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Summary

The EUROSIDER project

A Safer Injecting Drugs Education Research to reduce HIV/HCV risk transmission in people who inject drugs in four countries

Three partners will coordinate the work streams:

INSERM, AIDES, Regenboog Groep/Correlation Network

To ensure the steady and effective implementation of the different project steps.

National implementations will be carried out by the project’s 4 local partners, all of whom have a proven track record of European collaboration:

Initiative for Health Foundation (Bulgaria), Praksis (Greece), GAT (Portugal), ARAS (Romania).

Objectives

The main objective of this project is to contribute to a better Hepatitis C policy and practice by developing the transferability of an effective community-based intervention towards PWID in several political and epidemiological contexts in order to reduce HIV-HCV risk transmission. This Individually-Tailored Support and Education for Safer Injection (ITSESI) intervention consists in providing face-to-face educational session on injecting practices and giving information about HIV-HCV prevention and care among difficult-to-reach populations of PWID.

Specific Objectives:

• To assess the national and local context of services working in the area of HIV/HCV prevention
• To implement and evaluate the ITSESI intervention to reduce risks of (re)infection for PWID’s
• To prepare and disseminate validated tools for effective HIV/HCV risk reduction under PWID’s
• To advocate on policy level for implementation of these ITSESI tools.

Study design

The project will last for 24 months with 4 phases:

• The first phase will be an exploratory study using qualitative interviews and quantitative available data of each local context chosen to implement the intervention.
• The second phase will consist in the implementation of ITSESI intervention in harm reduction programs through a training phase (key-trainers and national field stakeholders).
• The third phase will consist in the evaluation of ITSESI intervention. This study will enrol 300 PWID (75 per harm reduction centre or per country) seeking support for their injection practices and to provide them with the intervention. They will be interviewed using a face-to-face questionnaire at baseline (M0) and at 6 months (M6). This evaluation will also use a qualitative study conducted in each site using focus group and semi-structured interviews with participants to investigate their experience, perception and possible difficulties related to this educational intervention.
• The fourth phase will consist in drafting, promoting and disseminating all the ITSESI toolkit (handbook, scientific publication, training conference/seminar, events to policy makers) necessary to transfer the intervention in other contexts and more globally at a European level.
What is an ITSESI session?

It will be optimally organized as a series of individually tailored face-to-face educational sessions, which could take place “on site” or in harm reduction programs, provided by peer educators, nurses or trained social workers, with PWID who seek support on their injection practices that include both:

- The direct observation by trained NGO staff or volunteers of participants’ self-injecting the psychoactive product they habitually inject using a standardized checklist when supervising injection. Hygiene (Whether/how cleaning site of injection/hands), Preparation (syringe, spoon, fingers, type of product, acidification, water, heating, mixing, filtering, use of spared equipment), Pre injection (how cleaning site/searching where to inject, leaking needle...), Injection (arm, legs etc., alternate site, number of attempts, right orientation, speed etc.), Injection done or not (why not done-observations), Post-injection (management of bleeding and of used equipment, clean hands).

- An educational exchange on the injection practices of individual participants and the questions they raised;
- The trained NGO staff or volunteers analysed the participant’s injecting practices, identified the injection-related risks and explained safer injecting practices to the participant.
- A provision of information about why and how they can have access to HCV testing and HCV clinical services (contact of HCV screening centres, HCV physicians, social workers for health insurance renewal or registration, ...).
Preliminary results:

➔ Training:
11 persons attended the training of trainers, 68 participants attended the local session training.

➔ Context:
The fieldworkers had to adapt the intervention to protect themselves and their clients from the police threat. The change was specifically in the phase of injection observation. Based on the risks for users having the product with them, it was decided to use video or pad/placebo for demonstration.

➔ Qualitative part:
ITSESI has been an opportunity to improve professional practices and the understanding of the real patterns of drug use. Professionals have better skills promoting safe injection.

During this project, the professionals reported better knowledge of the user community. The intervention creates the opportunity to strengthen our knowledge of PWID, their practices and their real life conditions. The involvement of participants also enabled assessment of the evolution of PWID profiles and new patterns of use.

The Eurosider project highlights the structural barriers to good injection practices, which could prove difficult for professionals.

➔ Quantitative part:
Overall, 305 participants were included in the Eurosider cohort, with 75 users per countries, and 80 user from Romania.

Participants in Portugal and Greece had greater social insecurity than people from Bulgaria and Romania.

In Greece and Portugal the majority of people injected more than 3 times a day (59% and 63%, respectively). With regard to risk practices, more than 80% of the total sample re-used their injection equipment at least once in the previous month. Almost half of the Bulgarian participants declared injecting equipment sharing in the previous month. On the contrary, sharing percentages in both Portugal and Romania were low (under 23%).

In Romania and especially Bulgaria, a high percentage of participants reported current HCV infection (64% and 76%, respectively). With regard to current treatment for HCV, access was quite low in all four countries (6% of HCV-positive users were being treated).

Regarding injection risk practices (‘sharing’, ‘re-use’, ‘rushing injection’), we found a decrease of these practices in the intervention group. We also found a decrease in self-reported injecting related complications (‘vascular’ and ‘infectious’). No difference was found in the percentage of participants reporting being injected by someone else between the two groups.

➔ Advocacy and dissemination:
By implementing the project in 4 European countries, gaining support by the resp. Ethical Committees and (local) policy makers, awareness and insight into this specific area was increased. In certain countries, specific advocacy measures were adapted to ensure the implementation of the project.

By informing interested stakeholders on several major conferences in Europe (European harm reduction Conference, Lisbon Addiction conference, Hepatitis Community Summit) awareness increased for the need and the effectiveness of the method.
Introduction

The present research project aimed to study the transferability of an educational intervention for people who inject drugs (PWID) already validated in France to 4 other European countries. This full report describes context, methods and findings.

The situation of HIV-related epidemiology for PWID in Europe varies substantially from one country to another. This is because public health policy – including policies on access to care and harm reduction services for PWID – is still country-centered rather than dictated at a European level. In Eastern Europe where access to opioid substitution treatment (OST) and needle syringe programs (NSP) remains limited, injecting drug use is still the key driving force of the HIV epidemic (1). In Western Europe, OST and NSP have been found to reduce greatly HIV transmission in PWID (2, 3). For example, in France, HIV prevalence decreased from 40% in 1988 to 11% in 2011 after the implementation of a national harm reduction policy (4, 5). In terms of Hepatitis C Virus (HCV) infection, its burden remains an important public health issue among drug users, particularly among PWID (6, 7). Indeed, injecting drug use - specifically the sharing of needles, syringes (8) and other drug injecting paraphernalia (9) - is known to be the single greatest risk factor of HCV infection. Today, HCV prevalence is between 60 and 80% among PWID in 25 countries and >80% in 12 others, even in countries where harm reduction programs are accessible (10). The results of HCV epidemic modelling performed by Vickerman et al. confirmed that scaling-up OST and high coverage NSP might not be sufficient to reduce HCV prevalence among PWID and that other interventions are needed (11).

Additionally, other complications related to drug injection have been widely reported (12, 13). A study conducted in Vancouver showed that the majority of Emergency Room admissions of PWID were due to abscesses, cellulitis and other skin infections related to injecting practices (14). Despite being documented since the 1970s (15), these complications remain a significant problem among PWID. Moreover, the injection of crushed pills not intended for intravenous use, such as morphine sulphate (16) and buprenorphine (17), constitutes a growing problem. These at-risk injection practices, which are increasingly documented, lead to several health problems beyond local lesions such as cardiovascular and pulmonary complications (18, 19).

In France, where harm reduction programmes exist throughout the country, HCV prevalence among PWID was estimated at 44% in 2011 (5). The Coquelicot survey conducted in 2011 showed that among PWID, younger people (under 30) more frequently reported injecting. Moreover, the survey suggested that there are wide geographical disparities in HIV and HCV prevalence within France (5). It appears also that the most difficult-to-reach PWID have higher rates of HIV/HCV risk behaviours, including increased cocaine injection, and have less access to prevention and care services (20). In this context, in 2011 French field workers started to develop a community-based educational intervention to reduce injection-related risks, based on an individually tailored educational intervention provided by peer educators, nurses and trained social workers. The stakeholders together with academic researchers designed the evaluation of this programme (the ANRS-AERLI study). It showed a significant reduction in unsafe HIV/HCV transmission practices and local complications at injection sites and an increase in HCV testing uptake in participants who received the AERLI intervention (21, 22). In addition, the engagement of community stakeholders in advocating the intervention, given the positive results, helped to bring about a change in French law whereby the AERLI intervention can now officially be implemented in the nation’s harm reduction centres. Currently, the OUTSIDER study is validating the AERLI intervention in an outreach context for the most difficult-to-reach PWID in France. The project presented here aims to transfer AERLI - renaming it ITSESI (Individually-Tailored Support and Education for safer injection) - to other European countries where innovative actions are needed to tackle the HCV epidemic.
The impact of this project will help shape European policy and recommendations in terms of the reduction of harm caused by drug-related infections, more specifically HCV, and will encourage drug users to engage more with testing and treatment delivered at the community level (23).

The project will be built on existing evidence (ongoing actions and information). It will be implemented in four countries of the European Union, which have been selected according to current data on HCV (hepatitis C) prevalence, on existing epidemiological data and on national drug policy. 

The first three are Bulgaria, Greece and Romania as reports from EMCDDA and European Council have prioritized these countries for HIV and HCV prevention measures. All three have insufficient financial resources to implement costly prevention and treatment programmes. They will benefit directly from the cost-effective ITSESI intervention to reduce HIV/HCV infections. The fourth country selected is Portugal because drug use there is decriminalized. We made this choice, as there is a large diversity of drug policies in Europe - which means that the ITSESI intervention may not be accepted or implemented in the same way in each country.

In 2012, increases in HCV and very high prevalence of HCV among PWID (50–80%) were reported in nine European countries including Bulgaria, Greece, and Romania (24). In Greece, the scale-up of prevention coverage started in 2011. However, this has been impeded by financial constraints since late 2012. In Romania, coverage has reduced substantially since 2010, when a Global Fund grant ended, and OST remains limited. Since July 2013, the main harm reduction provider (Romanian Anti-AIDS Association, ARAS) has had to halve services due to limited resources. In Bulgaria, a Global Fund grant has ended in 2014. Data from Portugal show a prevalence of HCV infection between 63-88% among PWID in 2014 (26).

Irrespective of differences in national contexts, these numbers underline the persistence of risky behaviours in PWID in the four selected countries, in particular in PWID disconnected from the standard system of prevention and care. This suggests that current harm reduction programmes are insufficient for this population with respect to reducing harm caused by injecting practices. Consequently, there is a need to experiment with, evaluate, and implement innovative strategies as soon as possible to improve effectively PWID health.

The documents necessary for the assessment methodology and for the implementation of the intervention will be provided in a validated European training manual, applicable in different settings and contexts in different European countries, including countries neighbouring the EU.

Partner organisations (hereafter-termed local partners) in the selected countries have been chosen based on their long-standing experiences in the field and their capacity to promote outcomes of their interventions at a national level. By involving policy makers from the selected countries, local interventions can be scaled up at a national level.
Study objectives and methods

Objectives

The main objective of this project is to study the transferability of an effective community-based intervention to PWID in several political and epidemiological contexts with an aim to reducing the risk of HIV-HCV transmission. This Individually-Tailored Support and Education for Safer Injection (ITSESI) intervention consists in offering educational supervision during all phases of the injection sequence, from pre- to post-injection, and in providing i) tailored education for each risky act, ii) prevention messages related to HIV/HCV risk transmission and iii) information about access to screening and care for HIV and HCV.

The specific objectives of the project are as follows:

1 – Exploratory phase: To assess national and local contexts regarding HIV/HCV prevention services in 4 European countries

2 – Implementation and evaluation: To implement and evaluate the ITSESI intervention in these 4 European countries

3 – Dissemination and advocacy: To develop and disseminate validated ITSESI tools and to advocate the implementation of the ITSESI intervention at the local national and European policy level

The intervention

This community-based intervention is based on 2 main prevention components:

• offering an educational supervision of injection;
• providing prevention messages related to HIV/HCV risk transmission and information about access to screening and care for HIV and HCV.

The main objective of this intervention is to enable PWID to learn to inject more safely in order to manage better autonomously the risks associated with the practice of injection, notably viral infection (HIV and HCV) and other damages and infections associated with injection.

The second objective is to provide information about access to screening and care for HCV (and HIV) in order to help and to facilitate access to services for PWID.

It will be optimally organized as a series of individually tailored face-to-face educational sessions, taking place, provided by peer educators, nurses or trained social workers, with PWID who seek support on their injection practices that include both:

• the direct observation (with no commentary) by ITSESI providers of a PWID self-injecting either the psychoactive product (which he/she habitually uses) or a “placebo” drug injected in a pad (if the real injection is not possible) or the observation of a video recorded by the participant using a standardized checklist: Hygiene (Whether/how cleaning site of injection/hands); Preparation (syringe, spoon, fingers, type of product, acidification, water, heating, mixing, filtering, use of spared equipment); Pre-injection (how cleaning site/searching where to inject, leaking needle...); Injection (arm, legs etc., alternate site, number of attempts, right orientation, speed etc.); Injection done or not (why not done-observations); Post-injection (management of bleeding and of used equipment, clean hands).

• An educational exchange on the injection practices of individual participants and the questions they raised: the trained NGO staff or volunteers analysed the participant’s injecting practices, identified the injection-related risks and explained safer injecting practices to the participant.

• A provision of information about why and how they can have access to HCV testing and HCV clinical services (contact of HCV screening centres, HCV physicians, social workers for health insurance renewal or registration, ...).

This intervention will be provided in harm reduction services or “on site” where PWID usually inject their product such as in community-based settings, squats, where PWID live, but also in the street using mobile unit dedicated to delivering harm reduction tools and prevention interventions.
Ethical issues

This main protocol has received the approval (IRB 00003888) of the INSERM Ethics Evaluation Committee (CEEI - IRB) in France and will be submitted to each national ethics committee in the 4 countries.

Research participants will be adults capable of giving full informed consent. Researchers will emphasise that participation is voluntary and anonymous and that participants can refuse or withdraw consent at any time without adverse consequences (see consent form).

Methods

The project will use a cascade of different methodologies for the assessment, implementation (training), evaluation, validation and utilisation (advocacy) of the educational intervention.

1 - Exploratory phase

An assessment of how the ITSESI intervention can be implemented in each of the 4 countries involved will be performed, in order to ensure that the intervention is adapted to local and national contexts. To reach this goal, an analysis of the literature will be performed (scientific publications, EMCDDA data, national and local reports) and some informal interviews with field workers and a simple emailed questionnaire to perform a rapid assessment of local contexts (epidemiological, legal, social, medical, etc.) will all be used. Indicators for the report will be:

• HIV and HCV prevalence
• Access to HCV care: % of PWID tested, diagnosed, treated
• Description and accessibility to services for HCV testing and care
• Type of drugs most injected by PWID, drug use patterns
• Access to prevention services: needle exchange programs, mobile units, education interventions
• HCV risky practices: % of HCV risky practices
• Specific country’s drug policy: level of repression/criminalization, tolerance, stigmatization.

A qualitative study will carry out before the training phase and will consist in focus groups with field workers to understand better the local context and to discuss the structural and legal environments. These focus groups will also aim to present the study and the preliminary versions of the associated tools (questionnaires) to field workers, in order to discuss these documents and to identify practical elements to be taken into account for the operational implementation of the study. The content of the intervention will also be discussed, in particular the material needed by ITSESI providers to conduct the intervention – i.e. the educational supervision of injecting practices - in the best possible conditions. The management of overdose situations will also be discussed, notably the possible use of naloxone by PWID and partnership with emergency room.

2 - Implementation and evaluation

In this phase, the ITSESI intervention will be implemented and evaluated in the local partners’ harm reduction programmes. Any field worker (peer educator, health professional, social worker) can provide the ITSESI intervention. This phase will consist in:

2-1. Implementation of the ITSESI intervention: training the local partners from each country.

Training will be provided through the means of an ‘implementation research KIT’, which includes objectives, contents, methods and techniques, the validation process, protocol and background documentation for implementation. Training will start with an English-speaking meeting (English will be the official language for the project) in Bucharest with 3 field workers (including a site coordinator) from each country receiving both training in ITSESI research and the intervention. A training focus group will be established in Bucharest with the local ITSESI trainers from all the countries involved. It will be used to increase understanding about the field workers’ acceptability of the project in the various countries and to validate the tools used. After being certified as “local ITSESI trainers”, they will then translate the implementation research KIT into each country-specific language. After this, they will provide training in their local...
sites to other field workers already involved in the EUROSIDER project. The latter will in turn provide the intervention to PWID (hereafter “ITSESI providers”). Indicators for this phase will be:

- the number of field workers trained in Bucharest (local ITSESI trainers), and results from pre- and post-training knowledge tests for these individuals.
- the number of ITSESI providers trained by local ITSESI trainers, and their willingness to implement the ITSESI intervention.

### 2-2. Evaluation of the ITSESI intervention

This second part of the project is based on a quantitative evaluation which consists in enrolling 300 PWID seeking support for their injection practices (75 per country). Participants will be recruited through several local harm reduction (HR) programs in the four countries selected under these following conditions:

- each program has more than 100 PWID,
- each program already performs HCV and HIV prevention through harm reduction interventions.

