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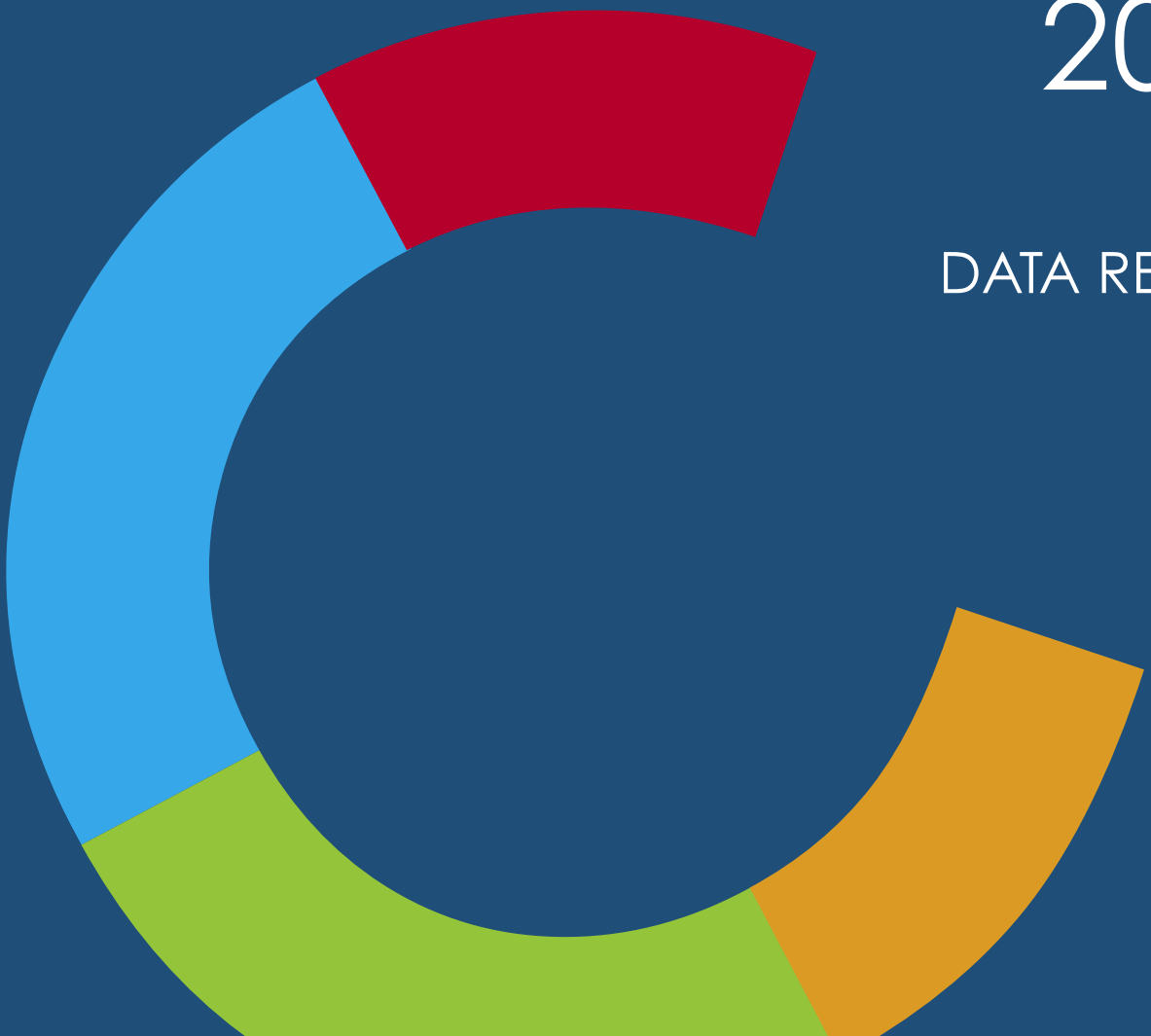
CIVIL SOCIETY MONITORING OF HARM REDUCTION IN EUROPE 2021

DATA REPORT



ISBN - 9789082810967

This project has been supported by the European Commission. Correlation - European Harm Reduction Network is co-funded by the European Union.

Recommended citation:
Rigoni, R.; Tammi, T.; van der Gouwe, D.; Moura,J.; Prins-Schiffer, K (2022). Civil Society Monitoring of Harm Reduction in Europe, 2021. Data Report. Amsterdam, Correlation – European Harm Reduction Network.

