2.3 | Regional Update
Western Europe

Table 2.3.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Western Europe

Country/territory with reported injecting drug use	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)[b]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[c]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[d]	Harm reduction response		
					NSP[1 e]	OST[2 f]	DCR[g]
Andorra	nk	nk	nk	nk	✖	✖	✖
Austria	17,500 (12,000–23,000)[h]	0.7–5.3	43.4–65.3	nk	✔ (31)	✔ (B,M,O)	✖
Belgium	5,125 (3,377–7,829)[3]	3.4–6 [(s)]	28.1–80 [(s)]	0–2.8 [(s)]	✔ (69)(P)	✔ (B,H,M)	✖
Cyprus	467 (418–539)[3]	0–1.3	51.3	1.7	✔ (1)(P)	✔ (1)(B,O)	
Denmark	12,754 (10,066–16,821)[i 3]	2.1[i]	52.5	1.3[j 4]	✔ (135)[i]	✔ (B,H,M)	✖
Finland	15,650 (12,200–19,700)	0.7 [(s)]	60.5	nk	✔ (40)	✔ (B,M,O)	✖
France	122,000[l]	5.1–8[i] [(s)]	41.7[l] [(s)]	4.8 (3.4–6.2)[m 4]	✔ (532)(P)	✔ (19,484)(B,M,O)	✖
Germany	94,250 (78,000–110,500)	3.4[j]	75[j n]	7.2 (6–8.4)[o 4]	✔ (250)	✔ (2,786–6,626)(B,H,M)	✔ (27)
Greece	9,439 (8,110–11,060)[3]	0.7–0.8	48.7–68.8	2.9–3.6	✔ (6)(P)	✔ (17)(B,M,O)	✖
Iceland	nk	nk	63[p 4]	nk	✖	✔ (B,M)	✖
Ireland	6,289 (4,694–7,884)[q]	5.8[v 4]	74.6 (72.3–76.9)[4]	0[k 4]	✔ (32)(P)	✔ (332)(B,M,O)	✖
Italy	326,000[q]	11.5	58.5	5.1 (0.9–9.3)[r 4]	✔	✔ (B,M,O)	✖
Luxembourg	1,485 (1,253–1,919)[j 3]	2.4	71.8–90.7[s]	3.9[s]	✔ (8)	✔ (B,M,O)	✔ (1)
Malta	nk	0	36.3		✔ (7)	✔ (≥2) (B,M)	✖
Monaco	nk	nk	nk	nk	✖	✖	✖
Netherlands	2,390 (2,336–2,444)[3]	0 [(s)]	47.6–67.4 [(s)]	1–13 [(s)]	✔ (175)[5] (P)	✔ (B,H,M)	✔ (40)
Norway	10,238 (8,810–12,480)[3]	2.4	69.9	0 [(s)]	✔ (29)[rr](P)	✔ (B,M)	✔ (1)
Portugal	10,950–21,900[3 s]	4.9–17.2	36.5–83.1	2–3.4	✔ (1,620)(P)	✔ (B,M)	✖
Spain	83,972[t]	32.3	79.6 (73.3–85.9)[u 4]	3.6 (1.8–5.3) [4]	✔ (2,274)(P)	✔ (497–2,229)(B,H,M)	✔ (7)
Sweden	nk	2 [(s)]	59.7[(s)]	2.3 [4]	✔ (2)	✔ (B,M)	✖
Switzerland	31,653 (24,907–38,399)[v]	1.4 [4]	78.3[w 4]	4[4]	✔ (101)(P)	✔ (B,H,M,O)	✔ (7)
Turkey	nk	0.5	5.3 [(s)]	5.2 [4]	✖	✖	✖
United Kingdom	133,112 (126,852–143,278)[3 x]	0–4.3 [(s)]	26.1–61.2	8.9 (0–17.8)[y 4]	✔ (1,523)(P)	✔ (B,H,M,O)	✖