All 300 participants will be followed up for six months and will be allocated to two different groups: 1 control group (n=35) and 1 intervention group (n=40) who will be provided with the ITSESI intervention (up to 3 sessions). All the participants will complete a questionnaire at baseline (M0) and at 6 months (M6) through face-to-face interviews with trained interviewers not involved in the educational sessions (i.e. not ITSESI providers or trainers). These data will include socio-demographic information (gender, age, education level, relationship status, employment status, housing situation), information on history of drug use (age at first drug injection), drug use in the previous month (frequency of drug sniffing and/or drug injection) and alcohol use (using the AUDIT-C questionnaire). We will also collect information about access to care, HIV and HCV testing and diagnosis, and access to (prescribed and non-prescribed) opioid substitution treatment (OST). Behavioural data related to the risk of HCV transmission during the previous month will be collected using the validated BBV-TRAQ-SV questionnaire (51). Participants will receive different compensations by vouchers: 5 euros for the M0 questionnaire, 10 euros for the M6 questionnaire and 5 euros for those who received the ITSESI intervention.

During the educational session where field workers observe PWID self-injecting their drug or, if the context does not permit it, injecting a placebo drug in a pad or observing a video recorded by the participant, some data regarding injecting practices will be collected.

**Outcomes and covariates**

The intervention’s effectiveness will be assessed by comparing the change from M0 to M6 of this main outcome between the two groups (control versus intervention):

Reporting HIV/HCV risk practices defined as reporting at least one HIV/HCV risk practice during the previous four weeks such as: sharing of syringes/needles, sharing of other injecting paraphernalia (filter, swab, water, cup, etc.)

We also will collect the following secondary outcomes:

Complications at the injection site, defined as reporting at least one complication at the injection site during the previous four weeks from the following list: bruises, abscesses, edema, burns, infections, necrosis, other.

We will test the following covariates with the outcomes: (1) socio-demographic characteristics (sex, age, educational level (≥High School Certificate vs < High School Certificate), relationship status (single, married, couple, divorced, separated, widowed), employment status (paid activity or not), precarious housing or not (community-based shelter, street, squat, caravan); (2) history of drug use (age at first drug injection); (3) alcohol consumption (AUDIT-C); (4) recent drug use (heroin, cocaine or crack, sulphate morphine, buprenorphine, etc...), polydrug use, frequent injection on a daily basis, being on OST; (5) prison history and (6) access to care.
## Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>M0</th>
<th>M6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socio-demographic characteristics (DEM)</td>
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</tr>
<tr>
<td>Socio-economic data (SOC)</td>
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<tr>
<td>History of drug use (HIST)</td>
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<td>Current drug use (CONS)</td>
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<tr>
<td>Alcohol use (AUDIT)</td>
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<td>Overdoses (OD) and suicidal risk (SUIC)</td>
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<tr>
<td>HIV-HCV risk practices related to drug use (RIS)</td>
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<tr>
<td>Complications at injection sites (foot, arm etc.) (LOC)</td>
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<tr>
<td>Health issues and access to care (HEAL)</td>
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<tr>
<td>HIV – HCV – HBV screening (SCR)</td>
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<tr>
<td>Illegal activities (CRI)</td>
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<tr>
<td>Prison history (PRIS)</td>
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<tr>
<td>Injection Network (NET) and initiation to injection (INI)</td>
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<td>Sexual risk behaviours (SEX)</td>
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<tr>
<td>Other HIV-HCV risk behaviors (ARIS)</td>
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</table>

### Sample size

To calculate the sample size we consider the main endpoint: reporting at least one HIV/HCV risk practice in the previous month at M6. We will compare the reduction of risk practices in the control group and intervention group. To hypothesize the number reporting this outcome in our study we looked at previous similar studies. In the Australian study ABRIBUS, 75% of PWID reported at least one HCV at-risk practice during the previous month (33). In Eastern European countries, the proportion of HIV-HCV risk practices is known to be higher than in western countries, because of low NSP and OST coverage (52). The recent study ANRS-AERLI conducted in France, which aimed at evaluating the same educational intervention (aside: ITSESI is the renamed title specifically for this project (see “Section a. State-of-the-art and objectives” above)) showed that, at baseline, 44% of participants reported having at least one HIV-HCV risk practice and that after 6 months a decrease of up to 25% was observed in reporting this in those who had received at least one educational session (53). ANRS-AERLI included a control group and the results showed a significant positive impact of the intervention on reducing HIV-HCV risk practices.

Given this information from previous studies, in the 4 country-level contexts we are going to study (Bulgaria, Greece, Portugal and Romania), we hypothesize that the proportion of participants who will report at least one HIV-HCV risk practice in the previous month at baseline will be higher than in France as these countries have limited access to NEP, OST and other prevention services. Consequently, we attribute the value 60 % as the hypothetical value at M0 in the 2 groups. Hypothesizing a decrease of HIV-HCV risk practices at 6 months of 16% in the control group and 35% in the intervention group, an alpha=5 % and a power of 80 %, we need to have a total sample of 82 in each group at the end of the study (54). Given an expected attrition rate (lost-to-follow-up) of 40% after 6 months, we have to enroll 300 participants in total from among the 4 countries (Bulgaria, Greece, Portugal and Romania), 75 per country.

### Statistical analyses

We will first describe the population enrolled in the study by collecting socio-demographic, behavioural and drug use data, and we will compare them using a chi-square test for categorical variables, and the Student’s t-test for continuous variables. We will also compare the two groups.

A logistic mixed model will then be used to identify factors associated with each outcome: Reporting at least one HCV risk practice and reporting at least one complication at the injection site. We will adjust the model on the group of participants. In the two multivariate models, we will confirm whether the interaction variable “follow-up X group” (M0 or M6 X control or intervention) is associated with the two outcomes (HCV risk practices and local complications) while adjusting for all confounders. These confounders will also include variables built in the qualitative studies.

Due to the high degree of confounding in the data we will then use a P-value <0.20 to select the variables eligible to enter the logistic mixed models. An exchangeable correlation matrix will be used.
for the mixed models. A backward procedure will be used to identify the best model. This will consist in removing variables one at a time based on a P-value >0.05. The log-likelihood ratio test will also be used to identify the best pattern of predictors.

3 – Dissemination and advocacy

3-1. Produce a European training manual, which will be developed based on the evaluation of the ITSESI implementation in the four countries, and directed at field workers and peers with a view to increasing their HCV prevention capacities.

3-2. Produce scientific publications based on the outcomes of the evaluation of the implementation in the four countries, directed at European stakeholders including researchers, policy makers and policy implementers, in order to increase their awareness and knowledge about the efficacy of ITSESI in harm reduction.

3-3. Organize a European workshop to promote the (cost) effectiveness of ITSESI and to discuss opportunities for and barriers to implementing the intervention on a wider scale in other European countries. A workshop report will address the main outcomes and recommendations to advocate further the intervention.

Data flow

Data has been collected and de-identified on paper-based questionnaires and then filled in a computer software by the interviewer. The online questionnaire will be sent to the research team to be analyzed.

Qualitative data from focus group will be registered with consent of all participants, transcribed and translated; the interviews transcripts will not contain any personal data and the recordings exclusively used for the study will be deleted at the end of the study.

All collected data will be anonymised in such a way that the subject is no longer identifiable, in order to comply with European data protection law (European Data Protection Directive 95/46/EC).

organisation of the research

All project partners (i.e., the 3 WP partners (INSERM, AIDES and Correlation Network) and the four Local partners (Initiative for Health Foundation (Bulgaria), Praksis (Greece), GAT (Portugal) and ARAS (Romania)) met four times during the project period to discuss and organise workflow and tasks. During these meetings, attention will be paid to optimising synergy between the horizontal work streams, in particular in the fields of dissemination, policy and advocacy.

To detect any shortcomings or delays, and to ensure the reliability of the projects results, the project process has been evaluated by INSERM through log frame templates.
Results

WP1- Exploratory Phase

Harm reduction (HR) for people who use drugs (PWUD) is proven to be a valuable and effective public health approach (1). Evidence from several countries indicates that interventions like needle and syringe programmes (NSP) (2,3) and opioid substitution treatment (OST) not only reduce morbidity and mortality (4) arising from HIV and hepatitis C virus infection, but also facilitate the social inclusion of people who inject drugs (PWID) (5). Literature indicates that the net social benefit accrued from harm reduction interventions outweighs the total economic cost (5,6). In this perspective, other HR tools and interventions are being implemented and rolled out, including drug consumption rooms (currently operational in 7 countries in Europe) (7). Despite advances in harm reduction, many countries still face HIV and HCV epidemics in drug users. Even in countries where harm reduction is well established, PWID are more likely to become infected because of risky injection practices or complications. This is very closely linked to their precariousness and social marginalization. Consequently, consolidating harm reduction policies and providing complementary tools to existing strategies is indispensable. In order to further reduce unsafe HIV/HCV transmission practices, an innovative HR educational intervention, which comprises individually tailored support and education for safer injection (ITSESI), provided by peer educators, nurses and trained social workers, was designed in France. This educational intervention, called AERLI in the French context and ITSESI in the English-speaking context, has already been validated in HR programs in France where significant reductions in unsafe HIV/HCV transmission practices and local complications at injection sites (Roux et al, 2016, Addiction), as well as improved access to HCV testing (Roux et al, 2016, Plos One), were observed. These results led us to develop the Eurosider project, whose aim is to transfer the ITSESI intervention to four other European countries with different access to HIV/HCV prevention and care programmes and different drug policies, and to evaluate its effectiveness there. More specifically, the objectives of Eurosider are to study the feasibility and the impact of implementing the intervention at a European level targeting four countries: Bulgaria, Greece, Portugal and Romania.

This article provides results on the first phase of Eurosider, which aimed at understanding the local context of each country where the ITSESI intervention will be implemented in order to anticipate barriers to its implementation and to adjust the intervention adequately.

The provision and reach of HR services depends on a variety of domestic and international factors including funding (9), the legal environment, and political will (10). In several countries, especially the 4 included in the Eurosider project, HR funding has been drastically reduced1 leading to less sustainability of HR services, depleted supplies of injection equipment, and reduced access to testing and care, in particular for hepatitis C and HIV (11,12).

Recent changes to how harm reduction programs and services across European countries are funded are a determining factor in hampering the dissemination of harm reduction tools. More specifically, the integration of Romania and Bulgaria into the European Union (EU) means they are no longer eligible to receive grants from the Global Fund to Fight AIDS, Tuberculosis & Malaria (The Global Fund), which was the main funding2 source for associations working with drug users in the two countries (13,14). The transitional financial support from the EU to fund their activities ended in June 2017 (13). Since then, associations have been using funds allocated to the fight against tuberculosis (TB). Bulgaria and Romania have had to implement somewhat conflicting policies. On the one hand, state and EU regulations encourage the repression of drugs, while on the other hand, the same bodies promote the protection of human rights of drug users and particularly

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1 The funding crisis for harm reduction: Donor retreat, government neglect and the way forward | July 21 2014
2 Total harm reduction in Romania spending for PWID in 2011 was USD 1,649,849. Only 7% of this amount was provided from domestic sources, while 93% came from international donor funding (EHRN). Harm reduction was included in the Global Fund grant for tuberculosis (TB) in Romania (until 31 March 2018). The actual budget for harm reduction in 2015–2019 is EUR 545,291. The Global Fund TB grant, the National Health Insurance House (NHIIH), the Norwegian Financial Mechanism, and SIDACTION (France) provide those funds.
exposed minorities (for example, Roma (15) and sex workers) (16)

In Greece, the financial crisis, accompanied by a drastic reduction in the means dedicated to social support (17) hit the population hard, especially the poorest and the most marginalized populations. This worsening economic situation went hand in hand with a tightening of drug policy in the country (closure of the only supervised injecting facility, police repression against PWUD) (18,19) and an alarming increase in HIV and HCV morbidity (17). From 2010 to 2012, HIV prevalence among PWID increased from 3.7% to 47.8%. With regard to the HCV epidemic, data for the period 2010-2013 for injecting drug users approaching drug treatment and harm reduction programs in the country indicate that the levels range between 48% to 74%. According to Greece Drug Report 2017, on 2015 the same trends continue.

In contrast, Portugal, which is often cited as a success story in the field of addiction (20) (21) and health (4), has shown a great degree of autonomy in its drug user and HR policies, (22) and has been resilient in the face of economic downturn thanks to NGO actions throughout the country and the fact that it is less dependent on EU and international funding (5).

Results from phase A presented below summarize the key factors in each country, which could have an impact on the ITSESI implementation. Furthermore, we present results from the quantitative data collected from institutional reports found on the main websites (EMCDDA, WHO), from the completed questionnaires, as well as from 30 selected articles from the 100 we found from our PubMed search (4 for Bulgaria, 45 Greece, 38 Portugal and 13 Romania).

Public expenditure trends in terms of harm reduction in the four Eurosider countries

The results on Harm Reduction Investment (5) in Europe in 2017 showed a decreasing trend for four associated indicators: HR Coverage, transparency of spending data, government investment in HR and civil society’s view on the sustainability of funding. Values for all four items were low for Romania and for Bulgaria, and estimations of government drug-related public expenditure were between EUR 700 000 and EUR 1 million per year. In Greece, drug-related public expenditure decreased (2009-2015) due to the crisis, affecting as much the direct assistance and support unit of the care structure OKANA as the funding of the OST and Street work programmes of the KETHEA’s Harm Reduction-Motivation Unit. Global investment in HR remained low in Greece, as did the civil society’s view on the sustainability of funding. Portugal obtained moderate scores for 3 of the 4 indicators and a strong score for civil society’s view. No specific budgets exist to finance drug policy in the country, and public entities are provided with specific funds as part of their global budget on an annual basis, awarded by the sub-commission on public expenditures as part of the Technical Commission for Drugs, Drug Addictions and the Harmful Use of Alcohol.

2013, the decisive year for current HR policy from the point of view of two of the country’s NGOs (ARAS and PRAKSI):

“In Romania, of the six NGOs providing needle exchange programmes in 2010, only two – ARAS and Carusel - were still functioning in 2013. ARAS is currently the biggest harm reduction provider in Romania, delivering OST and NSP support to PWID. ARAS services were financed by the European Structural Funds until 30th June 2013. ARAS is planning to continue providing NSP and OST in part time for a couple of months after the EU project stops. Consequently, 3,000 IDUs will lose access to NSP and 300 OST patients will be left without treatment. 120 of these people are living with HIV, the majority being OST patients. On the other hand, Carusel is a new NGO, operating a drop-in center in one of the most deprived areas in Bucharest.” (ARAS)

3 HIV infection: Latest epidemiological data, October 2017 (Hellenic Center for Disease control and prevention.)
4 Reitox Focal Point, 2014
6 Kethea is currently a self-governing legal entity under private law, operating under the auspices of the Hellenic Ministry of Health and Social Solidarity.
“Tsiboukli, A. (2015) describes the impact of last years’ economic crisis and austerity in Greece to the drug treatment services, their funding and the violations of human rights that occurred at those times. As for the latter, she refers on the one hand, to the public exposure, humiliation, forced testing for HIV/AIDS by the Greek police of women being (or suspected to be) HIV-positive, in 2013. Moreover, she specially refers to two police operations that had also a so-called “public health” and in fact a strong social control essence: the Xenios Zeus and the Thetis operation in 2013, in cooperation with the Hellenic Center for Disease Control & Prevention and the National Health Operations Center (EKEPY) that actually led to detaining immigrants (including to a large extent, drug users) in detention camps, such as Amygdaleza. Several organizations strongly expressed their opposition such as OKANA, KETHEA and NGOs (KETHEA, 2013; OKANA 2013) and the practice of migrants’ drug users being recorded and medically examined without their consent.” (PRAKSIS)

Results regarding the possible need to adapt IT-SESI to country-specific contexts

Our results of Phase A of the exploratory study indicate that the intervention will indeed need to be adapted. The challenge however will be to adapt it to each country’s specific context while maintaining a form of standardization of data collection, in order that data can be compared across countries. For example, the direct observation of the injection practices of users as provided for in the original French protocol will need to be modified for the four study countries. Given the legal risks for users and fieldworkers in these countries, two possible options are to observe injection by watching films recorded by the users themselves, or to directly observe how users inject a placebo into an artificial arm or a pad.

The problems surrounding access to HCV treatment (lack of availability of new treatments at the national level, administrative discrimination, access to health care in general, etc.) for a large part of the populations in Bulgaria, Romania and Greece, will necessitate reducing or removing the parts of the French-validated assessment relating to the screening and treatment of hepatitis C. One cannot ethically promote access to screening if there is no possibility of treatment afterward diagnosis. Another illustration of the need to adapt the original protocol to the specific contexts of the 4 study countries is the necessity to implement enhanced strategies for the protection of personal data in order to guarantee the safety of individuals in the face of possible police repression.

Romania, an old fight

Harm reduction services started in Romania in 1999-2000. Despite NSP being increased almost continuously between 2003 and 2010 (23), they started to be scaled down once the Global Fund’s Round 6 HIV grants to the country ended (23). In 2011, two reports (one by the Compartment for Monitoring and evaluation of HIV/AIDS infection in Romania (under the auspices of the National Infectious Diseases Institute “Matei Bals”), the other a joint report by the EMCDDA and ECDC) warned of a rapid increase in HIV cases among PWID (24). In 2012, another EMCCDA report (25) concluded that more syringes were needed as a consequence of the fact that heroin was being replaced by new psychoactive substances (NSP). In the same year, the last major NEP in Bucharest was officially shut down. In January 2013, the National Anti-drug Agency (NAA) procured 800,000 syringes and distributed them to the associations ARAS and CARUSEL to support the continuation of NEP. In July of the same year, UNICEF facilitated a meeting between Ministry of Health officials and protesters (including people who use drugs, professionals and activists) who had gathered in front of the ministry. After an advocacy campaign, NGOs obtained 169,000 syringes from the National HIV Prevention Coordinator (26). Finally, in October 2013, ARAS started an NEP, 60% of the 1 million euro budget being financed by the Bucharest Municipality, while ARAS funded the rest. Nevertheless, as a part of the agreement, ARAS
was required to register personal information of all clients accessing the service (26).