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Correlation - European Harm Reduction Network is co-funded by the European Union

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CIVIL SOCIETY MONITORING OF HARM REDUCTION IN EUROPE 2021

DATA REPORT

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PREFACE

This is the third and last civil society-led C-EHRN Monitoring Report which is produced within the framework of the Operating Grant of the EU Health Programme[1] (2018-2021). It is time to stand still and look at what we have achieved so far, what still needs to be done and where we see room for improvement.

The main aim and purpose of C-EHRN monitoring activities is to improve knowledge and information and complement existing data and monitoring efforts in Europe in specific areas of harm reduction based on the perspective of civil society organisations (CSOs). The data collection helps us to assess the implementation of certain drug and health policies at national and local level and supports our advocacy efforts at European and EU Member State level.

CSOs working in the health field play a crucial role at many levels. They are a vital partner to both European and national institutions in shaping public health strategies and policies and they are, in most countries, a fundamental vehicle for their implementation. CSOs are also essential in bridging the gap between policymaking and the communities they represent and they approach this in a professional, efficient and democratic manner. This became even more apparent during the current COVID-19 pandemic when CSOs were able to rapidly adapt to the situation, dedicating expertise and capacity to help policymakers in developing and communicating their pandemic response strategies to the public, while feeding back essential information for better decisions based on people's diverse needs and concerns. As such, our monitoring acknowledges the important function of civil society and harm reduction services and fosters their expert role in national and European drug policy.

The development and implementation of the civil society monitoring tool for harm reduction in Europe is one of the most important achievements of C-EHRN in recent years. Nevertheless, we realise that the current monitoring approach has its limitations. An accurate implementation of monitoring is a long-lasting process which requires sufficient resources, annual evaluation, subsequent adjustments and improvements in its methods and indicators to increase data quality and consistency, as well as to ensure its relevance and impact.

The adapted 2021 civil society monitoring absorbed experiences from the past years. During evaluation meetings with our expert groups, it was decided to keep most of the questionnaire of 2020 intact for 2021. That was done both because the questionnaire of 2020 has worked reasonably well and also to allow for comparisons between 2021 and the previous year.

We kept our focus on the situation at city level which allowed more accurate and precise information. Consequently, the information provided in this report sometimes represents the situation in a particular city or region. Although this information is not representative for a country, it reflects the fact that the situation in a country is diverse and most often dependent upon the approach at city level.

Small modifications were made for clarity in the sections of essential harm reduction services, overdose prevention, Hepatitis C, civil society involvement and new drugs trends. More modifications were made in the COVID-19 section to cover a new phase of the pandemic.

In addition to the survey, and on an experimental basis, the expert groups decided to try new forms of data collection. In 2 countries – Finland and the UK – online Focus Group Discussions (FGDs) will be performed to gather data on new drug trends. That was decided due to the low response rate in the online survey and also due to feedback from our Focal Points that this remains the most difficult section of the survey to complete.

1 *C-EHRN received an Operating Grant within the framework of the EU Health Programme from 2018-2021.*

2021 was the final year for our Operational Grant. We hope that we will be able to sustain and maintain our network and further improve our monitoring efforts. We do have enough ideas for 2022 and beyond and will go for it together with our members, the Focal Points and other experts who make our network what it is.

We believe – and this was echoed by our Focal Points during the European Harm Reduction Conference in 2021 – that our monitoring activities matter. We hope that this report will help to further strengthen the position, role and perception of community-based harm reduction organisations and that this report will support our advocacy effort at European, national and local levels.

More than one hundred organisations and individuals from 34 European countries have contributed to this Monitoring Report. Thanks go to our Focal Points and associated experts at national and local level who have filled-in the online questionnaire and provided all information and data on time. Without their dedication and commitment, we would not have been able to produce this report

We are also grateful to the Scientific Expert Group and the thematic experts who helped to evaluate and adapt the Monitoring Tool 2021. This applies in particular to *Dagmar Hedrich* and her EMCDDA colleagues for their ongoing and patient support.

Specific thanks go to *Roberto Perez Gayo* who provided ongoing support and supervision to the Focal Points and to the authors of this report: *Rafaela Rigoni, Tuukka Tammi, Daan van der Gouwe and Joana Moura*.

Last but not least, we thank the European Commission and De Regenboog Groep for providing financial and moral support throughout the years.

