EURO HRN
European Harm Reduction Network

Harm Reduction in Europe:
mapping coverage and civil society advocacy

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Acknowledgements

Harm Reduction in Europe: mapping coverage and civil society advocacy

Written by Claudia Stoicescu and Catherine Cook

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Abbreviations and Acronyms

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral treatment
ATS	Amphetamine-type stimulants
BMT	Buprenorphine maintenance treatment
CLAT	The Latin European Harm Reduction Conference
CSOs	Civil society organisations
DCR	Drug consumption room
EuroHRN	European Harm Reduction Network
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GP	General practitioner
HAT	Heroin-assisted therepy
HBV	Hepatitis B
HCV	Hepatitis C
HIV	Human immunodeficiency virus
IDU	Injecting drug use
MMT	Methadone maintenance treatment
NIROA	Non-injecting routes of administration
NSP	Needle-syringe exchange programme
OSF	Open Society Foundations
OST	Opioid substitution therapy
PED	Performance enhancing drugs
RTI	Route transition interventions
TB	Tuberculosis
UNICEF	United Nations Children's Fund
UNODC	United Nations Office for Drugs and Crime
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organisation

Foreword by João Castel-Branco Goulão

In the late 1990s Portugal was faced with serious challenges in relation to problematic drug use and drug dependency. Action was required and a number of innovative measures were adopted to meet these challenges. In particular, there was a focus on those people who, for many reasons, including social marginalization, were not turning to conventional treatment services, or for whom those services were not effective.

In the first instance, it was necessary to address a main reason people may not want to come forward. Thus, a new law was adopted which decriminalized drug consumption and centres instead on the need for therapeutic evaluation, rehabilitation and reducing drug related harms.

This step led to the approval of a legal framework that emphasised comprehensive harm reduction interventions and which took effect with the Decree Law 183/2001 of 21st June.

Law reform alone, however, is not enough. The multi-faceted dimension of the issue and the interaction between diverse areas of public services (Protection Services, Education, Employment, Housing, amongst others) demand holistic approaches – and partnership. When it comes to harm reduction, civil society organizations, with their specific local knowledge and relationships with those most at risk, are often the most appropriate entities to implement these types of interventions.

This has long been recognized in Portugal and, over the past decade, the Institute for Drugs and Drug Addiction (Instituto da Droga e da Toxicodependência, IDT), has defined as one of its priorities the creation of the National Network of Harm Reduction by establishing partnerships with civil society organizations. According to an independent evaluation of Portugal's National Strategy in the Fight against Drugs (1999-2004), harm reduction, based on this partnership with civil society organizations, was considered one of the key strengths of the framework.

Today, the strategic response to drug-related harms in Portugal remains largely based on the creation of partnerships between the public and social sectors.

This public-social partnership (which also includes the private sector) has enabled positive results not just in relation to drug use or health harms, but across a wide range of important areas; and not just to individuals, but to communities:

- A reduction in drug-related crimes, and a greater sense of security in the community
- A reduction in discarded drug paraphernalia in the community
- A reduction in risk behavior and the subsequent reduction in the transmission of infectious diseases – central to our public health priorities
- Improved data quality and research on the prevalence and incidence of various infectious diseases among people who use drugs, which in turn informed programmes.

The constant dynamic interaction between the IDT and civil society organizations clearly translates into added value with gains for both sides. These gains are in turn fostering an increased knowledge and understanding of drug use and related harms in Portugal. It is a partnership that has informed the best means of intervention, and enabled partner organizations to achieve better results.

From an economic point of view, and considering the current financial crisis, the existence of this network of partners enables the implementation of a greater number of evidence-based solutions in the field, with a decreased cost burden to each entity given that costs are being spread amongst them.

I cannot, as President of the IDT and National Coordinator for issues involving Drugs, Drug Addiction and Alcohol Abuse, commend highly enough the fundamental role of civil society in reducing drug related harms for the benefits of individuals and society.

This report represents a window into where we are in addressing drug use and related harms, and which factors continue to challenges effective responses. It also provides a valuable insight into how civil society organisations are contributing to the reduction of drug related harms across Europe. To all policy makers and politicians who are as interested as I am in meeting the challenges we continue to face in relation to drugs, I urge you to read it, learn from it, and support this vital work.

João Castel-Branco Goulão

Introduction

1.1 WHAT IS THE EUROPEAN HARM REDUCTION NETWORK (EUROHRN)?

The European Harm Reduction Network, or EuroHRN, was formed in 2009 by ten civil society organisations with a shared interest in advocating for and sharing knowledge on harm reduction within Europe.

EuroHRN works to reduce the health and social harms related to drugs and the policy environment, by promoting the human rights and health of people who use drugs through collective advocacy, research and information exchange.

The overall objective of EuroHRN is to expand the knowledge base of harm reduction in Europe, raise awareness of drug-related harms, and promote and support public health and human rights based responses to drug use across Europe.

EuroHRN is comprised of three sub-regional networks (SRNs) covering North, South and Eastern Europe and managed by a coordinator based at Harm Reduction International (formerly known as the International Harm Reduction Association). The SRNs aim to establish a pool of local experts and contacts, engage in local advocacy opportunities, disseminate harm reduction news and information, and mobilise resources to support activities and ensure the sustainability of the network.

EUROHRN AIMS TO:

- Facilitate networking at European, sub-regional and national level
- Advocate for harm reduction in the European region
- Map the state of harm reduction and drug user organising in Europe
- Establish and promote models of meaningful participation of people who use drugs and their associations

1.2 AIMS AND OBJECTIVES OF THIS REPORT

This report presents the findings of the EuroHRN civil society audit, an activity aimed at collating existing epidemiological and service coverage data and consulting with experts in order to map key issues for harm reduction in Europe. This includes coverage of harm reduction interventions, policies and civil society advocacy priorities.

A complementary questionnaire was disseminated to focal points in each EuroHRN member country to understand the barriers to accessing these services at the national and local levels.

This activity aims to provide a snapshot of the current state of harm reduction across the region, provide a baseline for EuroHRN and civil society in the region and act as a regional advocacy and planning tool.

1.3 METHODOLOGY

The information collated in Sections 2 and 3 of this report was gathered using the latest existing data sources, including research and reports from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), multilateral agencies, international non-governmental organisations and expert opinion from civil society and drug user organisations working in the harm reduction field in Europe.

Countries and regions were identified based on the coverage and membership of the European Harm Reduction Network. [1]

1. See www.eurohrn.eu for more details.

Therefore, this report examines the sub-regions of Eastern Europe, North Europe and South Europe. Civil society focal points within each country were identified through consultations with the EuroHRN steering group and other key partners.

Unless otherwise indicated, statistical data was sourced from and peer reviewed by the EMCDAA. The chapters in Section 3 were peer reviewed by coordinators of the sub-regional networks and other experts in the field (see Acknowledgements).

In addition to secondary data, a qualitative questionnaire[2] examining harm reduction policies, interventions, barriers to service access and scale up and national advocacy priorities was disseminated to civil society focal points in each of 36 countries between November 2010 and January 2011. Responses from 28 countries were returned (see sub-regional chapters for more details) within the timeframe provided.

1.4 LIMITATIONS

This report aims to provide a snapshot of harm reduction programmes, barriers to access and advocacy priorities for EuroHRN member countries, and as such has several limitations. It does not provide a systematic overview or evaluation of service coverage and quality implemented in the region. Qualitative responses and anecdotal data gathered through the questionnaires disseminated to national civil society focal points aim to provide some indication of potential barriers to service access, scale up and quality, as well as suggest directions for further research and advocacy by EuroHRN, its partners and member countries.

This report draws heavily on data collected by the EMCDDA on the epidemiology of drug use and coverage of key harm reduction interventions in Europe. The data presented here represents the most reliable estimates currently available; however, lack of uniformity in measures, data collection methodologies and definitions renders cross-national comparisons challenging. Any limitations on reliability are indicated within the text. The significant data gaps point to the need for improved monitoring and evaluation systems and data reporting on these issues in some parts of Europe.

Where information is gathered through the civil society focal points, this is indicated within the text.

1.5 STRUCTURE OF THE REPORT

Section 1 provides a brief introduction to the EuroHRN and to the information presented in this report.

Section 2 comprises four parts. The first two, Drug use and Drug-related harms, provide a general overview of the most recent data on drug use trends and selected drug-related harms in the region. The third part summarises findings on harm reduction coverage, barriers to service access and scale up across the region, as well as emerging advocacy issues for Europe. Finally, advocacy priorities for civil society emerging out of this exercise are presented for Europe and for the three sub-regions.

Section 3 presents region- and country-specific findings for each of the sub-regions covered by the EuroHRN: Eastern Europe, North Europe and South Europe. Within each sub-regional chapter, text boxes highlight relevant emerging issues and innovative harm reduction practices in the region.

2. The questionnaire is available online at www.eurohrn.eu or by writing to eurohrn.audit@ihra.net.

2. DRUG USE, DRUG-RELATED HARMS AND HARM REDUCTION IN EUROPE

HARM REDUCTION IN EUROPE: PAST, PRESENT AND FUTURE

Harm reduction programmes emerged in Europe during the 1980s in response to HIV and Hepatitis C epidemics among people who inject drugs. Programmes such as needle and syringe exchange (NSPs) and opioid substitution treatment (OST) spread rapidly across Europe and beyond. Within a decade, such programmes had gained broad acceptance and were being implemented across much of Europe and elsewhere. Soon after, harm reduction approaches became an integral component of the European Union's drug strategy.

Three decades later, in 2011, Europe is still the birthplace of many innovative harm reduction practices, and European countries feature among those with the highest coverage of harm reduction programmes in the world. Several European countries have seen dramatic reductions in HIV prevalence among people who inject drugs, which has been attributed to the early implementation and scale up of harm reduction programmes. These successful outcomes have formed the basis of UN targets for harm reduction programme coverage.

However, harm reduction in Europe is by no means universal: in some countries the programmes are too small to have a measureable impact on drug-related epidemics; in other parts of the region long-standing harm reduction programmes are under threat. A concerted effort from the harm reduction community and policy makers will be needed to protect and improve harm reduction responses across Europe in the face of economic hardship, austerity and cuts.

Table 2.1: Drug injecting and related harms in Europe[i]

Country or territory	People who inject drugs[1]	Prevalence of injecting drug use in the adult population (rate per 1000 in ages 15-64)[2]	HIV prevalence among people who inject drugs (%) [3]	Hep C prevalence among people who inject drugs (%)[4]	Hep B (HBsAg) prevalence among people who inject drugs (%) [5]	Prevalence of drug injecting among prisoners (%) [6]	HIV prevalence among prisoners who inject drugs (%)[7]	Hep C prevalence among prisoners who inject drugs (%)[7]	Hep B (HBsAg) prevalence among prisoners who inject drugs (%)[7]	Drug related deaths[8]
North Europe										
Austria	12,000 – 23,000*	2.19 – 4.19*	1.0-10.7	47.1 – 52.6						169
Belgium	23,200 – 28,400*	3.46 – 4.24*	3.3 – 6.4 (S)	27.0 – 82.7 (S)	1.9 – 4.0 (S)	4.0	0.3 (Flemish) 1.1 (French)*	17.4(S) * (Flemish) 27.7(S) (French)	2.2* – 5.4	
Denmark	10066-16821	2.8-4.7	2.1	52.5			0.0*	85.0*(S)		211
Finland	12200 - 19700	4.5	0.1 – 1.3	21.4 – 56.4			0.1	21.4		169
Germany	78,000 – 110,500[b]	1.4 – 2.0[b]	3.4	75 (S)		22.0	1.4 - 18*(S)	82.5*(S)		1449
Ireland	4,694 – 7,884*	2.0 – 3.37*	12.5 (S)	72.3 (S)	0.0 (S)		3.5 - 5.8[c] *	71.7*-81.3*		185
Luxembourg	1253-1919	3.9-6.0	1.8	71.8 – 90.7	3.9	31.0	4.3*	90.7		10
Netherlands	2211 - 4321	0.29	1.7 – 8.2 (S)	64.6 – 86.2 (S)						129
Norway	8,599-12,038	2.7-3.8	2.8	74.1	1.2 (S)					275
Sweden	29,513[d]	4.9[d]	0.0 – 8.4(S)	32.1 – 88.2(S)	60.1 (S)		0.0- 7.7(S)	32.1 - 80.3(S)	60.1(S)	232
Switzerland	33,000[9]	6.5* [e 9]	1.4 [9]							
United Kingdom	139,365-149,154	3.4-3.7	1.5 [f] (England, Wales and Northern Ireland) 0.55 (Scotland)[10]	47.0[f] (England, Wales and Northern Ireland) 55.0 (Scotland)[10]	17.0 [f g] (England, Wales and Northern Ireland)[10]	7.0[h] (S) (England) 3.0 (Scotland) 1.0 (England and Wales)	0.5* (England and Wales)	29.8* (England and Wales) 42.0* (Scotland)		2,368
South Europe										
Cyprus	341-642	0.6-1.1	0.0 – 1.6	29.2 – 50.0	0.0					11
France	122,000*	3.2*	5.1 – 8.0 (S)	41.7 (S)			13.3*(S)	53.2-91.0*(S)		333
Greece	6,882-9727	0.9-1.3	0.1 – 0.7	44.9 – 55.5	2.3 – 2.7		63.1*			110
Italy	326,000*	8.34*	11.7	59.2				64.2*(S)		502
Malta			0.0	33.1						7
Portugal	10,950-21,900	1.5-3.0	9.2 – 18.4	33.5 – 84.5	2.7 – 6.1	2.0	28.1*(S)	61.9*(S)		
Spain	83,972[b*]	3.12*	34.5	59.1 – 73.3 (S)		3.0	39.7	89.0 - 91.7* (S)		519

Country or territory	People who inject drugs	Prevalence of injecting drug use in the adult population (rate per 1000 in ages 15-64)	HIV prevalence among people who inject drugs (%)	Hep C prevalence among people who inject drugs (%)	Hep B (HBsAg) prevalence among people who inject drugs (%)	Prevalence of drug injecting among prisoners (%)	HIV prevalence among prisoners who inject drugs (%)	Hep C prevalence among prisoners who inject drugs (%)vii	Hep B (HBsAg) prevalence among prisoners who inject drugs (%)vii	Drug related deaths
Eastern Europe										
Albania										
Bosnia-Herzegovina										
Bulgaria	20,250[9]	0.4%[9]	2.2 (S)	57.5 (S)	5.5 (S)	8.0	0.0	17.9	11.6	74
Croatia	2,696-4,148	0.9-1.4	0.0	44.0	0.5		0.0	44.0	0.5	87
Czech Republic	30,000-32,400	4.1-4.4	0.1 – 0.6	11.7			0.4	52.0		44
Estonia	8,132-3,4443	8.9-37.1	54.3 – 89.9 (S)	89.2 – 90.5 (S)						67
Hungary	2,069-5,813	0.3-0.8	0.0	22.6	0.5	0.2		11.5 (S)		27
Latvia			22.6 (S)	74.4 (S)		10.0				24
Lithuania	5,000[9]	0.22[9]	0.6 – 9.7 (S)	70.3 – 89.7 (S)	3.3 – 8.9 (S)					60
Macedonia										
Montenegro										
Poland			9.2	47.3 – 64.0 (S)	1.2 – 8.5 (S)	3.0				214
Romania	17, 767[d] (S) [11]	18 [i 11]	1.1	60.2 – 65.6 (S)	11.5 (S)					33
Serbia										
Slovakia	13,732-34,343	3.5-8.9	1.0 (S)	50 (S)						25
Slovenia	7,320	5.4	0.0	22.3						36

(S) indicate that an estimate is based on sub-national data. * indicates that an estimate is from 2000 or earlier.

a. Figures represent national estimates unless otherwise indicated. (S) indicate that an estimate is based on sub-national data. * indicates that an estimate is from 2000 or earlier.
b. Estimate based on opioid injecting only
c. Estimate includes ever-IDUs and non-IDUs
d. There is no available figure for injecting drug use. This estimate is based on problematic drug use, which includes injecting drug use.
e. To standardise the estimated prevalence (%) of IDU among the general population aged 15-64 years as reported by Mathers et al. (2008) (0.65%) to the rate per 1000 (6.5), the figures were multiplied by 10.
f. Estimate based on current and former injectors
g. Proportion of hep B antibody positive
h. Estimate based on female prisoners only.
i. Estimate based on adult population 18-49 years old.