The Ministry of Health declared that there were no funds available for providing emergency assistance to people who inject drugs (PWID) and that any additional costs should be added to the following year’s budget to address the issue (24).

According to ARAS, which is the major harm reduction organization in the country, “PWID and harm reduction services have a somber future in Romania“:

Indeed, no local or state authority provides services specifically tailored to PWID. Furthermore, access to medical and social services is restricted and often discriminatory (e.g., a large number of drug users and people from the Roma community (27) (15) do not have documents and consequently cannot legally access treatment for HIV or HCV (28)).

“A new grant (EEA/Norway Grants) for Romania between 2014 and 2021 will include a focus on “improving the situation of vulnerable groups”, although no details as to what support may go to the harm reduction sector is yet available. In addition, for several years the French NGO, Sidaction, has continuously supported the harm reduction activities of ARAS.” (29).

Needle exchange services in Romania are finding it increasingly difficult to cope with this new trend given the soaring demand on the one hand and diminishing resources on the other.

**Bulgaria, a dangerous uncertainty**

Information on financial investment for HR in Bulgaria is not very accessible, as highlighted in the report by Catherine Cook (5).

HR services in Bulgaria were previously very dependent on international financial support provided through the Global Fund’s “Prevention and Control of HIV/Aids” programme. Even though this financial support ended in July 2016, a solution for the crisis has yet to be found. The Prevention and Control Program, funded by the Global Fund, ended in June 2017, leading to a sharp contraction in prevention activities for the most vulnerable groups in the country. The last NSPs closed in May 2017 and this service is no longer provided in the country, except by NGOs distributing old stocks on a voluntary basis and on a small scale (30). Even though the National Program for Prevention and Control of HIV/AIDS 2017-2020 was adopted in March 2017, NGOs are still waiting for a solution from the Ministry of Health and the latter has not yet made a call for tenders for the provision of funding harm reduction services (30).

“Hopefully, there will be a public tender for harm reduction service providers in 2018 but currently it is not clear when this will happen, at what scale or for how long. There is neither decree nor call of proposal related to the new strategy. The part of the 2017-2020 National Program related to prevention activities among target populations has not started as of today; this presents a huge risk for the spread of the epidemic and the risk of not detecting the new cases of HIV.” (Initiative for Health Foundation)

The effects are already being felt very strongly in the field. The association Initiative for Health Foundation works with 2,000 PWID and has to use TB funds (Global Fund) to support their harm reduction services. Currently, there are two free and six paid programs for opioid substitution treatment in Sofia. “The capacity of free programs is very limited and there is a waiting list. Fees in paid programs are often outrageous for PWID” (Initiative for Health). In general, harm reduction interventions have very low coverage in the country, a situation made all the more difficult by increasing needs due to the evolution in drug usage patterns. “Police data show that pure heroin sometimes accounts for less than 3% of a dosage. This suggests that synthetic drugs are increasingly being used, often replacing heroin, leading to an increase in the need for injection equipment to secure more daily injections. Synthetic drugs are also the primary drugs used by the gay community (i.e., during Chemsex). PWID more often divert unprescribed methadone” (Initiative for Health).

In Bulgaria, the implementation of “therapeutic communities” focused on abstinence could constitute competition for organisations seeking
funding for HR services, as the financing of the former by international resources is more in line with current public policy regarding drug use (30, 31, 32). The high percentage of users (more than a third) imprisoned despite the fact that the country’s HR offer for prisoners is almost nonexistent (30) is a disturbing signal highlighting the need for a more global harm reduction approach.

**Greece, going backwards**

Sociologists, health professionals and journalists have described the impact of economic austerity on the Greek health system for several years now (17,33,34). Since 2010, the bankruptcy of public services and social protection schemes has witnessed an unprecedented reduction in health budgets (e.g., 40% for the public hospital budget) producing dramatic effects (35). In 2016, of the country’s 11 million inhabitants, 35.6% were at risk of poverty or social exclusion\(^{10}\). The precariousness of employees and the impoverishment of large parts of society have continued to increase. HR services (i.e., provisions for injecting equipment and exchange activities), are primarily funded by the government, and coordinated by OKANA\(^{11}\), with intermittent contributions from the EU (for example through the National Strategic Reference Framework (NSRF-ESPA)) or from private funding. There are indications that drug-related expenditure declined markedly between 2011 and 2014 (36).

In 2013, sterile injecting equipment was provided at 19 different sites including 7 fixed locations, and 12 locations where outreach workers and mobile units operated. The main development in 2012-2013 was the expansion of specific HR programmes beyond the Greater Athens area, with several new low-threshold programmes being opened in Thessaloniki. Approximately 430,000 syringes were distributed at needle and syringe exchange sites in 2013, which is almost seven times as many as in the year preceding the financial crisis (approx. 61,500 in 2010)\(^{12}\). It is estimated that these services reached more than 7,100 PWID, which is six times more than in 2010. This expansion of HR services (Syringes and OST) was due to a large number of PWID being diagnosed with HIV in Athens (in 2011-2012) (40). Among other reasons, the outbreak was also a result of the financial austerity that began in 2008 and which resulted in budgetary cuts in the field of drug treatment and harm reduction, as well as in the health system in general (37). This increase in the number of syringes distributed was accompanied by an increase in the number of users accessing these services. Furthermore, the syringes provided were of better quality. The pilot project Aristotle, which operated mostly thanks to EU funding, was included in this vast response and led to the opening of ODYSSEAS, the first drug consumption room in Greece, which also provided sterile injecting equipment and safe injection education for PWID. Before completing its first full operational year, ODYSSEAS was closed down in August 2014. Today, drug consumption rooms are not legal in Greece despite the efforts of civil society (38). Moreover, as Fotiou et al. (37) describe, despite the scaling up of OST and NSP services in 2011, the coverage of prevention services for PWID is poor and significantly lower than international levels.

There is also overwhelming evidence of police repression against drug users in Athens in 2013 (Thetis operation)(39).

In 2014, Action Plan for responding to the HIV/AIDS epidemic among PWID in Athens and the rest of Greece\(^{10}\) was not adopted by the Greek Ministry of Health, but rather issued/published by the National Coordinator on Drugs. The harm reduction services be monitored and coordinated by the special Committee established, chaired by the Directorate of Public Health of the Ministry of Health, which consists of the agencies that drafted the Action Plan and are responsible for its implementation. These agencies are Hellenic Centre for Diseases Control and Prevention (KEELP-NO), KETHEA, OKANA, 18 ANO and the Prevention

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\(^{10}\) The extreme poverty rate increased from 2.2% in 2009 to 14% in 2013. In 2013, 44.3% of the population lived below the poverty line. (Public Policy Analysis Group of Athens University of Economics and Business; AUEB). Data regarding the risk of poverty in 2016 come from Eurostat 2017.

\(^{11}\) The Organisation Against Drugs (OKANA) is a legal entity under private law, operating under the supervision of the Ministry of Health and Social Solidarity.

Centres of the Municipality of Athens and NGOs. However, the number of syringes distributed by the agency reduced significantly when funding through the European National Strategic Reference Framework (NSRF-ESPA) ended: 240,134 syringes were distributed in 2014 versus 90,828 in 2015.

With the continued poor economic outlook in Greece, injection-related drug use is increasingly associated with homelessness (40,41). Professional and volunteer networks are trying to cope with an imminent public health disaster, given the disturbing increase in new cases of HIV and HCV detected in PWID. Harm reduction has to face the double challenge of financial and legal (18) hurdles as well as police harassment (17), since the injection of drugs in open areas – which is illegal in Greece - cannot be overcome without implementing a tailored plan.

**Portugal, a success story?**

The main source of funding for HR activities for PWUD at the national level in Portugal comes from SICAD (The National Drug Agency) and to a lesser extent from certain municipalities through local councils (22). Financial participation at different levels (national and local) and the relative autonomy of the Portuguese harm reduction policy, with little dependency on EU and international funding, has led to high coverage of OST but low coverage of NSP, especially in smaller cities and rural areas (42).

HR activities in Portugal are similar to those provided elsewhere (21): access to needle and syringe exchange programmes (NSP), opioid substitution treatment (OST), rapid testing services (HIV/HCV), outreach programmes and mobile units in the major cities across the country. The distinction of the Portuguese approach lies in its decriminalization policy and the early recognition of harm reduction in the national drugs strategy in 1999 and the social support services which complement its healthcare strategy (22). In the years 2000 there was a scale up of treatment and HR services, along with a wider change in social policies. This was important to reduce the heroin epidemic (and HIV epidemic in PWID).

In Portugal, the “Commission for the Dissuasion of Drug Abuse” (composed of health, social and judicial workers whose aim is to examine the situation of individual drug users) can refer users to dedicated health services (43).

Although drug use is decriminalized (but still penalized), it is not without financial penalty. Current policy is based on a principle of “voluntary compliance”. The commission is dedicated to finding a solution for each individual but has the power to fine non-dependent drug users, especially if they refuse referral. Accordingly, for such users, it is in their best interest to accept this policy of voluntary compliance (43).

The Independent Institute for Drugs and Drug addiction, formerly responsible for implementing the national drug strategy, was absorbed by the National Health Service (SICAD), which cut its budget by 10% in 2012 (21). SICAD lost the responsibility for the operation of drugs services, which are now under regional health authorities, but is still the head of drug policy in Portugal, and the main funder of HR programs. All this is under Ministry of Health – both SICAD and regional health authorities. “A number of HR services are also facing partial closure or experiencing significant delays in receiving public funding.” (GAT). Additionally, despite national policy which promotes HR services for drug users, some municipalities can choose to not support or fund it (42).

**Evolution of patterns of use**

Initially, injecting drugs mainly concerned adult men who consumed heroin. In recent years, a new drug-user profile has emerged because of the multiplication of the products being injected. The evolution of drug consumption practices and the substances injected, constitute specific determiners for each of the countries in Eurosider. These substances include licit products and

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13 ΕΚΤΕΠΝ (2017). Η Κατάσταση του Προβλήματος των Ναρκωτικών και των Οινοπνευματωδών στην Ελλάδα 2017 [Annual Report: The state of drugs and alcohol problem in Greece 2017; Athens, Greek REITOX Focal Point; University Mental Health Research Institute, 2017]

emerging new psychoactive substances, thereby multiplying the frequency of the injections and thus the risk of complications linked to this use. In 2009, there was an unprecedented rise of new synthetic drugs in Europe (44). These substances, often nicknamed “legal highs” by the media, are characterized by the high number of injections a day: three to five times higher than the 3 injections associated with heroin (44).

The socioeconomic and cultural profile of users varies according to products and country of consumption. For example, community-based associations in Bulgaria have reported a recent and greater increase of injected amphetamines than their counterparts in the other 3 study countries. Portugal has seen heroin consumption decline while cocaine is on the rise. Testimonies on the consumption of “Sisa” in Greece (45) confirm that the poorest populations choose cheaper and particularly toxic drugs, while heroin is particularly present in the Roma ghettos of Romania.

Younger users are characteristic in Romania. Although official data is lacking, testimonies describe the use of drugs by injection in pre-adolescents and adolescents coming from marginalized minorities and street children.

In general, few articles and studies have attempted to analyse in detail the use of drugs by injection in women (except for sex workers, where several studies have been performed (REF)). Less numerous than men, women who inject drugs find it difficult to voice specific problems and unmet needs. Accordingly, operators in the field should watch for collateral indications including the impact of consumption by injection on women’s sexual life, on maternity and on relationships with male partners. One of lines of investigation within the framework of Eurosider is to shed light on the specific resources women benefit from in terms of harm reduction.

Discussion

The political and economic environment in a given country has an impact on patterns of drug use and their evolution. Accordingly, an individually tailored educational intervention focused on drug injecting practices may meet the needs of PWID seeking care and support, and this is why we are assessing the feasibility of bringing the ITSESI intervention to countries other than France.

One of the points of convergence between international and European health institutions (EMCD-DA, WHO), as regards the objectives of the fight against the transmission of HIV and HCV (11) there is a considerable burden of HCV and HIV infections among people who inject drugs (PWID, is the commitment to implementing strategies of harm reduction for PWUD and to ensuring access to screening and healthcare services for infected people. The example of the Aristotle program in Greece demonstrates how a rapid and massive intervention can have a strong impact on tackling an HIV (and HCV) outbreak among PWID (40). The exploratory phase of the Eurosider project, which we have already completed, was a necessary step to understand how country-specific, context-based barriers could affect the implementation of the innovative educational harm reduction tool ITSESI, already validated in France, and to understand how to adapt that protocol accordingly. To do this, attention must be made to each country’s political environment and more specifically to the funding of HR services there. The decrease in financing of HR in 3 of the Eurosider countries has pushed local associations to advocate for the redirection of European and national grants dedicated to “the war against drugs” towards HR needs (46).

Indeed, reductions of subsidies to community-based organisations and to HR services are inversely proportional to the increase of finances for repression of drug use and users (29).

The means used to prohibit drugs has been intensified throughout the European continent, contributing to discriminating and penalizing representations of users (47). The contradictions of this European financial strategy find themselves at the heart of Eurosider: on the one hand, com-
pulsaory austerity policies which damage vulnera-
ble populations, associations and public health in
general, and on the other hand, support via the
financing of community associations or projects
to contain an impending epidemiological threat
which could potentially be very expensive for
the whole continent. Through its various agen-
ties, Europe therefore attempts to mitigate the
difficulties which it itself has created through its
double rhetoric of economic rigorousness yet a
requirement for solidarity.

This “double bind” or “paradoxical injunction” to
cite Bateson (48) at the school of Palo Alto, brings
severe consequences for the most vulnerable
populations and social workers who accompany
them.

Despite having previously been condemned by
international observers upon for decriminalizing
drug use, today Portugal (49) is cited as an example
of a health success story. Its health policy not only
acts as a figurehead of social transformation (50),
but is the “missing link” between public order and
health. A certain homogeneity in illegal drug health
policy exists throughout Europe, with sanctions
ranging from financial penalties to imprisonment,
depending on the type of drug consumed (30).
This situation calls for urgent and vehement
advocacy for greater respect of the rights of
PWUD, especially regarding access to HR services
and care. The evolution of patterns of drug use in
recent years outlined above and the increase in
injection practices, highlight the pressing need for
appropriate responses and an awareness of the
level of stigma (in the sense of Goffman “Stigma”
(1963)) which PWUD suffer from.

The risk of detention for drug use is very real
in three of the Eurosider countries (Romania,
Bulgaria and Greece) and varies in severity
according to the socio-economic profile of the
user (51). Each of the three countries sets out
its policy of prohibition as a function of its other
social order and internal security “priorities”. The
result of these policies which prioritize “threats”
is the double penalisation through discrimination
of certain drug users (52) for example, homeless
persons and migrants in Greece (45), Roma in
Romania (28), sex workers in Bulgaria, etc. In the

In this context, harm reduction programmes,
and more particularly outreach activities, are not
simply health support tools, but a bridge between
an excluded community and the rest of society
(53). Fieldworkers, who most of the time, come
from NGOs or community-based associations, are
an essential interface between drug users and
society and act as guarantors of better health
for both populations by minimizing the risks of
transmission of infectious diseases.

The strengthening of communities based on the
approach of individual capacity appropriation and
autonomy in seeking healthcare services is urgent
and vital (54).

As such, the implementation of ITSESI, which seeks
to increase users’ self-autonomy constitutes a
promising opportunity for European countries.
This success of this type of innovative and
community-based action relies on the knowledge
and experience of drug users and of the NGOs
that support them. Furthermore, it is essential
that a secure political and legal environment
exists for field workers, that these workers can
be mobilized by ensuring the sustainability of
their jobs, that minimum supplies of injection
equipment are provided, and that the ITSESI itself
is first internationally validated.

With regard to the latter point, the Eurosider pro-
ject, which focuses on bringing ITSESI initially to
four European countries to validate it, mirrors as
closely as possible the realities of the field, and is
based on the principles of research-action15 and
implementation16 , adjusting and evaluating the
intervention simultaneously. It should produce
both political and health arguments in favour of
adopting ITSESI on a Europe-wide basis. Therefore,
the fact that the intervention’s implementation
and its evaluation occur simultaneously ensures
the approach is objective (55). Being integrated
into a pre-existent system while adapting itself to
sociocultural specificities brings researchers and

15 P.M. Mesnier, P. Missotte, La recherche-action, une autre manière de
c chercher, se former, transformer, Editions L’Harmattan (2003)
16 Epi-Ethno Sante (2007), La charte de Recherche-Action l’Institut,
epi-etno-sante.org
workers together to analyse and to improve professional practices. Unlike other study approaches, our project focuses on measuring the real impact of the ITSESI intervention, in terms of coverage, quality, sustainability and power of social transformation, by measuring indicators which are immediately reflected by the intervention itself.

The exploratory phase of Eurosider comprises a country- and context-specific evaluation, thereby ensuring that the risk of generalisation is avoided. A crucial element of this is that the project includes and follows so-called “junkies” (56), who reflect all the negative representations of drug users in any country, and who are most often distant from prevention and care.