nk= not known
[(s)] = sub-national data

a Unless otherwise stated, data are sourced from Mathers B et al. for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, Lancet, 372(9651):1733–1745.
b Unless otherwise stated, data are sourced from European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) (2012) Statistical Bulletin 2012: Table INF-1. Prevalence of HIV infection among injecting drug users in the EU countries, Croatia, Turkey and Norway, 2010 or most recent year available, http://www.emcdda.europa.eu/stats12#display:/stats12/inftab1.
c Unless otherwise stated, data are sourced from EMCDDA (2012) Table INF-2. Prevalence of HCV antibody among injecting drug users in the EU countries, Croatia, Turkey and Norway, 2010 or most recent year available, http://www.emcdda.europa.eu/stats12#display:/stats12/inftab2.
d Unless otherwise stated, data are sourced from EMCDDA (2012) Table INF-3. Prevalence of markers for HBV infection among injecting drug users in the EU countries, Croatia, Turkey and Norway, 2010 or most recent year available, http://www.emcdda.europa.eu/stats12#display:/stats12/inftab3.
e The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines, pharmacy-based NSP sites and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets, and (NP) = needles and syringes not available for purchase.
f The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine, (BN) = buprenorphine-naloxone combination, (H) = heroin-assisted therapy, (O) = any other form (including morphine and codeine).
g DCR = drug consumption room.
h Year of estimate: 2000
i Year of estimate: 2006
j Year of estimate: 2007.
k Year of estimate: 2003.
l Year of estimate: 1999.
m Year of estimate: 1992–1995.
n Year of estimate 2004.
o Year of estimate: 1992–1994.
p Year of estimate: 1990–1993.
q Year of estimate: 1996.
r Year of estimate: 1990–91 and 1992–93.
s Year of estimate 2005.
t Year of estimate: 1998.
u Year of estimate: 1999–2001, 2003.
v Year of estimate: 1997.
w Year of estimate: 2002.
x Year of estimate: 2004–2010.
y Year of estimate: 1996–2000.

Map 2.3.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)

- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not known
- DCR available

Harm Reduction in Western Europe

Injecting drug use (IDU) remains common in Europe for both opioids and amphetamines, with significant user populations in Italy, France, Spain, the UK and Germany. Approximately 1 million people who inject drugs (PWID) reside in Western European countries.[6] While low HIV prevalence among PWID in many countries in Western Europe has been linked with the early implementation of harm reduction programmes, the scope and reach of programmes remains uneven. Almost all countries in the region have operational needle and syringe exchange programmes (NSPs) and opioid substitution therapy (OST), but some national programmes are too small to have any clear impacts, and many of the larger programmes are under constant threat of closure. European countries continue to feature among those with the highest coverage of harm reduction programmes globally,[z] but to protect and promote these services moving forward will require concerted cooperation between harm reduction advocates and policymakers, particularly in a time of ever-increasing financial hardship.[7]

NSPs are available in all countries in the region except for Andorra, Monaco, Iceland and Turkey. Geographical coverage, however, varies greatly from country to country, with only one NSP site reported in Cyprus, for example, compared with more than 1,000 in Spain and Portugal.[2] No considerable expansion in NSPs has been reported in the region since 2010, although one new programme has opened in Helsingborg in Sweden, which is the first such development in over two decades in the country.

Various forms of OST are provided across the region through publicly and privately funded clinics and pharmacy dispensing programmes. These include methadone maintenance treatment (MMT), buprenorphine maintenance treatment (BMT), heroin-assisted therapy (HAT) and other forms of OST including morphine and codeine. Turkey introduced buprenorphine-naloxone combination for substitution therapy in 2010. Even though regional and national OST coverage rates vary substantially, levels of coverage in Western Europe (61% of PWID receiving OST) are high compared with other world regions.[2] In some countries, however, OST programmes are implemented on a very small scale. Cyprus and Malta operate only one and two OST sites, respectively.

The majority of the countries in Western Europe lead in the provision of harm reduction services in prisons. However, coverage of prison NSPs and OST varies across the region, and there is lack of data for all countries. Extensive prison NSPs are in place in Spain and Luxembourg.[7]

The decrease in new HIV infections within the EU over the last decade has been brought about by a number of factors, including more easily available harm reduction measures and a decline in IDU, as well as better prevention and treatment services. But while NSPs and OST have become widely accepted within the EU, other effective interventions such as drug consumption rooms (DCRs) and HAT remain controversial and rare. There are 85 DCRs in six countries across the region.[8] Denmark is the first country in the world to have passed legislation to regulate the operation of such facilities via a new law adopted on 1 July 2012.