1. European Monitoring Centre on Drugs and Drug Addiction (2010) Statistical Bulletin: Table PDU – 102 – part ii Injecting Drug Use.
2. European Monitoring Centre on Drugs and Drug Addiction (2010) Statistical Bulletin: Table PDU – 102 – part ii Injecting Drug Use.
3. European Monitoring Centre on Drugs and Drug Addiction (2010) Statistical Bulletin: Table INF-1. Prevalence of HIV infection among injecting drug users in the EU, 2008 or most recent year available.
4. European Monitoring Centre on Drugs and Drug Addiction (2010) Statistical Bulletin: Table INF-2. Prevalence of HCV antibody among injecting drug users in the EU, 2008 or most recent year available.
5. European Monitoring Centre on Drugs and Drug Addiction (2010) Statistical Bulletin: Table INF-3. Prevalence of markers for HBV infection among injecting drug users in the EU, 2008 or most recent year available.
6. European Monitoring Centre on Drugs and Drug Addiction (2010) Statistical Bulletin: Table DUP-4. Prevalence of injecting drug use within prison among prisoners, 2000–08.
7. European Monitoring Centre on Drugs and Drug Addiction (2010) Statistical Bulletin: Table INF-117. Prevalence of HIV, HCV and HBV among drug users in prison, 1991 to 2008.
8. European Monitoring Centre on Drugs and Drug Addiction (2010) Statistical Bulletin: Table DRD 1 – part ii Numbers of drug-induced deaths and toxicology, 2008 or last year with available information.
9. Mathers, B., L. Degenhardt, et al. (2008). "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review." The Lancet 372(9651): 1733-1745.
10. Health Protection Agency (2010) Shooting Up: Infections among Injecting Drug Users in the UK 2009: An update: November 2010. London
11. Reitox National Focal Point in Romania (2010) Romania: New Developments, Trends and In-Depth Information on Issues of European Interest.2010. National Report to the European Monitoring Centre on Drugs and Drug Addiction.

2.1 DRUG USE

The use of illicit psychoactive substances in Europe is well researched in comparison with most other regions of the world. The most commonly used drugs are cannabis, cocaine (including crack cocaine and its derivatives), ecstasy, amphetamine-type stimulants, and opioids (see table 2.2 for more information). Current and emerging concerns in the European drug use landscape include increasing numbers of cannabis and stimulant users seeking treatment, increasingly complex patterns of poly-drug use (often including alcohol), and the emergent and unique service needs of an aging opioid user population.[14]

Injecting remains a common route of drug-taking for both opioids and amphetamines with the largest user groups located in Italy, France, Spain, the UK and Germany. The largest user groups as a proportion of the population are found in Romania, Estonia and Italy (see table 2.1 for more information).

Despite their relative strength, European drug use monitoring systems retain a number of significant knowledge gaps in areas such as vulnerable subpopulations (e.g. migrants, street-involved people and young people). For example, the emphasis on school-based surveys for gathering information on young people's drug use omits those outside or excluded from mainstream education. Data collection also tends to focus on lifetime use or last yearly use of a substance, rather than more useful indicators for measuring specifically harmful patterns of use.[1] Several countries remain heavily reliant on service or treatment data which masks the needs of those who cannot or do not access these services. The absence of clear and accurate drug use data hampers the effective targeting of harm reduction programmes.

2.2 DRUG-RELATED HARMS

Drug-related harms can be social, economic or medical and affect individual users as well as families and communities. Among the most serious health-related harms are overdose and infectious diseases, particularly via injecting drug use.

Overdose

Over the past decade Europe has seen between 6,400 and 8,500 overdose deaths per year.[2] In 2007 Germany and the UK accounted for over half of Europe's reported drug-related deaths,[x] while the highest drug-induced mortality rates among 15-64 year olds are found in Norway, Estonia, Ireland, Denmark, Finland and the UK – all above 40 deaths per million per year.[3] Drug-related deaths account for approximately 4% of deaths among Europeans aged 15-39 years old; opioids are identified in three-quarters of these cases.[16] A number of risk factors have been identified including the mode and prevalence of drug use (e.g. opioid use, injection, poly-drug use), age, recent periods of detox (including prison sentences), and the ability to access health services. WHO-Europe recently published recommendations on overdose prevention and quality of care in prisons in response to evidence showing an increased overdose risk by recently released prisoners.[4] Non-fatal overdose, which is reportedly experienced by most opioid users, increases the risk of fatal overdose and is associated with several negative health outcomes.[5 6]

Improvements in the reliability of European data have led to a better understanding of overdose trends, and most countries have now adopted a case definition in line with the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA).[7] However, national differences in overdose reporting can still hamper inter-country comparisons.

Infectious diseases

The extent to which HIV, viral hepatitis and tuberculosis affect people who inject drugs varies dramatically among countries. The significant differences in HIV prevalence between Western and Eastern Europe have been attributed to a disparity in harm reduction responses. For example, early adoption of harm reduction measures in the Netherlands, Switzerland and the UK have led to a stable and relatively low national HIV prevalence among people who inject drugs.[8] In contrast several Eastern European countries are seeing growing epidemics associated with injecting drug use, often with co-infections of HIV, hepatitis C and/or TB.[18]

There is a lack of data on the impact of infectious diseases on prisoners in Europe, but alarming rates of HIV in Southern European prisons and hepatitis C prevalence in numerous prison populations point to an urgent need for action (see table 2.1 for more details).

x The EMCDDA definition of drug-induced deaths or drug-related deaths refers to 'people who die directly due to use of illegal substances, although these often occur in combination with other substances such as alcohol or psychoactive medicines. These deaths occur generally shortly after the consumption of the substance.'

Table 2.2: Drug use in Europe[14]

Substance	Last year use	Last month use
Cannabis	about 23 million European adults (6.8 %) or a third of lifetime users	about 12.5 million Europeans (3.7 %)
Cocaine	4 million European adults (1.3 %) or a third of lifetime users	around 2 million (0.5 %)
Ecstasy	about 2.5 million (0.8 %) or a quarter of lifetime users	nk
Amphetamines	around 2 million (0.6 %) or a sixth of lifetime users	nk
Opioids	People who use opioids 'problematically': estimated at between 1.2 and 1.5 million Europeans	Principal drug in more than 50 % of all drug treatment requests About 670 000 opioid users received substitution treatment in 2008

2.3 SUMMARY OF FINDINGS: HARM REDUCTION RESPONSES, BARRIERS AND CIVIL SOCIETY ADVOCACY PRIORITIES

Coverage of harm reduction programmes

Thirty-six countries in the region are known to implement NSPs and OST, with five also providing heroin-assisted treatment (HAT).[20] Five countries have NSPs and 23 offer OST in prisons and other places of detention. However, provision of harm reduction services in these settings continues to lag behind provision in the wider community, especially in South and Eastern Europe (see section 3 for more details).

Europe is home to the largest number of drug consumption rooms (DCRs) in the world. Approximately 60 are in operation in 36 European cities, mostly in North Europe.[xi] [9] The introduction of DCRs in most of Eastern Europe faces significant political opposition, with most CSOs in that region still advocating for the implementation and expansion of the most basic harm reduction interventions.

Barriers to NSPs in Europe include limited or nonexistent coverage outside major cities, restricted opening hours, and admission criteria such as age restrictions.[10] In Eastern Europe additional barriers include fear of police harassment and arrest, perceived stigma, lack of secure funding and political opposition.[21] Access to OST is similarly restricted by lengthy waiting lists, strict admission criteria, and a lack of national evidence-based standards for OST provision and quality of care. Across Europe the populations at greatest risk of exclusion from harm reduction services are women, young people and migrants.[21]

HIV, viral hepatitis and tuberculosis services

In November 2010 the EMCDDA reported that uptake of HIV, viral hepatitis and tuberculosis testing remains low in many European countries, and released a set of guidelines for testing for blood-borne infections among people who inject drugs.[11] According to CSOs in Europe the requirement to be drug-free as a prerequisite for access to treatment presents a significant barrier to take-up of testing and treatment services for HIV, hepatitis C and TB.[21] The cost of HCV treatment remains prohibitive for some subpopulations such as migrants, as do limited integration of services and weak referral systems, particularly outside of major cities.[21] A highly effective integrated response to HIV, hepatitis and tuberculosis responses, including prevention, diagnosis and treatment services, is recommended by several international agencies[xii] for people who use drugs both in the community and in prison.[5] [8] [12]

Overdose responses

Naloxone is a highly effective, side-effect free intervention for the prevention and management of overdose, but availability is poor and peer-distribution remains controversial.[xiii] [13] [14] Peer distribution of naloxone

xi Two pilot projects of medically supervised injecting centres also operate in Australia and Canada.

xii The package and recommendations were developed by WHO, UNODC in 2009 and have since been enshrined in the political declaration and plan of action of the Commission on Narcotic Drugs (CND) and an ECOSOC resolution in 2009.

xiii Naloxone reverses the effects of opioids (including heroin), particularly the respiratory depression that leads to death in case of overdose.

can bypass barriers to formal medical care, such as fear of arrest and discrimination.[9] [27] Peer distribution of naloxone is reported only in Spain, Denmark, Italy and to a limited extent, France and the United Kingdom. In most countries in the region naloxone is only authorised for use by medical staff in emergency units.

Harm reduction in recreational settings

Amphetamine-type stimulants (ATS) are reported to be widely used by young people aged 15–34 years in recreational settings across the region, but there is a lack of disaggregated data to distinguish between recreational use and more problematic patterns.[15] Pill testing, particularly on-site within nightlife settings, has been employed to detect adulterants and new synthetic drugs, thereby reducing potential harms.[16] This intervention remains controversial and has been reported to be "steadily less common in Europe."[40] The majority of programmes related to recreational drug use remain unevaluated, and few syntheses of evidence addressing young people's recreational use have been conducted to date. [15] [40] Interventions such as outreach, counselling, and information, education and communication (IEC) materials are provided by CSOs in a majority of countries in North and South Europe and nearly half of Eastern European countries. Pill testing is implemented to varying degrees in Austria, Germany, Switzerland, Denmark, Norway, Spain and the Netherlands.[21]

Drug user involvement in harm reduction responses

Meaningful involvement of people who use drugs in service design, implementation, monitoring and evaluation is generally scarce across Europe. Levels of engagement are assessed using the "pyramid of involvement" model which outlines a range of increasingly-involved roles for people who use drugs from passive target audiences to tokenistic speakers or representatives, and finally to equal participants in decision-making bodies. [17] Three forms of user involvement have been described: individual-level involvement in the work of CSOs; organisational-level involvement in the form of participation in consultations, decision-making and policy-making bodies; and drug user organising around autonomous groups who work toward self-determined agendas.

In most countries in Europe user representation occurs at individual and program levels only. Representation is generally tokenistic or consultative, with former and occasionally active users engaging with services as peer educators, NSP assistants, outreach workers and other "gatekeepers." In the Netherlands, where user-led groups pioneered harm reduction initiatives in the 1970s, CSOs report that most user-led initiatives are dormant or no longer directly involved in service development.[18]

Across the region, barriers to participation include the limited capacity of the few existing user-run organisations to engage in advocacy, the criminalisation of drug possession, and the high levels of perceived stigma against people who use drugs.[4] CSOs across Europe have highlighted the need to consolidate and strengthen existing user groups, raise public awareness and exchange best practices around effective and meaningful user involvement in service design, implementation, monitoring and evaluation.[4]

2.4. EMERGING ADVOCACY ISSUES FOR EUROPE

Despite long-standing support for harm reduction in parts of Europe, this regional consensus is under threat from political changes, financial hardship and a growing emphasis on abstinence-based treatment and supply reduction. While there is widespread acceptance of NSPs and OST across Europe, other interventions remain controversial. These include DCRs, HAT and prison-based NSPs, as well as innovative responses to overdose and drug use in recreational settings, particularly in South and Eastern Europe. There is an urgent need to scale up access to harm reduction services and to integrate them into existing services including primary healthcare, low-threshold service centres, sexually transmitted infections (STIs) clinics and prison healthcare facilities.[xiv]

Although most countries in Europe make explicit reference to harm reduction in their national policy documents,[19] this does not imply consistent financial support. International funds, largely via The Global Fund, have supported the scale-up of service provision across Eastern Europe in the past decade and remains the major funder for harm reduction in the region. Between 2003 and 2009, The Global Fund has provided over $29.9 million for harm reduction in 7 countries. The principal challenge to harm reduction programmes in Eastern Europe is the unwillingness of many national governments to supplement service provision needs if countries become ineligible for international funds

xiv New EMCDDA guidelines recommend that health providers initiate examination, testing and counselling in IDUs in a variety of healthcare settings including primary healthcare, low-threshold service centres, rehabilitation centres, sexually transmitted infections (STIs) clinics and prison healthcare facilities.

and other international contracts.[21] In other countries where national governments co-finance harm reduction programmes CSOs have reported that this support is insufficient to scale-up service coverage adequately.

Finally, it is important that services which have made an impact on epidemics in North and South Europe are sustained and supported to deliver effective HIV, viral hepatitis and TB prevention, treatment and care. The sustainability and scale up of evidence - and human rights-based harm reduction interventions in the face of financial austerity and cuts to services is a challenge that will require a concerted effort from stakeholders across the region. Without these efforts the gains made by harm reduction in Europe could be lost.

CIVIL SOCIETY ADVOCACY PRIORITIES

A key outcome of the audit was to identify advocacy priorities for each of the European sub-regions. In addition to this, several cross-cutting priorities for advocacy emerged across the European region:

- Scale up evidence-based harm reduction services such as NSPs and OST, particularly outside of major cities, and in prisons and other places of detention
- Remove barriers to harm reduction service access, particularly for the most marginalised groups including young people, illegal migrants and women
- Effectively integrate testing and treatment services for HIV and AIDS, viral hepatitis and tuberculosis within drug treatment services
- Expand availability and peer access to naloxone for overdose prevention
- Challenge stigma and discrimination against people who use drugs

Within each of the sub-regions, civil society organisations identified advocacy priorities particularly relevant to each regional context:

EASTERN EUROPE

- Ensure adequate and secure funding for harm reduction programmes from national governments
- Reorient drug policies to reflect evidence-based public health and human rights-based approaches, including decriminalising drug use for personal possession
- Implement evidence-based harm reduction services, particularly NSPs, and scale up provision of OST in prisons and other places of detention
- Scale up provision of current NSP and OST programmes in the community

NORTH EUROPE

- Ensure that adequate harm reduction services remain part of national policy agendas
- Increase access to social support and housing services for people who use drugs
- Improve integration of testing and treatment services for HIV, viral hepatitis and tuberculosis
- Develop existing civil society networks for people who use drugs

SOUTH EUROPE

- Implement evidence-based harm reduction services, particularly NSPs, and scale up provision of OST in prisons and other places of detention
- Implement and scale-up drug consumption rooms (DCRs)
- Increase integration of harm reduction interventions, including overdose prevention programs and safer nightlife initiatives, testing and treatment services for HIV, viral hepatitis and tuberculosis within national public health goals
- Improve the meaningful involvement of people who use drugs in service design, provision, monitoring and evaluation.