Katrin Schiffer

On behalf of the C-EHRN Team

ACRONYMS AND ABBREVIATIONS

3-MMC	3-Methylmethcathinone; metaphedrone
ACF	A-Clinic Foundation
AFEW	AIDS Foundation East-West
AIDS	Acquired Immunodeficiency Syndrome
alpha-PVP	alpha-Pyrrolidinovalerophenon
ART	Antiretroviral Therapy
ARV	Antiretroviral
BBV	Blood-Borne Virus
C-EHRN	Correlations – European Harm Reduction Network
CCM	Country Coordinating Mechanism
CEO	Chief Executive Officer
COVID	Coronavirus Disease
CS	Civil Society
CSFD	Civil Society Forum on Drugs
CSI	Civil Society Involvement
CSO	Civil Society Organisation
DAA	Direct-Acting Antiviral
DCR	Drug Consumption Room
DPNSEE	Drug Policy Network South-East Europe
ECDC	European Centre for Disease Prevention and Control
EASL	European Association for the Study of the Liver
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
EuroNPUD	*European Network of People who Use Drugs*
FGD	Focus Group Discussion
FP	Focal Point
GFATM	Global Fund to Fights AIDS, Tuberculosis and Malaria
GHB	Gamma Hydroxybutyrate
GP	General Practitioner
HAT	Heroin Assisted Treatment
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HOPS	Healthy Option Project Skopje
HR	Harm Reduction

HRI	Harm Reduction International
HSE	Health Service Executive [Ireland]
ID	Identification
IFRC	International Federation of Red Cross and Red Crescent Societies
INGO	International Non-Governmental Organisation
INHSU	International Network on Health and Hepatitis in Substance Users
INPUD	International Network of People who Use Drugs
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex
LGBTQIIA+	Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Intersectional, Asexual and allies
LSD	Lysergic acid diethylamide
MDMA	3,4-Methylenedioxymethamphetamine; ecstasy
MSM	Men-who-have-Sex-with-Men
NDT	New Drug Trend
NGO	Non-Governmental Organisation
NHS	National Health Service [UK]
NICE	National Institute for Health and Care Excellence [UK]
NIMBY	Not-In-My-Back-Yard
NPS	*New Psychoactive Substance*
NSP	Needle/Syringe Programme
OAT	Opioid Agonist Therapy
OD	Overdose
OST	Opioid Substitution Therapy
PLWHIV	People Living With HIV
PW	People Who
PWUD	People Who Use Drugs
RoA	Route of Administration
Reitox	Réseau Européen d'Information sur les Drogues et les Toxicomanies
RKI	Robert Koch Institut
SDF	Scottish Drugs Forum
SEG	Scientific Expert Group
STI	Sexually Transmitted Infection
TB	Tuberculosis
THL	Terveyden ja hyvinvoinnin laitos [Finland]; National Institute for Health and Welfare
WHO	World Health Organization

INTRODUCTION

1

THREE YEARS OF C-EHRN CIVIL SOCIETY-LED MONITORING OF HARM REDUCTION IN EUROPE

The C-EHRN Civil Society-led Monitoring of Harm Reduction in Europe 2021 Data Report is the third of a series. 2018 marked the start of developing a framework for European civil society-based monitoring aiming, in the long-term, at improving harm reduction responses and policies in Europe. The first annual report was published in 2019 [1] targeting developments in the areas of Hepatitis C (HCV), new drug trends, overdose prevention and civil society involvement in drug policies, themes chosen by the members of the network due to their crucial importance for harm reduction. The second report, published in 2020 [2], added two new sections to cover the effects of the rising COVID-19 pandemic on harm reduction service delivery and map the availability of essential harm reduction services. The same six areas are covered in this third report.

Civil society has an important role in holding governments and donors accountable, among others, by engaging in independent monitoring and evaluation of services and programmes [3]. In combination with advocacy, monitoring tools are crucial strategies to hold governments accountable and to improve the implementation of policies and programmes in line with the needs of PWUD and their environments [4]. C-EHRN uses an online survey as a monitoring tool to collect the experiences of harm reduction service providers and service users at the ground level. The reports intend to serve as a complementary source of data both for EMCDDA [5,6] and HRI [7], as well as to network members. The Monitoring seeks to reflect the experiences of harm reduction service providers, focusing on how drug policies and specific harm reduction guidelines are (or are not) being implemented at the street level. Such in-depth and rich information is crucial for the development of policies and services for PWUD and can be of great value for civil society organisation (CSO) advocacy and for policymakers.