Western Europe is reported to have the highest regional level of antiretroviral therapy (ART) coverage among PWID in the world, but considerable barriers to universal access remain. Coverage of ART in prisons varies across the region,[7] while poverty and social exclusion impede access and adherence. In some countries (such as Portugal) it has been reported that doctors have refused to allow people who use drugs (PWUD) to initiate ART.[7]

In those Western European countries that saw the first heroin epidemics, populations of PWID are growing older. Harm reduction services will need to monitor their specific health and social needs, as well as the challenges that an ageing population presents to service providers.[9]

While heroin remains the most popular drug among older users, amphetamine-type stimulants (ATS) are the most popular amongst young people.[9] ATS users are estimated to make up 28% of those entering treatment in Sweden, 17% in Finland[10] and smaller proportions in Belgium, Denmark, Germany and the Netherlands.[10] Solid data on prevalance of ATS injection, however, are not available.

Indeed, while the monitoring of drug use and related harms in Europe continues to be good, there are significant gaps in knowledge, particularly in relation to young people, migrants, street-involved people and other vulnerable populations. In the case of young people, the focus on home and school surveys inevitably excludes those outside mainstream education and outside the home, and more attention and funding is needed for other forms of data collection. Drug use studies also tend to examine imprecise and problematic criteria such as lifetime or last yearly use, which may obscure specific patterns of use that may be driving drug-related harms. Service and treatment data in many countries, meanwhile, obscure non-service-using populations, contributing to a general paucity of data that diminishes the potential impact of harm reduction.

Funding for drug policies, meanwhile, has been hit hard by European governments' responses to the economic crisis. In its 2011 annual report, the European Monitoring Centre for Drugs and Drug Addiction estimates that from 2008 to 2011 these cuts ranged from 2% to 44%.[10] Meanwhile, the European

z According to the 2009 WHO, UNODC, UNAIDS target-setting guide, <100 syringes distributed per person who injects drugs per year is considered low coverage; 100–200 is medium coverage, and >200 is high coverage.

Union (EU) is becoming increasingly fragmented on a political level in its approach to harm reduction. Countries such as the UK that have championed the harm reduction approach in the past are beginning to shift towards more abstinence-oriented policies.[11] How this will impact the EU as a whole is, as yet, uncertain, but is likely to become clearer with the drafting of the new EU drugs strategy due for completion at the end of 2012.

Developments in harm reduction implementation

Needle and syringe exchange programmes

With a few exceptions, NSPs are widely available in Western Europe (see Table 2.3.1). Across the region a variety of service delivery models are in place including stand-alone sites, pharmacy-based services, vending machines (in Austria, Denmark, France, Germany, Italy and Spain), outreach and peer outreach services,[1] and mobile NSPs exist in roughly half of the countries in the region.[1] Portugal and France have high proportions of NSP sites with outreach workers (96 and 91, respectively), while with 1,360 sites Portugal is leading the way in pharmacy-based services to supplement fixed NSP outlets.[1]

Despite good levels of provision across most of Europe in comparison with other world regions, the reach of interventions remains uneven among and within countries. Only one operational NSP site is reported in Cyprus, three in Sweden and up to 2,274 in Spain and 1,620 in Portugal. The number of NSP sites has doubled in Luxembourg and Belgium, while in Sweden, a third NSP site was established in Helsingborg in 2010, and an additional site is planned to be opened in Kalmar in late 2012. No considerable expansion in other countries was reported since 2010. Furthermore, national NSP coverage estimates often hide dramatic geographical variations. This represents an important gap in accessibility in smaller cities and rural areas in, for example, Spain, Portugal, Ireland, Germany, Finland, Belgium and Austria.[12]

Another measure of service coverage, however, and one that allows for international comparisons of available data, is the number of syringes distributed per PWID per year.[13] Luxembourg and Norway are the only two countries in the region that distribute 200 or more syringes per person per year, which represents high coverage according to the joint WHO, UNODC and UNAIDS technical target-setting guide.[13] Coverage remains low in Sweden, Cyprus and Greece, where less than 100 syringes are distributed per person per year.[14]

Increased occurrence of non-opioid injecting, such as the use of anabolic steroids, has been documented in some parts of Europe (for example, Belgium and the UK). However, shortage of data on the prevalence of steroid injecting and its low priority within national drug budgets have prevented the development of targeted strategies to address this user group's needs.[15]

Due to service-user anonymity there are no available data on the average age of NSP clients, but data from EMCDDA and WHO Europe indicate that, as a group, the population of PWID across the region is growing older.