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4. European Monitoring Centre on Drugs and Drug Addiction (2010) Statistical Bulletin: Table INF-2.Prevalence of HCV antibody among injecting drug users in the EU, 2008 or most recent year available.
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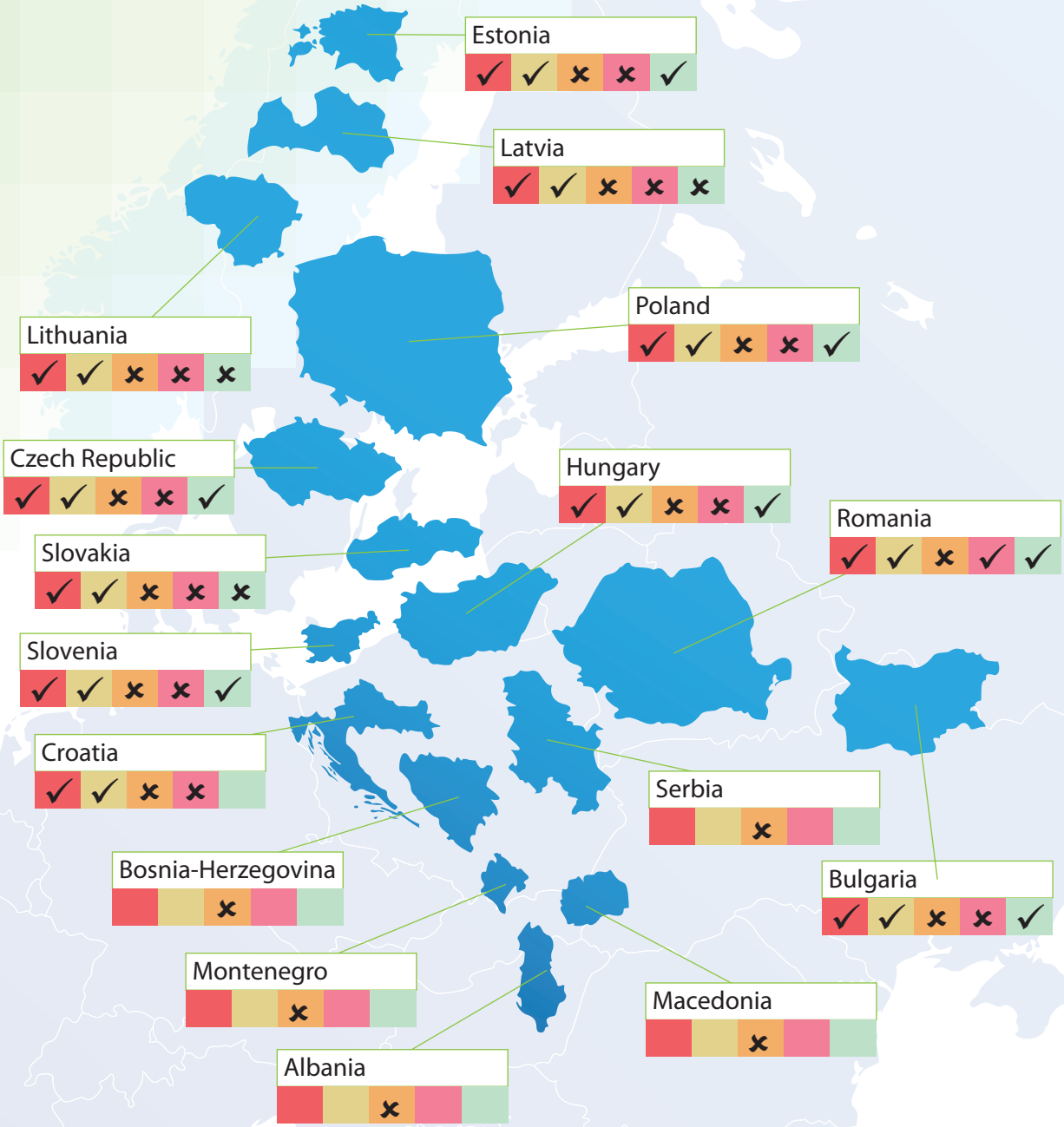
3.1 EASTERN EUROPE

- ALBANIA
- BOSNIA-HERZEGOVINA
- BULGARIA
- CROATIA
- CZECH REPUBLIC
- ESTONIA
- HUNGARY
- LATVIA
- LITHUANIA
- MACEDONIA
- MONTENEGRO
- POLAND
- ROMANIA
- SERBIA
- SLOVAKIA
- SLOVENIA

Availability of harm reduction interventions in Eastern Europe



- Needle and syringe exchange
- Opioid substitution therapy
- Drug consumption rooms
- Prison needle exchange programme
- Prison opioid substitution therapy

Table 3.1.1: Availability and coverage of harm reduction interventions in Eastern Europe

Country Or Territory	NEEDLE AND SYRINGE EXCHANGE PROGRAMME			OPIOID SUBSTITUTION THERAPY			Drug Consumption Rooms[1]	Prison Needle Exchange Programme Existence[2] and Availability[3]	Prison Opioid Substitution Treatment Availability,[a 4] Initiation (I) and Continuation (C)[5]
	Availability, Syringe Vending Machine (S), And Pharmacy Based NSP (P)[6]	Number of sites[7]	Syringes distributed annually through specialised sites per person injecting drugs[b 8]	Availability and form[c 9]	Number of sites[10]	% opioid users receiving OST[11]			
Albania		3			1		No		
Bosnia-Herzegovina		6			6-8		No		
Bulgaria	Yes	100		Yes (M, BN, SM)	17		No	No	Yes (C)
Croatia	Yes (P)	42	79 (62 – 95)	Yes (M, B)			No	No	
Czech Republic	Yes	109	149 (143 – 155)	Yes (M, B, BN)	47	35 (33 – 38)	No	No	Yes, limited (I, C)
Estonia	Yes	36	144 (58 – 246)	Yes (M, B[d])	8		No	No	Yes (C)
Hungary	Yes (S)	25	76 (51 – 144)	Yes (M, BN)	13		No	No	Yes, rare (I, C)
Latvia	Yes	13-22	18 (13 – 26)	Yes (M, B)	1-9		No	No	No
Lithuania	Yes	10-19		Yes (M, B)	14-18	9 (9 – 9)	No	No	No
Macedonia		15			9		No		
Montenegro		18					No		
Poland	Yes	27		Yes (M, BN)	22	6 (5 – 6)	No	No	Yes, rare (C)
Romania	Yes	49		Yes (M, B, BN)	6-8		No	Yes, rare	Yes (I, C)
Serbia		13			14		No		
Slovakia	Yes (P)	20	14 (7 – 19)	Yes (M, B[e], BN, SM)	12	5 (3 – 7)	No	No	No
Slovenia	Yes	17		Yes (M, B, BN, SM)	20		No	No	Yes, full (I, C)

a. Full: substitution/maintenance treatment exists in nearly all prisons
Extensive: exists in a majority of prisons but not in nearly all of them
Limited: exists in more than a few prisons but not in a majority of them
Rare: exists in just a few prisons

b. Data is from 2008 or most recent year available.

c. M = methadone; B = High-dosage buprenorphine; H = Heroin assisted treatment; BN = Buprenorphine-naloxone combination; SM = Slow-release morphine.

d. Legally available but no reported clients.

e. Legally available but no reported clients.

1. European Monitoring Centre on Drugs and Drug Addiction (2010) Drug consumption facilities in Europe and beyond, in Harm Reduction Monograph: Harm reduction: evidence, impacts and challenges.
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Harm Reduction in Eastern Europe

The authors would like to acknowledge the contributions of the following organisations in providing information for their respective countries:[a]

Stop AIDS Association (Albania), Association Margina (Bosnia-Herzegovina), Initiative for Health Foundation (Bulgaria), Udruga Terra (Croatia), Sananim (Czech Republic), Convictus Eesti (Estonia), The Hungarian Civil Liberties Union (Hungary), Labyrinth (Kosovo), Dialogs (Latvia), Coalition I CAN LIVE (Lithuania), Healthy Options Project Skopje (Macedonia), Juventas (Montenegro), Polish Drug Policy Network (Poland), Romanian Harm Reduction Network (Romania), Veza (Serbia), Odyseus (Slovakia), Stigma (Slovenia)

Across Eastern Europe, harm reduction approaches have become increasingly accepted and recognised in practice and at the policy level. Although harm reduction is explicitly mentioned as part of national health, drugs or HIV/AIDS strategies in all countries except Montenegro, service provision is overwhelmingly supported by international donors, particularly in non-EU member countries. NSP and OST service coverage varies widely among and within countries, remaining low in most countries for which data is available. There is no DCR or HAT provision in the region.

Harm reduction interventions are yet to be widely scaled up and adequately financed. Limited integration and coordination among low threshold drug services and HIV, viral hepatitis and tuberculosis testing and treatment remains a challenge in the majority of countries. Availability of harm reduction services in prisons and other closed settings is scarce and many programs remain in the pilot stage. Prison OST is provided in seven countries in the region, while NSPs are only available in five prisons in Romania. Naloxone for overdose prevention and management is available largely through emergency care units, but distribution is not permitted through peers or through harm reduction services such as NSPs and OST. Harm reduction interventions in recreational settings are limited to the provision of information, education and communication (IEC) materials, campaigns and peer outreach and are implemented in nearly half of the countries in Eastern Europe.

Across the region, meaningful drug user representation in service design, implementation, monitoring and evaluation occurs mostly at the programmatic rather than the organisational or policy levels.

Continued civil society advocacy is crucial for increasing concrete support for harm reduction from national governments across Eastern to supplement the significant gap expected to emerge once countries become ineligible for international funds.

CIVIL SOCIETY ORGANISATIONS HAVE IDENTIFIED SEVERAL ADVOCACY PRIORITIES FOR THIS REGION. THESE INCLUDE:

- Ensure adequate, predictable funding for harm reduction programmes from national governments[b]
- Reorient drug policies to reflect evidence-based public health and human rights-based approaches, including decriminalising drug use for personal possession[c]
- Implement evidence-based harm reduction services, particularly NSPs, and scale up provision of OST, in prisons and other places of detention[d]
- Scale up provision of current NSP and OST programmes in the community.[e]

NEEDLE AND SYRINGE EXCHANGE PROGRAMMES (NSPs)

NSP sites operate in each of the seventeen countries and territories that comprise the Eastern Europe region (see table 3.1.1). Distribution of sterile injecting equipment is largely through fixed and mobile sites, including distribution through mobile vans and outreach workers. The only exceptions are Croatia and Slovakia, which also dispense syringes through pharmacy-based NSPs, and Hungary, which operates one syringe vending machine.[1]

NSP service provision varies widely across the region from ten or fewer operational sites in Albania, Bosnia-

a Questionnaire responses from Latvia, Serbia and Slovenia were not available at the time of writing.

b Bulgaria, Croatia, Lithuania, Macedonia, Romania, Slovakia.
c Albania, Bosnia-Herzegovina, Macedonia, Montenegro, Romania.
d Bulgaria, Lithuania, Czech Republic.
e Kosovo, Romania, Slovakia.

Herzegovina and Kosovo,[2] to 100 or more sites in Bulgaria and the Czech Republic.[3] Among the six countries where data exists, service coverage ranges from low in Croatia, Hungary, Latvia and Slovakia to medium in the Czech Republic and Estonia.[f] Data on the number of needles/syringes distributed per person injecting drugs per year is unknown for eleven countries in the region.[1]

Service provision varies within countries, and is particularly limited outside of major cities in Albania, Bulgaria, Croatia, Estonia, Kosovo, Lithuania, Macedonia, Montenegro, Romania and Slovakia.[4] The only exception is the Czech Republic, where NSP services are well-established across the country.[5] In Albania, Montenegro and Romania operational NSPs are only found in Tirana, Podgorica and Bucharest respectively, although some mobile units based in Podgorica also operate outside of the capital.[4] A newly-operational NSP site in Timisoara, Romania established in 2008 was recently closed after contact with the community of people who inject drugs was lost.[6]

Several factors limit the quality and effectiveness of existing NSP services in the region. Fear of police harassment and arrest was cited as an important barrier to service access for people who use drugs, particularly in Albania, Bosnia-Herzegovina, Bulgaria, Hungary and Romania.[4] In Croatia, syringes are available for purchase at pharmacies, but some pharmacists in rural areas refuse to sell needles and syringes to people who use drugs.[7] Discrimination by medical workers was cited as a barrier to service access in Montenegro, where the only operational NSP site is integrated within primary health services.[8] Political resistance and lack of predictable, long-term funding pose significant obstacles to sustaining current coverage levels and scaling up NSP services across the region.[g 4]

The absence of professional standards for harm reduction service workers,[9] incomplete national data on drug use,[6] lack of indicators for monitoring service quality and effectiveness[9] and lack of gender-focused programs[10] further limit the reach and quality of existing services. NSP services remain stigmatised among the general public in a majority of countries in Eastern Europe.[h 4] Sustained advocacy efforts are required to increase tolerance for this intervention at the local level.

f According to the WHO, UNAIDS and UNODC target-setting guide (2009), low NSP coverage is 100 needles/syringes distributed per injector per year, medium coverage is >100– 200 needles/syringes distributed per injector per year and high coverage is >200 needles/syringes distributed per injector per year. Due to the difficulties in determining the size of the population who inject drugs and NSP monitoring data, these estimates should be interpreted with caution.

g In Croatia and Slovakia, the government financially supports NSP services, but unpredictable funding threatens the sustainability of services.

h Kosovo, Bosnia-Herzegovina, Montenegro, Romania, Estonia, Slovakia, Lithuania, Hungary.

NEW DRUGS: ADVOCATING FOR EVIDENCE-BASED DECISION-MAKING IN ROMANIA

Valentin Simionov

The 'smart drugs' market in Romania first began to expand in 2007. Increasingly more synthetic drugs, largely cannabinoids, cathinones, piperazines and stimulants, have since been marketed online and subsequently in local 'smart shops' as air fresheners or bath salts. Reliable figures and data prevalence of use are not available.

Dramatic media coverage of hospitalizations attributed to new drugs and pressure from a reactive public pressed the government to implement strict measures to prohibit new drug production, distribution and consumption. In February 2010, the Government amended the legislation on controlled substances, initially adding 36 psychotropic plants and substances to the controlled substances list, and including another 6 shortly after. These measures had limited or no impact on the market. Retailers introduced new substances, which were not prohibited by the law, and increasingly more injecting heroin injectors switched to injecting synthetic stimulants due to their wider availability and legal status.

Further measures were taken in February 2011 with the government initiating a consultation at the ministry level, also involving civil society representatives. 'Control teams' were formed within the Ministry of Interior, Ministry of Health, Ministry of Finance, Ministry of Agriculture and the Office for Consumers Protection with the aim of reporting monthly on the new drugs situation. A growing number of municipalities have restricted selling licensing criteria with the aim of shutting down 'smart shops'. In some counties, for instance, smart shops cannot operate less than 2 km far from schools.

The Romanian Harm Reduction Network and partner organizations have argued against shutting down smart shops based on EU regulations on the free movement of merchandise within the EU territory. Human rights concerns have also emerged around the illegal processing of personal information from users by some municipalities in Bucharest. Civil society organizations in Romania continue to advocate for informed decision-making, emphasizing that control measures on new drugs must be based on evidence rather than public and media pressure.

OPIOID SUBSTITUTION THERAPY (OST)

All countries in Eastern Europe implement some form of OST (see table 3.1.1). Methadone maintenance therapy (MMT) is available in fourteen countries in the region.[11] Additional forms of OST, such as high-dosage buprenorphine (BMT) are available in ten countries,[12] buprenorphine-naloxone combination in seven countries, and slow-release morphine in three countries.[13]

Service provision varies across the region, from less than 10 sites in Albania, Bosnia-Herzegovina, Estonia, Latvia, Macedonia, and Romania to between 10 and 20 sites in Bulgaria, Hungary, Lithuania, Serbia, Slovakia and Slovenia.[3] The exceptions are Poland, where 22 sites provide OST for 6 (range 5-6) per cent of opioid users, and the Czech Republic, where 47 sites[3] provide OST for 35 (range 33-38) per cent of opioid users in the country.[14] Service coverage data (percent of opioid users receiving OST) are unavailable for the majority of countries in the region.

There are several challenges to OST access and provision in most countries.[i 4] Service access is restricted by fear of stigma,[j] long waiting lists,[k] age restrictions[l] and a lack of evidence based standards for OST provision and quality of care, particularly for women who use drugs.[15] In Hungary, Macedonia and Montenegro, reported shortages of trained medical professionals willing to staff drug services further limits OST scale up, as well as the quality of existing services.[4] In Bulgaria and Montenegro, fees for accessing OST are reported to deter some people who use drugs from accessing the service. The few free OST programs that are implemented in Bulgaria prioritise people who use drugs living with HIV and pregnant women.[15] Start up of OST in Kosovo was pending approval from the Ministry of Health at the time of publication, with waiting lists already in existence. However, rollout is not expected until 2012.[2]

Across the region, lack of political support and limited state funding for OST is a barrier to service quality and scale up.[m] There is an urgent need to strengthen advocacy efforts with national and local governments in the region.

i Albania, Czech Republic, Hungary, Bulgaria, Lithuania, Slovakia, Estonia, Romania, Montenegro, Macedonia, Bosnia-Herzegovina, Albania.

j Lithuania, Macedonia, Montenegro.

k Montenegro, Romania, Albania, Kosovo.

l Estonia, Montenegro and Romania.

m Particularly in Albania, Czech Republic, Hungary, Kosovo, Lithuania and Romania.

DRUG CONSUMPTION ROOMS (DCRs)

There are no countries in Eastern Europe that implement DCRs.

Across the region, legal and political barriers and lack of sustainable funding for existing harm reduction interventions such as NSPs and OST mean that implementation of DCRs remains controversial. The Czech Republic is the only country in the region where implementation of DCRs was reported to be a concrete advocacy priority for civil society.

HIV, VIRAL HEPATITIS AND TUBERCULOSIS (TB) SERVICES

HIV testing and treatment services

Free, universal access to voluntary counseling and testing (VCT) and antiretroviral treatment (ART), including for people who use drugs, is reported to be widely available in Bosnia and Macedonia.[4] However, across the region, access and take up of HIV testing and treatment services are restricted by several factors. Barriers include limited awareness among people who use drugs about the availability of testing sites,[n] confidentiality concerns around the disclosure of test results,[o] restricted hours of operation at existing testing facilities,[p] insufficient availability/provision of testing services[q] and stigma associated with a positive HIV test result.[r 4] In Albania, the lack of rapid finger-prick or saliva tests for HIV is reported to deter some people who inject drugs that may have vein problems from seeking a test.[16] Although VCT is provided at a cost in public health care centres in Romania, free access to VCT is only available in the community through NGOs in Bucharest and within prisons.[6] Provision of VCT by CSOs and outreach teams remains controversial in Slovakia and Estonia, where there remains a need to further diversify means of provision.[4]

Data on the extent of ART coverage among people who inject drugs (i.e. numbers and ratios of people who inject drugs living with HIV that are receiving ART) are largely unknown for most countries in the region.[17] ART is free to all people who use drugs that are living with HIV irrespective of drug use status in Croatia,[18] Hungary,[19]

n Bulgaria.

o Croatia.

p In Slovakia, for instance, The National Reference Centre offers VCT services over two hours for two days a week, and there are only two NGOs in the country that offer this service.

q Kosovo. Hungary. For instance, Hungary implements occasional HIV testing campaigns, but there is no permanent availability of VCT testing services at fixed sites.

r Kosovo.