METHODOLOGY

C-EHRN has established four expert groups to support the development of the monitoring framework, draft the questionnaires, assess the data and review the final report: A scientific expert group (SEG) and three thematic expert groups for Hepatitis C (HCV), overdose prevention (OD), and new drug trends (NDT)[2]. These groups, together with C-EHRN staff, have contributed to the development of the framework of C-EHRN monitoring and have added to the formulation of the questionnaires. To gather data on the experiences of harm reduction service providers and service users at ground level, C-EHRN builds on a network of national Focal Points (FPs).

C-EHRN FOCAL POINTS

The Focal Points are organisational members of C-EHRN selected by:

- Their willingness to commit to the network's principles, mission and vision at the national and European level;
- Proven thematic expertise in the field of drug use and harm reduction;
- Connectedness at the national and European level; and,
- Ability to fulfil the role of an intermediary at a national level.

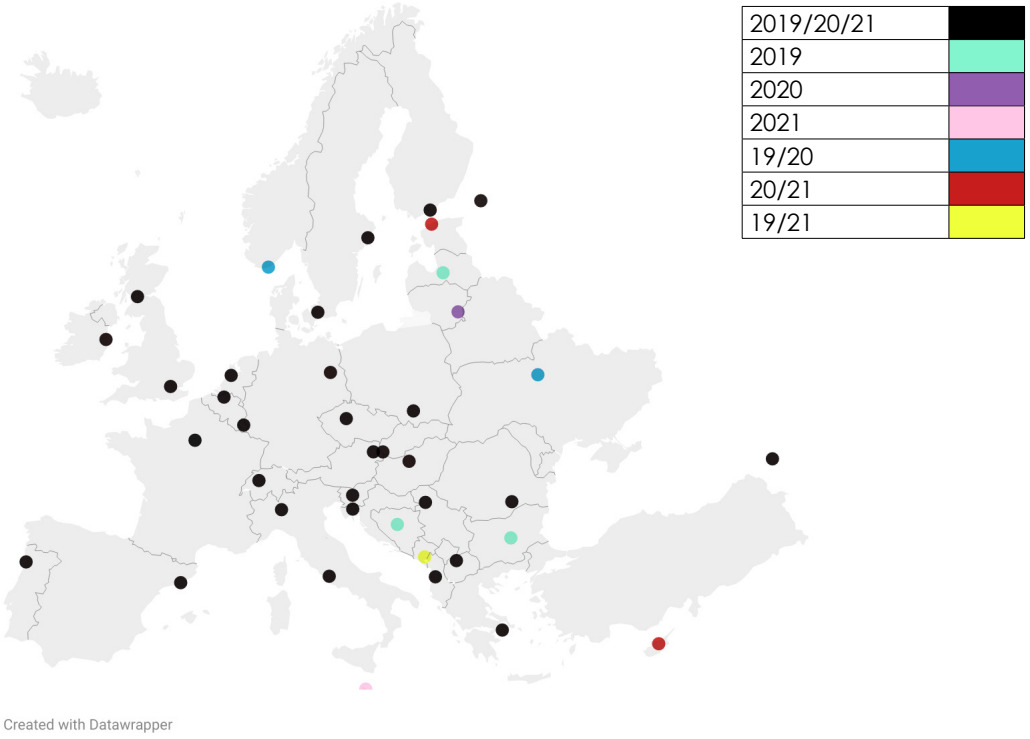
2 *The names of participants can be found under "contributors".*

C-EHRN strives to select at least one FP per country, but some countries can have more than one representative if additional thematic expertise is needed, or no FP when no member is available for such a role.

The tasks of FPs include being consulted for specific thematic or regional expertise, providing inputs and information, particularly for monitoring purposes, including answering the monitoring questionnaire annually. FPs do not receive financial support to perform their functions. Nevertheless, they receive a few benefits, such as being invited to the annual C-EHRN conference (one scholarship available per country); free C-EHRN seminars and training; being able to promote their activities on the network's website and through the network's other communication channels and in speaking on behalf of the network at national level.

Some of the C-EHRN FPs have varied along the 3 years of data gathering and reporting. Map 1 and Table 1 show C-EHRN FPs undertaking monitoring in the different reporting years (2019, 2020 and 2021). Currently, there 35 FPs in 34 countries[3].

