 40 %) has also been found in national and local samples in other countries.
- HCV prevalence data from young IDUs (aged <25) are available from few countries only, with levels in excess of 40 % in some studies and less than 20 % in others.
- Availability of data on prevalence in new injectors (injecting <2 years) is very limited, but similar high levels are found, with the lowest levels falling below 10 % in a few countries.
- The sparse trend data that are available suggest stable prevalence over time in those countries that provided data, with some exceptions (Figure INF-6, Figure INF-7, Figure INF-8, Figure INF-17).
- The prevalence of HBsAg, the marker for current infection with HBV, among IDUs (mostly in drug treatment) shows similar wide variation, ranging from 0 % in one country's local sample to 8 % in another's national sample. This may relate to variation in the combined effect of risk behaviours among IDUs (sexual risk and needle sharing) and of (lack of) vaccination against HBV.
- The highest prevalence rates are in excess of 5 % whilst some countries have less than 2 % prevalence. However as few countries are providing data on HBsAg the picture is far from complete.
- Some countries show high values of antibodies for HCV and HBV but relatively low prevalence of HBsAg, which might be attributed to the effect of recently introduced vaccination against HBV.
- The prevalence of specific antibodies against HBV (especially anti-HBc), which indicate a history of infection, also varies strongly within and between countries. Several countries, both old and new, have sample studies showing

relatively low rates of less than 20 %, but at the same time more than 60 % prevalence is found in local samples in some countries. The prevalence of antibodies against HBV appears to vary more than the prevalence of HCV, both within and between countries.

- Some countries show consistently low prevalence of antibodies against both HBV and HIV, two infections that are transmitted sexually. This might suggest that in those countries sexual risk behaviour among IDUs could be relatively low.
- Some countries show consistently high figures across HIV, HCV and HBV, both in the total samples and in young and new IDUs, suggesting current transmission of these infections among injecting drug users.
- Trends data for HBsAg are only available from five countries, and these show mixed results.
- Trends in HBV antibody prevalence show varying changes over time, with some minor increases and falls in recent years. There were declines in the first half of the 1990s in Italy and UK while Portugal shows a decline in the second half of the 1990s (Figure INF-9, Figure INF-10, Figure INF-18, Figure INF-19).
- Data on the notification of hepatitis are not reliably comparable indicators across countries, due to differences in case definitions and high proportions of asymptomatic cases that are not notified. The proportion of IDUs among notification data, however, may give a comparable indication of the relative importance of drug injecting as a transmission category for both HCV and HBV.
- Absolute numbers of IDU related hepatitis C notifications show a variety of trends with no consistent patterns discernable.
- In the countries that provided data, the HCV notifications for 1992 to 2003 suggest that the large majority of new cases of hepatitis C (mostly considering acute cases only) are IDUs.
- Proportions of IDUs among notified cases of hepatitis C vary from about 50 % in some countries to over 75 % in most others. Where trends in numbers are sufficient to permit a percentage interpretation, they do in the main show some slight decrease (Figure INF-12, Figure INF-13, Table INF-5 part (i)).
- Hepatitis B notification data 1992 to 2003 for the countries with data available suggests that the proportion of IDUs has been increasing during the 1990s.
- Absolute numbers of cases of IDU-related hepatitis B show strong variations in trends. Even the countries with past increases tend to show more recently declines in the past three to four years, both in absolute numbers and in percentage terms (Figure INF-14, Figure INF-15, Table INF-6 part (i)).

Data tables

The tables deal with prevalence of infectious diseases (specifically, HIV, HCV and HBV) among injecting drug users and with new notifications of these diseases among drug users. Summary tables by country show estimates of the percentage of IDUs infected. Fuller tables on which the summaries are based can be found in the statistical bulletin annex.

page

Table INF-0. Bibliographic references

- Table INF-0 part (i). Bibliographic references: prevalence data 6.5
- Table INF-0 part (ii). Bibliographic references: notifications data 6.13

Table INF-1. Prevalence of HIV infection among injecting drug users in the EU: summary table 6.14

Table INF-2. Prevalence of HCV infection among injecting drug users in the EU: summary table 6.15

Table INF-3. Prevalence of markers for HBV infection among injecting drug users in the EU: summary table 6.16