Although the overall objective is to offer a new harm reduction tool to limit the transmission of infectious diseases and decrease the complications linked with the injection and to validate it at the European scale, given the key factors discussed here in terms of implementing Eurosider, it is also a question of strengthening the link between society, field workers and drug users, as well as arguing for and demonstrating the autonomous and constructive capacities of users (52) structural, and environmental forces produce vulnerability to health harms among people who inject drugs (PWID). In short, the overall goal is social transformation. Drug users, who are more often associated with delinquency than with the need for healthcare services, are most often relegated to the bottom of public policy priorities. Yet, one would think that apart from human rights aspects, a certain “common sense” about health and a longer-term economic vision, should have already convinced the concerned governments of the importance of supporting harm reduction. The fight against HIV and HCV among drug users concerns the entire civil population, as the negative impact of uncontrolled epidemics is compounded by the exorbitant cost of providing large-scale treatment, not to mention disastrous economic and social consequences. This way, Eurosider’s exploratory phase of contexts highlights the priority areas of advocacy: human rights, protection of minorities, promotion of united and unified legislation etc. In addition, it highlights the need to gather the diverse strengths of different stakeholders to join together in a common fight for the financing of harm reduction services, for access to healthcare and fair treatment in Europe, and for the right to participate in the public debate on the policy of prohibition on drugs.

WP2. Training

1. Training of trainers

The session took place in Bucharest, on 4 consecutive days from the 16-19 April, 2018. The session was held at the Hotel Mercure UNIRI, Bucharest. A total of 11 participants (4 men 7 women) attended the session. 3 from IHP, Bulgaria, 3 from Praksis, Greece, 2 from GAT Portugal and 3 from ARAS, Romania. The 11 participants were experienced trainers, fieldworkers and project managers, bringing together a rich diversity of experiences, relevant skills, and, of course, national contexts and languages. Two trainers came from AIDES, and the project coordinator from INSERM was present for most of the training. All the participants responded to the evaluation questionnaire which was distributed at the end of the 4 days. Across the 8 indicators, satisfaction ranged from 70-100% ‘very satisfied’. If this is widened to include also those ‘satisfied’, the score is 100% across all the indicators except for one unsatisfied response about the venue. Difficulties that the participants underlined most were ones linked to the question of language barriers. This affected mostly the group dynamics and to a lesser extent the rhythm of the session. The requirement for the training had been that all could speak English, however 3 out of the four NGO’s sent participants that needed permanent or partial translation. This meant that some group activities and wider group solidarity were compromised. It also had a tiring effect on those translating.
2. National trainings

Each partner organised two training sessions in their national language from June to November 2018.

The target of 64 participants was exceeded with 68 fieldworkers trained to take part in the research and intervention. A wider public of fieldworkers outside of the partner organisations was reached both in Romania and Portugal. These facts augur well for the sustainability of the intervention after the end of the project.

The feedback from the trainers was that the manual provided gave good guidance and work on the way that knowledge on prevention harm reduction should be manipulated in the educational session based on the observation of injection. The participative and trainee-centred approach was particularly appreciated.

3. European Training Manual

Based on the national training manuals and their experiences, trainers gave feedback to shape the European Training Manual. It was decided that the basic frame of the manual could be kept, changing wording where appropriate. However, all references to the Research component needed to be removed. Trainers also felt it important to add a section with their advice and tips for future trainers, for example, that the ITSESI intervention is complementary to other Harm reduction services and that the training be followed by those already experienced in harm reduction activities.

The three aspects of this training workpackage were a great opportunity for AIDES to be involved in a European project and showcase its Community-based approach to involving and meeting the needs of the communities most vulnerable to infection. Whilst contributing to the objectives of transferring an effective intervention to fight HIV and HCV, the project has brought the NGO’s and partners involved closer together and allowed for other projects, exchanges and alliances to be envisaged.

WP3. Evaluation

The evaluation of the project consists of qualitative data analysis (focus groups with professionals involved in the intervention) and quantitative data from questionnaires among persons who inject drugs and participating in the ITSESI intervention: 305 questionnaires at M0 (inclusion) and 202 questionnaires at M6 (follow-up).

Adaptation of the intervention: except in Portugal, the fieldworkers had to adapt the intervention to protect themselves and their clients from the police threat. The change was specifically in the phase of injection observation. Based on the risks for users having the product with them, it was decided to use video or pad/placebo for demonstration.

Qualitative data

Focus groups were carried out among fieldworkers in the different partner countries. These group discussions allowed participants to share their experience of the ITSESI educational sessions. The discussions must contribute to the evaluation of the intervention, its improvement and its adaptation in different contexts. All the discussions were recorded, translated and transcribed.

Evolution of professional practices

“Today, after the various observations I made, what I realized was that some users have been consuming for 5, 10 years, in the same way, with a habit, with a precise method, even if he wanted to lie to me about something they would have heard about that should not be done, they showed me exactly their method of use. That’s how I felt it: “That’s how I do it, I do it all the time so that’s it.” (Praxis)

ITSESI has been an opportunity to improve professional practices and the understanding of the real patterns of drug use. Professionals have better skills promoting safe injection:

“Of course it upgrades. We never thought about this during the years that we could observe injecting, because of the law provisions. What we had was that we were explaining million things

17 Interviews guidelines are available in annex
in theory, but we never knew what happened in practice, we couldn’t comment this practice, we never saw how they did it. So this is something very valuable I think. We are able now really to upgrade ourselves as professionals, we can see what and where the needs are. We never touched this matter before. We never even thought of observing or something like that.” (IHF)

During this project, the professionals reported better knowledge of the user community.

I wanted to add something that dated yesterday: I was talking with a user who has been consuming for many years and he told me that he had taken this Thai in Russia, which is not the same as today you took it once and you hung out all day. Now he needs it every hour. This person must suddenly, inject up to 15 times a day.

In no case, the number of injection kits distributed by the State, the associations, corresponds to the needs of the people. For example: at the time the person needed a kit per day, now 7. There may be a need of 1000, we have only 10, and we distribute only 10. (Praksis)

The intervention creates the opportunity to strengthen our knowledge of PWID, their practices and their real life conditions. The involvement of participants also enabled assessment of the evolution of PWID profiles and new patterns of use.

“At the time the intravenous it was to be more “smashed”. Now there are substances that are consumed only by injection. The Thai can also be caught by the nose but there is heroin that is just made to be injected. It is in a shape that looks like play dough. It’s also a consequence of the crisis in the country.” (Praksis)

“The users change and we see in the meeting places of older people. They also seem to make different choices from the younger ones.

- And in this “hidden” population I take into account the population of female users who are not easily met because they seem to have found a way of not being very often in the gathering places, at least compared to what I imagine myself as a proportion of the women user population”. (Praksis)

Evolution of the relationship between professionals and users

Speaking freely about injection practices has in part enhanced the trust relationship between professionals and PWID, even if they are former beneficiaries of the service.

“Oh, absolutely, I learn some things about the clients, important ones, which I didn’t know, although they’ve been our clients for 15 years. For example I didn’t know about one of our female clients, that she never injected herself, I was shocked... I’ve been thinking that she... But she was actually injected by someone else. And they have been our steady clients, we know their full story. And I’ve been explaining “You should do this, you should do that” but she had never shared that she hadn’t been injecting herself. She’d been collecting ideas to know what to require for herself.”(IHF)

“The challenge of this program is that users who are on the street trust the process and a relationship is created. From the moment it happens ... I think it starts to happen and grow at an impressive rate, for me anyway that was not present from the beginning. I do not think it’s the 5 euros that do that. That they come to wait 1 hour, while during this hour he could do something else and earn more money, it is not thanks to the counterpart that it makes sense. My observation is that there is a need to be in front of a person who will take note of his opinion, he will give them importance and they will convey something of their personal reality. I think that, given the way I have seen colleagues do, there is this respect that is not obvious for a user to have outside. Because in Greece there are still many people who turn a blind eye to these things.” (Praksis)

The testimonies of professionals confirm that this kind of intervention makes sense and remains very useful for the people.

“All these pedagogical indications, that people accept because it’s explained in fact, it’s not just” do like that because that’s how it’s done “, but there is the whole explanation behind, there is a reason for each gesture, and so people interiorize very easily and as they say, there are not thirty-six options, that’s it or it’s not that.” (GAT)
Acceptability of the intervention

In all countries, both PWID and professionals welcomed the educational intervention. The challenge was in obtaining the approval from decision makers and official authorities. This highlights that the structural evolution, especially around drug policy, is crucial to the intervention’s success. However, the individual’s change of practice accounts for the improvement in injection technique.

“Regarding the simulation, I remember that we said at the beginning, beyond the legal framework that does not allow us to do otherwise, we also had our fears, our apprehensions: “I will now observe a real use”. It was something very new for us, or at least for me. But I wonder if it has changed. I tell myself that because in talking with members of my team they told me that they finally liked it to see how it went.” (Praksis)

For fieldworkers involved, the educational intervention goes beyond practice and reveals issues like inequality within injecting couples.

“When it’s a single person, it is one trainer working with him/her. But if they’re a couple, we feel more comfortable this way. And the people do too. Then we are two by two, you see? And we think it works well this way – to work together with them. The pre-injecting interview we do individually with people. We explicitly ask their consent and we are ready to react – for example if some of them state “I want to share something with you only” or something like that, we give them the space to do so. This is to avoid the domination of one of the partners - if the other one has something to say, which is impossible during the session. We keep an eye on these issues in advance – if such indications are in place during the pre-injecting interview.” (IHF)

Challenges and limitations

The legal context clearly has a strong impact on implementation, especially for direct observation. That was the reason for switching direct observation with video or injected placebo.

“I think the greatest difficulty was that our situation was different from that of France, about the observation of use, which is prohibited in Greece.” (Praksis)

One of the hardest challenge was for the peer workers who no longer inject but have to observe the injection of others. It could be a drawback of the intervention if peers are inadequately prepared for that.

“In fact he injected for thirteen years, and if Eurosider really was a challenge for someone it’s for him, because to see the others shoot in front of him, with all he liked so much ... it was a great difficulty, but at the same time it made him evolve and grow and understand that what he is doing is really a job.” (GAT)

The Eurosider project highlights the structural barriers to good injection practices, which could prove difficult for professionals.

“Another thing is the dead ends which makes it difficult for us as professionals: I teach you to drive but I give you no car. I tell you that your space must be clean, but when you have to use it in the street you can not do it. I tell you that you must always have a new kit, but when it is not possible to access what do I tell you? I tell you that you should not throw it in the normal trash but in a special bin but you can not find it ... What am I telling you? It’s pathways without issues and we have no answer to give. This is complicated.” (Praksis)

Finally, an obstacle to implementation is the challenge to integrate the intervention within routine activities because of a lack of human resources, time and funding.

“A new project inside the association, and that brought a lot of people in relation to that. This has reduced the daily resources in terms of time, because it makes a workload: it was necessary to occupy the room for the Eurosider, plus the questionnaires beside, suddenly this set was complicated to manage.

There were people who expressed some dissatisfaction because they felt that the team was less available for their daily tasks, which they normally did, that is to say, to accommodate the rest of the time, public, which does not necessarily participate in the Eurosider.” (GAT)

In the perspective of transferability, the amount of incentives should be revised to support the participants, who are mostly socially deprived.
**Quantitative data**

**Introduction**

Overall, 305 participants were included in the Eurosider cohort, with 75 users per country (80 users from Romania). Overall attrition rate (i.e., percentage of lost to follow-up) was 33.8%, ranging from a high of 47% in Greece to a low of 12% in Bulgaria (Table 1).

**Table 1. Participants by country**

<table>
<thead>
<tr>
<th>Country of interview</th>
<th>Baseline (M0)</th>
<th>6 months (M6)</th>
<th>% of lost to follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>75</td>
<td>24.6</td>
<td>66</td>
</tr>
<tr>
<td>Greece</td>
<td>75</td>
<td>24.6</td>
<td>40</td>
</tr>
<tr>
<td>Portugal</td>
<td>75</td>
<td>24.6</td>
<td>47</td>
</tr>
<tr>
<td>Romania</td>
<td>80</td>
<td>26.2</td>
<td>49</td>
</tr>
<tr>
<td>Total</td>
<td>305</td>
<td>100.0</td>
<td>202</td>
</tr>
</tbody>
</table>

The descriptive results of baseline data are presented below for each of the four study countries. We used the p-value of a Chi2 test to determine whether there was a significant difference between countries regarding sociodemographic characteristics, drug use, injection practices, etc.

**Interpretation of p-value**

When a p-value is smaller than 0.05 (5%), then the analyzed event or characteristic significantly differs across the defined groups (here countries), with a 5% chance of being inaccurate.

When a p-value if larger than 0.05, then we cannot conclude that there is any significant difference between countries regarding the studied event or characteristic.

**Sociodemographic and socioeconomic characteristics**

Table 2 displays sociodemographic and socioeconomic characteristics in each study country.

In the whole sample, only 17% of participants were women, which confirms the low rate of consultation for women in specialized services. Women were under-represented in Greece (7%).

Access to health insurance is quite limited in Bulgaria, with only 35% of Bulgarian participants in the present study being covered, versus over 45% in the other three study countries. All people residing in Portugal are covered by a national universal healthcare system, so they are not concerned by this question.

Participants in Portugal had greater social insecurity than people from other countries (especially Bulgaria and Romania): 87% were not living in a couple, 57% were living in precarious or very precarious housing (the latter including being homeless or living in a car) and 55% had slept in the street at least once in the previous month. Furthermore, only 11% of the Portuguese sample population had a job and 63% had received food aid at least once in the previous month.

Participants in Greece also had social insecurity: 21% were living very precarious housing, 41% had experienced homelessness in the previous month and 84% were unemployed. Finally, 35% had received food aid in the previous month.

In Bulgaria and Romania, the sociodemographic situation was better: very few people declared living in the street or in a car (5% and 1%, respectively) and only 11% and 10%, respectively, had experienced homelessness in the previous month, while 28% of Bulgarian participants and 36% of Romanian participants were living in their own home. A majority of users in the two countries were living with their family, or with a friend. In Romania especially, more than half of the participants lived with their family.

Users in Bulgaria and Greece were more likely to have been held in custody in the previous 6 months (resp. 51% and 67%). Lifetime overdoses were less frequent in Portugal (36% declared a lifetime overdose).

The percentage of participants on opioid substitution treatment was higher in Portugal (75%) and Bulgaria (85%). Among treated users, methadone was the most prescribed treatment for all countries (86% overall) except for Greece, where participants mostly took buprenorphine (81%).
Table 2. Sociodemographic characteristics

<table>
<thead>
<tr>
<th></th>
<th>Bulgaria</th>
<th>Greece</th>
<th>Portugal</th>
<th>Romania</th>
<th>Total</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>57 (76)</td>
<td>70 (93)</td>
<td>63 (84)</td>
<td>62 (78)</td>
<td>252 (83)</td>
<td>0.068</td>
</tr>
<tr>
<td>Female</td>
<td>18 (24)</td>
<td>5 (7)</td>
<td>11 (15)</td>
<td>17 (21)</td>
<td>51 (17)</td>
<td></td>
</tr>
<tr>
<td>Transgender</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1 (1)</td>
<td>1 (1)</td>
<td>2 (1)</td>
<td></td>
</tr>
<tr>
<td><strong>Median age (IIQ)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>38 (34-40)</td>
<td>39 (35-44)</td>
<td>42 (38-45)</td>
<td>36 (32-41)</td>
<td>38 (34-43)</td>
<td></td>
</tr>
<tr>
<td><strong>Education level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.000</td>
</tr>
<tr>
<td>Less than High School diploma</td>
<td>38 (51)</td>
<td>40 (53)</td>
<td>55 (74)</td>
<td>66 (83)</td>
<td>199 (66)</td>
<td></td>
</tr>
<tr>
<td>High School diploma or university degree</td>
<td>36 (49)</td>
<td>35 (47)</td>
<td>19 (26)</td>
<td>14 (18)</td>
<td>104 (34)</td>
<td></td>
</tr>
<tr>
<td><strong>Country of birth</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.001</td>
</tr>
<tr>
<td>Born in the country where the interview took place</td>
<td>73 (97)</td>
<td>63 (84)</td>
<td>70 (93)</td>
<td>79 (99)</td>
<td>285 (93)</td>
<td></td>
</tr>
<tr>
<td>Born elsewhere</td>
<td>2 (3)</td>
<td>12 (16)</td>
<td>5 (7)</td>
<td>1 (1)</td>
<td>20 (7)</td>
<td></td>
</tr>
<tr>
<td><strong>Living in a couple</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>37 (49)</td>
<td>58 (77)</td>
<td>64 (87)</td>
<td>36 (45)</td>
<td>195 (64)</td>
<td>0.000</td>
</tr>
<tr>
<td>Yes, but not with an injecting drug user</td>
<td>15 (20)</td>
<td>13 (17)</td>
<td>5 (7)</td>
<td>23 (29)</td>
<td>56 (18)</td>
<td></td>
</tr>
<tr>
<td>Yes, with an injecting drug user</td>
<td>23 (31)</td>
<td>4 (5)</td>
<td>5 (7)</td>
<td>21 (26)</td>
<td>53 (17)</td>
<td></td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.000</td>
</tr>
<tr>
<td>Precarious or very precarious housing</td>
<td>4 (5)</td>
<td>17 (23)</td>
<td>43 (57)</td>
<td>1 (1)</td>
<td>65 (21)</td>
<td></td>
</tr>
<tr>
<td>Family, friend</td>
<td>50 (67)</td>
<td>37 (49)</td>
<td>23 (31)</td>
<td>50 (63)</td>
<td>160 (52)</td>
<td></td>
</tr>
<tr>
<td>Own house</td>
<td>21 (28)</td>
<td>21 (28)</td>
<td>9 (12)</td>
<td>29 (36)</td>
<td>80 (26)</td>
<td></td>
</tr>
<tr>
<td>Sleeping in the street*</td>
<td>8 (11)</td>
<td>31 (41)</td>
<td>41 (55)</td>
<td>8 (10)</td>
<td>88 (29)</td>
<td>0.000</td>
</tr>
<tr>
<td>Employment</td>
<td>31 (41)</td>
<td>12 (16)</td>
<td>41 (55)</td>
<td>8 (10)</td>
<td>88 (29)</td>
<td>0.000</td>
</tr>
<tr>
<td>Public allowance (state aid)</td>
<td>5 (7)</td>
<td>26 (35)</td>
<td>40 (53)</td>
<td>17 (21)</td>
<td>88 (29)</td>
<td>0.000</td>
</tr>
<tr>
<td>Food aid*</td>
<td>1 (1)</td>
<td>26 (35)</td>
<td>47 (63)</td>
<td>3 (4)</td>
<td>77 (25)</td>
<td>0.000</td>
</tr>
<tr>
<td>Health insurance</td>
<td>26 (35)</td>
<td>35 (47)</td>
<td>NA*</td>
<td>45 (56)</td>
<td>108 (35)</td>
<td>0.026</td>
</tr>
<tr>
<td>Held in custody in previous 6 months</td>
<td>38 (51)</td>
<td>50 (67)</td>
<td>14 (19)</td>
<td>7 (9)</td>
<td>109 (36)</td>
<td>0.000</td>
</tr>
<tr>
<td>Lifetime incarceration</td>
<td>32 (43)</td>
<td>37 (49)</td>
<td>35 (59)</td>
<td>44 (55)</td>
<td>148 (51)</td>
<td>0.230</td>
</tr>
<tr>
<td>Lifetime overdose</td>
<td>41 (55)</td>
<td>48 (65)</td>
<td>27 (36)</td>
<td>37 (46)</td>
<td>153 (50)</td>
<td>0.004</td>
</tr>
<tr>
<td>Opioid substitution treatment</td>
<td>64 (85)</td>
<td>26 (36)</td>
<td>56 (75)</td>
<td>35 (44)</td>
<td>181 (60)</td>
<td>0.000</td>
</tr>
</tbody>
</table>

*All residents of Portugal are covered by a universal health care system, so they are not concerned by this question.