Serbia, Bosnia, Kosovo, Macedonia and Romania. However, the extent of service take-up is unknown.[4] In some countries in the region, barriers to ART access for people who use drugs are posed by complex administrative procedures from diagnosis to treatment start-up,[s] and stigma and discrimination against people who use drugs that are living with HIV by health care workers and GPs.[t 4]

Viral hepatitis testing and treatment services

Among countries where data is available, only Romania, Slovenia and Slovakia implement hepatitis B vaccination programmes targeted at high-risk groups including people who use drugs.[20] HBV vaccination programs in prisons are implemented in Estonia, Lithuania and Slovenia.[27]

In several countries across the region,[u] eligibility criteria that includes abstinence for several months prior to commencing Hepatitis C (HCV) treatment poses an obstacle to access for people actively injecting drugs.[4] In Serbia, people who use drugs must be abstinent for one year prior to starting treatment.[21] Treatment is also inaccessible to people who use drugs that do have health insurance in Bulgaria and Slovakia.[4] Additional barriers cited by CSOs across the region include limited HCV testing options (i.e. using rapid tests),[v] weak national surveillance systems for HBV and HCV among people who inject drugs,[w] inadequate knowledge of the transmission modes and risks associated with HCV among people who use drugs,[x] lack of funding for HCV as compared with resources for HIV prevention and treatment,[y] high treatment costs,[z] stigma associated with an HCV diagnosis[aa] and weak referral systems between GPs and drug services.[ab]

Tuberculosis testing and treatment services

Barriers to TB testing and treatment access among people who use drugs were reported in some countries in the region. These include weak referral systems,[ac] eligibility criteria for accessing treatment[ad] and limited coordination between drug services and other health institutions[ae] as well as between government and CSOs.[af] People who use drugs in Romania are not included in routine TB testing or in national data collection on TB prevalence.[6] In Slovakia, the NGO Odyseus has recently introduced low threshold HIV/TB testing for marginalized groups, including migrants who use drugs through its outreach work.[ag]

Strong referral systems among HIV, HCV and TB services were reported in Albania, Bosnia, Bulgaria, Croatia, Czech Republic, Hungary and Macedonia.[4]

HARM REDUCTION IN PRISONS

Availability of harm reduction interventions in prisons is very limited across Eastern Europe (see table 3.1.1). Romania is the only country in the region that implements NSPs in five prisons with technical and financial support from UNODC.[22]

Prison OST is confirmed in seven countries, but service coverage varies widely among and within countries.[23] Some degree of provision is reported in prisons in Croatia[7] and pre-detention trial units in Albania, although OST is not available as an integral part of health services in Albanian prisons.[16]

The Czech Republic, Hungary, Romania and Slovenia provide initiation and continuation of OST in prisons to varying degrees (see table 3.1.1).[24] Continuation of OST in prison is available in Bulgaria, Estonia, Poland and Montenegro[8] if the inmate was already enrolled in OST prior to arrest.[23] MMT start up in Kosovo prisons is planned to begin after 2011.

Barriers to implementation and scale up of harm reduction interventions in prisons include lack of political will,[ah] denial of the existence of drug use in prisons,[ai] shortages of staff for medical services within prisons,[aj] lack of funding and data gaps on the extent of drug use in prisons across the region.[ak 4]

s Bulgaria
t Slovakia.
u Albania, Bulgaria, Hungary, Macedonia, Montenegro, Romania, Slovakia and Serbia.
v Croatia.
w Estonia.
x Kosovo.
y Kosovo.
z Macedonia.
aa Montenegro.
ab Montenegro, Romania.
ac Kosovo, Romania.
ad Slovakia.

ae Albania.
af Bosnia.
ag From September 2010 to August 2012 the Slovakian NGO Odyseus implements "Imp.Ac.T: Improving Access to HIV/TB testing for marginalized groups", a project supported by European Commission, which aims to broaden access to HIV and TB testing, prevention, treatment and care for people who inject drugs and migrants who use drugs in Slovakia, Czech Republic and Italy.
ah Bulgaria, Croatia, Czech Republic, Hungary, Lithuania, Macedonia.
ai Bulgaria, Slovakia.
aj Bosnia-Herzegovina, Croatia, Slovakia.
ak Romania.

OVERDOSE RESPONSES

For most countries where data is available, overdose prevention responses include limited or rare provision of overdose information material to people who use drugs, individual overdose risk assessment, overdose response training[al] and risk education on drug-related deaths.[25] In the Czech Republic, Lithuania and Slovenia, provision and reach of overdose prevention responses is reported to be extensive.[am]

The availability of naloxone remains very limited in most countries across Eastern Europe. However, systematic data on the coverage of this intervention is not known. Naloxone is not provided at all in Albania, but it is available to varying degrees through emergency care units in all other countries for which information is available.[4] Across the region, naloxone distribution is not permitted through peers or through harm reduction services such as NSPs and OST.[4] Peer distribution of naloxone is presently being considered in Estonia.[9]

Barriers to the implementation and scale-up of effective overdose responses, including naloxone provision, include laws limiting management and transportability of naloxone by non-medical personnel, delays in the provision of emergency care responses for overdose[an] and shortages of naloxone in emergency units.[ao] [4] There is an urgent need for advocacy around scaling up the distribution of naloxone beyond medical services to harm reduction programmes, outreach workers and people who use drugs, their families and communities.

HARM REDUCTION FOR RECREATIONAL DRUG USE

Harm reduction interventions in recreational settings, including information, education and communication (IEC) materials, campaigns and peer outreach, are implemented in nearly half of the countries in the region.[ap] [4] Initiatives in Bosnia-Herzegovina and Slovakia also provide counselling, condoms and information about sexually transmitted infections (STIs) including HIV.[4] Pill testing in recreational settings is not offered in any countries in the Eastern Europe region.

Implementation and scale up of harm reduction interventions in recreational settings across Eastern Europe is limited by several factors. These include a lack of systematic data on prevalence and trends in recreational drug use and existing harm reduction responses and minimal or no funding for such initiatives across the region.[4] In Hungary, resistance from a majority of nightclub owners limits coverage of existing initiatives.[26]

POLICY SUPPORT FOR HARM REDUCTION

Harm reduction is explicitly mentioned within national health, drugs or HIV/AIDS strategies of most countries that comprise the Eastern Europe region. However, in many states in the region, this support is largely 'on paper' only. In August 2011, Hungary adopted a new drug strategy focused strongly on abstinence-based approaches, and slashed the country's drug budget by 50%; the strategy was in the process of being finalised at the time of publication.[27] [30]

Funding for harm reduction responses in Eastern Europe comes largely from The Global Fund.[27] The top three largest recipients in the region are Bosnia-Herzegovina, Macedonia and Serbia.[28] Other donors that support harm reduction in Eastern Europe include the European Commission, UNODC, OSF, UNICEF and PSI.[4] Additional funding for harm reduction service provision is provided by national governments in Estonia, Montenegro, Bulgaria, Hungary, Croatia, Czech Republic, Lithuania and Slovakia. However, in some countries, government funds for harm reduction are reported to be insecure and insufficient to sustain and scale up the level of service coverage required to have an impact on HIV and viral hepatitis epidemics.[aq] [4] [29] In Bulgaria and Serbia, state funding supports MMT programmes, but not NSPs.[4]

In Montenegro, a state grant was utilised to open the first drop-in center for people who use drugs, but at the time of publication all harm reduction services in the country were financed by The Global Fund.[31]

In the past decade, the influx of funds from international donors has supported and encouraged scale up of service provision across the region. However, there is considerable concern around the willingness of some national governments to supplement service needs once countries become ineligible for The Global Fund funds and other international contracts expire. A case in point is Romania, where in June 2010, programs

al According to the EMCDDA (2010) (2) Overdose response training is defined as: One-to-one or group education sessions on risks, prevention of risks and on management of overdoses. This training should include: information on risk situations and risky behaviour, how to recognise overdoses, and how to respond adequately (at least the recovery position).

am 'Extensive' is defined by the EMCDDA (2010) "a majority of the target group (but not nearly all of them) have received the service during the last year at least once."

an Bulgaria.

ao Macedonia.

ap Bosnia-Herzegovina, Macedonia, Bulgaria, Croatia, Czech Republic, Hungary, Lithuania and Slovakia.

aq Croatia, Lithuania, Slovakia.

developed with international donor support over the previous ten years were left without funds once the country became ineligible for The Global Fund round 10. As an emergency, short-term solution, some NSPs and OST services are presently funded through European Structural Funds, but the government still refuses to lend its support.[6] Other countries in the region may be facing similar circumstances within the next two to four years. Sustained civil society advocacy is crucial for maintaining and increasing concrete support for harm reduction from national governments across Eastern Europe.

DRUG USER INVOLVEMENT IN HARM REDUCTION RESPONSES

Meaningful involvement[31] of people who use drugs in service design, implementation, monitoring and evaluation is very scarce across Eastern Europe. In most countries user representation occurs largely at the program rather than at the organisational or policy levels.[4] Generally, representation is tokenistic or consultative, with former and, occasionally, active users given the roles of peer educators, NSP "assistants", outreach workers and other "gatekeepers."[ar 4] One exception is Bosnia-Herzegovina, where users are represented at the municipal level in the country's three largest cities, Sarajevo, Tuzla and Zenica, as advisers for policies affecting young people's health and social inclusion.[32] Another is Bulgaria, where the only known user-run organisation in the country was invited to become a member of the National Coordinating Committee on HIV/AIDS, opening the possibility to participate in decisions regarding funding for harm reduction programs.[15]

Barriers to the participation of people who use drugs at all levels of practice and policy include limited capacity of the few existing user-run organisations and networks to engage in advocacy, the criminalisation of drug possession for personal use and the high level of stigma against people who drugs.[4] CSOs articulated the urgent need to consolidate and build the capacity of existing organisations of people who use drugs, raise public awareness and share examples of best practice on how to effectively and meaningfully involve users within service design, implementation, monitoring and evaluation.[4]

ar Albania, Kosovo, Montenegro, Macedonia, Bulgaria, Croatia, Czech Republic, Slovakia.

CIVIL SOCIETY AND ADVOCACY

Across Eastern Europe, CSOs advocating for harm reduction operate mainly at the national and regional levels.[4] Funding for advocacy activities is largely nonexistent, or in a few cases supported by international donors such as The Global fund, OSF, UN agencies and others.[as 4] In one case, it was reported that despite the availability of funding for advocacy activities by international donors, CSOs may not have the capacity to engage in advocacy while they struggle to provide a basic level of services.[33]

National harm reduction networks operate in Romania, Macedonia, Hungary, Lithuania and the Czech Republic.[4] In Bosnia-Herzegovina, harm reduction organisations are linked virtually but do not have the resources to mobilise into a formal national structure.[32] In Lithuania, a new network was formed at the end of 2008 but has yet to become active at the national level.[34] The majority of CSOs in Eastern Europe also engage regionally through their participation in international networks such as the Eurasian Harm Reduction Network (EHRN), the International Drug Policy Consortium (IDPC) and EuroHRN.

In all countries where information was available, CSOs identified the following advocacy priorities:

- Ensure adequate, predictable funding for harm reduction programmes from national governments[at]
- Reorient drug policies to reflect evidence-based public health and human rights-based approaches, including decriminalising drug use for personal possession[au]
- Implement evidence-based harm reduction services, particularly NSPs, and scale up provision of OST, in prisons and other places of detention[av]
- Scale up provision of current NSP and OST programmes in the community.[aw]

Additional advocacy priorities in the region include addressing stigma and discrimination against people who use drugs, and particularly women who use drugs;[ax] developing harm reduction training curricula for law enforcement and police forces;[ay] and increasing public awareness of harm reduction and drug policy issues

as Kosovo, Hungary, Lithuania, Romania, Slovakia.
at Bulgaria, Croatia, Lithuania, Macedonia, Romania, Slovakia.
au Albania, Bosnia-Herzegovina, Macedonia, Montenegro, Romania.
av Bulgaria, Lithuania, Czech Republic.
aw Kosovo, Romania, Slovakia.
ax Montenegro, Romania.
ay Bosnia-Herzegovina.

through mass media, social media and public debates.[az] In Bulgaria, Hungary, Romania and Slovakia additional priorities include advocating for evidence-based decision-making with regard to the recent expansion of the smart drugs market in Romania; protecting existing harm reduction services at the policy level;[ba] consolidating users' groups and support their engagement with national-level policy-making;[bb] integrating STI testing, including for HIV, within NSP services;[bc] and advocating for the provision of naloxone via low-threshold harm reduction programmes.[bd]

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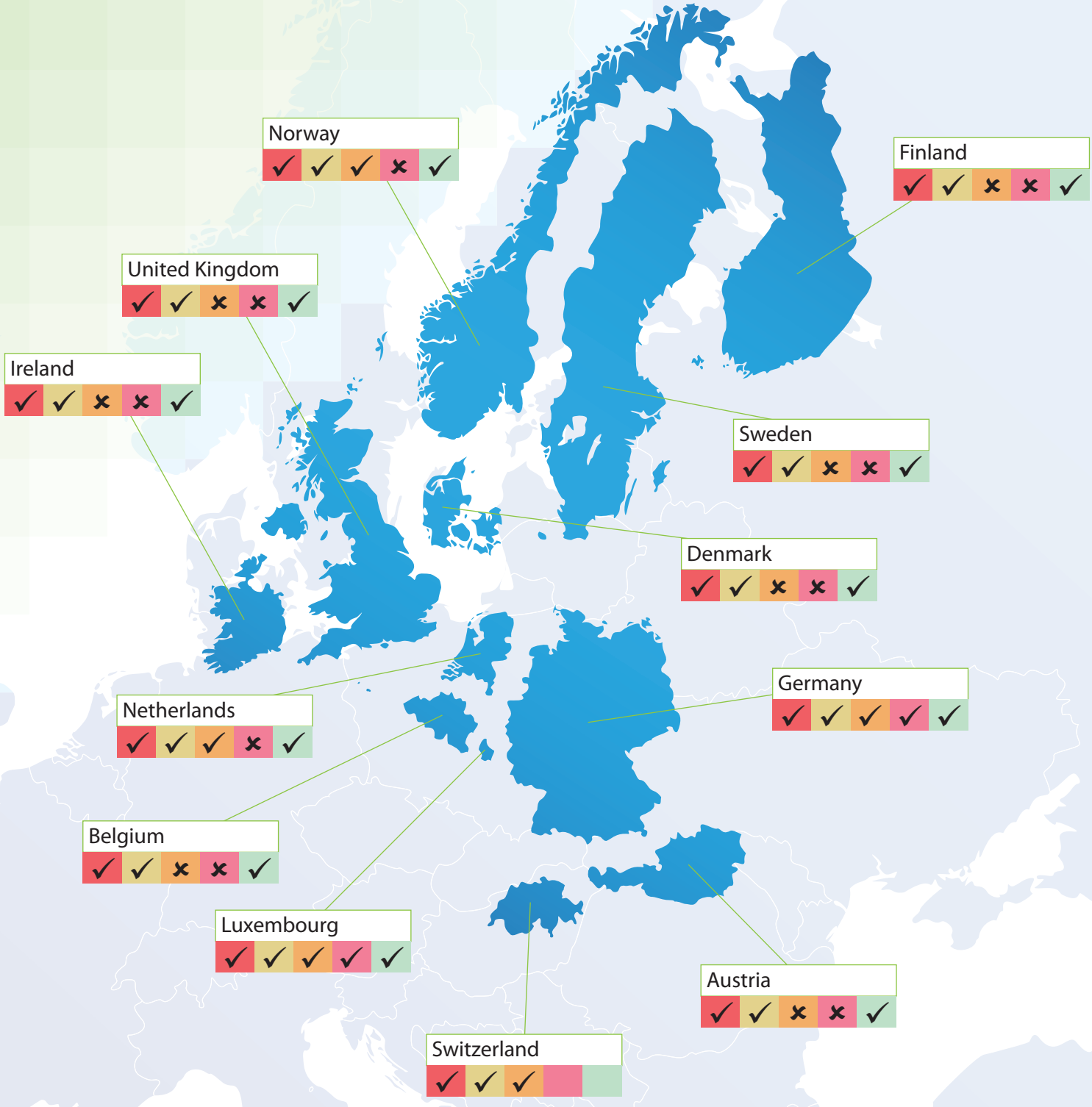
az Romania.
ba Hungary.
bb Bulgaria.
bc Slovakia.
bd Slovakia.