Table INF-0 part (i). Bibliographic references: prevalence data

Country	Ref.	Source
All countries	1a	Rotily M, Weilandt C, Bird SM, Käll K, van Haastrecht HJA, Iandolo E, Rousseau S. Surveillance of HIV infection and related risk behaviour in European prisons – a multicentre pilot study. Eur J Public Health. 2001 Sep;11(3):243-50.
	1b	Weilandt C, Rotily M. European Network on HIV/AIDS and Hepatitis Prevention in Prisons - 2nd Annual Report. Marseille/Bonn, ORS/Wiad, 1998.
	2	EMCDDA. The state of the drugs problem in the acceding and candidate countries to the European Union. EMCDDA 2003.
	3	Data provided by the European Centre for the Epidemiological Monitoring of AIDS (EuroHIV) (2004).
Belgium	1	Eurotox, Brussels (unpublished data).
	2	Raes V., Medische registratie druggerelateerde infectieuze aandoeningen 2002 en 2003. De Sleutel, Merelbeke.
	2a	Raes V. De Sleutel, Dienst Wetenschappelijk Onderzoek. Jaarverslag 1999. Merelbeke, July 2000.
	2b	De Sleutel. Jaarverslag 1999. Merelbeke, July 2000; Jaarverslag 2000; Jaarverslag 2001. Medische registratie, gegevensverwerking 2000; Medische registratie, gegevensverwerking 2001
	3	Vandenbussche, E., (2001), Vlaamse Registratie Middelengebruik (VRM): registratiegegevens 1999, VAD, Brussel.
	6	Data from prison Lantin (French Community), 1999. Service de santé de l'Administration des établissements pénitentiaires, Brussels (unpublished data).
	7	Data from 1 prison in the Flemish Community. Service de santé de l'administration des établissements pénitentaires, Brussels (unpublished data).
	8	Matheï C. Free Clinic, Van Arteveldestraat 64, Antwerp, Belgium, Antwerp (unpublished data).
	10a	Denis B, Hayani A, Jamoulle M et al. Toxicomanie et virus de l'hépatite C, B et HIV. Bulletin de la Société Clinique de l'Hopital Civil de Charleroi, 1993 (44) :209-213.
	10b	Denis B., Dedobbeleer M, Collet T et all. High prevalence of hepatitis C virus infection in Belgian intravenous drug users and potential role of the Cotton-filter in transmission. Acta Gastro-Enterologica Bélgica, Vol LXIII, April-June 2000.
	13	Todts S. Risicogedrag bij injecterende druggebruikers in Vlaanderen. GiG project, VAD and Free Clinic, 1997
Czech Republic	1a	National Institute of Public Health, National Reference laboratory on AIDS, Prague, (unpublished data).
	1b	National Reference Laboratory for AIDS, Bulletin of Centre of Epidemilogy and Microbiology vol. 11 (2002) no. 1-12 (Národní refenční laboratoř pro AIDS, Zprávy Centra Epidemiologie a Mikrobiologie volume 11 (2002), no. 1-12)
	3	General Directory of Prison Service, Prague, unpublished data
	4	National Monitoring Centre for Drugs and Drug Addiction (2004d) Results of the First Part of "HCV Seroprevalence Study Among Injecting Drug Users". Notes: unpublished
	5	Mravčík, V., Zábranský, T., Korčišová, B., Lejčková, P., Škrdlantová, E., Šťastná, L., Macek, V., Petroš, O., Gajdošíková, H., Miovský, M., Kalina, K. and Vopravil, J. (2003) Annual Report: Drug Situation – The Czech Republic 2002. Prague: Office of the Government of the Czech Republic.
	7	Brůčková, M., Malý, M., Vandasová, J. and Rychtařík, J. (2004) Trendy výskytu a šíření HIV/AIDS v ČR v roce 2003. SZÚ Praha Notes: 13, únor 2004 - č.2
Denmark	1a	P.B. Christensen, H.B. Krarup, H.G.M. Niesters, H. Norder and J. Georgsen: Prevalence and incidence of bloodborne viral infections among Danish prisoners. Eur J Epidemiol 2000; 16: 1043-1049.
	1b	P.B. Christensen, H.B. Krarup, H.G.M. Niesters, H. Norder O.B. Schaffalitzky de Muckadell, B. Jeune and J. Georgsen: Outbreak of Hepatitis B among Injecting Drug Users in Denmark. J Clin Virol 2001; 22: 133-141
	1c	P. B. Christensen, R. E. Engle, S.E.H. Jacobsen, H.B. Krarup, G. Georgsen and R.H. Purcell: High Prevalence Of Hepatitis A Antibodies among Danish Prisoners and Drug Users. J Med. Virol 2002; 66: 49 - 55
	2	Fuglsang T, Fouchard JR, Ege PP. Prevalence of hiv, hepatitis C and B among drug users in the city of Copenhagen. Ugeskrift for Læger 2000; 162: 3860 – 4.
	5	Susan Cowan, Department of Epidemiology, Statens Serum Institut, 2003. (unpublished data).
Germany	1	IFT Institut for Therapy Research. EBIS-Report National Monitoring System for outpatient advisory and treatment facilities in Germany. Reference period 1.1. - 31.12.1999 IFT: Munich, Germany, no date.
	2	Jugendberatung und Jugendhilfe (e.V.), Frankfurt, 1998 (unpublished data).
	3	Simon R, (DBDD) and Welsch K. (IFT) (2002) EBIS - Report of the National Monitoring System for outpatient advisory and treatment faciltities. Sucht, Sonderhaft.
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	5	Holbach, M., Frösner, G., Donnerbauer, E., Dittmeier, E. & Holbach, B (1998). Prävalenz von Hepatitismarkern der Typen A, B, C und assoziiertes Risikoverhalten unter Patienten nach intravenösem Drogenkonsum. Sucht, 44 (6), 390-398.
	6	Brack J. Hepatitis B and C in drug dependent patients: an epidemiological study. Suchttherapie Suppl. 2002; 3: S3-S10.11.
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	8a	see all countries 1a
	8b	see all countries 1b

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Table INF-0 part (i) – *continued from previous page*