*16 missing values in Portugal (21%) excluded here

* in the previous month
**Drug use**

The graph below (Graph 1) presents trends regarding drug use in each country.

In Bulgaria, the most injected substance was methadone (88%). Almost all of the Bulgarian study sample received prescribed methadone (84%). Among those who injected this substance, 92% said that they injected their prescribed methadone (61 participants). The second-most reported drug was amphetamines, also by injection (almost half of the participants).

In Greece, injecting cocaine was reported by 72% of participants, while over 60% reported injecting speedball. Over half the participants had injected heroin in the previous month. Greece users were also more likely to use benzodiazepines (56% versus under 25% in other countries).

In Portugal, people were more likely to inject speedball (71%). Sixty-five percent reported daily methadone use and 45% had injected heroin at least once in the previous month. Portuguese users were the only participants in the whole sample to inject crack (32%).

Finally, almost all Romania participants said they had injected heroin at least once in the previous month. Heroin was practically the only substance used by Romanian participants in Eurosider, except for methadone (prescribed or not).

For more detail, please refer to the complete table in the appendix section (Table 9).

**Graph 1. Main drug use by country in the previous month (%)**

* At least once

Reading: 96% of Romanian participants injected heroin at least once in the previous month, versus 24% of Bulgarian participants.

All Chi2 tests demonstrated a significant difference between countries regarding the use of each substance (p-value < 0.05)
Table 3 describes the drug use context for each country.

Alcohol consumption was significantly higher in Bulgaria and Portugal, since alcohol misuse concerned 37% and 32% of participants, respectively.

In Portugal and Bulgaria, approximately 60% of people declared mostly injecting alone. In Bulgaria and Romania, compared with other countries, participants were more likely to inject with a partner (more than one in five people).

In Greece and Portugal, most people (80%) injected in public spaces, probably due to the high level of social insecurity in these two countries. On the contrary, in Bulgaria and especially Romania participants used mostly private spaces (70% and over 90%, respectively). More stable housing and repressive policies regarding drug use could explain injection indoors. Indeed, in Romania where drug use is highly controlled, the rate of users injecting in the street or in a garage was lower than in the three other countries (8%).

With regard to disposal of used injecting equipment, Portuguese participants were more likely to declare using dedicated collectors (three out of four people), while the majority of users in other countries declared using public trashcans or public spaces (between 61 and 88%) more often. High rates of the latter in Bulgaria and Romania might be explained by the relatively fewer harm reduction services in comparison with Portugal and Greece.

Table 3. Drug use context

<table>
<thead>
<tr>
<th></th>
<th>Bulgaria</th>
<th>Greece</th>
<th>Portugal</th>
<th>Romania</th>
<th>Total</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol misuse¹</td>
<td>28 (37)</td>
<td>14 (19)</td>
<td>24 (32)</td>
<td>18 (23)</td>
<td>84 (28)</td>
<td>0.040</td>
</tr>
<tr>
<td>Time since first injection &lt; 10 years</td>
<td>11 (15)</td>
<td>19 (25)</td>
<td>13 (17)</td>
<td>15 (19)</td>
<td>58 (19)</td>
<td>0.391</td>
</tr>
<tr>
<td>Context of injection*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.000</td>
</tr>
<tr>
<td>Alone</td>
<td>45 (60)</td>
<td>37 (49)</td>
<td>44 (59)</td>
<td>35 (44)</td>
<td>161 (53)</td>
<td></td>
</tr>
<tr>
<td>With partner</td>
<td>16 (21)</td>
<td>4 (5)</td>
<td>8 (11)</td>
<td>19 (24)</td>
<td>47 (15)</td>
<td></td>
</tr>
<tr>
<td>With friend or family member</td>
<td>11 (15)</td>
<td>20 (27)</td>
<td>20 (27)</td>
<td>15 (19)</td>
<td>66 (22)</td>
<td></td>
</tr>
<tr>
<td>With a group</td>
<td>3 (4)</td>
<td>14 (19)</td>
<td>3 (4)</td>
<td>11 (14)</td>
<td>31 (10)</td>
<td></td>
</tr>
<tr>
<td>Injection in a public space*</td>
<td>22 (29)</td>
<td>61 (81)</td>
<td>60 (80)</td>
<td>6 (8)</td>
<td>149 (49)</td>
<td>0.000</td>
</tr>
<tr>
<td>Injection equipment disposal*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.000</td>
</tr>
<tr>
<td>In public trashcan</td>
<td>66 (88)</td>
<td>46 (61)</td>
<td>18 (24)</td>
<td>61 (76)</td>
<td>191 (63)</td>
<td></td>
</tr>
<tr>
<td>Using a dedicated collector</td>
<td>3 (4)</td>
<td>20 (27)</td>
<td>56 (75)</td>
<td>17 (21)</td>
<td>96 (32)</td>
<td></td>
</tr>
<tr>
<td>Kept for reuse</td>
<td>6 (8)</td>
<td>9 (12)</td>
<td>1 (1)</td>
<td>2 (3)</td>
<td>18 (6)</td>
<td></td>
</tr>
</tbody>
</table>

* more often
Injection practices

In Table 4, we observed injection-related risk practices in each country.

In Greece and Portugal the majority of people injected more than 3 times a day (59% and 63%, respectively). With regard to risk practices, more than 80% of the total sample re-used their injecting equipment at least once in the previous month. Almost half of the Bulgarian participants declared injecting equipment sharing in the previous month (defined as i) giving equipment to someone else after using or ii) receiving used equipment from someone else). On the contrary, sharing percentages in both Portugal and Romania were low (under 23%).

With regard to other practices, in Greece, more than 60% of people declared they injected quickly for fear of being seen, while this percentage did not exceed 45% in the other three study countries. Quick injection may be driven by the high level of social insecurity in the Greek cohort, as seen below.

Finally, Portuguese and especially Romanian participants, were more likely to have injected with the help of someone else in the previous month (45% and 53%, respectively).

**Table 4. Injecting-related risk practices**

<table>
<thead>
<tr>
<th>N (%)</th>
<th>Bulgaria</th>
<th>Greece</th>
<th>Portugal</th>
<th>Romania</th>
<th>Total</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency of injection</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fewer than 4 times a month</td>
<td>2 (3)</td>
<td>1 (1)</td>
<td>8 (11)</td>
<td>0 (0)</td>
<td>11 (4)</td>
<td>0.006</td>
</tr>
<tr>
<td>At least once a week</td>
<td>26 (35)</td>
<td>17 (23)</td>
<td>21 (28)</td>
<td>22 (28)</td>
<td>86 (28)</td>
<td></td>
</tr>
<tr>
<td>Every day</td>
<td>47 (63)</td>
<td>57 (76)</td>
<td>46 (61)</td>
<td>58 (73)</td>
<td>208 (68)</td>
<td></td>
</tr>
<tr>
<td><strong>Injection &gt;= 3 times a day</strong></td>
<td>10 (13)</td>
<td>44 (59)</td>
<td>47 (63)</td>
<td>27 (34)</td>
<td>128 (42)</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>Re-used own injection equipment</strong></td>
<td>50 (67)</td>
<td>62 (83)</td>
<td>45 (60)</td>
<td>48 (60)</td>
<td>205 (67)</td>
<td>0.008</td>
</tr>
<tr>
<td><strong>Injection equipment sharing at least once</strong></td>
<td>35 (47)</td>
<td>25 (33)</td>
<td>17 (23)</td>
<td>17 (21)</td>
<td>94 (31)</td>
<td>0.002</td>
</tr>
<tr>
<td><strong>Rushed injections due to fear of being seen</strong></td>
<td>34 (45)</td>
<td>46 (61)</td>
<td>33 (44)</td>
<td>26 (33)</td>
<td>139 (46)</td>
<td>0.004</td>
</tr>
<tr>
<td><strong>Injected by another person</strong></td>
<td>23 (31)</td>
<td>25 (33)</td>
<td>33 (45)</td>
<td>42 (53)</td>
<td>123 (41)</td>
<td>0.019</td>
</tr>
</tbody>
</table>

* Defined as i) giving equipment to someone else after using or ii) receiving used equipment from someone else

Other injection risk practices are presented in Table 5 below. Overall, Greece and Portugal were concerned by more risk practices than Bulgaria and Romania. More specifically, more than 60% declared not washing their hands before injecting, and 20% declared licking the needle before injecting. Most Greek and Romanian participants declared that they did not often clean the injection site before injecting.

Bulgarian participants declared mostly safer hygiene and technique practices, yet more unsafe practices regarding equipment (i.e., not using a new receptacle or new single-dose water container each time).

With regard to the the impact of the ITSESI intervention on cutaneous complications related to injection, Bulgarian users were less likely to declare both infectious (abscess, sepsis or necrosis) and vascular (collapsed vein, thrombosis or phlebitis) complications. Greek participants were more likely to declare vascular complications (more than half the participants) and Portuguese users were more likely to declare infectious complications (four out of ten people).

A more stable housing situation and better hygiene during injection might explain the low number of complications in Bulgaria compared with other countries. Furthermore, most Bulgarian users injected methadone (88%), so it is possible they were more attentive to hygiene when preparing as methadone injection requires more caution. The greater percentage of complications seen in Portugal and Greece may be due to the high percentage of users in our sample living in social insecurity and the greater frequency of stimulant (cocaine, crack, speedballs) injection.
<table>
<thead>
<tr>
<th></th>
<th>Bulgaria</th>
<th>Greece</th>
<th>Portugal</th>
<th>Romania</th>
<th>Total</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equipment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not often using a new syringe for injection*</td>
<td>15 (20)</td>
<td>11 (15)</td>
<td>10 (13)</td>
<td>9 (11)</td>
<td>45 (15)</td>
<td>0.468</td>
</tr>
<tr>
<td>Often using a syringe with separate needles*</td>
<td>70 (93)</td>
<td>24 (32)</td>
<td>64 (85)</td>
<td>27 (34)</td>
<td>185 (61)</td>
<td>0.000</td>
</tr>
<tr>
<td>If yes…</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not using a new syringe body*</td>
<td>18 (26)</td>
<td>17 (71)</td>
<td>12 (19)</td>
<td>13 (48)</td>
<td>60 (32)</td>
<td>0.000</td>
</tr>
<tr>
<td>Not using a new syringe needle*</td>
<td>12 (17)</td>
<td>10 (42)</td>
<td>11 (17)</td>
<td>7 (26)</td>
<td>40 (22)</td>
<td>0.056</td>
</tr>
<tr>
<td>Not often using a new receptacle*</td>
<td>42 (64)</td>
<td>18 (24)</td>
<td>9 (12)</td>
<td>28 (35)</td>
<td>97 (33)</td>
<td>0.000</td>
</tr>
<tr>
<td>Not often using a new single dose water container *</td>
<td>54 (82)</td>
<td>14 (19)</td>
<td>6 (8)</td>
<td>44 (56)</td>
<td>118 (40)</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>Hygiene</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not washing hands often*</td>
<td>29 (39)</td>
<td>47 (63)</td>
<td>50 (67)</td>
<td>44 (55)</td>
<td>170 (55.7)</td>
<td>0.003</td>
</tr>
<tr>
<td>Not cleaning the site of injection often*</td>
<td>33 (44)</td>
<td>44 (59)</td>
<td>38 (51)</td>
<td>52 (65)</td>
<td>167 (54.8)</td>
<td>0.049</td>
</tr>
<tr>
<td>Often licking the needle*</td>
<td>7 (9)</td>
<td>15 (20)</td>
<td>14 (19)</td>
<td>6 (8)</td>
<td>42 (14)</td>
<td>0.047</td>
</tr>
<tr>
<td><strong>Technique</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often pulling back the plunger repeatedly to bring blood back into the syringe*</td>
<td>21 (28)</td>
<td>53 (71)</td>
<td>46 (61)</td>
<td>32 (40)</td>
<td>152 (50)</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>Cutaneous complications in the previous 6 months</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infectious: Abscess/Sepsis/Necrosis</td>
<td>9 (12)</td>
<td>18 (24)</td>
<td>28 (38)</td>
<td>23 (29)</td>
<td>78 (26)</td>
<td>0.004</td>
</tr>
<tr>
<td>Vascular: Collapsed vein/Thrombosis/Phlebitis</td>
<td>9 (12)</td>
<td>40 (53)</td>
<td>14 (19)</td>
<td>31 (39)</td>
<td>94 (31)</td>
<td>0.000</td>
</tr>
</tbody>
</table>

* in the previous month
We described the evolution over time (from enrollment to the 6 month-follow up) of injecting practices, in the control and intervention groups (Graph 2). Regarding injection risk practices (‘sharing’, ‘reuse’, ‘rushing injection’), we found a decrease of these practices in the intervention group.

We also found a decrease in self-reported injecting related complications (‘vascular’ and ‘infectious’). No difference was found in the percentage of participants reporting being injected by someone else between the two groups.

**Graph 2. Percentage of injection-related risk practices and cutaneous complications for each group (control and intervention group) in M0 and M6**

No = Did not benefit from the intervention (control group), Yes= Benefited from intervention (intervention group)

Reading: 38% of the control group (group ‘no’) declared injecting equipment sharing in M0 and the same percentage of the control group declared injecting equipment sharing in M6.

In terms of injecting-related hygiene, no improvement was observed except for ‘washing hands’ which was highly improved in the intervention group (Graph 3). Regarding, injecting-related technique, few improvements have been observed in the intervention group.

All these results on evolution data are only descriptive but not analytic. Additional multivariable models have to be performed to confirm the effectiveness of ITSESI intervention on injecting practices.
Graph 3. Percentage of other injection risk practices for each group (control and intervention group) in M0 and M6

<table>
<thead>
<tr>
<th></th>
<th>% of other risk practices</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hygiene</td>
<td>Technique</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No washing hands</td>
<td>47</td>
<td>45</td>
<td>40</td>
<td>26</td>
<td>17</td>
<td>11</td>
<td>7</td>
<td>11</td>
<td>47</td>
<td>49</td>
</tr>
<tr>
<td>Yes washing hands</td>
<td>45</td>
<td>58</td>
<td>53</td>
<td>41</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>49</td>
<td>39</td>
</tr>
<tr>
<td>No cleaning site</td>
<td>45</td>
<td>45</td>
<td>26</td>
<td>17</td>
<td>7</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>47</td>
<td>43</td>
</tr>
<tr>
<td>Yes cleaning site</td>
<td>41</td>
<td>53</td>
<td>41</td>
<td>41</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>47</td>
<td>43</td>
</tr>
<tr>
<td>Licking needle</td>
<td>17</td>
<td>17</td>
<td>17</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>47</td>
<td>47</td>
</tr>
</tbody>
</table>

No = Did not benefit from the intervention (control group), Yes= Benefited from intervention (intervention group)

Reading: 47% of the control group (group ‘no’) did not wash their hands before injection (‘no washing hands’) in M0 versus 45% of the control group in M6.
**Access to specialized services**

Access to specialized services or mobile units differed across countries (Table 6): Portugal users were more likely to declare frequent use of these services (approximatively 90% people), while in Romania only 13% declared using such services frequently. In particular, participants in the four countries mostly reported benefiting from the free distribution of injecting equipment (88% in Greece and 85% in Portugal).

Fifteen percent of the overall sample had faced difficulties accessing care in the previous six months, this problem emerging mainly in Greece and Portugal (approximatively 20% of participants). While Romanian participants had limited access to services, only 10% of them declared difficulties with regard to access.