Opioid substitution therapy

All countries in the region, with the exception of Andorra and Monaco, provide MMT and BMT (see Table 2.3.1). Additional OST options, including HAT, buprenorphine plus naloxone combination and slow-release morphine, are widely available across the region. Turkey is reported as providing licensed buprenorphine-naloxone combination since 2010.[16] However, the number of clients currently enrolled in the programme is not known. In several countries, data on OST coverage at the national level are unavailable due to variation in the types of service provision sites, as well as a lack of strong national monitoring systems.

Fifteen EU Member States[aa] provide 95% of the total OST in Europe, and the number of OST sites in these countries continues to increase.[17] More than half – 700,000 – of Europe's population of people who use opioids are enrolled in OST.[ab] This demonstrates a strong coverage exceeding the UN's recommended target figure of 40% as sufficient to address the spread of HIV among PWID.[18] However, within Europe this coverage is far from even, with some countries such as Germany and Italy exceeding this average, and others such as Cyprus far below it at 5%.[19, 20] France has 19,484 OST sites, the highest number of any country in the region where data are available.[2]

In many countries OST provision includes access through general practitioners (GPs), although levels of regulation governing OST prescription by GPs vary considerably. For example, in Norway GPs can prescribe MMT and BMT to patients already enrolled in OST at a specialised centre, but they are not legally allowed to assess a patient's need for treatment. In France, experts estimate that two-thirds of GPs who are licensed to prescribe MMT and BMT are reluctant to do so, thus limiting accessibility for individuals living outside large cities.[21]

As with NSP clients, significant changes have been noted in the age profile of OST clients in Europe. In Greece 61% are aged 40 or over, while in the Netherlands the figure is around 75%, with the 40–49 age group making up almost half of all OST clients.[22] This trend has also been noted, albeit to a lesser extent, in other countries where data are available.

aa Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, UK.
ab Based on estimates derived from EMCDDA regional divisions, which may be different than those of HRI in this report. For more information, please see www.emcdda.europe.eu.

Heroin-assisted treatment in Europe

Heroin-assisted treatment (HAT) has increasingly emerged as an effective second-line treatment among individuals for whom OST and other drug treatment modalities have produced limited benefit.[18, 23] As of 2012, seven countries implemented supervised injectable heroin (diacetylmorphine) as maintenance treatment: Denmark, Germany, the Netherlands, Spain, Switzerland, the UK and Luxembourg (pilot programme). In 2011, Belgium's pilot HAT project was expanded to deliver treatment nationally.[24] According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), overall there were approximately 1,000 HAT patients in EU Member States and a further 1,400 in Switzerland as of April 2012.[18]

*For more information, see EMCDDA (2012) *EMCDDA Insights: New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*. Lisbon: EMCDDA.

Antiretroviral therapy

While Western Europe as a whole has the highest level of coverage across the globe, there is significant variation between countries.[2]

In Luxembourg, for example, the country with the greatest percentage of PWID living with HIV on treatment, 70% of PWID were enrolled on ART in 2010, while in Portugal only 10% of PWID living with HIV were on treatment.[2]

With early diagnosis of HIV, many more PWID are likely to obtain the maximum benefit from ART. For instance, a decrease in AIDS diagnoses in Austria, the Netherlands and Finland has been attributed to early diagnosis and initiation of ART.[25] High incidence rates of AIDS in some countries may indicate that PWID living with HIV are not accessing ART in the early stages following an HIV diagnosis.[2] Austria has one of the highest rates of HIV tests per capita in Europe, but it is unclear whether PWID are accessing the service in numbers comparable with other groups at higher risk of HIV.[25]

Across the region there remain significant barriers to PWID accessing and adhering to ART, including homelessness, lack of insurance, lack of support and stigma from health professionals.[26] Moreover, national data on ART coverage for PWID are not universally available within Western Europe, limiting a full understanding of availability, coverage and adherence.