Country	Ref.	Source
	9	Keppler K., Stover H. Ubertragungen von Infectionskrankheiten im Justizvolluzug – Ergebnisse einer Untersuchung und Vorstellung eines Modell projektes zur Infektions-Prophylaxe in Niedersachsen. (Transmission of infectious diseases during imprisonment – results of a study and introduction of a model project for infection prevention in Lower Saxony). Gesundheitswesen 1999.
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	11	Stark K., Bienzle U., Vonk R., Guggenmoos-Holzmann I. History of syringe sharing in prison and risk of hepatitis B virus, hepatitis C virus and human immunodeficiency virus infectious among injecting drug users in Berlin. Int J Epidemiol 1997; 26: 1359-1366
	12	Weber B., Rabenau H., Berger A, et al. Seroprevalence of HCV, HAV, HBV, HDV, HCMC and HIV in Hight risk groups / Frankfurt a. M., Germany. Zbl Bakt 1995; 282: 102-112.
	13	Trubner K, Polywka S, Puschel K, Laufs R. Hepatitis C in deceased drug addicts. Int J Legal Med. 1991; 104(5): 251-4.
	14	Neifer S, Molz B, Sucker U, Kreuzpaintner E, Weinberger K, Jilg W. [High percentage of isolated anti-HBc-positive persons among prisoners] Gesundheitswesen. 1997 Jun;59(6):409-12. German.
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	16	Stark K, Muller R, Bienzle U, Guggenmoos-Holzmann I. Frontloading: a risk factor for HIV and hepatitis C virus infection among injecting drug users in Berlin. AIDS. 1996 Mar;10(3):311-7.
	17	BKA (Federal Office of Criminology), 2000 (unpublished data)
	18	Heinemann A, Püschel K. Drogenkonsum und Infektionen im Strafvollzug. In: Drogen in der Metropole, Hg: Krausz, Raschke, Lambertus 1999; Freiburg.
Estonia	1	Kutsar K, Health Protection Inspectorate, Tallinn.
	2	See all countries 2
	3	Priimägi. L. & Tefanova. V., Tallo. T. (2003) "Emerging viral hepatitis B and C infections in Estonia". In: NATO Advanced Research Workshop "Emerging Biological Threat", October 5-8, 2003, Budapest, Hungary. Abstract book, p.11-12. Oral report October 6, 2003.
Greece	1	Greek REITOX Focal Point (EKTEPN), University Mental Health Research Institute (UMHRI).
	2	Therapy Center for Dependent Individuals (KETHEA)
	3	Hellenic Centre for Infectious Diseases Control (HCIDC - KEEL), Ministry of Health and Welfare.
	5	Organisation Against Drugs (OKANA). Methadone Substitution Programme – Salonica Units
	6	National School of Public Health – Reference Center of AIDS, Epidemiology and Biostatistics Unit, Athens.
	7	Organisation Against Drugs (OKANA) Methadone Substitution Programme – Athens Units.
	8	Diagnostic and Reference Laboratory of STDs and AIDS - "A.Sygros" Hospital.
	9	"18 ANO" Drug and Alcohol Dependence Treatment Unit - Attica State Psychiatric Hospital
	10	Mr. Papadourakis - Ministry of Justice
	12	Malliori, M., Sypsa, V. Psichogiou, M., Touloumi, G., Skoutelis, A., Tassopoulos, N., Hatzakis, A. & Stefanis, C. A survey of Bloodborne Viruses and Associate Risk Behaviours in Greek Prisons. Addiction (1998), 93(2), 243-245.
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Spain	1	Delegación del Gobierno para Plan Nacional Sobre Drogas (DGPNSD) Observatorio Español sobre Drogas (unpublished data).
	2	Delegación del Gobierno para Plan Nacional Sobre Drogas (DGPNSD) Observatorio Español sobre Drogas. Informe no 1. Ministerio de Justicia e Interior, Madrid, 1998
	3	Delegación del Gobierno para Plan Nacional Sobre Drogas (DGPNSD) Encuesta sobre Consumidores de Heroina en Tratamiento (ECHT). 1996 Report. DGPNSD, Madrid, 1997 (Polycopy).
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	4b	see all countries 1b
	5	Alfonso GR, Hurtado NI, Espacio CA, Santos RG, Tomas DS. Practicas de riesgo y seroprevalencia al VIH, VHB u VHC en los pacients Del Centro de Informacion y Prevencion del SIDA de Valencia. (Risk behaviours and seroprevalence to HIV, HBV and HCV in patients of the AIDS information and prevention center in Valencia, Spain). Gac Sanit 1999;13 (1): 16-21.
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Table INF-0 part (i) – *continued from previous page*