3.2 NORTH EUROPE

- AUSTRIA
- BELGIUM
- DENMARK
- FINLAND
- GERMANY
- IRELAND
- LUXEMBOURG
- NETHERLANDS
- NORWAY
- SWEDEN
- SWITZERLAND
- UNITED KINGDOM

Availability of harm reduction interventions in North Europe



- Needle and syringe exchange
- Opioid substitution therapy
- Drug consumption rooms
- Prison needle exchange programme
- Prison opioid substitution therapy

Table 3.2.1: Availability and coverage of harm reduction interventions in North Europe

Country Or Territory	NEEDLE AND SYRINGE EXCHANGE PROGRAMME			OPIOID SUBSTITUTION THERAPY			Drug Consumption Rooms Existence[1] and Number[2]	Prison Needle Exchange Programme Existence[3] and Availability[4]	Prison Opioid Substitution Treatment Availability,[a 5] Initiation (I) and Continuation (C)[6]
	Availability, Syringe Vending Machine (S), And Pharmacy Based NSP (P)[7]	Number of sites[8]	Syringes distributed annually through specialised sites per person injecting drugs[b 9]	Availability and form[c 10]	Number of sites[11]	% opioid users receiving OST[12]			
Austria	Yes (S, P)	27		Yes (M, B, BN, SM)		44 (42 - 46)	No	No	Yes, full (I, C)
Belgium	Yes (P)	34		Yes (M, B)			No	No	Yes, full (I, C)
Denmark	Yes (S, P)	135		Yes (M, B, H)			No	No	Yes, full (I, C)
Finland	Yes	52		Yes (M, B, BN)		29 (24 – 32)	No	No	Yes (C)
Germany	Yes (S, P)	250		Yes (M, B, BN, H)	2,786-6,626	60 (46 – 85)	Yes (27)	Yes, rare	Yes, limited (I, C)
Ireland	Yes	33		Yes (M, B[d], BN[e])	332	47 (41 – 54)	No	No	Yes, extensive (I, C)
Luxembourg	Yes (S)	4	175 (135 – 207)	Yes (M, B, SM)		55 (43 – 65)	Yes (1)	Yes, extensive	Yes, full (I, C)
Netherlands	Yes (P)	150		Yes (M, B, H)			Yes (approx. 40)	No	Yes, extensive (I, C)
Norway	Yes	22	326 (272 – 381)	Yes (M, B)			Yes (1)	No	Yes, extensive (I[f], C)
Sweden	Yes	2	4 (4 – 4)	Yes (M, B)			No	No	Yes (I, C)
Switzerland	Yes (P)	101		Yes (M, B, H)			Yes (7)		
United Kingdom	Yes[g] (P)	1,523		Yes (M, B, BN, H)		46 (44 – 47)[h]	No	No	Yes, limited (I[i], C)

a. Full: substitution/maintenance treatment exists in nearly all prisons
Extensive: exists in a majority of prisons but not in nearly all of them
Limited: exists in more than a few prisons but not in a majority of them
Rare: exists in just a few prisons
b. Data is from 2008 or more recent year
c. M = methadone, B = High-dosage buprenorphine, H = Heroin assisted treatment, BN = Buprenorphine-naloxone combination, SM = Slow-release morphine
d. Legally available but no clients reported
e. Legally available but no clients reported
f. Initiation of OST has to be carried out by an external regional maintenance treatment provider
g. Except in Northern Ireland where there are no fixed specialist NSP sites
h. Data from England only
i. Except in Northern Ireland

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Harm Reduction in North Europe

The authors would like to acknowledge the contributions of the following organisations in providing information for their specific countries:[a]
Verein Wiener Sozialprojekte (Austria); Free Clinic (Belgium); Gadjuristen (Denmark); A-Clinic Foundation (Finland); akzept (Germany); Irish Needle Exchange Forum, Citywide Drugs Project (Ireland); Correlation Network (Netherlands); Randi Ervik, Assistant Professor, Diakonhjemmet University College (Norway); Swedish Drug Users Union (Sweden); Infodrog (Switzerland), Contact Netz (Switzerland), Groupement Romand D'Etudes des Addictions (Switzerland); The UK Harm Reduction Alliance (United Kingdom)

Harm reduction has been a longstanding public health approach used in practice and policy in most North European countries. Key interventions such as NSPs and OST form an integral component of drug services across the region. Nearly half of the countries in the region operate DCRs and provide HAT.

However, the accessibility and scope of harm reduction services remains limited in several settings and among particular subgroups of people who use drugs. There is a substantial need to integrate HIV, viral hepatitis and tuberculosis prevention and treatment, and reduce restrictions on their accessibility. Despite the scale up of harm reduction interventions in prisons over the last two decades, barriers to access remain, particularly around treatment continuity pre- and post-release from prison. Availability of prison-based NSPs is a major gap, with provision limited to two countries in the region. Other harm reduction initiatives, such as naloxone distribution and safer nightlife initiatives, remain to be adequately scaled up.

In recent years, several countries have experienced political changes that have threatened support for harm reduction initiatives. Effective advocacy is urgently required to scale up coverage to adequate levels, prevent the 'roll-back' of achievements already gained and to retain harm reduction on national policy agendas.

Direct involvement of people who use drugs in service planning, implementation, monitoring and evaluation remains limited. There is a need for greater recognition and empowerment of organisations of people who use drugs as partners at the organisational and policy-making levels.

a Questionnaire response from Luxembourg not available at the time of writing.

CIVIL SOCIETY ORGANISATIONS HAVE IDENTIFIED SEVERAL ADVOCACY PRIORITIES FOR THIS REGION. THESE INCLUDE:

- Provide and increase access to DCRs, NSPs and OST (including HAT)
- Improve coverage and integration of HIV, viral hepatitis and TB prevention and treatment services
- Provide basic housing and social support for homeless people who use drugs
- Develop national and pan-European drug user and civil society networks
- Advocate for drug policy change and in particular, decriminalisation of drug use.

NEEDLE AND SYRINGE EXCHANGE PROGRAMMES (NSPs)

NSP sites operate in all states in the region, but coverage varies considerably (see table 3.2.1).[1] Several NSP service delivery models[b] are implemented across the region to varying degrees. For instance, Sweden and Norway rely on one type of outlet,[2] whereas in Austria, Denmark, Luxembourg and Germany, needle and syringe distribution through fixed outlets is supplemented by vending machine distribution.[3] Mobile NSP sites operate in nearly half of the countries in this region.[c] [4] The availability of a variety of service provision models may increase NSP access for some groups of who inject drugs that may not access fixed sites regularly.[5] For instance, mobile van sites and public vending machines have been shown to attract younger people who inject drugs and those with higher risk profiles more effectively than other NSP delivery models.[5]

A majority of countries have moderate to high coverage of sterile injecting equipment distribution.[d] [6] Among these is Norway, the country with the highest

b Service delivery models include fixed specialist sites, those situated within drug services, pharmacy-based NSPs and mobile distribution (including peer outreach).

c Austria, Finland, Ireland, Netherlands, and UK.

d Targets for syringes distributed per person injecting drugs per year as defined by WHO, UNODC and UNAIDS (2009) guidelines are low (100), medium (>100– 200) and high (>200). These countries include Austria (176), Finland (166), Ireland (164), Luxembourg (144), Netherlands (127), Norway (434), and the UK (188).

reported coverage in North Europe and globally.[e] [8] However, many CSOs report inadequate coverage outside of main cities and in rural areas.[f] [7] Irish NSP service provision outside Dublin, for instance, is limited or nonexistent,[22] and in Belgium and Denmark, coverage remains low.[8]

In some countries, limited hours of operation and age restrictions are reported to impede access to NSPs.[g] [7] In Finland, Ireland and Sweden, operational barriers are compounded by psychosocial deterrents to service access, including fear of police surveillance[h] and stigma toward people who use drugs.[i] [7]

In countries where political support for harm reduction is present, CSOs report that a lack of financial support[j] and insecure funding[k] remain impediments to NSP scale up.[7]

Non-opioid injecting, such as the use of anabolic steroids and performance-enhancing drugs (PED), has been reported in Belgium and the UK.[7] [9] [10] But a shortage of data on the prevalence of steroid and PED injecting, its low priority within national drug budgets and inadequate national NSP monitoring systems, have prevented the development of targeted strategies to address this user group's needs (for more information see box below).[l]

A recent increase in non-injecting routes of administration (NIROA) and a decrease in drug injecting have been documented in some countries.[7] [11] Interventions to facilitate transitions away from injecting (route transition interventions or RTIs),[12] to reduce and prevent injecting drug use and to promote safer non-injecting drug use are available in some countries as additions to existing harm reduction services. For instance, CSOs report that safer crack smoking kits[m] are widely distributed in the Netherlands, but numbers of people reached are unknown,[40] and distribution outside the Netherlands remains very limited.[n] [7] Recent civil society efforts to amend existing laws prohibiting the distribution of crack smoking kits, aluminum foil and other RTIs in the UK have resulted in a recommendation by the Independent Advisory Council on the Misuse of Drugs to include aluminium foil to the current list of permitted items.[13]

OPIOID SUBSTITUTION THERAPY (OST)

Methadone maintenance therapy (MMT) and buprenorphine maintenance therapy (BMT) are implemented in all North European countries (see table 3.2.1).[o] Additional OST options, such as HAT, buprenorphine plus naloxone combination and slow-release morphine, are available across the region, except in Belgium, Norway and Sweden. Almost half of the countries in the region provide HAT, with pilot projects underway in Belgium and Luxembourg.[14]

PERFORMANCE ENHANCING DRUGS (PEDs)

Maria Phelan

The use of anabolic steroids or performance enhancing drugs (PEDs) is on the rise in Europe, and particularly in the UK. Although systematic data on this issue is scarce, figures for England and Wales are provided by the British Crime Survey (BCS). The BCS estimates that in the 16-59 year old age group around 226,000 people admitted to ever having used anabolic steroids, with 50,000 having used in the past year, and 19,000 in the past month.[a] More than 70% of users in the UK inject PEDs.[b] Reports suggest that steroid injecting is on the rise predominantly amongst young men. A study conducted between 1999 and 2006 of agency-based syringe-exchange programmes showed a six fold[c] increase in the number of steroid injecting clients accessing the service. An examination of NSPs between 1991 and 2006 showed a 2000% increase in steroid injectors attending this service.[d]

A range of adverse effects have been associated with PEDs, ranging from physical and psychological harms to death. Steroid injecting is associated with multiple health harms including damage to the injection site, abscesses and blood borne viruses such as HIV and Hepatitis C.

Steroid use may be driven by a complex cocktail of structural and social factors including media, peer influence, occupation and body image dissatisfaction[e]. This is an emerging issue for the harm reduction community, and more research is needed to fully understand the needs of this diverse group.

Key harm reduction points for practitioners working with individuals that use PEDs (adapted from 'An introduction to anabolic steroids')[f]:

- Use the smallest dose of steroids and do not adopt other users' regimes
- Limit the length of On cycles
- Be aware of counterfeit drugs
- Always use sterile injecting equipment
- Know how to inject safely. Do not share equipment
- Spend adequate time on training nutrition and sleep
- Know the dangers of recreational drug use
- Be aware of side effects. At the first sign of them, discontinue use and seek medical advice.

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The nature of OST provision varies from distribution through privately and publicly funded clinics to pharmacy dispensing programmes.[15] In some countries, this includes access through general practitioners (GPs),[14] although levels of regulation governing OST prescription by GPs vary considerably across the region.[p] For instance, in Norway GPs are not legally entitled to assess a patient's need for OST and provide treatment, but they can assume responsibility for a patient from a specialised OST centre.[15] In Finland and Ireland, GPs are authorised to prescribe OST, but few are reported to do so.[7]

The variety in service provision alternatives and a lack of national standardised indicators for monitoring OST implementation make it challenging to estimate the number of OST outlets operating in each country.[16 17]

In some countries, OST access and provision remain inadequate, especially outside major cities, due to rising patient demand for treatment and a shrinking supply of GPs who are accredited or willing to provide it.[7] In Austria and Germany, strict regulatory frameworks governing OST prescription, specialised OST licensing and enforced criminal sanctions have been reported to discourage GPs from undertaking OST accreditation, and from actively prescribing it once accredited.[7 18]

In some countries, service access is limited by long waiting lists for entry[q] and rigid bureaucratic procedures governing patient eligibility, assessment, start-up and supply.[r 7] For instance, waiting times of 13 months for OST eligibility assessment have been reported in Ireland.[7] In Norway, criteria for accessing OST include a minimum age of 25 years, with new guidelines being developed at the time of writing.[19] Even in countries where no age restriction for OST access exists, there have been reports of young users being denied access to OST or being referred to abstinence-based services instead.[s 7] In the UK, supervised consumption requirements and time limitations in terms of treatment duration[18] may pose additional barriers to treatment effectiveness.[7]

A decentralised approach to treatment provision in a number of countries means that political support for OST scale up must be sought at multiple levels. Increasing funding cuts, stigma associated with both accessing and prescribing OST, and a lack of evidence-based standards for OST provision and quality of care have been reported to further challenge OST access and scale-up.[7]

p Austria, Belgium, Finland, Germany, Ireland, UK.

q Austria, Finland, Ireland, Sweden, Norway.

r Denmark, Finland, Norway, Sweden, UK.

s Belgium, Netherlands.

DRUG CONSUMPTION ROOMS (DCRs)

The majority of DCRs in the world operate in five North European countries (see table 3.2.1).[20] Adequate DCR coverage has increased clients' access to health, treatment and social services, and reduced public drug use, without incurring any harms.[20] DCRs also enable rapid intervention during an overdose, thus reducing the occurrence of fatal overdoses and the health risks associated with non-fatal overdoses.[14 21]

In countries where DCRs operate, several factors are reported to limit access to this intervention. In Germany, for instance, OST recipients cannot legally utilise DCRs;[22] in Switzerland, access is limited to residents of the province in which the facility is located.[25] The only DCR in Norway has limited opening hours and only allows the injection of heroin on its premises,[14] and in the Netherlands, the acceptance criteria are strict.[t 42]

Legal and political barriers prevent the piloting and implementation of DCRs in other countries in the region.[7 23]

HIV, VIRAL HEPATITIS AND TUBERCULOSIS (TB) SERVICES

HIV testing and treatment services

Despite the free availability of HIV testing and treatment in many states in the region, several factors impede uptake of these services. In Ireland, the requirement to make an appointment for HIV counselling and testing (VCT) and to be enrolled in MTT as a condition for ART access have been reported as obstacles for some people who use drugs.[24 23]

Access to ART for people who inject drugs that are living with HIV varies among countries, from high estimated coverage[u] in places such as Finland, Germany and the Netherlands, to medium coverage in Norway, the UK, Luxembourg and Austria.[8] In Switzerland, ART is only available to health insurance holders and enrolment in MMT is a prerequisite for ART access.[25] Across the region, CSOs suggest that fear of stigmatisation[v], fear of legal repercussions,[w] lack of motivation[x] and distrust

t Criteria includes an age restriction, evidence of long-term, problematic drug use, homelessness, police background check, and submission of personal identification to the police.

u Indicative coverage targets for ART are subject to debate. Since the highest coverage achieved in high-income countries is 75–80%, the target setting guidelines consider coverage of over 75% high-level coverage. The targets for effective response to viral hepatitis and tuberculosis are likely to be higher (WHO, UNODC, UNAIDS 2009).

v Finland, Ireland.

w Ireland.

x Sweden.

of government institutions[y] may restrict service access.[7] While service integration between harm reduction and HIV services is not the norm across the region, some providers offer routine HIV testing upon admittance to OST programmes.[7]

Viral hepatitis testing and treatment services

Hepatitis B vaccination programmes targeting specific high-risk groups, including people who inject drugs, operate in most countries.[z] [26] However, CSOs reported that access to HIV, hepatitis and TB testing and specialised services is often less available outside of large cities.[7]

There are significant barriers to the diagnosis and treatment of viral hepatitis among people who inject drugs, particularly in the context of co-infection with HIV. In Austria, Finland and Ireland, CSOs report that the stigma attached to hepatitis C (HCV) may influence access to treatment.[7] Limited integration and weak referral systems among drug services, particularly outside of main cities, have been cited as impediments to the diagnosis and management of HCV.[aa] [7]

The cost of HCV treatment remains prohibitive for subgroups of people who use drugs in a number of countries. For example, in Germany, the cost is not covered by health insurance.[7] Similar policies in Switzerland pose considerable financial obstacles for the uninsured.[7] In Finland, HCV treatment is not presently offered to people who are actively using drugs.[7] Additional barriers cited by CSOs include limited awareness regarding the availability of HBV and HCV testing and treatment, inadequate knowledge of the harms associated with HBV and HCV/HIV co-infection among health professionals, limited HCV testing options and lack of national data collection on viral hepatitis.[ab] [7]