Responding to an HIV outbreak among people who inject drugs in Greece

In 2011 Greece reported an outbreak of new HIV infections among people who inject drugs.[27-29] By the end of July 2011, 113 cases had been reported by the national surveillance system, compared with between three and 19 reported cases per year from 2001 to 2010. A rapid situation analysis by the EMCDDA found that several factors may have contributed to the increased risk of acquiring HIV, including the absence of comprehensive harm reduction programmes for HIV prevention among PWID, as well as targeting of injectors by the police, which has previously been shown in other settings to hinder service uptake and encourage increased risk-taking behaviour such as needle and syringe sharing. The rapid assessment also revealed that Greece has relatively few low-threshold programmes for PWID (OST waiting lists range from five to seven years), and coverage of NSPs and OST is low.[30]

The response from public health authorities and civil society in Greece has included a major restructuring of the OST programme, including the immediate provision of 28 new OST units, a switch from high to low dead space syringes, and an awareness campaign targeted at injectors in Athens, where incident cases are concentrated.[31]

Drug consumption rooms

The provision of DCRs varies across the region, with nationwide coverage in Switzerland and the Netherlands, regional coverage in Germany and Spain, and DCRs in the capital cities only in Norway and Luxembourg. In total there are 85 DCRs across 56 cities in these six countries, the majority of them integrated into more general health and social service provision networks.[32] With a widespread switch from injecting to sniffing drugs across the region there has been an increase in DCR booths dedicated to this purpose, including a pilot study in Luxembourg in 2012.[33]

New legislation governing DCRs was introduced in Denmark in July 2012, making it the first country in the world to have legally regulated DCRs. This followed political discussion generated by a mobile DCR operated by an NGO without police interference in Copenhagen since 2011.[32]

Despite the progress that has been made in the implementation of DCRs in Europe, most countries still do not allow their operation. Moreover, a number of barriers to access remain in relation to those DCRs that do exist such

as exclusion criteria that deny access to clients who receive OST (Luxembourg and Germany) and exclude non-nationals (Switzerland), as well as restricted opening hours, age restrictions for under 18s and regulations around the type of substance that can be consumed on the premises.[7]

Viral hepatitis

In contrast to low HIV prevalence among PWID in many countries in Western Europe, rates of viral hepatitis (HBV and HCV), and HCV in particular, remain disproportionately high among PWID. According to a recent systematic review on the epidemiology of viral hepatitis among PWID, there are an estimated 727,500 PWID with HCV and 480,000 PWID with HBV across the region.[4]

Prevalence of HCV varies widely across the region, from a high of 71.8–90.7% in Luxembourg, a significant public health issue, to a low of 5.3% in Turkey[34] (see Table 2.3.1). Rates of HCV among PWID in Cyprus have increased significantly between 2004 and 2010, with a steep rise from 9.1% to 51.3%,[34] based in part on widespread equipment sharing as well as a general shortage of services.[35] HCV rates are particularly high among new injectors, and there are reported rises in prevalence among these populations in Greece and Portugal.[34] Reported prevalence can also vary significantly within countries, based on sampling biases and regional variations.[34]

Barriers to HCV testing and treatment include lack of data, lack of awareness among medical professionals of the risks of co-infection with HIV, and restrictive costs, which are often not covered by health insurance or unavailable to the uninsured. In Spain and Finland PWUD are excluded from HCV treatments.[7]

HBV rates among PWID are similarly varied across the region, although general levels of prevalence are low. The highest is in the UK with 8.9%, while Ireland and Norway report 0%.[4] HBV vaccination programmes targeting specific high-risk groups, including PWID, operate in most countries in Western Europe, with the exception of Malta and the Flemish part of Belgium.[37] In Portugal, the requirement to pay for HBV vaccination is reported to prevent many PWID from accessing this service.[38]

Tuberculosis

Data on tuberculosis (TB) prevalence among PWID in Western Europe are scarce. Estimated incidence of TB in the general population vary, but are less than 24 per 100,000 population in almost all countries for which data are available.[39] The only exceptions are Spain and Portugal, where TB rates exceed those in other Western Europe countries at 25 and 49 per 100,000 population, respectively.[39] According to the EMCDDA, high rates of TB were reported among PWID in treatment in Greece, while systematic testing in drug treatment facilities in Austria and Norway did not identify any cases.[40] An increase in the number of cases of TB among migrants who use drugs has been reported in Ireland, Sweden and Switzerland, but data are not available for this population. In Portugal, distrust of the public health care system and fear of discrimination from health professionals are reported to pose barriers to TB testing and treatment.[38]