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	9	Pallas JR, Farinas-Alvarez C, Prieto D, Delgado-Rodriguez M. Coinfections by HIV, hepatitis B and hepatitis C in imprisoned injecting drug users. Eur J Epidemiol 1999; 15(8):699-704.
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	13	De la Fuente L. Estudio sobre el cambio de vía de administración de la heroína en tres ciudades españolas (Madrid, Barcelona y Sevilla), unpublished data.
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	17	Anon. (1998) Seroprevalence of hepatitis C virus infection at the time of entry to prison in the prison population in the north-east of Spain [in Spanish]. Rev Esp Salud Publica 72: 43-51.
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Country	Ref.	Source
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	14a	Wiessing LG, Houweling H, Meulders WAJ, Cerdá E, Jansen M, van Loon AM, Sprenger MJW. Prevalence of HIV infections among drug users in Southern Netherlands. [In Dutch]. RIVM report nr. 214230001. Bilthoven, The Netherlands: National Institute of Public Health and Environmental Protection (RIVM), 1995.
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	21	National Institute for Public Health and the Environment (RIVM), Bilthoven (unpublished data).
Austria	1	Eigner R. Federal Ministry for Social Security and Generations, Special Register for Drug related Deaths (unpublished data).
	1a	Birgit Langer, Federal Ministry for Health and Women, Special Register for Drug related Death, unpublished data.
	2	Inpatient Treatment Center Lukasfeld, Vorarlberg (unpublished data).
	3	Verein Wiener Sozialprojekte, low threshold facility Ganslwirt, Vienna (unpublished data).
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Poland	1	Szata W. (2003) Aids i zakażenia HIV w roku 2001. Przegdąd Epidemiologiczny, nr 1-2/2003.
	1a	Rosinska M. (2004) Aids i zakażenia HIV w roku 2002. Przegląd Epidemiologiczny, nr 1-2/2004 Szata W. (2003) Aids i zakażenia HIV w roku 2001. Przegląd Epidemiologiczny, nr 1-2/2003 Szata W. (2002) Aids i zakażenia HIV w roku 2000. Przegląd Epidemiologiczny, nr 1-2/2002 Szata W. (2001) Aids i zakażenia HIV w roku 1999. Przegląd Epidemiologiczny, nr 1-2/2001 Szata W. (2000) Aids i zakażenia HIV w roku 1998. Przegląd Epidemiologiczny, nr 1-2/2000 Szata W. (1999) Aids i zakażenia HIV w roku 1997. Przegląd Epidemiologiczny, nr 1-2/1999 Szata W. (1998) Aids i zakażenia HIV w roku 1996. Przegląd Epidemiologiczny, nr 1-2/1998 Szata W. (1997) Aids i zakażenia HIV w roku 1995. Przegląd Epidemiologiczny, nr 1-2/1997
	2	Bielak, A. National Institute of Hygiene. Warszawa, Poland (unpublished data).
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	2	Monteiro Carvalho C. - Centros de Atendimento a Toxicodependentes (CAT), Serviço de Prevenção e Tratamento da Toxicodependência (SPTT), DR Centro Coimbra (unpublished data).
	3	Centros de Atendimento a Toxicodependentes (CAT), Serviço de Prevenção e Tratamento da Toxicodependência (SPTT), DRN Norte Porto, (unpublished data).

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	6	Direcção Regional do Alentejo (unpublished data).
	7	Direcção Regional de Lisboa e Vale do Tejo (CAT de Sintra) (unpublished data).
	8	Viegas E. - Drug treatment Centre CAT Boavista– SPTT, Porto (unpublished data).
	9	Marinho RT, Moura MC, Giria JA, Ferrinho P. Epidemiological aspects of hepatitis C in Portugal. J Gastroenterology and Hepatology 2001; 16: 1076-9.
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	10a	IDT (2004). A Situação do País em Matéria de Droga e de Toxicodependência. Relatório Anual - 2003 (Vol. I). Lisboa: IDT.E2
	11	Direcção Regional do Algarve do SPTT. Pina, António P.B. - Toxicodependentes em tratamento no Algarve - Revista Toxicodependências, Edição SPTT, Vol. 6, N extordmasculine 1, Ano 2000, pp.37-48.
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	15b	See all countries 1b
	16a	Félix da Costa N, Viana L, Correia J, "Dois Dias de Consultas de Toxicodependências em Portugal – resultados de 1994, Toxicodependências, 1, 3 - 20, 1996.
	16b	Félix da Costa N, Correia J, Ferraz de Oliveira, F, "Tratamento da Toxicodependência – Estudo Sagital de 1995", Toxicodependências, 3, 39 – 53, 1996.
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	16d	Félix da Costa N, "Toxicodependentes em Tratamento – Estudo Sagital de 1997", 1, 35 – 48, 1999.
	17a	Godinho J, Costa H, Padre-Santo D, Rato C, "Infecção pelo HIV, Hepatite C e Hepatite B. Dados Epidemiológicos, Características Sócio-Demográficas e Factores de Risco", Toxicodependências, 3, 55 – 60, 1999. and Godinho J, 1999, op. cit.; CAT Coimbra, 2000, op. cit.; CAT Xabregas, 2000, op. cit.; CAT Taipas, 2000, op. cit.; CAT Cedofeita, 2000, op. cit. Godinho J, Costa H, Costa C, "Comportamentos de Risco de Doenças Infecciosas", Toxicodependências, 3, 55 – 60, 1996.
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	19	Padre-Santo D, Banza R, Silva A, Costa H, Godinho J, "Estudo Evolutivo do Programa de Substituição Opiácea no CAT de Setúbal", Toxicodependências, 3, 61 – 68, 1999.
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	22	ODT/IDT (unpublished data).
Slovenia	1	Institute of Public Health of the Republic of Slovenia, Ljubljana.
	2	Klavs I, Poljak M. Unlinked anonymous monitoring of human immunodeficiency virus prevalence in high- and low-risk groups in Slovenia, 1993-2002. Croat Med J 2003, 44:545-549.
	2	Okruhlica, L. Surveillance of Drug Related Infectious Diseases in IDUs Utilizing Drug Treatment. EMCDDA EU expert meeting on drug related infectious diseases, Lisbon 20-21 October 2003. Meeting Report. EMCDDA 2004.
	4	Okruhlica, L., Centre for Treatment of Drug Dependencies. Bratislava.
	3	Data provided by EuroHIV, 2004: [Office of Public Health of Slovak Republic, Bratislava]
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	1b	Liitsola. K., Ristola. M., Holmström. O., Salminen. M. O., Brummer-Korvenkontio. H., Simola, S., Suni, J. & Leinikki, P. 2000. An outbreak of the circulating recombinant form AECM240 HIV-1 in the Finnish IDU population. Aids. (Letter) 14:2613-2629.
	2	Needle exchange data, National Research and Development Centre for Welfare and Health (STAKES), Helsinki (unpublished data).
	3	Ovaska A, Holopainen A and Annala T. Final Report on the activities in the health information service experiment on 4 April – 31 December 1997. Helsinki, Terveysneuvontapiste Vinkki, Helsinki, 1998.
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	6	Brummer Korvenkontio H. National Public Health Institute (KTL) Department of Infectious Diseases Epidemiology (unpublished data).
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Norway	1	Konør H, MARIO – Methadone assisted rehabilitation in Oslo, unpublished data.
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Germany	21	Robert-Koch-Institut (Hrsg.) Gesundheitsberichterstattung de Bundes, Heft 15. Hepatitis C. //www.rki.de//Epidemiologisches Bulletin 16.1.2004
Estonia	1	Kutsar K, Health Protection Inspectorate, Tallinn.
Latvia	3	Perevoscikovs J. State Public Health Agency. (Epidemioloģijas biļetens, Nr. 84 (720) June 16, 2003)
Lithuania	4	Bagdonaite J., Centre for Communicable Diseases Prevention and Control, Vilnius, Lithuania (unpublished data)
Luxembourg	1d	Origer A., Ministry of Health – Luxembourg
Hungary	1	Csohán Á. National Center for Epidemiology, Department for Epidemiology, Budapest. (personal comm.)
Netherlands	23	Koedijk, F., Op de Coul, E.L.M., Van de Laar, M. Aangifte acute HBV in 2003 (in progress, Infectieziekten Bulletin 2004); Koedijk, F., Op de Coul, E.L.M., Van de Laar, M. Chronische hepatitis B infecties in Nederland, 2001-2003 (in progress, Infectieziekten Bulletin 2004)
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Poland	3	National Focal Point, pers. comm. 2004.
Slovenia	1	Institute of Public Health of the Republic of Slovenia, Ljubljana.
Slovakia	1	Okruhlica, L., Klempova, D.: Hodnocení programu vakcinace proti hepatitidě typu B u uživatelú drog v Bratislavě (Evaluation of a Hepatitis B Vaccination Programme among Drug Users in Bratislava), Adiktologie, 2002, 2, p.11-18.
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Norway	4	Marte Ødeg ard Lund, SIRUS – Norwegian Institute for Alcohol and Drug Research, unpublished data.
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Bulgaria	1	Tomov N. National Centre for Addictions.