Tuberculosis testing and treatment services

The extent of coverage for viral hepatitis and TB services is largely unknown.[15] [16] Barriers to TB detection and management, especially TB/HIV co-infection include limited coordination among drug agencies, differences in practices within countries, lack of awareness around the prevalence and harms of TB and low prioritisation of this issue in terms of service capacity.[7] An increase in cases of TB among migrants who use drugs has been reported in Ireland, Sweden and Switzerland but data on figures among this population are unknown.[7]

The presence of HIV infection and other factors including incarceration, homelessness and poverty may increase vulnerability to TB infection among people who inject drugs.[27] Increased availability, access and advocacy for housing support, vocational counselling and social assistance are particularly relevant in the context of HIV, viral hepatitis and TB infection. Social reintegration initiatives that are not reliant upon abstinence or treatment have been recognised as an "essential component of comprehensive drug strategies."[14]

HARM REDUCTION IN PRISONS

Three out of 10 countries worldwide that have introduced NSPs in prisons are located in this region (see table 3.2.1).[ac] [15] Service models vary and include injecting equipment exchanges and automated syringe vending machines.[27] All countries offer OST to prisoners, but coverage varies widely within and among countries.[28] [29] Switzerland is the only country globally to provide HAT to prisoners in two facilities.[30] Existing harm reduction programmes have not been scaled up nationally across prison systems, leaving gaps between need and provision,[7] [27] and the implementation of harm reduction services is often dependent upon the policies of individual provinces and prison directors, which renders service provision inconsistent.[7] [31]

Although the scope of OST has extended considerably across Europe in the past two decades,[23] [24] CSOs in a majority of countries report that in many prisons the focus remains on drug control rather than evidence-based harm reduction interventions.[7]

OST access and continuity in prisons continues to lag behind the standards of OST in the community.[23] [32] Constraints to substitution treatment access for specific target groups persist within some countries. For example, in Bavaria, Germany, only opioid-dependent prisoners living with HIV or those who are at an advanced stage of pregnancy are offered OST.[ad] [25] Sweden, in comparison, has four detention centres that provide OST with strict access criteria.[ae] [33]

y Austria.

z Belgium (French-speaking community), Denmark, Germany, Netherlands, Austria, Finland, Sweden, United Kingdom and Norway.

aa Austria, Denmark, Finland and the UK.

ab For instance, CSOs in Ireland cite the lack of availability of dry spot blood testing.

ac Germany, Luxembourg, Switzerland.

ad Statistical analysis has shown that treatment is often only marginally better in other German states: the coverage ratio is only about 3% compared to 30–50% OST coverage in the community (Stöver H. et al. 2008).

ae The programme accepts only 14 individuals who must be able to show evidence of a steady address or apartment, as well as active employment or student status.

Across the region, continuity of treatment and care is interrupted or changed as a result of detention, during detention or when making the transition to living in the community upon release from prison. For instance, in Finland and Sweden, OST is continued in prison only if the prisoner was already undergoing treatment prior to arrest.[7] A study in Germany found that 70% of opioid-dependent prisoners had to stop treatment when they entered prison.[34] Lack of continuity of care upon initiation and release affects the quality and benefits of OST, denying opioid-dependent prisoners the opportunity to stabilise their lives and improve their health outcomes.[35]

OVERDOSE RESPONSES

Across the North Europe region, overdose prevention responses including the provision of overdose information material to people who use drugs, individual overdose risk assessment, overdose response training[af] and risk education on drug-related deaths are implemented to varying degrees.[36] The provision and reach of overdose prevention responses, excluding provision of naloxone, varies from extensive in Ireland, Finland, Germany and the United Kingdom to limited or rare in Belgium (particularly the French community), Sweden and Norway.[36]

Naloxone availability is limited in most countries in the region. Peer distribution is practised in Denmark, but intervention coverage is limited to Copenhagen.[7] In the UK no formal peer distribution network exists.[7] CSOs report a number of barriers to scaling up peer distribution of naloxone in the UK, including prescription laws limiting the transportability of naloxone, police attendance at emergency calls for drug overdose and fear of arrest.[7]

In Finland, Ireland and the Netherlands, naloxone is available only to medical emergency response staff,[7] and in Germany a limited number of drug treatment institutions offer naloxone, but the extent of coverage is not known.[7] Naloxone is not available in Austria, Belgium and Sweden.[7]

There are a number of obstacles to implementation and scale-up of overdose prevention programmes, including peer distribution of naloxone. These include a lack of reliable, comparable and baseline data on overdose and legal barriers, particularly around naloxone administration and transportability by non-medical staff.[7] As a result, interventions are often "sporadic and limited."[14] A number of pilot projects are presently underway,[37]

af The EMCDDA (2010) defines overdose response training as: "one-to-one or group education sessions on risks, prevention of risks and on management of overdoses, which should include information on risk situations and risk behaviour, how to recognise overdoses, and how to respond adequately (at least the recovery position)."

USER-FRIENDLY SERVICES: BETWEEN GOOD PRACTICE AND A RUBBER HAMMER

John-Peter Kools

"In many countries users are no longer treated as criminals, but as patients or clients. Is that an improvement: criminal or patient? That's like being hit by an either an iron hammer or a rubber one. A rubber one is preferable, but it's still a hammer."
– a drug user activist

User-friendliness (UF) is commonly recognised as a key principle of good quality service delivery. Although many users of harm reduction services will immediately identify whether a service is user-friendly, it is challenging to articulate what that constitutes. There is no standardized checklist of components, but some key elements related to technical service-delivery and attitude can be identified:

- **Accessibility** *(Do the location/opening times match clients' schedules, giving them as many opportunities as possible to access the service?)*
- **Appropriateness of services delivery** *(Does the service provide what clients really need?)*
- **Satisfaction** *(Are clients asked to reflect on the quality of services?)*
- **Ability to influence service-delivery** *(Is there a client council or some other formal/informal consultation of clients, and is it implemented in practice?)*
- **Peer involvement** *(Is there meaningful peer involvement in the development, management and /or delivery of services?)*
- **Non-judgmental attitude of staff** *(Are clients treated with dignity and respect of staff?)*
- **Safety** *(Does the service provide physical safety from violence, intimidation, interference from others – including police?)*
- **Privacy** *(Are service users' details being treated confidentially? Are client data well protected?)*
- **Proportionality** *(Are the agency regulations and requirements proportional to the direct health and social benefits of the service?)*
- **Ownership** *(Do people feel that that the service is primarily for them, not for the sake of the organisation or, for instance, to reduce public nuisance?)*

User-friendly qualities are essential to service effectiveness. If people appreciate a service, they are more likely to use it, which benefits everyone: user, provider and the wider community.

including a large-scale randomised controlled trial of naloxone distribution to prisoners upon release in England.[38] Across the region, it is important for people who use drugs and CSOs to lobby for peer distribution of naloxone and its integration within mainstream drug and harm reduction services.

HARM REDUCTION FOR RECREATIONAL DRUG USE

Safer nightlife initiatives, including pill testing, outreach, counselling in recreational settings, and information and education campaigns, are implemented in Austria, Germany, Switzerland, Denmark, Norway and the Netherlands to varying degrees.[7] Pill testing is omitted from Switzerland's federal law on drugs, and the authority to allow drug testing rests with each of the 26 Swiss cantons.[39] [40] Several cantons in the German-speaking parts of the country, including Zurich, have authorised this intervention.[38]

With the exception of initiatives in Austria and the Netherlands, which are partly funded and supported by the government, programmes in the majority of countries are self-funded, privately-funded or run by volunteers.[7] In the Netherlands, on-site pill testing in party settings has been prohibited since January 2002, but it remains accessible through the Drugs Information and Monitoring System, with self-tests also available in smart-shops and over the internet.[41] [7] In Denmark, the main source of harm reduction information for partygoers is a peer-run website.[ag] [7]

In the majority of states, significant challenges to coverage and quality of safer nightlife initiatives remain. These include a lack of coordination among existing initiatives, lack of comparable and complete data on effectiveness and coverage, and prioritisation of "problem drug use" rather than recreational drug use in programme funding, research and policy.[7]

Documented growth of international travel associated with nightlife suggests that scale-up of evidence-based interventions promoting health and safety may be required internationally.[42]

Safer nightlife initiatives such as distribution of free water, availability of immediate emergency care and outreach with party-goers, are provided by several organisations in Europe. In 2010, the Netherlands-based Trimbos Instituut launched a how-to handbook on

DRUG CONSUMPTION ROOMS (DCRs) IN EUROPE

Jean-Paul Grund[i] & Cas Barendregt [ii]

Drug consumption rooms (DCRs) are professionally supervised healthcare facilities where problem drug users can consume their drugs under safer and more hygienic conditions. Europe leads globally on DCR coverage, with six European countries (Germany, Luxemburg, Norway, Spain, Switzerland, and The Netherlands) having established DCRs in response to open drug scenes and public drug use. DCRs try to encourage safer drug use, improve the health status of drug users and reduce public nuisance. While DCRs contribute to the prevention of the spread of infectious diseases such HIV and HCV, they also reduce exposure to overdose. While most DCRs target injecting drug users, in The Netherlands, Germany, Spain and Switzerland, separate facilities are also offered to people who smoke cocaine (crack) and/or heroin.

'Specialised' or stand-alone DCRs only offer a safe injecting space, whereas 'integrated' consumption rooms are also offer medical, social and treatment services to substance users. DCRs have increased access to services for 'hard-to-reach' drug users in particular and contributed to new forms of services, such as hepatitis testing and treatment for people who inject drugs in Amsterdam or Chill Out rooms ("Tagesruheräume") for cocaine users in Frankfurt and Bremen. Where coverage, capacity and opening hours are sufficient to cover local needs, DCRs could help reduce overdose deaths.

Public drug use is associated with feelings of insecurity amongst community members where such facilities are located and the general public. DCRs can reduce the level of public drug use, but this depends on their accessibility, opening hours and capacity.

Evidence recently reviewed by the EMCDDA indicates that, in settings where public drug consumption poses serious public health and social order concerns, DCRs may have specific benefits for individual and public health and social order. They have become a primary 'point of access' to services for those most at risk and who are out of reach of more traditional service providers.

Their impact is most tangible when part of a pragmatic, flexible and comprehensive approach to problem drug use addressing the associated individual and social harms at community level. Such an approach may include abstinence and various forms of drug substitution treatment, social services, such as supported housing, day spending facilities, reintegration and labour training, as well as medical and psychiatric treatment.

Sources:

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1. CVO Addiction Research Center, Utrecht, The Netherlands (jpgrund@drugresearch.nl)
2. IVO Addiction Research Institute, Rotterdam, The Netherlands (barendregt@ivo.nl)

working effectively with relevant stakeholders to create safer nightlife settings.[ah] [43]

POLICY SUPPORT FOR HARM REDUCTION

All countries in the region explicitly mention harm reduction in their national drug policy documents (see table 3.2.1).[44] In Austria, harm reduction is also supported sub-nationally, with a mandate to implement NSP and OST in each province, whereas Sweden's national drug action plan emphasise abstinence-based approaches and zero-tolerance for drugs despite providing funding for CSOs that lobby for harm reduction.[ai] [7]

Despite policy support at national levels, implementation of harm reduction initiatives within many countries rests with sub-national health authorities. As a result levels of coverage vary within countries and increased pressure is placed on CSOs and user groups to lobby at the local level. For example, despite the existence of a national law allowing NSPs to operate in Sweden,[aj] NSP implementation relies on municipality and city council approval, limiting coverage to the south of Sweden.[7]

The current period of economic austerity has had a negative impact on harm reduction.[7] In the UK, changes in government and substantial public spending cuts have destabilised financial and policy support for harm reduction. Following a relatively predictable stream of support for harm reduction since the 1980s, the UK government's 2010 drug strategy mentions harm reduction briefly, placing a disproportionate emphasis on recovery through abstinence-based approaches.[45]

In some countries where harm reduction has traditionally been an integral part of national drug strategies,[ak] there is growing concern around the development of social control and surveillance components alongside integrated harm reduction services. [46] The scale up of DCRs in Amsterdam provides a telling example: in 1998 the police in Amsterdam began to advocate for the creation of DCRs on a par with harm reduction activists and health services. While this resulted in close cooperation between the police forces and DCRs, a system developed where the police often referred drug users to the DCRs, but also became controlling and had full access to visitor lists.[47]

A second, related phenomenon is the visible shift from harm reduction services as a human rights-based set of interventions toward a highly integrated, medicalised and streamlined approach more appropriately deemed 'harm management.' [48] For instance, the three largest cities in the Netherlands[al] implement a comprehensive service provision system which includes harm reduction programmes alongside social benefits, housing, medical care and re-integration into the labour market.[47] Some have argued, however, that the aims of effectiveness and efficiency have trumped the human rights and ethical aspects of service provision, and have turned the individual into 'a mouse in a labyrinth': an object rather than subject of interventions.[43]

DRUG USER INVOLVEMENT IN HARM REDUCTION RESPONSES

Widespread, meaningful involvement of people who use drugs at the multiple levels that fulfill the greater involvement principle is rare across the region.[am] [49] In the Netherlands, where user-led groups pioneered harm reduction initiatives globally in the 1970s, CSOs report that most user-led initiatives are presently dormant or no longer directly involved in service development.[50]

Despite CSO reports of involvement in negotiations around user access to services[an], peer work as part of harm reduction service provision[ao] and legal consultations related to drug use[ap], participation is limited to a few organisations in main cities.[7] In the majority of countries, the involvement of people who use drugs in service design, planning and evaluation is restricted to tokenistic consultations, often with well-known user advocates.[7]

A number of CSOs highlighted the need for greater direct involvement in all phases of service planning and implementation, as well as increased user group involvement in drug policy matters.[7] The explicit recognition and empowerment of people who use drugs

ah The accompanying website, the Healthy Nightlife Toolbox (http://www.hnt-info.eu/), also provides a database with relevant literature and documentation of existing interventions.

ai Preliminary results of a 2010 government evaluation in Sweden have suggested the need for implementation of a wider harm reduction definition that extends beyond NSP and OST provision to include HAT, and to distinguish between problematic and recreational drug use.

aj Swedish law on NSPs is presently under review.

ak Germany, Netherlands, Switzerland and to some extent, the United Kingdom.

al Amsterdam, Rotterdam and Utrecht.

am A typology of drug user participation in harm reduction responses has been previously represented as a "pyramid of involvement" which describes a range of increasingly-involved roles for people who use drugs, from passive target audiences, to tokenistic speakers or representatives, and finally, to equal participants in decision-making bodies. Three forms of greater user involvement have been described: individual-level involvement in the work of CSOs; organisational-level involvement in the form of participation in consultations, decision-making and policy-making bodies; and drug user organising, which refers to more autonomous groups of people who use drugs who work toward self-determined agendas affecting their interests.

an Germany

ao Finland

ap Denmark

and their organisations as valuable partners at the service provision, organisational and policy-making levels was cited as an area for improvement.[7] This includes support through funding and capacity building and the development of organisational systems.[40]

CIVIL SOCIETY AND ADVOCACY

Civil society organisations advocating for harm reduction have an established presence at multiple levels across the region.[7]

Funding for advocacy initiatives is provided by national and local governments through Ministries of Health and through local health and welfare services in half of the countries in North Europe.[aq] [7] The Netherlands and the UK are the only countries that finance harm reduction advocacy both domestically and internationally.[7] Other reported funding sources for advocacy activities across the region include the pharmaceutical industry,[ar] European regional networks and private organisations. CSOs in Denmark, Belgium, and the UK report that funding specifically allocated to advocacy is lacking.[7]

National harm reduction networks are reported to be active in Germany, the United Kingdom and Ireland.[7] In the Netherlands, the creation of a national network is presently underway.[41] Across the region, CSOs expressed the need to strengthen coordination and partnerships with organisations across Europe.[7]

CSOs identified several key advocacy issues across the region. In nearly half of the countries, advocacy priorities included:

- Provide and increase access to DCRs, NSPs and OST (including HAT) [as]
- Improve coverage and integration of HIV, viral hepatitis and TB prevention and treatment services[at]
- Provide basic housing and social support for homeless people who use drugs[au]
- Develop national and pan-European drug user and civil society networks[av] [7]
- Advocate for drug policy change and in particular, decriminalisation of drug use.[aw]

Additional reported advocacy priorities in the region included upholding harm reduction on national policy agendas,[ax] developing user and civil society networks,[ay] improving access to and integration of testing and treatment for HIV and viral hepatitis,[az] and implementing heroin-assisted therapy.[ba] In countries where problematic drug use has been reported among foreign nationals,[bb] eliminating limits to service access based on proof of insurance or citizenship was also identified as a priority.[7] A small number of countries prioritised engaging the public in the harm reduction debate,[bc] promoting safer nightlife initiatives,[bd] improving access to OST in prisons[be] and increasing the availability of naloxone for overdose management.[bf] [7]