Models for delivering integrated HIV, viral hepatitis and TB services are not well documented across Europe. Recently, the WHO Regional Office for Europe prioritised investigating strategies for the effective delivery of integrated HIV-TB interventions.[41] A WHO-supported assessment of existing strategies in Porto, Portugal, documented two models[ac] and emphasised the importance of a client-centred approach that combines collaboration among existing services, outreach programmes and uninterrupted provision of OST and other drug treatment while providing TB-HIV care.[42]

Harm reduction in prisons

Data from the EMCDDA on HIV and viral hepatitis infection among PWID in prisons across the region are only available for four countries: Spain, Malta, Finland and Sweden.[43] HIV prevalence among prisoners who inject drugs ranges from 0.2% in Finland to a high of 39.7% in Spain.[43] The highest reported HCV levels among PWID in prisons are in Luxembourg, where 90.7% of PWID are HCV-positive.[44]

Although data on TB among prisoners who inject drugs are scarce, studies show that the risk of TB in prisons is on average 23 times higher than in the general population.[45]

Relative to other world regions, countries in Western Europe lead in the provision of harm reduction services in prisons. Prison NSPs are available in Spain, Luxembourg, Switzerland and Germany, and very limited NSP pilot programmes exist in Scotland. Only one prison, however, offers the service in Germany, and in Switzerland provision of NSP in prisons depends on the decision of each canton.[46] The only pilot NSP that was available in Portuguese prisons was terminated in 2007 due to logistical challenges and resistance from prison guards.[1]

OST is available in prison settings to varying degrees in most countries in the region, with the exception of Greece. In Sweden, OST in prison started as a pilot project in 2007 and was continued as a national programme in 2010, but coverage remains poor.[47] Switzerland is the only country in the region which provides HAT in prisons, with two facilities presently offering this service.[48] In Finland, Sweden and Malta OST cannot be initiated in prison, but PWID may continue treatment if they were already accessing OST in community settings at the time of their arrest.[49, 50]

ac The two strategies included a 'combined model' where all services are provided within a central location by a multi-disciplinary team, and a 'collaborative' model, characterised as client-centred and informal, which involves collaboration of service providers and outreach teams to deliver treatment in a location convenient to the client.

Overdose

Opioid overdoses are a major cause of mortality among PWID, accounting for between 10% and 23% of drug-related deaths in the 15–49 age group.[51] The most likely periods for PWID to overdose are after release from prison or if OST is interrupted. A study of 382 PWID taking part in a prison-based OST programme documented no deaths during OST but 13 deaths when OST was interrupted – eight of them overdose-related.[52]

Across the region, overdose prevention responses are implemented to varying degrees but include the provision of overdose information material to PWUD, individual overdose risk assessment and overdose response training. Naloxone is a registered medication in all Western European countries, but its availability varies across the region and within countries. In Scotland, for example, nurses and pharmacists can prescribe and dispense the Scottish Naloxone Programme's kits, while elsewhere in the UK the medication is only currently available through limited-scale pilot programmes, with scale-up anticipated soon.[53] In a new review released in May 2012 the UK Advisory Council on the Misuse of Drugs (ACMD) recommended that the government take concrete steps to make naloxone more widely available[ad] including by easing restrictions on who can be supplied with naloxone and investigating how peers can be trained to administer it in emergencies. In 2011 Scotland promoted the availability of naloxone to approved services without prescription for use in emergencies.[54]

Naloxone is only available on a takeaway basis in Italy, Germany, Spain, Scotland and Norway.[55] In Denmark a small-scale trial of peer distribution of naloxone operates in the country's capital, with a limited number of social workers prescribed the medication, and further expansion of the programme is still pending.[56]

Policy developments for harm reduction

At a national level all countries in the region,with the exception of Italy and Sweden, explicitly support harm reduction in their national drug policy strategies. Implementation of harm reduction services in many countries, however, is carried out by local governments. In Sweden, for example, the provision of NSPs is reliant on local political approval, which has hindered the scale-up of new programmes, including in the country's two largest cities.[57]