Table INF-1. Prevalence of HIV infection among injecting drug users in the EU: summary table by country

Country	Year	Number tested	% infected (1)	Study design (2)	Setting/comments (3) (4) (5)	Ref.
Belgium	2002-2003	549	(0.0-5.6)	DT; SR	DTC, LTS; serum	1, 2a, 2 b, 8
Czech Republic	2003	2320	0.1-0.7/ (0.0)	DT; SR	DTC, NSP, LTS, STI, OHC, HTC, IDUnk. opiate substitution centres; serum, saliva	1b, 5, 7
Denmark	1996-97	608	(0.0-3.4)	SP	PRI, DTC, serum	1a, 1b, 1c, 2
Germany	2000-01	2255	2.8-4.0	DT; SR	DTC, ODD	1, 3, 17
Estonia	2001-02	4228	6.2-13.0 / (41)	DT	DTC, NSP, PHL, GPs, STI, OHC, ANT, HTC; serum	1, 2
Greece	2003	2031	0.2-0.8 / (0.0-1.2)	DT	DTC, LTS, OHC, PHL; serum	1, 2, 9
Spain	2002-2003	1815	9.7-21.3 / (33.0)	DT	DTC, HTC, STI; serum (IDUs starting detoxification treatment)	25, 26, 28
France	2002-2003	1022	(13.7-23.0)	SR; SP (UAT)	NSP, DTC, LTS, STR, GPs, residential centres; 25 cities, IDUnk	4a, 4b, 16, 17
Ireland	1998-99	682	3.5 -5.8	SP; SP (UAT)	PRI; saliva, IDUnk	2, 4, 8, 3
Italy	2003	70484	14.2 / (0.99-37.5)	DT	DTC; serum, saliva; IDUnk (since 2004 prisons included)	1a, 1b
Latvia	2003	1285	6.6-9.7 / (22.0)	DT; SP	DTC, OHC, NSP, STR, HTC; serum	4, 5, 6, 7
Lithuania	2003-2004	1571	2.4 / (0.0-0.4)	DT; SP	DTC, NSP, OHC; serum	1, 3
Luxembourg	2003	221	4.5	SR	DTC, LTS, OHC, ARR, PRI	1c
Hungary	2003	464	0.0 / (0.0)	DT; SP	DTC, PHL, STR; serum, saliva	1, 2
Netherlands	1998-2002	1595	(0.5-25.9)	SP	DTC, NSP, LTS, STR, methadone service; saliva and serum	1, 3, 4, 6, 8, 9, 21
Austria	2003	422	6.8 / (2.5-4.0)	DT	ODD, DTC, LTS, NSP; serum	1, 1a, 2, 3, 4
Poland	2002	2791	6.7-(29.7)	DT; SP	PHL, HTC, DTC, STI, STR; serum	1a, 2
Portugal	2003	8176	15.0-16.0	DT	DTC; IDUnk	10a
Slovenia	2003	1188	0.0 / (0.0)	DT; SP (UAT)	DTC, NSP; saliva	1, 2
Slovakia	2003	1044	0	DT	DTC; serum	4, 3
Finland	2003	732	(0.0-0.4)	DT	NSP; serum	6
Sweden	1997	196	2.6	SP	PRI, 9 sites; saliva	1
United Kingdom	2003	8433	(0.3-2.9)	DT; SP (UAT)	DTC, NSP, LTS, primary care and outreach, named HIV tests; saliva and serum	5, 20
Bulgaria	2003	992	(0.0)	DT	DTC, NSP, LTS, HTC; serum	1a
Romania	2001	2135	(0.0)		Public Health Departments	1
Norway	2004	264	(0.4)	SP	NSP, STR; serum	2a, 2b