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aq Austria, Finland, Germany, Netherlands, Sweden, Switzerland.
ar Germany.
as Austria, Belgium, Denmark, Finland, Germany, Ireland, Sweden.
at Austria, Germany, Switzerland.
au Sweden, Germany, Denmark, Belgium.
av Denmark, Germany, Finland
aw Sweden, Germany, Denmark, Belgium
ax Belgium, Netherlands, UK.
ay Germany, Finland, Denmark.
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ba Norway, Belgium, Germany.
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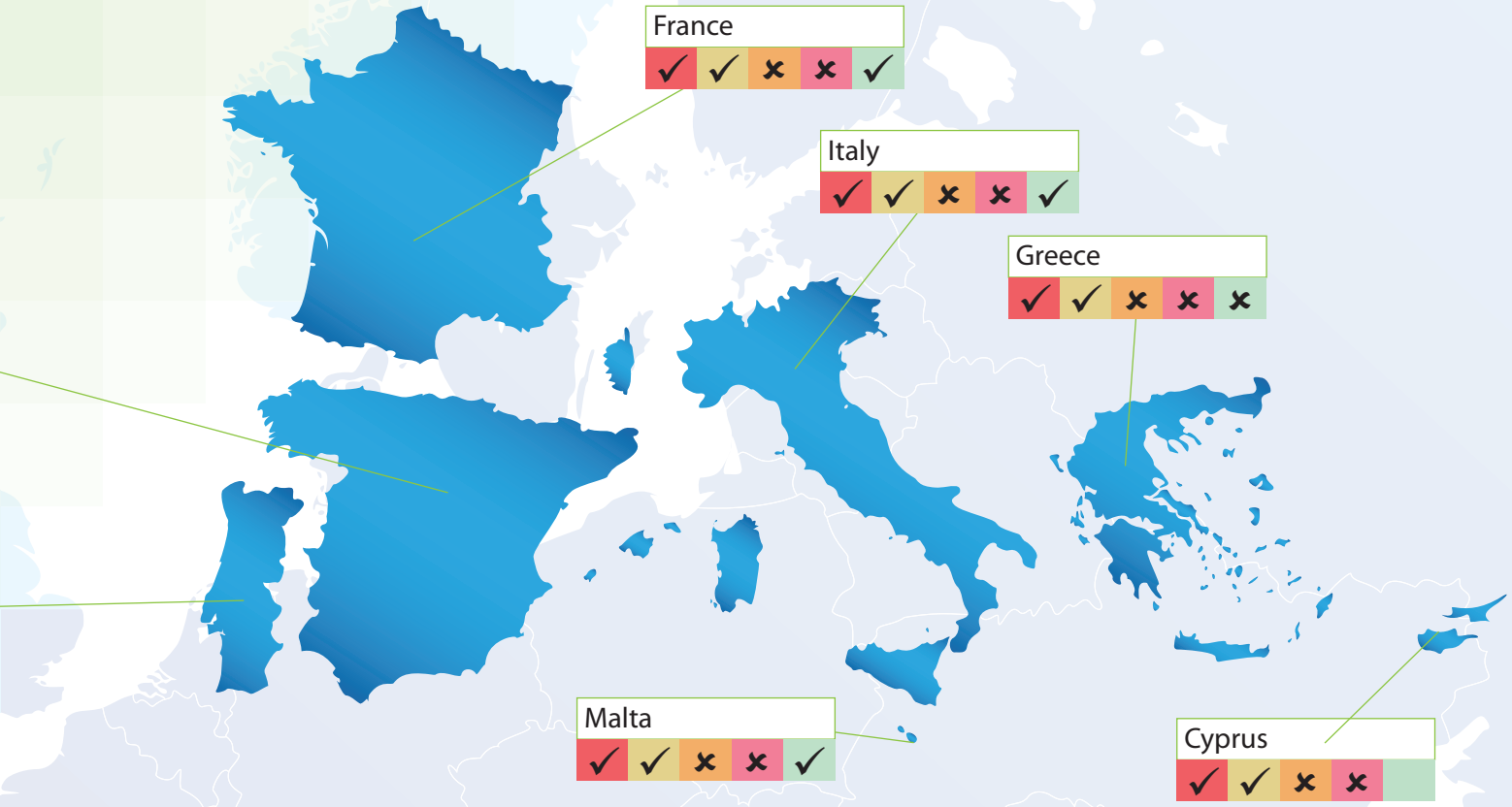
3.3 SOUTH EUROPE

- CYPRUS
- FRANCE
- GREECE
- ITALY
- MALTA
- PORTUGAL
- SPAIN

Availability of harm reduction interventions in South Europe



- Needle and syringe exchange
- Opioid substitution therapy
- Drug consumption rooms
- Prison needle exchange programme
- Prison opioid substitution therapy

Table 3.3.1: Availability and coverage of harm reduction interventions in South Europe

Country or Territory	NEEDLE AND SYRINGE EXCHANGE PROGRAMME			OPIOID SUBSTITUTION THERAPY			Drug Consumption Rooms Existence[1] and Number[2]	Prison Needle Exchange Programme Existence[3] and Availability[4]	Prison Opioid Substitution Treatment Availability,[a 5] Initiation (I) and Continuation (C)[6]
	Availability, Syringe Vending Machine (S), And Pharmacy Based NSP (P)[7]	Number of sites[8]	Syringes distributed annually through specialised sites per person injecting drugs[b 9]	Availability and form[c 10]	Number of sites[11]	% opioid users receiving OST[12]			
Cyprus	Yes	1	0 (0 - 0)	Yes (B, BN)	1	7 (6 – 9)	No	No	
France	Yes (S, P)	416 - 2,014		Yes (M, B)	19,484	50 (50 – 50)	No	No	Yes, limited (I, C)
Greece	Yes (P)	4	7 (6 – 8)	Yes (M, B, BN)	17	26 (23 – 30)	No	No	No
Italy	Yes (S)			Yes (M, B, BN)		53 (52 – 55)	No	No	Yes, extensive (I, C)
Malta	Yes	7	141 (134 – 146)	Yes (M, B)	≥2		No	No	Yes, full (C)[d]
Portugal	Yes (P)	27	149 (112 – 224)	Yes (M, B)			No	Yes, limited	Yes, full (I, C)
Spain	Yes (P)	1,271 – 1,458		Yes (M, B, H)	497 – 2,229		Yes (7)	Yes, extensive	Yes, full (I, C)

a. Full: substitution/maintenance treatment exists in nearly all prisons
Extensive: exists in a majority of prisons but not in nearly all of them
Limited: exists in more than a few prisons but not in a majority of them
Rare: exists in just a few prisons

b. Data is from 2008 or most recent year

c. M = methadone, B = High-dosage buprenorphine, H = Heroin assisted treatment, BN = Buprenorphine-naloxone combination, SM = Slow-release morphine

d. Available but no clients reported

1. European Monitoring Centre on Drugs and Drug Addiction (2010) Drug consumption facilities in Europe and beyond, in Harm Reduction Monograph: Harm reduction: evidence, impacts and challenges.
2. European Monitoring Centre on Drugs and Drug Addiction (2009) NR 2009.
3. European Monitoring Centre on Drugs and Drug Addiction (2010) Statistical Bulletin: Table HSR4. Year of introduction of needle and syringe programmes (NSPs) and types of programmes available in 2008.
4. European Monitoring Centre on Drugs and Drug Addiction (2009) Statistical Bulletin: Table HSR-7. Availability and level of provision of selected health responses to prisoners in 26 EU countries, Norway and Turkey (expert ratings).
5. European Monitoring Centre on Drugs and Drug Addiction (2009) Statistical Bulletin: Figure HSR-2. Provision of substitution/maintenance treatment (OST) in the community and availability of OST programmes in the prison.
6. European Monitoring Centre on Drugs and Drug Addiction (2010) Statistical Bulletin: Table HSR9. Opioid substitution treatment in prison in EU 27, Croatia, Turkey and Norway.
7. European Monitoring Centre on Drugs and Drug Addiction (2010) Statistical Bulletin: Table HSR4. Year of introduction of needle and syringe programmes (NSPs) and types of programmes available in 2008.
8. Mathers B et al (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage. Lancet 375 (9719):1014-28.
9. European Monitoring Centre on Drugs and Drug Addiction (2010) Statistical Bulletin: Figure HSR-3. Syringes distributed through specialised programmes per estimated IDU in 2008 or most recent year.
10. European Monitoring Centre on Drugs and Drug Addiction (2010) Statistical Bulletin: Table HSR1. Table HSR-1. Year of introduction of methadone maintenance treatment (MMT), high-dosage buprenorphine treatment (HDBT), buprenorphine/naloxone combination, heroin-assisted treatment and slow-release morphine.
11. Mathers B et al (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage. Lancet 375 (9719):1014-28.
12. European Monitoring Centre on Drugs and Drug Addiction (2010) Statistical Bulletin: Figure HSR-1. Opioid substitution treatment clients as a percentage of the estimated number of problem opioid users, 2008 or most recent year available.

Harm Reduction in South Europe

The authors would like to acknowledge the contributions of the following organisations in providing information for their respective countries:[a]
Agência Piaget para o Desenvolvimento (Portugal); Association Francaise pour la Reduction des Risques (France); Auto Support des Usagers de Drogues (France); Itaca Association (Italy); Associación Benestar i Desenvolupament (Spain); Asociación de Pacientes Dependientes a Opiáceos (Spain); Creu Roja/Red Cross (Spain).

Harm reduction approaches are well-established in practice and policy in most countries in the south of Europe. Coverage of NSPs and OST varies widely, with countries in the region boasting some of the highest (France, Spain and Portugal) and the lowest (Cyprus) coverage rates in Europe. Spain is the only country in the region that implements heroin-assisted treatment (HAT) and drug consumption rooms (DCRs).

Harm reduction interventions are yet to be widely implemented, scaled up and adequately financed across the region. Limited integration among low threshold drug services and HIV, viral hepatitis and tuberculosis testing and treatment is a concern in all countries. Availability and coordination of harm reduction services in prisons and other closed settings remains very limited. There is an urgent need for provision and scale up of OST pre- and post-release from prison. Peer access to naloxone for overdose prevention and management is limited to Spain and Italy. Safer nightlife initiatives are implemented to varying degrees across the region and within countries.

Harm reduction is explicitly supported in policy documents in all countries in the region. However, recent funding cuts to health and social welfare interventions and continued opposition by local and national authorities, have restricted the implementation of interventions such as DCRs and the scale up of existing interventions to levels sufficient to impact drug-related epidemics.

As in other regions of Europe, involvement of people who use drugs at all levels of service design, implementation, monitoring and evaluation often takes the form of tokenistic consultations and requires sustained advocacy from civil society organisations and drug user groups.

ADVOCACY PRIORITIES IDENTIFIED BY CIVIL SOCIETY ORGANIZATIONS (CSOS) FOR THIS REGION INCLUDE:[a]

- Implement evidence-based harm reduction services, particularly NSPs, and scale up provision of OST in prisons and other places of detention
- Implement or scale up DCRs
- Increase integration of harm reduction interventions, including overdose prevention programs, safer nightlife initiatives, and testing and treatment services for HIV, viral hepatitis and tuberculosis
- Improve the meaningful involvement of people who use drugs in service design, implementation, monitoring and evaluation.

NEEDLE AND SYRINGE EXCHANGE PROGRAMMES (NSPs)

NSPs operate in the majority of states in South Europe with the exception of Cyprus, where the only existing NSP site has yet to receive government endorsement (see table 3.3.1).[1] The latest available data indicate that the number of operational NSP sites varies widely from less than ten in Greece (4) and Malta (7), to up to 1,458 in Spain and 2,014 in France – the country with the largest reported number of sites in Europe.[1] Pharmacy-based NSPs are available in most countries in the region, except Italy, Malta and Cyprus, which rely on fixed and mobile outlets. NSPs operating through vending machines are available in some parts of Italy, Spain and France.[1]

The rate of syringe distribution varies considerably across the region from low coverage in Greece with an estimated 7 (range 6-8) syringes distributed annually per person injecting drugs, to moderate coverage in Portugal with an estimated 149 (range 112-224) syringes per person injecting drugs per year.[1] Barriers to scaling up NSPs include insufficient and insecure funding for harm reduction programmes[c], public opposition to opening

a Questionnaire responses from Cyprus, Greece and Malta were not available at the time of writing.

b France, Italy, Portugal and Spain.

c Italy.

new NSP sites in residential neighbourhoods[d] and lack of political will or active political opposition.[e 2]

Access to NSPs is reported to be limited or nonexistent outside of major cities and in rural areas, as well as outside of the city centre within cities where programmes are available.[2] In Portugal and Spain, where service coverage is moderately high, restricted opening hours (i.e. regular operating hours, typically 9:00-17.00) pose barriers to access for many people who use drugs that circulate during late evenings, nights and weekends.[2] Additional barriers to accessing NSPs across the region include stigma toward people who use drugs,[f] fear of police surveillance[g] and limited financial and human resources for distributing sterile injecting equipment through mobile and outreach NSPs.[h 2]

Problem cocaine use, and specifically use of crack cocaine, has been reported in France, Spain, Portugal and Italy.[3] However, systematic data on the prevalence and patterns of crack use and targeted harm reduction responses for this user group remains limited and tends to be under-represented in more widely available estimates of regular cocaine users.[3]

Targeted harm reduction responses for crack cocaine use are not implemented systematically anywhere in the region. The few existing interventions in Portugal, France and Spain are initiated by NGOs without any government support. In Spain and Portugal, where users are reported to smoke crack using handmade pipes fashioned out of syringe or methadone containers, some NSPs distribute aluminum foil.[2] In Portugal several outreach teams also distribute crack smoking kits as part of an experimental study evaluating the acceptance of this intervention among people who use drugs.[18] Elsewhere in the region, crack smoking kits are reportedly available only through a small number of drug services in Paris.[2] In the absence of ammonia – reportedly the preferred substance used to cook crack cocaine – some NGOs in Catalonia distribute sodium bicarbonate.[3]

d Spain.
e Portugal, Italy.
f Spain.
g Spain.
h Portugal.

OPIOID SUBSTITUTION THERAPY (OST)

Methadone maintenance treatment (MMT) and buprenorphine maintenance treatment (BMT) are available in all countries in South Europe, with Greece and Italy also providing buprenorphine-naloxone combination therapy (see table 3.3.1). HAT is available in Granada in the South of Spain in the context of the PEPSA trial.[4 5 6]

The most recent data indicate that provision varies across the region, from less than five OST sites in Cyprus (1) and Malta (≥2) to between 497 and 2, 229 sites in Spain and 19,484 in France.[7] A more accurate indicator of service coverage is the percentage of people using opioids enrolled in OST programmes;[10] however, available data is incomplete.[8] Of the countries for which data is available, only France and Italy provide high coverage of OST as defined by WHO, UNODC and UNAIDS (i.e. at least 40% of the total number of people using opioids enrolled in OST).[9]

Service access and uptake is limited by several factors, including insufficient geographical coverage within countries,[i] strict initiation criteria[j] and lengthy waiting lists.[k 2] In some countries, the poor availability of flexible dosing (i.e. individualized and 'take-home' doses) of MMT and BMT and the necessity to visit the dispensing centre daily act as barriers to access for some individuals.[l 2] In Portugal for instance, where MMT is the leading form of OST dispensed, its administration in insufficient doses[m 10] may act as a barrier to treatment effectiveness.[2]

In most countries where data is available, accredited general practitioners (GPs) can legally initiate OST, but the degree to which they do so varies.[10 2] OST, and particularly MMT, remain stigmatised among people who inject drugs,[n] as well as among GPs.[o 2] For instance, in France, approximately two-thirds of GPs who are licensed to prescribe MMT and BMT do not do so, thus limiting accessibility for individuals that reside far from major dispensing centers and in rural areas.[2] In Portugal, strict OST licensing requirements for practitioners act as an additional barrier to its wider accessibility.[2]

Limited integration and effective coordination

i France, Italy, Spain.
j France, Spain, Portugal.
k Portugal, Spain.
l France, Spain, Portugal.
m According to the WHO, UNODC and UNAIDS, an adequate dose of methadone consists of 60mg or more per day.
n In France, for instance, there are reports of some people who use drugs purchasing methadone on the illicit black market in an attempt to avoid stigma by active peers. Similarly, some GPs working outside major cities avoid taking on patients who use drugs and initiating them on MMT or BMT due to the stigma it carries among their professional peers.
o France, Spain, Portugal.

between OST and broader health care services,[p] and a lack of national guidelines for OST provision[q] pose further challenges to OST accessibility and scale up.[2]

DRUG CONSUMPTION ROOMS (DCRs)

Spain is the only country in South Europe that implements DCRs (see table 3.3.1).[11] DCRs are often targeted at specific user groups depending on the route of drug administration.[12] Of the seven DCRs in existence in Spain, two DCRs in Bilbao and Barcelona are targeted at people who smoke or inhale drugs, while the remaining five are directed at those who inject.[2] CSOs reported a need to scale up consumption rooms for people who smoke or inhale drugs, as well as implement DCRs targeted at users who snort and sniff drugs.[2]

Access to existing DCRs in Spain is limited by a number of factors, including narrow geographical coverage among provinces and outside of major cities, restricted opening hours, age restrictions for those under 18 and regulations on the types of substances that can be consumed on the premises.[2] Fear of arrest and perceived stigma pose additional barriers for some individuals. CSOs in all countries reported an urgent need for advocacy to increase the acceptability of this intervention and reduce the stigma associated with its use in the community and among people who use drugs.[2]

In Portugal, no legal restrictions to DCRs exist, but approval must be secured by each city council. To date, there are no cities in Portugal that have approved the piloting or implementation of a DCR.[2] On 19 May, 2009 the drug user organization ASUD stirred public and high-level political debate about DCRs in France by opening a "real/false" drug consumption room in Paris.[13] The French Ministry of Health has subsequently approved the implementation of DCRs, but the Prime Minister continues to oppose this measure.[14] As in other countries in the region where this intervention is not employed, the most significant barriers to implementation are lack of political will,[r] policy and legal restrictions[s] and negative public opinion.[t2]

SEX WORK AND HARM REDUCTION

Thierry Shaffaseur and Pye Jakobsson

Despite being implemented in many countries, harm reduction for sex workers is still a novel idea. Sex workers may experience a number of harms, including harms associated with drug use, vulnerability to HIV and other STIs, violence and discrimination. Harm reduction approaches can play an important role in protecting the human rights of sex workers, advocating for the decriminalisation of sex work and implementing strategies for the prevention of negative health outcomes. Such strategies can include peer outreach, provision of condoms and materials for safer drug use, labour regulations for the health and safety of sex workers, training in condom-negotiating skills and tips and self-support networks for street-based sex workers.