Despite long-standing support for harm reduction within the region, however, since 2010 there have been incidences of policy shifts away from harm reduction from countries that have traditionally been strong advocates for the approach. For example, the UK has one of the lowest levels of HIV among PWID in Europe, which is often attributed to the early introduction of harm reduction programmes in the country.[58] But support for harm reduction in the UK has been undermined in the past two years due to leadership changes, although tensions remain between ministries. In March 2012 the UK government published a new roadmap document entitled *Putting Full Recovery First*, which strongly prioritised an abstinence-based approach. In response to the roadmap, civil society organisations (CSOs) such as the Terrence Higgins Trust, the National AIDS Trust and Release have addressed an open letter to the UK government, warning that ministers will be putting lives at risk and reversing decades of success in HIV prevention if harm reduction is undermined.[59]

At the regional level, policy developments currently centre around the drafting of the new EU drugs strategy. The current strategy will come to an end in 2012, and the new drug policy framework will be the first adopted under the Lisbon Treaty. At the time of writing, the new strategy is being drafted, but it has been a relatively closed process. CSOs were not invited to provide input, and it is, therefore, not possible to comment on its content. Moreover, although harm reduction objectives are strongly present in the demand reduction area of current EU drug policy documents, the recent rollback of EU funding opportunities for harm reduction may become an obstacle for its sustainability in Europe.

The EU, as a bloc, has traditionally been a strong voice for harm reduction at the international level. But recently the EU has become increasingly fragmented. This shift can be attributed in part to ongoing advocacy from countries that are anti-harm reduction (in particular Sweden and Italy) and in part to harm reduction being viewed as less important for diplomacy for countries that had previously adopted strong leadership roles at the international level.[ae]

ad Although naloxone has been available under UK law since 2005, it remains a prescription-only drug and is only licensed for use in injectable form. As such, non-medical services and people who use drugs, their families and peers, who may be more frequently present during the occurrence of opiate-related overdoses, are not able to legally hold stocks of naloxone and administer it in emergencies.

ae See section 1 'Policy Development' for further information on the EU at an international level.

Civil society and advocacy developments for harm reduction

CSOs and organisations of PWUD continue to play a central role in harm reduction advocacy and responses in the region. National harm reduction networks are active in many countries including Germany, the UK, Ireland, France and Portugal. Italian harm reduction organisations are currently in the process of forming a national network, planned to be launched in late 2012. At the time of writing, CSOs in Portugal were mobilising a national civil society forum on harm reduction to respond to significant funding cuts for harm reduction services.[60]

Many CSOs are involved at the European level and internationally through participation in several networks such as the Eurasian Harm Reduction Network, EuroHRN, Correlation, the International Drug Policy Consortium and others. Regular Europe-wide events bring CSOs together to share the latest experiences on harm reduction and drug policy. Over the past two years, these have included the first European meeting on harm reduction in Marseille,[61] the EU Civil Society Forum on Drugs,[62] the EU Civil Society Forum on HIV[63] and the final conference of the Correlation Network in Ljubljana, Slovenia.[64]

In April 2010 the European Harm Reduction Network, a project funded by the European Commission (EC), was launched with the aim of advocating for and sharing knowledge on harm reduction within Europe. The project culminated in a meeting of network members at a pan-European conference in October 2011 in Marseille, France during which the European Network of People who Use Drugs (EuroNPUD) was formed. The second phase of the project will focus on overdose prevention and advocacy, recommendations on the set-up, development, study and impact of DCRs in Europe as well as supporting harm reduction stakeholders in Europe in sharing best practices.

The Correlation Network, established in 2005 and also funded by the EC, has undertaken two phases of development. Correlation I (2005–2008) identified gaps and inequalities in access to health and social services, with a focus on marginalised groups. It looked specifically at health issues such as HCV and HIV/AIDS within most-at-risk populations, particularly drug users and young people at risk. Correlation II (2009–2012) built on this experience, focusing on the improvement of prevention, care and treatment services and targeting blood-borne viruses, in particular HCV and HIV/AIDS, among vulnerable and high-risk populations. Correlation has recently undergone an organisational restructure and has become a more sustainable network.[65]

Documenting organisations of people who use drugs in Europe[af]

In 2011, as a part of the European Harm Reduction Network (EuroHRN) project, the first comprehensive survey of organisations of people who use drugs in the European Union was carried out. The aim of the survey was to map the current state of drug user organising across Europe to inform recommendations for initiating such organisations in those countries where they are currently lacking, and to strengthen them where they are weak. The methodology used to acquire this data included the creation of a Directory of Organisations of People who Use Drugs in Europe. The second component was a detailed report of the state of drug user organising in Europe.