Notes:

This summary table intends to give a global overview of HIV prevalence in IDUs in the EU. In this table data are reported for the most recent year available. Data sources for more than one year are used if they improve generalisability (e.g. national data, out-of-treatment data). Prevalence in this table should not be compared with previous versions to follow changes over time, as inclusion of sources may vary according to data availability. For time trends see Tables INF 8-10 in the annex of this statistical bulletin.

(1) The figures given in brackets show local estimates (or range of estimates) within the country.

(2) Self-reported test results are less reliable than biological test results.

(3) Having health problems is one selection criterion for admission to drug treatment in some countries or cities (Greece, Portugal, Rome), due to long waiting lists or special programmes for infected IDUs, and this may result in upward bias of prevalence. Prevalence from treatment data should therefore be interpreted in combination with non-treatment data. On the other hand, data from Italy and Portugal include non-IDUs and may thus underestimate prevalence in IDUs.

(4) IDUnk = IDU not known, prevalence may be too low.

(5) ODD = overdose deaths; DEM = drug emergencies; DTC = drug treatment centres; NSP = needle exchanges; LTS = low-threshold services; PHL = public health laboratories; STI = STI clinics; ANT = antenatal clinics; OHC = other hospital or clinics; PRI = prisons; ARR = arrests; GPs = general practitioners; HTC = HIV testing centres; STR = street; OTH = other.

Sources:

See Table INF-8.

Table INF-2. Prevalence of HCV infection among injecting drug users in the EU: summary table by country

Country	Year	Number tested	% infected (1)	Setting/comments (2) (3) (4) (5)	Ref.
Belgium	2003	367	(35.0-79.1)	DTC, LTS; serum	2a, 2b, 8
Czech Republic	2002-03	1853	52.0 / (29.7)	LTS, PRI; serum	3, 4
Denmark	1997	602	(75-85)	PRI, DTC; serum	1, 2
Germany	1998-01	675	(65.7-82.5)	DTC, LTS, PRI; saliva, serum	2, 4, 7
Estonia	2002	63	(90.5)	LTS	3
Greece	2003	2058	35.8-67.2 / (31.1-82.1)	DTC, LTS, OHC, PHL; serum	1, 2, 9
Spain	2003	40	(59.1)	Blood samples in blotting paper. Heroin users age 30 or less recruited in community	29
France	1995-97	429	(53.2-91)	PRI, PHL; serum	5a, 5b, 6, 11
Ireland	1998-99	682	71.7-81.3	PRI; saliva	2, 4
Italy	2003	79160	65.1 (42.1-97.2)	DTC, PRI; saliva, serum; IDUnk	1
Latvia	2001	261	(83)	NSP	2
Lithuania	2000	693	79		2
Luxembourg	1998	116	37	PRI ; saliva	4
Hungary	2003	466	10.4-(30.0)	DTC	1
Netherlands	1996-00	487	(47.2-73.3)	DTC, NSP, LTS	9, 11
Austria	2003	341	33.1 / (44.0-51.0)	DTC, NSP, LTS, ODD; serum	1a, 1b, 2, 3, 4
Poland	2002	165	(60.6)	DTC, STR; serum	2
Portugal	2003	8058	44.9-62	DTC, therapeutic, outpatient and detoxication units; serum; IDUnk	10a
Slovenia	2002-2003	768	22.2-(32.5)	DTC; serum	1, 2
Slovakia	2002	80	(32.5)	DTC; serum	2
Finland	2002-2003	833	(11.4-52.0)	NSP; saliva, serum	1, 1a, 6
Sweden	1994	913	(91.1)	PRI, OHC ; 16 % non-participation	2
United Kingdom	2002-2003	5815	(19.0-55.0)	DTC, NSP, LTS, primary care and outreach; saliva	8, 20, 21
Bulgaria	2001	435	(60)	DTC, NSP, LTS, outreach.	1a
Romania	2001	1200	(51.0)	DTC	1
Norway	2004	264	(68.0)	NSP, STR; serum	2

Notes:

This summary table is meant to give a global overview of HCV prevalence in IDUs in the EU. In this table data are reported for the most recent year available. Data sources for more than one year are used if they clearly improve generalisability (e.g. national data, out-of-treatment data). Prevalence in this table should not be compared with previous versions to follow changes over time, as inclusion of sources may vary according to data availability. For time trends see Tables INF 11-13 in the annex of this statistical bulletin.