**Table 6. Specialized services**

<table>
<thead>
<tr>
<th>N (%)</th>
<th>Bulgaria</th>
<th>Greece</th>
<th>Portugal</th>
<th>Romania</th>
<th>Total</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent use of specialized services or mobile units</td>
<td>29 (39)</td>
<td>24 (32)</td>
<td>67 (89)</td>
<td>10 (13)</td>
<td>130 (43)</td>
<td>0.000</td>
</tr>
<tr>
<td>Type of services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing or medical care</td>
<td>13 (18)</td>
<td>14 (19)</td>
<td>48 (64)</td>
<td>17 (21)</td>
<td>92 (31)</td>
<td>0.000</td>
</tr>
<tr>
<td>Psychological or psychiatric care</td>
<td>3 (4)</td>
<td>19 (26)</td>
<td>23 (31)</td>
<td>1 (1)</td>
<td>46 (15)</td>
<td>0.000</td>
</tr>
<tr>
<td>HIV/HCV/HBV testing</td>
<td>12 (17)</td>
<td>37 (50)</td>
<td>45 (60)</td>
<td>6 (8)</td>
<td>100 (33)</td>
<td>0.000</td>
</tr>
<tr>
<td>Treatment for addiction, incl. pharmacological treatment</td>
<td>21 (29)</td>
<td>21 (28)</td>
<td>50 (67)</td>
<td>10 (13)</td>
<td>102 (34)</td>
<td>0.000</td>
</tr>
<tr>
<td>Access to help for administrative procedures</td>
<td>1 (1)</td>
<td>9 (12)</td>
<td>28 (37)</td>
<td>0 (0)</td>
<td>38 (13)</td>
<td>0.000</td>
</tr>
<tr>
<td>Employment and training support</td>
<td>0 (0)</td>
<td>5 (7)</td>
<td>15 (20)</td>
<td>0 (0)</td>
<td>20 (7)</td>
<td>0.000</td>
</tr>
<tr>
<td>Housing and accommodation support</td>
<td>0 (0)</td>
<td>3 (4)</td>
<td>18 (24)</td>
<td>0 (0)</td>
<td>21 (7)</td>
<td>0.000</td>
</tr>
<tr>
<td>Free distribution of injection equipment</td>
<td>38 (51)</td>
<td>66 (88)</td>
<td>64 (85)</td>
<td>13 (16)</td>
<td>181 (59)</td>
<td>0.000</td>
</tr>
<tr>
<td>Faced difficulties with access to care or with continuity of care</td>
<td>10 (13)</td>
<td>13 (18)</td>
<td>15 (21)</td>
<td>8 (10)</td>
<td>46 (15)</td>
<td>0.282</td>
</tr>
</tbody>
</table>
**HIV and Hepatitis C (HCV): testing, status and treatment**

Table 7 shows information about HIV and HCV in the study sample. Almost all participants had been tested at least once in their lives for HIV and HCV, except in Romania where 10% of the sample had never been tested. Greek participants were more likely to have had recent tests for HIV and HCV (76% and 79%, respectively).

With regard to HIV status, a higher prevalence was observed in Greece and Portugal, where respectively, 37% and 35% were seropositive. Almost all HIV-infected users had access to HIV treatment, with a larger percentage in Portugal.

In Romania and especially Bulgaria, a high percentage of participants reported current HCV infection (64% and 76%, respectively). With regard to current treatment for HCV, access was quite low in all four countries (6% of HCV-positive users were being treated).

### Table 7. HIV and HCV status

<table>
<thead>
<tr>
<th></th>
<th>N (%)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bulgaria</td>
<td>Greece</td>
<td>Portugal</td>
<td>Romania</td>
<td>Total</td>
<td>p-value</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time since last HIV test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 year or more</td>
<td>32 (43)</td>
<td>18 (24)</td>
<td>31 (42)</td>
<td>29 (36)</td>
<td>110 (36)</td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>43 (57)</td>
<td>57 (76)</td>
<td>42 (57)</td>
<td>42 (53)</td>
<td>184 (61)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never tested</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1 (1)</td>
<td>9 (11)</td>
<td>10 (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never tested</td>
<td>3 (4)</td>
<td>0 (0)</td>
<td>1 (1)</td>
<td>9 (11)</td>
<td>13 (4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seronegative</td>
<td>58 (77)</td>
<td>47 (63)</td>
<td>47 (64)</td>
<td>52 (65)</td>
<td>204 (67)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seropositive</td>
<td>14 (19)</td>
<td>28 (37)</td>
<td>26 (35)</td>
<td>19 (24)</td>
<td>87 (29)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On HIV treatment at time of study</td>
<td>10 (71)</td>
<td>22 (79)</td>
<td>22 (88)</td>
<td>13 (68)</td>
<td>67 (78)</td>
<td>0.420</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time since last HCV test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 year or more</td>
<td>26 (35)</td>
<td>16 (21)</td>
<td>37 (50)</td>
<td>35 (44)</td>
<td>114 (38)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>46 (61)</td>
<td>59 (79)</td>
<td>35 (47)</td>
<td>37 (46)</td>
<td>177 (58)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never tested</td>
<td>3 (4)</td>
<td>0 (0)</td>
<td>2 (3)</td>
<td>8 (10)</td>
<td>13 (4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCV status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seronegative</td>
<td>10 (13)</td>
<td>16 (21)</td>
<td>12 (16)</td>
<td>18 (23)</td>
<td>56 (18)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previously seropositive but cured</td>
<td>4 (5)</td>
<td>18 (24)</td>
<td>24 (32)</td>
<td>3 (4)</td>
<td>49 (16)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seropositive</td>
<td>57 (76)</td>
<td>41 (55)</td>
<td>35 (47)</td>
<td>51 (64)</td>
<td>184 (61)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never tested</td>
<td>4 (5)</td>
<td>0 (0)</td>
<td>3 (4)</td>
<td>8 (10)</td>
<td>15 (5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On HCV treatment at time of study</td>
<td>1 (2)</td>
<td>4 (10)</td>
<td>3 (9)</td>
<td>2 (4)</td>
<td>10 (6)</td>
<td>0.261</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Field experiences

Initiative For Health Foundation (IHF) / Bulgaria

The main achievements could be summarized in three main directions:

First of all we have already trained professionals as a trainers in a new innovative for Bulgaria intervention for prevention of HCV/HIV among injecting drug users. The ITSESI intervention gives us a different approach for solving and preventing the high risk of blood transmitted disease among PWID.

The second achievement are 16 trained professionals on local level from the field of different areas connected with drug addiction field (social workers, field workers; doctors; psychologist etc.) We provided two trainings in June,2018. The first training was from 12th to 15th of June. The group was with 8 participants. The second training was from 26th to 29th of June. The group was also with 8 participants. All the participants (our colleagues and professionals from the harm reduction field and also from the prevention, treatment and rehabilitation) were very impressed from the ITSESI intervention and ITSESI idea as an individual tailored approach to the drug users. There were a lot of discussions mainly around the possibility for an implementation of the original ITSESI intervention concerning the legislation in our country.

The third achievement is the implementation of the ITSESI intervention on site. The feedback from the PWID who were involved in the intervention shows that they are grateful for the individually tailored approach that gives them a unique opportunity to observe their behaviour, to discuss and to understand the care for their health.

Finally an achievement is the good partnership with all project partners and excellent coordination of the applicant that supports the smooth project implementation.

1. Strengths and weaknesses of the project for your team

- As strengths, we would first of all identify the ability to work individually with clients regarding their behavior when using drugs.
- In our opinion also the ITSESI intervention gave us an unique opportunity to build a good relationship with the clients, that helps to influence their injecting practice.
- We would also identify the practical experience we gained during the project as a strong point for further work with clients using drugs.
- One of the most valuable benefits for the teams is the ITSESI training. The training gave us the instruments to train other colleagues and to involve more professional in a new approach in their work with clients.
- At a certain moment the main difficulties encountered during the implementation are to motivate the PWID to get to the organization for the survey and the intervention. We solve the problem moving the survey to the mobile unit.
- As a weakness we identify the fact that the clients joined the intervention as a one-off study, though they were given the opportunity to retake. They did not have a will to have a second session because it is not paid.

2. Strengths and weaknesses of the project for your beneficiaries

- The opportunity for individual counseling session affected in a positive way the PWID’S behavior.
- The ITSESI session influence the injecting practice of the clients.
- The ITSESI intervention was an occasion to recall risky sexual behavior.
- As a strength we want to mark that we have clients that changed their usual injecting practice and some of them stop to inject between the M0 and M6.
- As a weaknesses we see the remoteness of the drop-in center and we should work in the mobile unit that sometimes was not very comfortable.
- A weakness was the low incentives also.
3. Remark and comments on the whole project.

• The project offers something absolutely new for our clients that makes it very valuable for them and gives an option to see and understand their behavior and attitudes towards their injecting practices in a different way.
• The downside was that we did not have the ability to observe directly the injecting practices and had to rely solely on phone recordings, which were not always of good quality, and this sometimes made the work of the first part difficult.

PRAKSISS-GREECE

Reasons for reduced participation in the second part of the Research (M6) and difficulties

The intravenous drug users (IDUs) who were the target group of the ITSES intervention or were included in the control group, did not refuse to participate in the harm reduction research intervention during the recruitment phase. However, the phenomenon of non-attendance occurred either during the first phase (in a few cases) or mainly during the second phase. More specifically, while 75 individuals were included in the survey according to the protocol (40 persons in the intervention group and 35 in the control group), 40 individuals (25 in the intervention group and 15 in the control group), finally attended the second phase (M6). In general, the participants were mostly men, over 30 years old and were in injecting drug use for many years.

The reasons for not attending the second part according to the team that implemented the intervention are as follows:

• Active User’s Profile - Research Participants: Intravenous Drug Users who were approached and participated in the survey had difficulty to be consistent and attend their scheduled appointments and as a result they often lost them - due to the nature of the dependency/addiction (compulsive search for the substance, craving the substance, repeated use, intoxication, withdrawal syndrome, loss of sense of time due to both dependence and their living in precarious conditions).
• In addition, the participants (IDUs) either did not have personal mobiles/phone numbers at the beginning of the intervention or they had lost/sold/changed them during the last (6) six months, making it difficult to find them during the second phase. The team members had to wait to reach them or they tried several times to find them at PWIDs gathering points, as these may have changed at times. In some cases, due to the difficulty of telephone communication (lack of it) and the specific traits of the drug users mentioned above, it was impossible to integrate them in the second phase. Some of them came long after the implementation of the research was completed.
• In some cases we were not able to find our participants in the usual (or new) PWIDs gathering points where PRAKSISS Mobile Medical Unit implements harm reduction services and streetwork interventions in a daily basis. The possible reasons could be: imprisonment, inclusion in a therapeutic program which could have as result the avoidance of staying at the PWIDs gathering points. Also, increased police arrests and changes in relative policies after the change of Greek government on July 2019, may have added another severe barrier to their participation.
• Finally, one participant moved to another town aiming at finding a job. Another participant tried to be detoxified (“off”) by moving to another town and avoiding triggers.
• Given all these reasons and difficulties of the context mentioned above, the number of 40 IDUs who achieved to participate in M6 may not be considered as a small one.

Strengths and weaknesses of the project for the team

In total, two (2) trainings of 4-day duration each, were held by PRAKSISS in Athens and 17 people working in several services of PRAKSISS were trained.

Participants had a wide variety of experience from different perspectives, having several profession-
al backgrounds, covering PRAKSIS main services involved in harm reduction for IDUs. Participants were psychologists, social workers, social scientists, peer workers, cultural mediator/interpreter, nurse, some of them being coordinators of services for harm reduction that were involved in all phases of ITSESI evaluation. More specifically, the participants are coordinators of services and fieldworkers mainly from PRAKSIS Polyclinics of Athens, PRAKSIS Mobile Medical Unit (providing a wide range of public health services including prevention interventions for HIV, HCV, testing and respective support, other harm reduction services), outreach teams, PRAKSIS Shower Bus, PRAKSIS Day Center for the Homeless (Athens). Therefore, trainees had knowledge and professional experience in Addiction issues, Harm Reduction and streetwork.

The training and the handbook were well structured and very helpful in understanding and implementing ITSESI intervention. The structure, information, timetable and experiential exercises (inclusion of role – plays) included in the training had as a result the clarification of both the ITSESI intervention and the role of professionals in the field. However, it was identified that the enrichment of the following topics was needed: types of psychoactive substances - effects - harm reduction messages, safe and dangerous injection sites and harm reduction instructions, information on HIV/HCV and other STDs. The usefulness of updated information on safe injection techniques, the inclusion of videos with correct injecting practices were also mentioned. Further information on counseling techniques such as “Motivational Interviewing” were also useful for some of the participants. Last but not least, it could be recommended a different format for peer workers that could be used in the future, to make the training more attractive and easier for them to participate. For instance, instead of a 4-day training, a more intensive format could be developed and used in the future (e.g. a 2-day training format).

Strengths and weaknesses of the project for the beneficiaries

The context of operation of harm reduction interventions in Greece is highly impacted by the legislation barriers, not allowing for the original version of the protocol to be implemented in PRAKSIS premises. Moreover, the fact that the majority of IDUs do their drug-use in open areas of Athens streets, since the majority of them are either homeless or live in precarious conditions or not in their own house in general, made very difficult the implementation of the video version. In other words, the majority of them either had no smartphone or was afraid of other people gaining access to it (in case the phone was stolen or were arrested by the police etc.). For all these reasons, the intervention was adapted to the country’s legal framework and as a result, the simulation version of ITSESI was implemented instead (observation of the simulation of their usual injecting drug use).

Although various harm reduction interventions targeted at IDUs have been implemented in Greece until today, a research intervention that includes individually tailored support and education for safer use was implemented for the first time. This makes the above intervention innovative. According to the feedback provided by the participants in the research intervention, this project was different as they received individually tailored and direct advice about their injecting practices rather than general guidelines. This has helped to dispel myths, get proper and detailed information on risky practices and finally reinforce good injecting practices. The positive effect on reducing HIV/HCV transmission and vein damage was also mentioned by some of them. In addition, they stated that they received care, concern, interest and support, emphasizing the importance of contact and trust between the professional and the participant. Some people noticed that even the participation in the M0 questionnaire, triggered a reflection on all distinctive steps of injecting procedure, that they never had thought before.
One weak point of the intervention is the one session of observation. More follow-up educational sessions might be helpful in changing attitudes and behavior. Another difficulty arises from the field. The majority of IDUs use drugs in open gathering points and roads (where they are visible) and live in precarious conditions. There are not sharp containers available at the PWIDs gathering points, so the used injecting equipment is thrown away at the place where they make drug use. In addition, they do not have access to clean water to wash their hands and the gathering points are dirty and with garbage. Another issue is that organizations implementing harm reduction interventions operate at specific times of the day and do not work during weekends and (bank) holidays and there is lack of syringe dispensing/exchanging machines. The issues mentioned above make extremely difficult for the participants to put into actual practice the safe injection practices.

**General comments on the whole project**

The pioneering project providing individually tailored training of IDUs was found to be extremely useful and may have led to behavioral changes, according to some of the participants’ self-reports and the research team’s observations (use of tourniquet, use of alcohol tissues for disinfection of hands, rotation of injecting sites, search for clean space for intravenous use).

In addition, the Mobile Medical Unit operates in a daily basis, implementing an integrated program of harm reduction services as a direct, flexible and individualized response through primary health care services, counseling, psychosocial support, rapid test for HIV, HEP B & HEP C and referrals to other services. The participants felt safe and free to ask for the services mentioned above.

Another interesting part is the exchange of knowledge, experience and know-how both with the research team in France that has successfully implemented the AERLI intervention as well as with other countries involved in the project in order to enrich the Greek experience.

Last but not least, it should be noted that the training as also the ITSESI intervention as such, introduced an innovative and highly promising practice for fieldworkers as also a precious tool for advocacy on the real needs of IDUs, based on scientific evidence. This intervention is perceived as very significant as also easily adaptable to other sub-populations of IDUs, such as refugees- a growing IDU group in Greece at the moment.
GAT - Portugal

Introduction

This is a cross-sectional study that intends to understand positive and negative aspects of ITSESI implementation in Portugal, in the fieldworkers’ perspective. The research questions are: (1) What are the advantages of ITSESI project on team/organization and on people who use drugs? (2) What are the less positive aspects of ITSESI project on team/organization and on people who use drugs? (3) What should be changed to improve ITSESI implementation?

Methods

Participants: All fifteen fieldworkers that had participated on ITSESI implementation were invited to answer a short questionnaire, but only twelve did it. Seven participants were from Oporto and five from Lisbon.

Data collection procedure: Data collection was made using Google Forms, between October 11th and October 15th. This research consisted of asking five questions about advantages and less positive aspects of ITSESI implementation, and how it could influence future participants/users, but also teams/organizations. Fieldworkers could make suggestions to improve ITSESI intervention. The confidentiality and anonymity were maintained throughout all the process.

Data analysis: Data were analysed through thematic content analysis (Bardin, 2011) using NVivo 12 software, where several categories emerged. Data were quoted by an external researcher, to minimize data contamination.

Results

Strengths and weaknesses of the project for your team or organization

Strengths: Fieldworkers reported increased knowledge and ability to intervene (overdose management, health issues) with the target population (people who inject drugs) and also mentioned that Eurosider provided the opportunity to develop new interventions. Implementing ITSESI brought teams closer to users and made them more aware of the user’s needs. It was also very important to allow teams/organizations to legally supervise (observe) the moment of the consumption (under a research project approved by a national ethics committee). The provision of new injecting paraphernalia (provided in the context of Eurosider by Apothicom) to participants was also referred by fieldworkers as positive. Collaboration between teams and organizations and exchange of experiences was a plus in Eurosider implementation in Portugal - we brought together 15 fieldworkers from 4 organizations from 2 cities, Lisbon and Porto.