Map 1: Location of C-EHRN Focal Points (2019/2020/2021)



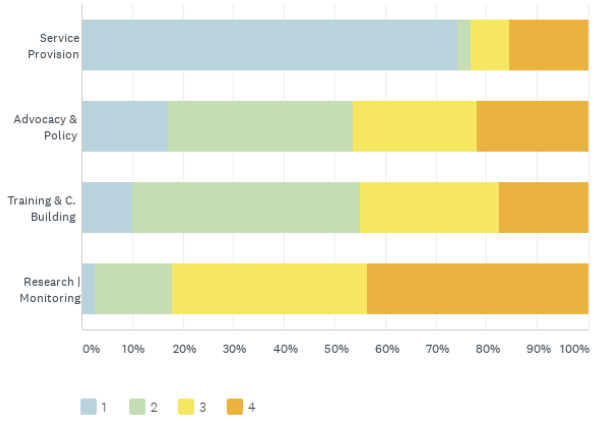
3 *FP names, organisations, cities and countries can be found under "contributors".*

Table 1: C-EHRN Focal Points undertaking the Monitoring (2019/2020/2021)

Country- City	2019	2020	2021	Total yrs
Albania- Tirana	1	1	1	**3**
Austria- Vienna	1	1	1	**3**
Belgium- Antwerp	1	1	1	**3**
Bosnia and Herzegovina	1	0	0	**1**
Bulgaria	1	0	0	**1**
Croatia- Rijeka	1	1	1	**3**
Cyprus- Nicosia	0	1	1	**2**
Czech Republic- Prague	1	1	1	**3**
Denmark- Copenhagen	1	1	1	**3**
Estonia- Tallinn	0	1	1	**2**
Finland- Helsinki	1	1	1	**3**
France- Paris	1	1	1	**3**
Georgia- Tbilisi	1	1	1	**3**
Germany- Berlin	1	1	1	**3**
Greece- Athens	1	1	1	**3**
Hungary- Budapest	1	1	1	**3**
Ireland- Dublin	1	1	1	**3**
Italy- Milan	1	1	1	**3**
Italy- Rome	1	1	1	**3**
Latvia	1	0	0	**1**
Lithuania- Vilnius	0	1	0	**1**
Luxembourg- Luxembourg	1	1	1	**3**
Malta- National level	0	0	1	**1**
Montenegro- Podgorica	1	0	1	**2**
North Macedonia- Skopje	1	1	1	**3**
Norway- Kristiansand	1	1	0	**2**
Poland- Krakow	1	1	1	**3**
Portugal- Vila Nova de Gaia	1	1	1	**3**
Romania- Bucharest	1	1	1	**3**
Russia- Saint Petersburg	1	1	1	**3**
Serbia- Novi Sad	1	1	1	**3**
Slovakia- Bratislava	1	1	1	**3**
Slovenia- Ljubljana	1	1	1	**3**
Spain- Barcelona	1	1	1	**3**
Sweden- Stockholm	1	1	1	**3**
Switzerland- Bern	1	1	1	**3**
The Netherlands- Amsterdam	1	1	1	**3**
Ukraine- Kyiv	0	1	1	**2**
United Kingdom- Glasgow	1	1	1	**3**
United Kingdom- London	1	1	1	**3**
Total	35	35	35	

PROFILE OF FPS

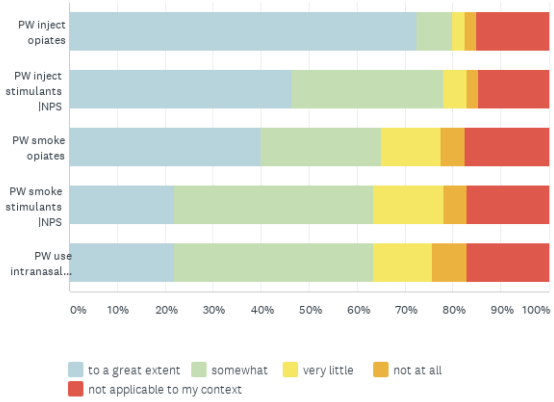
More than 70% of C-EHRN FPs[4] have - as the main priority of their organisation - the provision of services, making them highly appropriate in describing how harm reduction activities are implemented in practice. That is followed by advocacy and policy activities (17%), training and capacity building (10%) and, to a much lesser extent, research (2,5%) (see Figure 1).