(1) The figures given in brackets show local estimates (or range of estimates) within the country.

(2) Saliva tests for hepatitis C antibodies underestimate prevalence. If test sensitivity is known then figures can be adjusted upwards by dividing prevalence by test sensitivity. Test sensitivity is around 70-90 % in older studies and may be up to 90-95 % in some recent studies. Figures have not been adjusted.

(3) Having health problems is one selection criterion for admission to drug treatment in some countries or cities (Greece, Portugal, Rome), due to long waiting lists or special programmes for infected IDUs, and this may result in upward bias of prevalence. Prevalence from treatment data should therefore be interpreted in combination with non-treatment data. On the other hand, data from Italy and Portugal include non-IDUs and may thus underestimate prevalence in IDUs.

(4) IDUnk = IDU not known, prevalence may be too low.

(5) ODD = overdose deaths; DTC = drug treatment centres; NSP = needle exchanges; LTS = low-threshold services; PHL = public health laboratories; OHC = other hospital or clinics; PRI = prisons; STR = street; OTH = other.

Sources:

See Table INF-11.

Table INF-3. Prevalence of markers for HBV infection among injecting drug users in the EU: summary table by country

Country	Year	Number tested	% positive HBsAg (1)	% positive any marker (1)	Setting/comments (2) (3) (4) (5)	Ref.
Belgium	2003	362	(3.9)	(12.0-61.9)	DTC, LTS; serum	2a, 2b, 8
Denmark	1997	602		(64-68)	PRI, DTC; serum	1, 2
Germany	1999	140	2.0	(52-63)	DTC	4
Estonia	2002	100		(59.5-68.2)	LTS	3
Greece	2003	2040	2.3-5.8 (0.0-7.1)		DTC, LTS, OHC, PHL; serum	1, 2, 9
Spain	2002-2003	805		(20.0-51.7)	DTC	29, 32
Ireland	1998-99	682		17.9-18.5	PRI, serum, saliva	2, 4
Italy	2003	62249		43.4 (26.3-90.6)	DTC, PRI; serum; IDUnk	1a, 1b
Latvia	2001	261		(38)	NSP	2
Lithuania	2000	698		7		2
Hungary	2002-2003	470	0.7 (2.6)		DTC, PHL, STR; serum, saliva	1, 2
Netherlands	1999-00	405	(3.0-4.4)	(35.2-67.5)	DTC, NSP, LTS surveys in and outside drug treatment; serum	6, 9, 11
Austria	2003	214		(7.0-34.0)	DTC, LTS, PHL, GPs, HTC; serum	2, 3, 4, 5
Poland	2002	164	(5.6)	(52.4)	DTC, STR, serum	2
Portugal	2003	8110	3.0-8.0	16.0-33.0	DTC; serum, dried blood spots; IDUnk	10a, 22
Slovenia	2002-2003	670	3.4	10.4	DTC; serum	1
Slovakia	2002	80		(6.3)	DTC; serum	2
Sweden	1997	184		57.6	PRI, 9 sites; saliva	5a, 5b
United Kingdom (E & W)	2003	2644		(2.0-29.0)	DTC, NSP, LTS, primary care and outreach; saliva	20
Bulgaria	2001	689	(5)	n.a.	DTC, NSP, LTS, outreach.	1a
Romania	2000	1200	(25)		DTC	1
Norway	2004	264		(42.0)	NSP, STR; serum	2a, 2b

Notes:

This summary table intends to give a global overview of prevalence of HBV markers in IDUs in the EU. In this table data are reported for the most recent year available. Data sources for more than one year are used if they clearly improve generalisability (e.g. national data, out-of-treatment data). Prevalence in this table should not be compared with previous versions to follow changes over time, as inclusion of sources may vary according to data availability. For time trends see Tables INF-14 and INF-15 in the annex of this statistical bulletin.

(1) The figures given in brackets show local estimates (or range of estimates) within the country.

(2) Saliva tests for hepatitis B antibodies underestimate prevalence. If test sensitivity is known then figures can be adjusted upwards by dividing prevalence by test sensitivity. Figures have not been adjusted.

(3) Having health problems is one selection criterion for admission to drug treatment in some countries or cities (Greece, Portugal, Rome), due to long waiting lists or special programmes for infected IDUs, and this may result in upward bias of prevalence. Prevalence from treatment data should therefore be interpreted in combination with non-treatment data. On the other hand, data from Italy and Portugal include non-IDUs and may thus underestimate prevalence in IDUs.

(4) IDUnk = IDU not known, prevalence may be too low.

(5) DTC = drug treatment centres; NSP = needle exchanges; LTS = low-threshold services; PHL = public health laboratories; OHC = other hospital or clinics; PRI = prisons; GPs = general practitioners; HTC = HIV testing centres; STR = street; OTH = other.

Sources:

See Tables INF-14 and INF-15.

List of supplementary material

The figures and supplementary tables listed here are available on the statistical bulletin website (http://stats05.emcdda.eu.int).