In many countries services targeting sex workers tend to have a "rescue" focus. The assumption is that sex work is not a profession one can freely choose and it is therefore always harmful to the individual. Providing access to health care, such as HIV prevention interventions, is often viewed as secondary to encouraging people to leave sex work. Approaching sex work from a harm reduction perspective not only respects the choice of the individual, but it also ensures that basic human rights, such as the right to the highest obtainable standard of health, are considered as part of interventions. This is particularly true for sex workers who use drugs, who experience the double stigma of engaging in multiple illicit and generally, illegal, practices.

It is crucial that alliances between harm reduction practitioners and sex work organizations are strengthened, and harm reduction approaches for sex work are systematically researched, implemented and evaluated.

p France, Spain, Portugal.

q Spain, Portugal. For instance, in Portugal MMT can only be prescribed by GPs working with the national Drug and Drug Dependence Institute (IDT), and MMT provision is not officially authorized by the IDT due to a lack of regulatory guidelines. MMT is provided only through some low-threshold programmes implemented by NGOs and who cooperate with a licensed IDT doctor.

r Italy, France, Portugal.

s Italy, France.

t Italy, Portugal.

HIV, VIRAL HEPATITIS AND TUBERCULOSIS (TB) SERVICES

HIV testing and treatment services

Implementation and scale up of harm reduction programmes has led to sustained low HIV incidence among people who inject drugs across this region.

However, some countries reported continuing barriers to HIV testing and treatment access despite its availability free of charge. In Spain, these include the lack of anonymity assurance around the disclosure of test results, stigma associated with a positive HIV test result, and lack of awareness among users around the availability of testing services.[2] In the Spanish context, a significant gap is the lack of culturally-specific harm reduction services for migrants who use drugs.[3] In northern Portugal, mobile VCT is employed widely to reach people who inject drugs that do not attend health centres.[2]

Where data is available, the number of people who inject drugs living with HIV that are receiving antiretroviral therapy (ART) in the region varies from 110 in Greece (ratio unknown) to 39 524 (ratio >63/100 people who inject drugs living with HIV) in Spain.[14] The social exclusion and poverty that many people who inject drugs living with HIV experience is reported to impede access and adherence to antiretroviral treatment (ARV).[2] Additional barriers in Portugal are posed by doctors' refusal to initiate people actively using drugs on ART and a lengthy, demanding process from diagnosis to treatment.[2]

Viral hepatitis testing and treatment services

Hepatitis B vaccination programmes targeted at high-risk groups, including people who use drugs, are implemented in France, Italy, Spain and Greece.[15] Greece, Spain, Italy and Portugal also implement HBV vaccination programs in prisons.[17] In Portugal, the requirement to pay for HBV vaccination is reported to deter some people who use drugs from accessing this service.[2] An outreach team in the North of Portugal has circumvented this obstacle by negotiating free access to HBV vaccination for its clients with the regional health administration.[16]

Several barriers continue to restrict access to HCV testing and treatment. In a number of countries in the region,[u] lack of awareness of transmission routes for HCV and limited peer support networks prevent some users from seeking an HCV test.[2] In Portugal and Spain, CSOs report that the lack of a rapid test for HCV deters some people who inject drugs that have vein problems from seeking a test.[2] Moreover, after undergoing a test, many users in Spain reportedly lack the resources to return for subsequent diagnosis and treatment.[2]

Barriers to accessing HCV treatment are numerous, even in countries where the state subsidizes most or all costs associated with treatment.[v] Negative associations with HCV treatment and its side effects deter some users from seeking treatment.[17] In Spain, access criteria, such as being drug-free, prevent some people who use drugs from benefitting from available treatments.[w] Although no formal criteria or guidance for prescribing HCV treatment exists in Portugal, many GPs refuse to initiate active opiate, cocaine and cannabis users on treatment due to false assumptions, including that adherence among people who use drugs tends to be low.[2 18 19] Moreover, referral processes may be lengthy and arduous, requiring registration with the relevant city council and several health service visits.[2]

Tuberculosis testing and treatment services

Several factors impede TB detection and management among people who use drugs in this region. In Spain and Portugal, CSOs report that many users access testing and treatment services only in the late stages of TB.[2] In Portugal, distrust of the public health care system and fear of discrimination from health professionals pose additional barriers to testing and take up. Screening processes that involve multiple appointments are a significant deterrent to take up of testing by people who use drugs, as do requirements to visit dispensing centres daily for treatment administration.[20] In Spain, public health agencies have the authority to coerce a patient who refuses to undergo treatment for TB to do so through a court order.[21]

HARM REDUCTION IN PRISONS

Spain is the only country in the region that implements NSPs extensively in prisons.[22 23]

OST is available for initiation and continuation in prisons in Portugal, Spain, Italy and France, but service coverage varies between countries and among prisons.[25] In Malta, OST is continued in prison if the inmate was already enrolled in the programme prior to arrest; however, there are no inmates presently accessing this service.[27] According to data from 2009, 12% of all prisoners

u France, Spain, Portugal.

v For instance, France.

w Access criteria includes being drug-free.

in Spain received MMT.[26] In France, this intervention remains limited, but anecdotal reports confirm that provision has increased since 2004.[27] There is no OST available in prisons in Greece, and in Portugal prisoners may be denied access if they are actively using drugs.[2] Across the region, poor coordination of OST continuity upon release from prison poses additional barriers to managing drug-related harms.[2]

Several factors act as barriers to accessing prison-based NSPs where these exist, and implementing them where they do not exist. CSOs noted that it is often individual prison directors who ultimately decide whether or not to implement a particular programme.[2] In some Spanish prisons, prison staff are reported to coerce prisoners into providing information on peers who utilise the service.[2] The only pilot NSP in Portuguese prisons was terminated in 2007 within a few months due to logistical challenges, methodological inconsistencies and resistance from prison guards and other prison professionals.[22]

Ideological arguments by policy-makers in France, Spain, Italy and Portugal that deny the existence of drug use in prisons, focusing instead on drug control and abstinence-based measures, continue to challenge implementation and scale up of evidence-based harm reduction interventions in prisons.[2]

OVERDOSE RESPONSES

Overdose prevention responses including provision of overdose training material to people who use drugs, individual overdose risk assessment, overdose response training and risk education on drug-related deaths are limited, rare or nonexistent in most countries across the region.[28] The exceptions are Greece and Italy, where responses are extensive,[x] and Portugal, where it is reported that overdose information materials and risk education training are widely implemented.[y 30]

Availability of naloxone and its distribution by peers varies among countries in the region. In some parts in Spain, in particular Catalonia, CSOs distribute naloxone among peers upon request and provide trainings on naloxone administration and management.[2] In Italy, naloxone is available for purchase at pharmacies without a medical prescription, and outreach workers may administer it directly to the individual in case of an overdose.[2] In France, despite naloxone's legal status and its availability for sale at pharmacies, take up by people who use drugs, their families and communities is reported to be low.[19] In Portugal naloxone is not available to outreach workers and peers,[z] but as reported here and across the region, it is a 'highly sought' intervention in 'short supply.'[2]

Additional factors that limit effective prevention and management of overdose in the region include legal barriers around its administration and transportability, and lack of awareness among people who use drugs, their families and communities about the benefits of naloxone as an evidence-based method for managing drug overdose.[2]

HARM REDUCTION FOR RECREATIONAL DRUG USE

Safer nightlife initiatives, including outreach, counseling in recreational settings, information and education campaigns and materials, are implemented in all countries in the region to varying degrees.

Harm reduction initiatives are implemented in Italy and Portugal, but coverage varies widely from region to region.[2] The most extensive harm reduction programs in recreational settings exist in Spain, where multi-regional projects such as Energy Control have been operating since 1997 with explicit policy support.[aa 29] Safer nightlife initiatives across the country provide risk reduction trainings to recreational professionals such as security, bartenders and event promoters, utilise peer outreach on- and off-site, employ a variety of new media outlets, including online tools such social networking sites, Bluetooth and text message to disseminate information to party-goers.[29] Energy Control and Ailaket, a project in the Basque region, also provide an instant alert system to users, health care referral systems and monitoring centres for a wide range of substances used in recreational settings.

Spain is the only country in the region where on-site pill testing in recreational settings is widely implemented.[29] In Portugal, only one outreach team, Check-in, is authorized to test drugs on-site in recreational settings.[30] In France, pill testing was legally permitted as a harm reduction measure in raves and other party settings until 2004.[19]

Several challenges remain to the implementation and scale up of safer nightlife initiatives in most countries

x 'Extensive' is defined by the EMCDDA (2010) "a majority of the target group (but not nearly all of them) have received the service during the last year at least once."

y i.e. to nearly all members of target group have received the service during the last year at least once, and in nearly all cities or towns where the size of the drug user population is sufficient for the implementation of the intervention.

z Outside of emergency services in Portugal, naloxone is also administered by nurses as part of one outreach team.

aa Harm reduction in recreational settings is explicitly mentioned in Spain's National Drug Strategy and in the ***Libre Blanc De Prevenció***, Spain's official 'white book of prevention' that details nationally-recognised good practices.

in the region. With the exception of Spain, where initiatives are subsidized by the state, existing projects elsewhere tend to be small-scale, volunteer-run or minimally funded.[2] The limited reach of interventions to settings outside the 'traditional' rave and techno scenes suggests that diversified approaches to delivering safer nightlife initiatives may be required.[29] CSOs expressed a need to move beyond information and education campaigns to disseminating an extensive range of materials in recreational settings, including earplugs, sniff tubes, personal drug use assessments, alcohol breathalyzers and condoms.

Safer nightlife and the NEW IMPLEMENTATION project

Thierry Charlois and Claudia Stoicescu

The high prevalence of synthetic drug and polydrug use in recreational settings such as clubs, raves or festivals makes these important venues for implementing harm reduction interventions. However, setting-based interventions remain scarce in most countries in Europe.

An innovative multi-country project[a], the 'Nightlife, Empowerment and Well-being Implementation' project (NEW Implementation), aims to respond to emerging challenges in recreational settings including party tourism, new drug use trends, the need to improve peer empowerment within the nightlife community, as well as filling geographic coverage gaps. The three-year project started in early 2011, and aims to develop, implement and exchange harm reduction guidelines, standards and good practices for recreational settings.

As part of the initiative, partners plan to implement a range of comprehensive activities to address drug use in recreational settings across Europe. This includes field interventions at six major international festivals in Europe and introduction of safer party labels in 12 EU cities involving the local communities ("Party +" network), as well as development of an early warning system on dangerous substances and new trends.

a Austria, Belgium, France, Germany, Italy, Netherlands, Portugal, Spain, with collaborating partners also located in Lithuania, Romania, Slovenia and the United Kingdom.

POLICY SUPPORT FOR HARM REDUCTION

All countries in the region, with the exception of Italy, make explicit reference to harm reduction in their national drug policy documents. In practice, support for harm reduction varies widely among regions in Italy, and most harm reduction programmes are still in pilot stage.[31] Along with Sweden, Italy has played a consistent role in opposing the European position on harm reduction during negotiations at the UNODC General Assembly. Across the region, implementation of harm reduction programmes generally rests with local governments.[2]

In some countries where formal support for NSPs and OST exists (i.e. France and Portugal), public acknowledgement of support for broader harm reduction interventions such as DCRs and pill testing is scarce.[2]

Where available, financial support for harm reduction varies within countries. For instance, while Barcelona and the Catalonia region benefit from partial government grants, this support is not available consistently to all regions.[2] Although the Portuguese government co-finances all NSP services across the country, this support is insufficient and increasingly delayed due to the economic crisis.[34] Other conditionalities on support include a two-year cap on project funding, which challenges the sustainability and continuity of several programmes around the country.[19] France's CAARUD framework guarantees sustainable funding to CSOs for 10 years provided that they meet strict monitoring and evaluation criteria, but some community-based organisations are either unable or unwilling to join.[29] Across South Europe, recent funding cuts to health and social welfare interventions, and opposition by some local authorities have restricted the scale up of interventions to levels sufficient to impact on drug-related epidemics.[2]

DRUG USER INVOLVEMENT IN HARM REDUCTION RESPONSES

Meaningful involvement of people who use drugs in service design, implementation, monitoring and evaluation is very limited across South Europe. CSOs report that user representation in the form of councils with consultative status to various drug and health services is present in some areas in France, Italy and Spain.[3] However, while users are physically represented at the individual and organizational levels, their level of involvement is often tokenistic.[2] OST and drug treatment centers in Spain operate under regulations specifying the involvement of two user advisors in clinical team meetings,

but in practice these rules are rarely implemented.[32]

Levels of representation of autonomous groups of people who use drugs working toward self-determination agendas in the region vary between countries. In France, representation of people who use drugs has reportedly weakened over the past decade. For instance, the number of ASUD member groups in France has been steadily decreasing, from 26 in 1998 to only four in 2010.[29] In Portugal, however, people who use drugs have become increasingly active, with CASO, a new national user group founded in 2010, now reporting more than 30 members.[16]

Meaningful user involvement in the region is hampered by the perception that people actively using drugs do not have the necessary technical expertise to contribute to agendas and services affecting their interests.[2] There is an urgent need for CSOs and user groups to advocate for the empowerment of people who use drugs through meaningful involvement in policy-making and service provision, including design, implementation, monitoring and evaluation.

CIVIL SOCIETY AND ADVOCACY

Civil society organisations advocating for harm reduction operate at the local, national, regional and international levels in the South Europe region.[3]

In France, Spain and Portugal, advocacy activities are partly funded by local or national governments and generally led and implemented by CSOs.[3] Additional funding sources reported by CSOs in the region include the European Commission and European regional networks.[34] There is no state support or funding provided for civil society organisations advocating for harm reduction in Italy.[35]

National harm reduction networks operate formally in France and Portugal, but coordination of local and national advocacy priorities among CSOs is also reported in Spain.[2] At the time of publication, CSOs advocating for harm reduction in Italy were in the process of mobilizing around a national network with a shared platform and agenda.[35] The majority of CSOs in this region are also involved regionally at the European level and internationally through participation in several networks such as EuroHRN, CLAT, ENCOD, Correlation, and DCD, or through membership in international organisations such as Harm Reduction International.

In all countries where information was available, CSOs identified the following advocacy priorities:

- Implement evidence-based harm reduction services, particularly NSPs, and scale up provision of OST in prisons and other places of detention[ab]
- Implement or scale up DCRs[ac]
- Increase integration of harm reduction interventions, including overdose prevention programs, safer nightlife initiatives, and testing and treatment services for HIV, viral hepatitis and tuberculosis[ad]
- Improve the meaningful involvement of people who use drugs in service design, delivery, monitoring and evaluation[ae]

Other advocacy priorities in the region included the development of national standards for distributing drug snorting and smoking materials through NSPs,[af] regulation of drug testing programs in recreational settings,[ag] and standardization of national access criteria to low-threshold harm reduction services.[ah]

ab France, Spain, Italy and Portugal.
ac France, Spain, Portugal.
ad France, Italy, Portugal and Spain.
ae France, Portugal, Spain.
af Portugal.
ag Portugal.
ah Spain.

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