Weaknesses: Most of the less positive aspects mentioned by fieldworkers are related to the work overload, lack of human resources and difficulties in combining/managing daily activities with Eurosider extra-work. One of the fieldworkers reported as “less positive” the fact that he/she was now more aware of the lack of responses in Portugal.

Strengths and weaknesses of the project for your beneficiaries

Strengths: The majority of fieldworkers reported that the main benefit for those users participating in the ITSESI sessions was the access to education and information related to their injecting practices, where they could discuss ways to minimize risks and prevent infections. Other aspect stressed by fieldworkers was the reinforcement of the closeness between professionals and users that allowed a better knowledge of the services by the users. The compensation (payment) to study participants was also seen as positive.

Weaknesses: Some fieldworkers reported the waiting times to participate in the study as less positive, but this aspect could be related to the lack of resources to implement ITSESI. Others also mentioned the fact that one educational session is not enough to change behaviours, and this might be related to the fact that the teams were not having the time and resources needed to offer more than one session to the participants, or that for participants using drugs in front of a professional could be a barrier. Fieldworkers suggested to expand this type of intervention to other modes of...
consumption (smoking) and to consider to add a more social focus (not only minimization of health risks).

**Remarks and comments on the whole project**

Fieldworkers suggested to implement ITSESI in a broader way, allowing for example smoking users to participate and benefit from an educational intervention. Fieldworkers were also critics of the existence of a control group – meaning that no one should be left with the opportunity to have an educational session. Other suggestions and comments were more related the way the project/intervention could be managed at the organizational level – to have more resources, better management of the daily workloads, more involvement of the team, etc.

**References:**

WP4. Advocacy and dissemination

Goal

The overall aim of the advocacy and dissemination was to raise awareness on project activities and finally to improve the knowledge and skills for safe injection strategies.

Main aims of our dissemination are:

• To provide stakeholders with information on the progress and results of the project.
• To provide stakeholders with knowledge and good practice examples.
• To raise awareness about the relevance and importance of live saving services.
• To ensure sustainability of project results after the project is finalised.

Main messages are:

• Implementation of safe injection knowledge and skills is life saving.
• National regulations and laws have to be adapted to make this intervention legal and fully acknowledged.
• The trainings and materials of the project are available and ready for implementation.

Objectives

The communication and advocacy objectives are the following:

A. Creating public access to findings developed throughout the project (reports, manuals, evaluation)

B. Increasing awareness about activities and outcomes of the project to multipliers and decision makers

In particular:

• Demonstrate the results of the methodology
• Undertake widespread promotion and dissemination through promotion of the results.
• Manuals and education materials will be disseminated through the website, e-mail alerts, conferences, newsletters and be disseminated as hard copy.

Stakeholders analysis

Working on harm reduction and on the prevention of HIV, HCV and TB and death linked to drug use and overdose for people who use drugs, requires approaches which can meaningfully address the different groups of stakeholders and beneficiaries which have a say in the introduction, development, definition, design, delivery, monitoring and accessing services for drug users.

These involve:

• policy makers in the area of health and criminal justice,
• health and social sector professionals
• health and social sector practitioners,
• grass root organisations, NGOs and other services providing care for people who use drugs and clearly the end beneficiaries,
• organisations of people who use drugs such as drug user unions.
Note: Project partner are requested to deliver these tasks in their particular country.

<table>
<thead>
<tr>
<th>Key message</th>
<th>Deliverable</th>
<th>To whom</th>
<th>Why</th>
<th>How</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of life saving services for drug users is crucial</td>
<td>Project reports</td>
<td>European bodies and agencies, national policy makers, CSO’s</td>
<td>To provide information about the current situation of HR in Europe</td>
<td>Targeted mailings, Printed copies of report</td>
<td>M24ff</td>
</tr>
<tr>
<td>National laws and regulations have to be adapted</td>
<td>National reports, National events</td>
<td>National policy makers and CSO</td>
<td>To raise awareness in the specific country and convince parties to collaborate</td>
<td>Targeted mailings, Printed copies of report</td>
<td>M24 ff</td>
</tr>
<tr>
<td>Skill building is necessary for HR staff and peers</td>
<td>Training manual</td>
<td>European bodies and agencies, national policy makers, CSOs</td>
<td>To improve policy and practice</td>
<td>Leaflets, Website, Social media, Electronic newsletter, conferences</td>
<td>M3-M24</td>
</tr>
</tbody>
</table>

**Sustainability plan**

Sustainability will be achieved through the maintenance of the information on the websites of Correlation – European Harm Reduction Website and the web portal harmreduction.eu.

The web portal will be a:

1. knowledge center and capacity building instrument for policy-makers and service providers
2. way to apply and implement the safer use training programme
3. source to disseminate the project findings, result and deliverables of the overall project

**Achievements so far:**

- By implementing the project in 4 European countries, gaining support by the resp. Ethical Committees and (local) policy makers, awareness and insight into this specific area was increased. In certain countries, specific advocacy measures were adapted to ensure the implementation of the project.
- By providing country based analysis and analysis of limitations, information was provided for policy makers and stakeholders.
- By implementing the training, peers and staff in involved services improved their skills and knowledge.
- By informing interested stakeholders on several major conferences in Europe (European harm reduction Conference, Lisbon Addiction conference, Hepatitis Community Summit) awareness increased for the need and the effectiveness of the method.
- By informing European agencies (EMCDDA, WHO Europe, CSF Drugs, C EHRN) and the publication in a scientific journal the supra national level is addressed to ensure acknowledgement.
References


43. Silvestri A. GATEWAYS FROM CRIME TO HEALTH: THE PORTUGUESE DRUG COMMISSIONS. :58.


# Annexes

## Table 9. Drug use in the previous month

<table>
<thead>
<tr>
<th>Drug</th>
<th>Bulgaria</th>
<th>Greece</th>
<th>Portugal</th>
<th>Romania</th>
<th>Total</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Heroin</strong></td>
<td>18 (24)</td>
<td>48 (64)</td>
<td>36 (48)</td>
<td>77 (96)</td>
<td>179 (59)</td>
<td>0.000</td>
</tr>
<tr>
<td>Used more than 28 days a month</td>
<td>6 (8)</td>
<td>28 (37)</td>
<td>16 (21)</td>
<td>53 (66)</td>
<td>103 (34)</td>
<td>0.000</td>
</tr>
<tr>
<td>Injection</td>
<td>18 (24)</td>
<td>42 (56)</td>
<td>34 (45)</td>
<td>77 (96)</td>
<td>171 (56)</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>Buprenorphine</strong></td>
<td>1 (1)</td>
<td>31 (41)</td>
<td>6 (8)</td>
<td>1 (1)</td>
<td>39 (13)</td>
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<td>17 (23)</td>
<td>1 (1)</td>
<td>1 (1)</td>
<td>20 (7)</td>
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</tr>
<tr>
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<td>1 (1)</td>
<td>1 (1)</td>
<td>0 (0)</td>
<td>3 (1)</td>
<td>0.783</td>
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<tr>
<td>Prescribed</td>
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<td>21 (28)</td>
<td>2 (3)</td>
<td>1 (1)</td>
<td>24 (8)</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>Methadone</strong></td>
<td>69 (92)</td>
<td>13 (17)</td>
<td>57 (76)</td>
<td>44 (55)</td>
<td>183 (60)</td>
<td>0.000</td>
</tr>
<tr>
<td>Used more than 28 days a month</td>
<td>47 (63)</td>
<td>4 (5)</td>
<td>49 (65)</td>
<td>28 (35)</td>
<td>128 (42)</td>
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</tr>
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<td>Injection</td>
<td>66 (88)</td>
<td>0 (0)</td>
<td>3 (4)</td>
<td>10 (13)</td>
<td>79 (26)</td>
<td>0.000</td>
</tr>
<tr>
<td>Prescribed</td>
<td>63 (84)</td>
<td>5 (7)</td>
<td>54 (72)</td>
<td>35 (44)</td>
<td>157 (52)</td>
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</tr>
<tr>
<td><strong>Morphine</strong></td>
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<td>2 (3)</td>
<td>0 (0)</td>
<td>4 (1)</td>
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<td>1 (1)</td>
<td>0 (0)</td>
<td>2 (1)</td>
<td>0.556</td>
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<td>0 (0)</td>
<td>0 (0)</td>
<td>2 (1)</td>
<td>0.103</td>
</tr>
<tr>
<td>Prescribed</td>
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<td>0 (0)</td>
<td>1 (1)</td>
<td>0 (0)</td>
<td>2 (1)</td>
<td>0.556</td>
</tr>
<tr>
<td><strong>Cocain</strong></td>
<td>5 (7)</td>
<td>54 (72)</td>
<td>20 (27)</td>
<td>2 (3)</td>
<td>81 (27)</td>
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<td>20 (27)</td>
<td>5 (7)</td>
<td>0 (0)</td>
<td>25 (8)</td>
<td>0.000</td>
</tr>
<tr>
<td>Injection</td>
<td>5 (7)</td>
<td>54 (72)</td>
<td>19 (25)</td>
<td>1 (1)</td>
<td>79 (26)</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>Crack or free base</strong></td>
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<td>2 (3)</td>
<td>36 (48)</td>
<td>0 (0)</td>
<td>38 (13)</td>
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<td>24 (32)</td>
<td>0 (0)</td>
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<td><strong>Speedball</strong></td>
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<td>54 (72)</td>
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<tr>
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<td>53 (71)</td>
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<td>102 (33)</td>
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<td>2 (3)</td>
<td>1 (1)</td>
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<td>0 (0)</td>
<td>0 (0)</td>
<td>35 (12)</td>
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<td>2 (3)</td>
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<td>15 (20)</td>
<td>2 (3)</td>
<td>43 (14)</td>
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<td>0 (0)</td>
<td>0 (0)</td>
<td>35 (12)</td>
<td>0.000</td>
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<td>44 (59)</td>
<td>2 (3)</td>
<td>92 (30)</td>
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<tr>
<td>Injection</td>
<td>1 (1)</td>
<td>0 (0)</td>
<td>1 (1)</td>
<td>0 (0)</td>
<td>2 (1)</td>
<td>0.556</td>
</tr>
</tbody>
</table>

*At least once in the previous month*
EUROSIDER – QUESTIONNAIRE M0 – inclusion

CONFIDENTIAL CODE: /___/___/ /___/___/ /___/___/___/

DATE: /___/___/ /___/___/ /___/___/

Place: □ 0 outside ■ 1 Mobile Unit □ 2 Association □ 3 Drug Consumption room
□ 4 other: ……………………….

Inclusion Criteria

Q1. Age? /__/__/__/

Q2. Have you used drug injection in the last week?
□ 0 No ■ 1 Yes

Q3. Do you understand national language?
□ 0 No ■ 1 Yes
If not, what is your language speaking? ____________________________ *

Q4. Do you live in this town?
□ 0 No ■ 1 Yes

Q5. Did you have already education/advice session by professionals of trained field workers on injection practice before?
□ 0 No ■ 1 Yes

If yes:
Q5.1. How long ago?
/__/__/ ______ year □ month □ week

Q5.2. How many sessions?
/__/__/ ______ 98 NA

Q1>=18 and Q2 and Q3 = Yes, Q4 and Q5 = No or Q5.1>1year □ Yes □ No

Included person? □ Yes □ No

1. Social and demographic profile

DEM1. Gender
□ 0 Male
□ 1 Female
□ 2 Transgender
□ 98 NA
□ 99 NR

DEM2. Education level?
□ 0 under High School
□ 1 High School degree
□ 2 University
DEM3. Country of birth ..........................................

*If you are not born in (Bulgaria or Greece or Romania or Portugal):*

DEM3.1. Since when do you live here:
- 0 less than 1 year
- 1 1-3 years
- 2 3-10 years
- 3 More than 10 years
- 98 NA
- 99 NR

DEM4. Currently do you live in couple?
- 0 No  ➤ pass in question DEM5
- 1 Yes  ➤ pass in question DEM5
- 98 NA  ➤ pass in question DEM5
- 99 NR

DEM4.1. If yes: Is your partner a drug user?
- 0 No
- 1 Yes but not by injection
- 2 Yes with injection
- 98 NA
- 99 NR

DEM5. Currently where do you live? (One choice available.)
- 0 in your own home
- 1 in therapeutic apartment
- 2 your family’s home
- 3 in hospital or clinic
- 4 in emergency shelter
- 5 Friend’s home
- 6 in shelter, hostel
- 7 Homeless
- 8 in a squat
- 9 in truck or caravan
- 10 other, specify.................................
- 98 NA
- 99 NR

DEM6. Did you sleep outside in the past month?
- 0 No
- 1 Yes
- 98 NA
- 99 NR

DEM7. Do you have child?
- 0 No  ➤ pass in question SOC1
- 1 Yes
2. Socio-economic characteristics (SOC)

SOC1. What is your employment situation?
- 1 you have official employment
- 2 you have an informal job
- 3 you are unemployed
- 4 you are student
- 5 other, specify ……………….
- 98 NA
- 99 NR

SOC2. Actually, do you receive a public allowance?
- 0 No
- 1 Yes
- 98 NA
- 99 NR

SOC3. Did you receive food aid during the last month
- 0 No
- 1 Yes
- 98 NA
- 99 NR

SOC4. Currently do you have health assurance?
- 0 No
- 1 Yes
- 98 NA
- 99 NR

3. Consumption use (INI)

INI1. How old were you when you started to inject drug?
/___/___/ years
- 98 NA
- 99 NR

INI2. Which product?
- 0 Heroin
- 1 Buprenorphine
- 2 Methadone
- 3 Morphine or codeine (Skenan®, Moscontin®, Lamaline®, Oxycontin®, Neocodion®, paracetamol codeine,
  Efferalgan® codeine, codoliprane®, dafalgan codeine®, dicodin®, prontalgin®)
- 4 Cocaine
- 5 Crack or freebase
6 Speedball
7 Amphetamines, methamphetamine, ecstasy
8 Methylphenidate (ritalin®, concerta®)
9 Benzodiazepines (lexomil®, lysanxia®, rivotril®, seresta®, tranxene®, valium®, Xanax®)
10 Ketamine
11 Hallucinogens, which one? ……………………
12 NPS or RC, which one? ……………………
13 other, specify ……………………..
98 NA
99 NR

IN13. What was the context of your first injection (several choices available)?
0 You were alone
1 You were helped by someone
2 You were in prison
3 You get information on the net before
4 Other, specify ……………………..
98 NA
99 NR

4. Current consumption of psychoactive products (CONS)

CONS1. Answer the following questions about your current drug of choice

What is your current #1 drug of choice (please do not list prescribed medications such as methadone or sub Oxone unless abused)? _______________________________

CONS1.1 How do you typically use your #1 drug of choice?
0 Smoke
1 Inject
2 Swallow it
3 Snort
4 Other, specify ……………………..
98 NA
99 NR

CONS1.2 What is your current #2 drug of choice (please do not list prescribed medications such as methadone or sub Oxone unless abused)? _______________________________

CONS1.3 How do you typically use your #2 drug of choice?
0 Smoke
1 Inject
2 Swallow it
3 Snort
4 Other, specify ……………………..
98 NA
99 NR
**CONS2. Which psychoactive products did you consume last month (including prescription drugs)?**

<table>
<thead>
<tr>
<th>Products</th>
<th>How many days by month?</th>
<th>How many times by day?</th>
<th>Prescribed?</th>
<th>By injection?</th>
<th>How?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1/1/1</td>
<td>1/1/1</td>
<td></td>
<td>No</td>
<td>0 Smoke</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>1 Inject</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 Swallow it</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 Snort</td>
</tr>
<tr>
<td>Héron</td>
<td>1/1/1</td>
<td>1/1/1</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine (1)</td>
<td>1/1/1</td>
<td>1/1/1</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Methadone</td>
<td>1/1/1</td>
<td>1/1/1</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Morphine (2)</td>
<td>1/1/1</td>
<td>1/1/1</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Other opioids (3)</td>
<td>1/1/1</td>
<td>1/1/1</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td>1/1/1</td>
<td>1/1/1</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Crack or free base</td>
<td>1/1/1</td>
<td>1/1/1</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Speedball</td>
<td>1/1/1</td>
<td>1/1/1</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Amphetamines (4)</td>
<td>1/1/1</td>
<td>1/1/1</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Methylphenidate (5)</td>
<td>1/1/1</td>
<td>1/1/1</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines (6)</td>
<td>1/1/1</td>
<td>1/1/1</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Ketamine</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPS or RC (7) which one?</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallucinogens (8) which one?</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabis (9)</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, specify…………………</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(1) e.g. Subutex, Temgesic, Suboxone,…
(2) e.g. Skan®, Moscontin®, Lamaline®
(3) e.g. pethidine, codeine, dinacon, efferalgan codeiné…
(4) speed, MDMA, ecstasy
(5) Ritaline, Concerta, Quasym
(6) lexomil, lysanxia, noctran, rivotril, seresta, tranxene, valium, xanax
(7) New psychoactives substances or Research Chemicals: cannabinoïdes, cathinoes, 6-APB, 2C-B, MDPV, 4-MEX, méphédrone, PVP, 3-MMC, 4-MA, 4-FA, PPP, pipérazines, BZP, TFMP, Methcat,…
(8) e.g. Artane, LSD/acide, mushrooms, DMT, NBOMe,…
(9) weed, shit, joints,…
CONS3. With whom do you more often inject? (One choice available)
- 0 Alone
- 1 With Your partner
- 2 With friend or family member
- 3 With a group
- 4 Other, specify: ______________________
- 98 NA
- 99 NR

CONS4. Where do you more often inject? (One choice available.)
- 0 In parking garage
- 1 In public toilets
- 2 In cellar
- 3 In stairwell
- 4 In the street
- 5 At home
- 6 In someone’s ?????
- 7 In a centre (association, health centre)
- 8 In a drug consumption room
- 9 Festive gathering (rave, teknival, etc…)
- 10 Other, specify: ________________________________
- 98 NA
- 99 NR

CONS5. What do you do with used equipment? (One choice available.)
- 0 Throw it where you inject
- 1 In public trash
- 2 Use of dedicated collector
- 3 keep for reuse
- 4 Other, specify: _____________________________
- 98 NA
- 99 NR

CONS6. Did you already assist to an educative session on safe injection for you or another person?
- 0 No  pass in question ADA1
- 1 Yes  pass in question ADA1
- 98 NA  pass in question ADA1
- 99 NR  pass in question ADA1

SOC5.1. If yes, it was how long ago?
/__/__/ __________ years  ______ month  ______ week  98 NA  99 NR

5. Sexual behaviour

SEX1. In the past 6 months, have you had sex ?
- 0 No
- 1 Yes with a man
- 2 Yes with a woman
- 3 Yes with both
- 4 Yes, with a trans person
- 98 NSP
- 99 NR

SEX2. In the past four weeks, how many sexual partners have you had?
SEX3. In the past four weeks, how many times have you had sex?
0 One to four
1 five to eight
2 nine to twelve
3 more than twelve
98 NSP
99 NR

SEX4. In the past four weeks, have you ever used drugs in a sexual context?
1 Always
2 Often
3 Sometimes
4 Rarely
5 Never
98 NSP
99 NR

SEX5. Was this by injection?
1 Always
2 Often
3 Sometimes
4 Rarely
5 Never
98 NSP
99 NR

SEX6. Which drugs? .........................