Results of the survey show that more than half of drug user organisations are based in Northern Europe (18 entries out of 30), and six countries from both Northern and Southern Europe are totally unrepresented. All groups surveyed are people who use/inject heroin, and the vast majority of them define themselves as activists and lobby groups who primarily represent active drug users. Many of the groups that took part in the survey came together at the first European meeting on harm reduction in Marseille and founded the European Network of People who Use Drugs.

Multilaterals and donors: developments for harm reduction

Although support for harm reduction from multilateral agencies is not targeted towards the high-income countries of this region, the EC has been an important donor for regional projects relating to injecting drug use and HIV. It has funded a range of new projects in recent years including the Access to Opioid Medication in Europe (ATOME) project which was launched in 2009 and will conclude in 2013. The overall goal of ATOME is to develop tailor-made recommendations for improving the accessibility, availability and affordability of controlled opioid medications, including OST medications. To date, the project has identified legal and regulatory barriers in the area of prescribing and dispensing opioid medication, including OST, in Cyprus, Greece and Turkey, with further country reports containing recommendations for legislative changes on their way. The EC has also funded a new project as part of its Lifelong Learning Programme (Leonardo) which will look to develop training guidelines and a professional profile for harm reduction outreach workers entitled 'Prowfile'.

af The directory of organisations of people who use drugs in Europe is available online at www.eurohrn.eu.

Despite a successful record of funding harm reduction since the early 1990s, however, the EC's Health for Growth Programme 2014–2020 call for proposals does not address the issue of drugs and harm reduction.[66] Furthermore, in its Justice Programme call for proposals, the EC indicates that in future funding it will address drug demand and supply through the angle of crime prevention and anti-drug trafficking only.[66] Finally, the Drug Prevention and Information Programme will become redundant after 2013, with no plans to replace it with alternate funding opportunities for drug demand reduction at the regional European level.[66] In response to these changes, the EU Civil Society Forum on Drugs[ag] appealed to the EC in January 2012 and urged for continuation of an effective civil society response to HIV/AIDS and drugs.

The WHO Regional Office for Europe, in collaboration with the European Centre for Disease Prevention and Control (ECDC), continues to collect data and monitor HIV epidemics across the region. In September 2011, 53 countries in the WHO European Region agreed on a new European Action Plan for HIV/AIDS 2012–2015.[67] Targets in the new action plan reflect those agreed by UN Member States at the 2011 High Level Meeting on HIV/AIDS and include reducing the number of new infections acquired through IDU by 50% by 2015. The EU drugs agency, the EMCDDA, launched its 2012 work programme[68] and is in the process of developing strategies for treatment monitoring and a new strategy for monitoring and reporting on drug-related issues in prisons across the European region.

Several European governments provide essential funds for harm reduction in low- and middle-income countries. These include the UK Department for International Development, the Netherlands MOFA, NORAD (Norway), GTZ (Germany) and the Swedish SIDA, but in this sector, too, budgets are becoming tighter.

The recent period of economic crisis has had a considerable impact on harm reduction financing at national level across the European region. In the UK, a recent survey of 540 UK drug service users and providers found that 75% have already witnessed cuts in funding for services.[69] Other countries such as Belgium, Ireland, Germany and Denmark report that funding harm reduction programmes is becoming increasingly difficult due to recent financial cuts by governments.[70] In Portugal, where harm reduction programmes were under threat of partial closure, funding from the government is regularly late, harm reduction programme workers do not receive their salaries on time, and financial resources to keep clients in programmes are more and more scarce.[71] In addition, to reduce costs, the Portuguese government plans to abolish the national institute for monitoring the drug situation (IDT).[71]

ag The Civil Society Forum on Drugs (CSF) meets at least once a year and serves as a platform for informal exchanges of views and information between the European Commission and EU civil society organisations.

The financial crisis is likely to lead to greater scrutiny of drug service funding, and it will be increasingly important to highlight the financial and social implications of HIV outbreaks and other likely implications of cuts to services. This is also an opportunity to advocate for the most efficient and effective drug services.

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