Figures

Figure INF-1. AIDS cases among IDUs by country (WHO European Region) and year of diagnosis (1982 to 2003) adjusted for reporting delays

Figure INF-2. AIDS cases by transmission group and year of diagnosis (1987-2003) adjusted for reporting delays, EU

Figure INF-3. HIV prevalence among injecting drug users: studies with national and subnational coverage 2002 to 2003

Figure INF-4. HIV prevalence among injecting drug users under age 25: studies with national and subnational coverage 2002 to 2003

Figure INF-5. HIV prevalence among injecting drug users (injecting less than 2 years): studies with national and subnational coverage 2002 to 2003

Figure INF-6. HCV prevalence among injecting drug users: studies with national and subnational coverage 2002 to 2003

Figure INF-7. HCV prevalence among injecting drug users under age 25: studies with national and subnational coverage 2002 to 2003

Figure INF-8. HCV prevalence among new injecting drug users (injecting less than 2 years): studies with national and subnational coverage 2002 to 2003

Figure INF-9. HBV prevalence among injecting drug users (percentage with HBsAg) - studies with national and subnational coverage 2002 to 2003

Figure INF-10. HBV (antibodies) prevalence among injecting drug users - studies with national and subnational coverage 2002 to 2003

Figure INF-11. HIV infections newly diagnosed in injecting drug users in selected EU countries, Russia and Ukraine, by year of report

Figure INF-12. Proportion of notified cases of hepatitis C that are reported as IDU for some EU countries

Figure INF-13. Numbers of notified cases of hepatitis C in IDUs 1992 to 2003 for some EU countries

Figure INF-14. Notified cases of hepatitis B, proportion of cases reported as IDU

Figure INF-15. Trends in numbers of notified cases of hepatitis B in IDUs, 1992 to 2003

Figure INF-16. Trends in HIV seroprevalence among injecting drug users 1991 to 2003

Figure INF-17. Trends in HCV seroprevalence among injecting drug users 1997 to 2004

Figure INF-18. Trends in HBV (HBsAg) seroprevalence among IDUs, 1997 to 2003

Figure INF-19. Trends in HBV antibodies seroprevalence among IDUs: trends for some EU countries 1991 to 2004

Figure INF-20. Prevalence of HIV infection among injecting drug users, 2002 to 2003

Figure INF-21. Prevalence of HCV infection among injecting drug users, 2002 to 2003

Figure INF-22. Prevalence of HBV infection (HBsAg) among injecting drug users, 2002 to 2003

Figure INF-23. Prevalence of HBV infection (antibodies) among injecting drug users, 2002 to 2003

Figure INF-24. Clinically diagnosed AIDS incidence per 100 000 population in Europe

Figure INF-25. Estimated access to highly active anti retroviral treatment (HAART) in WHO European Region, end of 2004

Figure INF-26. Trends in HIV seroprevalence among IDUs under the age of 25

Figure INF-27. Trends in HIV seroprevalence among new IDUs in some EU countries

Figure INF-28. Trends in HCV seroprevalence among IDUs under age 25 from 1994 to 2003

Figure INF-29. Trends in HCV seroprevalence among new IDUs, 1994 to 2003

Tables

Table INF-4. HIV infections newly diagnosed in injecting drug users, by year of report from 1992 to 2003, (a) cases per million population and (b) number of cases

Table INF-5. Notified cases of hepatitis C infection among injecting drug users: number of IDUs and percentage of IDUs among all cases with known risk factor

- Table INF-5 part (i). Notifications of IDUs with hepatitis C
- Table INF-5 part (ii). Notes and comments

Table INF-6. Notified cases of hepatitis B infection among injecting drug users: number of IDUs and percentage of IDUs among all cases with known risk factor

- Table INF-6 part (i). Notifications of IDUs with hepatitis B
- Table INF-6 part (ii). Notes and comments

Table INF-7. Incidence of hepatitis C virus antibody among injecting drug users

Table INF-8. Prevalence of HIV infection (%) among injecting drug users in the EU

- Table INF-8 part (i). Data
- Table INF-8 part (ii). Notes

Table INF-9. Prevalence of HIV infection (%) among injecting drug users under age 25, in the EU

- Table INF-9 part (i). Data
- Table INF-9 part (ii). Notes

Table INF-10. Prevalence of HIV infection (%) among new injecting drug users (injecting less than 2 years) in the EU

- Table INF-10 part (i). Data
- Table INF-10 part (ii). Notes

Table INF-11. Prevalence of hepatitis C infection (%) among injecting drug users in the EU

- Table INF-11 part (i). Data
- Table INF-11 part (ii). Notes

Table INF-12. Prevalence of hepatitis C infection (%) among injecting drug users under age 25 in the EU

- Table INF-12 part (i). Data

- Table INF-12 part (ii). Notes

Table INF-13. Prevalence of hepatitis C infection (%) among new injecting drug users (injecting less than 2 years) in the EU

- Table INF-13 part (i). Data
- Table INF-13 part (ii). Notes

Table INF-14. Prevalence of current hepatitis B infection (% with HBsAg) among injecting drug users in the EU

- Table INF-14 part (i). Data
- Table INF-14 part (ii). Notes

Table INF-15. Prevalence of antibodies against hepatitis B virus (%) among injecting drug users in the EU

- Table INF-15 part (i). Data
- Table INF-15 part (ii). Notes