6. Alcohol use (AUDIT) and tobacco (TAB)

ADA1. What is your frequency of alcohol consumption?
0 Never
1 One by month or less
2 2 - 4 times by month
3 2 - 3 times by week
4 At least 4 time by week
5 Everyday
98 NA
99 NR

ADA2. How many glasses of alcohol do you drink in a « normal day » when you drink?
0 1 or 2
1 3 or 4
2 5 or 6
3 7 or 8
4 10 or plus
ADA3. What is the frequency of your high alcohol consumption (at least 6 glasses) for a specific occasion?
- 0 Never
- 1 Less than one by month
- 2 One by month
- 3 One by week
- 4 Every day or almost
- 98 NA
- 99 NR

7. Overdoses (OD) and suicide risk (SUIC)

OD1. Were you been victim of overdose in your life?
- 0 No, never
- 1 Yes, 1 time
- 2 Yes, 2-3 times
- 3 Yes, more than 3 times
- 98 NA
- 99 NR

OD1.1. If yes, have you been victim of overdose during the last 6 months
- 0 No, never
- 1 Yes, 1 time
- 2 Yes, 2-3 times
- 3 Yes, more than 3 times
- 98 NA
- 99 NR

OD2. In your life, have you ever witnessed overdose?
- 0 No, never
- 1 Yes, only one time
- 2 Yes, more than one time
- 98 NA
- 99 NR

8. High risk practices related to drug use (RIS)

Injection

RIS1. During the last month, how often did you inject?
- 0 Less than 4 times a month
- 1 At least once a week
- 2 Everyday
- 98 NA
- 99 NR

RIS1.1. How many times a day?
On average: / ___ / ___ / injections a day
Maximum: / ___ / ___ / injections a day
RIS2. Which area of the body do you inject?

RIS2.1. At least one time (Several choices available)
- Arm
- Hand
- Foot
- Leg
- Groin
- Neck
- Body
- Muscle
- Breast
- Other, specify…

RIS2.2. The more often (One choice available)
- Arm
- Hand
- Foot
- Leg
- Groin
- Neck
- Body
- Muscle
- Breast
- Other, specify…

RIS3. In the last month, did you re-use your own injection equipment? (Syringe or other)
- 0 No ➤ Pass in question RIS4
- 1 Yes ➤ Pass in question RIS4
- 98 NA ➤ Pass in question RIS4
- 99 NR ➤ Pass in question RIS4

RIS3.1. What did you re-use?
- Syringe
- Syringe corps
- Needle
- Spoon or aluminium base
- Filter (Cotton, Sterifilt®, other)
- Alcohol cotton or disinfecting wipe
- Dry cotton (post injection)
- Water
- Other, specify…

RIS4. During the last month, did you use someone else’s injection equipment? (Syringe or other)?
- 0 No ➤ Pass in question RIS5
- 1 Yes ➤ Pass in question RIS5
- 98 NA ➤ Pass in question RIS5
- 99 NR ➤ Pass in question RIS5

RIS4.1. What did you use?
- Syringe
- Syringe corps
- Needle
- Spoon or aluminium cup
- Filter (Cotton, Sterifilt®, other)
- Alcohol cotton or disinfecting wipe
- Dry cotton (post injection)
- Water
- Other, specify…

RIS5. During the last month, did you give your injection equipment to someone after use (syringe or other)?
- 0 No ➤ Pass in question RIS6
- 1 Yes
RIS5.1. What did you use?
- Syringe
- Syringe corps
- Needle
- Spoon or aluminium cup
- Filter (Cotton, Sterifilt®, other)
- Alcohol cotton or disinfecting wipe
- Dry cotton (post injection)
- Water
- Other, specify …

RIS6. During the last month, where did you mainly get your injection equipment?
- 0 Pharmacy
- 1 In a harm reduction service
- 2 Automatic dispenser
- 3 Gift from a friend (news)
- 4 Borrowed from a friend (used)
- 5 Purchased in street
- 6 Other, specify ……………………………
- 98 NA
- 99 NR

RIS7. During the last month, did you rush your injections due to fear of being seen?
- 0 No
- 1 Yes
- 98 NA
- 99 NR

RIS8. During the last month, have you been injected by another person?
- 1 Always
- 2 Often
- 3 Sometimes
- 4 Rarely
- 5 Never
- 98 NA
- 99 NR
Sniffing

RIS10. During the last month, how often did you sniff a drug?
- 0 never ► Pass in question PRA1
- 1 Less than 4 times a month
- 2 At least once a week
- 3 every day
- 98 NA ► Pass in question PRA1
- 99 NR ► Pass in question PRA1

9. Injection Practices (PRA)

PRA1. During the last month, how often did you use a new syringe for your injection?
- 0 Never
- 1 Sometimes
- 2 Most of the time
- 3 Always
- 98 NA
- 99 NR

PRA2. During the last month, have you used a syringe with separate needles?
- 0 No ► Pass in question PRA3
- 1 Yes
- 98 NA ► Pass in question PRA3
- 99 NR ► Pass in question PRA3

If yes:

PRA2.1. Did you use new body syringe for your injection?
- 0 Never
- 1 Sometimes
- 2 Most of the time
- 3 Always
- 98 NA
- 99 NR

PRA2.2. Did you use new needle for your injection?
- 0 Never
- 1 Sometimes
- 2 Most of the time
- 3 Always
- 98 NA
- 99 NR

PRA3. During the last month, did you use new receptacle (spoon, metal cup…) to prepare your product?
- 0 Never
- 1 Sometimes
- 2 Most of the time
- 3 Always
- 98 NA
- 99 NR
PRA4. During the last month, did you use new single dose water container to prepare your product?
0 Never
1 Sometimes
2 Most of the time
3 Always
98 NA
99 NR

PRA5. During the last month, did you use a clean zone to prepare your product?
0 Never
1 Sometimes
2 Most of the time
3 Always
98 NA
99 NR

PRA6. During the last month, did you wash your hands before preparation of product?
0 Never
1 Sometimes
2 Most of the time
3 Always
98 NA
99 NR

PRA7. During the last month, did you filter your preparation before injection?
0 never
1 Sometimes
2 Most of the time
3 Always
98 NA
99 NR

If yes:

PRA7.1 Which kind of filter did you use?
1 Cigarette filters
2 Cotton
3 Stierfill
4 other, specify..........................
98 NA
99 NR

PRA7.2 Was this filter always new?
0 No
1 Yes
98 NA
99 NR

PRA8. During the last month, did you clean the point of injection before injection?
0 Never
1 Sometimes
2 Most of the time
3 Always
98 NA
99 NR
PRA9. During the last month, did you find the vein by touching?
- 0 Never
- 1 Sometimes
- 2 Most of the time
- 3 Always
- 98 NA
- 99 NR

PRA10. During the last month, did you lick the needle before injection?
- 0 Never
- 1 Sometimes
- 2 Most of the time
- 3 Always
- 98 NA
- 99 NR

PRA11. During the last month, did you find the vein at the first try?
- 0 Never
- 1 Sometimes
- 2 Most of the time
- 3 Always
- 98 NA
- 99 NR

PRA12. During the last month, did you pull back the plunger to verify if needle was well in the vein?
- 0 Never
- 1 Sometimes
- 2 Most of the time
- 3 Always
- 98 NA
- 99 NR

PRA13. During the last month, did you pull back the plunger repeatedly to bring the blood back in the syringe and reinject?
- 0 Never
- 1 Sometimes
- 2 Most of the time
- 3 Always
- 98 NA
- 99 NR

RA14. During the last month, did you apply pressure with a dry cotton to stop the bleeding after injection?
- 0 Never
- 1 Sometimes
- 2 Most of the time
- 3 Always
- 98 NA
- 99 NR

PRA15. During the last month, did you apply pressure with anything else (except dry cotton) to stop the bleeding after injection?
- 0 Never
- 1 Sometimes
2 Most of the time
3 Always
98 NA
99 NR

If yes:
PRA15.1. What did you use?
1 Specify
98 NA
99 NR

PRA16. During the last month, did you apply a healing cream after injection?
0 Never
1 Sometimes
2 Most of the time
3 Always
98 NA
99 NR

10. Treatments (SUBST)

SUBST1. In your life, have you already received an opioid substitution treatment?
0 No
1 Yes
98 NA
99 NR

SUBST2. Which one? (Several choices available.)
0 Buprenorphine/subutex®
1 Suboxone®
2 Methadone
3 Skenan®, morphine sulfate
4 Other treatment, specify
98 NA
99 NR

SUBST3. How old were you when you received your first opioid substitution treatment (buprenorphine, methadone, morphine sulfate)?
/___/___/ year
98 NA
99 NR

SUBST4. Currently, do you receive a treatment prescribed for opioid addiction?
0 No
1 Yes, by buprenorphine/subutex®
2 Suboxone®
3 Yes, methadone in capsules
4 Yes, methadone in syrup
5 Yes, Skenan®, morphine sulfate

PASS in question PRA16
PASS in question PRA16
PASS in question SANT1
PASS in question SANT1
6 Yes, medical withdrawal
7 Yes, other, specify
☐ 98 NA ➤ Pass in question SUBST5
☐ 99 NR ➤ Pass in question SUBST5

SUBST4.1. If yes, do you sometimes need to complete your substitution treatment by buying it in the street?
• 0 No ➤ Pass in question SUBST5
• 1 Yes
☐ 98 NA ➤ Pass in question SUBST5
☐ 99 NR ➤ Pass in question SUBST5

SUBST4.2. If yes, how often?
__/__/__ day  □ week  □ month  98 NA  99 NR

SUBST5. For which reason(s) did you get treatment right now? (Please check. There may be more than one answer.)
☐ 0 Police harassment/pressure
☐ 1 Court requirement (legal problems due to substance use)
☐ 2 Fear of losing children
☐ 3 Fear of losing partner/lover
☐ 4 Exhaustion
☐ 5 Heath reasons
☐ 6 Peer pressure
☐ 7 Family pressure
☐ 8 Work pressure
☐ 9 financial pressure
☐ 10 Overdose
☐ 11 just sick of using/lifestyle
☐ 12 other (please specify …
☐ 98 NA
☐ 99 NR

11. Health issues and access to care (SANT)

SANT1. Do you have one or more medical treatment for other health issue?
• 0 No
• 1 Yes, specify
☐ 98 NA
☐ 99 NR

SANT2 – During the last 6 months, have you suffered from these injecting-related health issues? (Several choices available.)
• 0 No
• 1 Bruises and hematoma
• 2 Cutaneous abscess
• 3 Sudden fever/ Cotton fever/ Dirty hit
- 4 Allergic reaction due to a dust or a cutting agent
- 5 Burn at injection point
- 6 Sepsis or septic shock (infection spread by bacteria in blood)
- 7 Amputation of fingers
- 8 Collapsed vein
- 9 Swelling of the hands and forearms
- 10 Swelling of feet or legs
- 11 Thrombosis, phlebitis (blood clot in a blood vessel)
- 12 Rolling veins
- 13 Libido loss
- 14 Absences
- 15 Liver problems
- 16 Necrosis
- 17 Other problem, specify

☐ 98 NA
☐ 99 NR

SANT3. During the last 6 months, were you in touch with specialized services or mobile units?

- 0 Never ➤ Pass in question SANT4
- 1 Part time
- 2 Often
- 3 Always ➤ Pass in question SANT4

☐ 98 NA ➤ Pass in question SANT4
☐ 99 NR ➤ Pass in question SANT4

SANT3.1. During the last 6 months, did you benefit from one of these proposed interventions by specialized services?

- Nursing or medical care
- Psychology or psychiatry care
- Testing
- Treatment for addiction, pharmacological treatment
- Access to rights (administrative papers)
- Employment and training aid
- Housing and accommodation aid
- Distribution of injection equipment
- Education and support to injection (AERLI)
- Emergency hospitalization postal
- Other, specify

☐ NA ➤ Pass in question SANT4
☐ NR

SANT4. During the last 6 months, did you face difficulties for access or continuity of care?

- 0 No ➤ Pass in question DEP1
- 1 Yes ➤ Pass in question DEP1
- 98 NA ➤ Pass in question DEP1
SANT4.1 If yes, generally for you, what are the mains barriers to access and/or continuity of care?
- Financial issues (treatment or consultations are too expensive,)
- Opening hours of health services unsuitable for my schedules
- Administrative issues
- I do not know where to go
- Fear of discrimination
- Fear to be arrested or denounced
- Other, specify

12. Testing (DEP)

DEP1. Have you already had an HIV test?
- No
- Yes

DEP1.1. If yes, when was the last one?

If HIV+

DEP1.3. Currently, do you have a treatment for your HIV infection?
- No
- Yes

DEP1.4. If yes, since how long?

DEP2. Have you already had an HCV test?
- No
- Yes

DEP2.1. If yes, when was the last one?

DEP2.2. Are you, or have you been infected by HCV?
DEP2.3. Did you receive treatment for hepatitis C?

- 0 No ➞ Pass in question PRIS1
- 1 Yes, but you are cured ➞ only question DEP2.3 then PRIS1
- 2 Yes and you are still infected by HCV ➞ Pass in question DEP2.4
- 98 NA ➞ Pass in question PRIS1
- 99 NR ➞ Pass in question PRIS1

DEP2.4. If you have still hepatitis C, are you currently under treatment?

- 0 No ➞ Pass in question PRIS1
- 1 Yes ➞ Pass in question PRIS1
- 98 NA ➞ Pass in question PRIS1
- 99 NR ➞ Pass in question PRIS1

DEP 2.5.1 If yes, since how long?

/__/__/ month / year / week 98 NA 99 NR

13. Prison experience (PRIS)

PRIS1. During the last 6 months, how many times have you been in police detention (custody)?

/__/__/ time 0 Never 98 NA 99 NR

PRIS2. In your life, have you already been in prison?

- 0 No ➞ Pass in question ENT1
- 1 Yes ➞ Pass in question ENT1
- 98 NA ➞ Pass in question ENT1
- 99 NR ➞ Pass in question ENT1

PRIS2.1. If yes, when was your last detention?

- 0 Less than 6 months
- 1 between 6 and 12 months
- 2 between 1 and 2 years
- 3 More than 2 years
- 98 NA
- 99 NR

14. Environment (ENT) – Initiation into injection (IAI)

ENT1. Taking the last 6 months, how much of that time did you spend living with someone who is a drug user? (excepting alcohol and cannabis)?

- 0 all the time
- 1 Most of the time
• 2 Half of the time
• 3 Less than half of the time
• 4 Never
  □ 98 NA
  □ 99 NR

ENT2. Among the people that you see frequently, how many of them are drug users? (except your partner and excepting alcohol and cannabis)
• 0 None
• 1 Less than half
• 2 Almost half
• 3 More than half
• 4 All
  □ 98 NA
  □ 99 NR

IAI1. Have you already helped someone to do an injection who never did it?
• 0 No
• 1 Yes
  □ 98 NA
  □ 99 NR

IAI2. Have you already advised another user regarding his practice of injection?
  ▷ Pass in question IAI3
• 0 No
• 1 Yes
  □ 98 NA
  □ 99 NR
  ▷ Pass in question IAI3

IAI2.1 If yes, what did it concern? (Several choices available.)
  □ 0 His actions (too much wipe his instruments; badly position the bevel of the needle, etc.)
  □ 1 His hygiene (any disinfection of the point of injection, dirty hands for injection, etc.)
  □ 2 Re-used of equipment
  □ 3 other, specify……………………
  □ 98 NA
  □ 99 NR

IAI3. Did you inform another user regarding HIV/ HCV?
• 0 No
• 1 Yes
  □ 98 NA
  □ 99 NR
EUROSIDER PROJECT
FINAL REPORT
NOVEMBER 2019