The populations to which FP organisations are able to provide services can be seen in Figures 2 and 3. The main services provided (offered by more than 50% of FPs) are outreach work; HCV and HIV prevention, testing and treatment; drop-in centres; needle and syringe exchange; STI prevention; and legal support. Less than 15% of FPs provide housing or shelter; Heroin Assisted Treatment (HAT); or Drug Consumption Rooms (DCRs).

Even though research is not a priority for the vast majority of C-EHRN FPs, all of them are involved in some type of research activity. Besides C-EHRN monitoring, 83% of FPs are involved in data collection for monitoring and evaluating within their own organisations, 53% perform needs assessments and 52% the monitoring of drug trends; more than 80% use the data collected for advocacy purposes. Virtually all FPs are involved in some kind of policy and advocacy activity, moslty at the local/regional or national level. Figure 4 shows the main research activities of FPs.

Figure 2: Populations to which FP organisations provide services (related to drug of choice)



PW: people who
NPS: new psychoactive substance(s)

Figure 3: Populations to which FP organisations provide services (key populations)

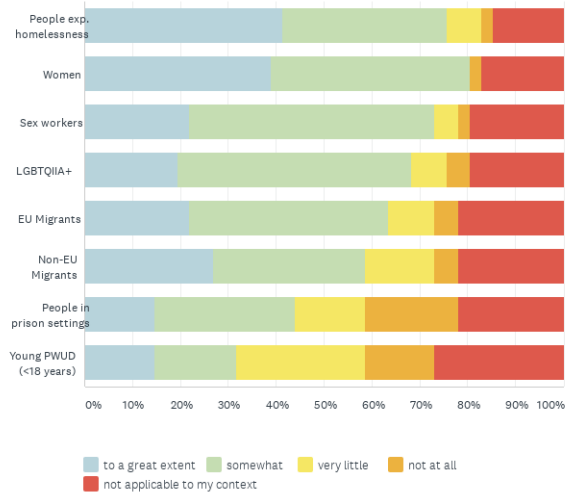
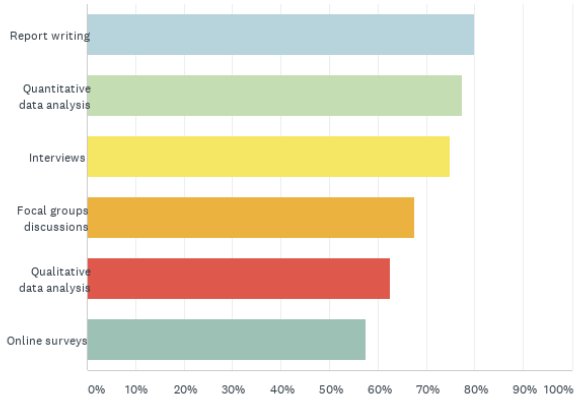


Figure 4: Main activities for those undertaking research



4 *Data extracted from the network member survey conducted in 2020.*

The survey questionnaire

FPs gathered data for this report based on a questionnaire distributed to them both as an online survey. The questionnaires for 2019, 2020 and 2021 are available at the C-EHRN website[5]. In 2019, a total of 100 questions focused on HCV (27 questions), OD (45), new drug trends (20) and civil society involvement (8). FPs were asked to respond to, and reflect about, their whole country and from this first reporting experience it became clear that this was not possible for many of the organisatons acting more locally. To respect this experience and increase data reliability, the 2020 survey questionnaire started focusing more at the city level and the experiences of C-EHRN FPs with harm reduction implementation. The survey questionnaire was adapted to reflect the new focus and became more concise. Two sections were added, on essential harm reduction services and the influence of COVID-19 on services. A total of 81 questions covered essential harm reduction services (6 questions), HCV (20), OD prevention (23), new drug trends and synthetic opioids (16), civil society involvement in drug policy (6) and the harm reduction response to COVID-19 (10). The survey for 2021 followed in great part the one from 2020, with small adjustments, allowing comparison of data reported in 2020 and in 2021 presented in this report.

Data gathering and analysis

Data was collected between May and July 2021. Closed questions were analysed for general percentages or represented in tables with descriptions of features per city/country. Open ended responses were analysed with thematic analysis (7) and key findings illustrated with quotes. When possible, comparative tables and analysis were built to describe differences between this and the last reporting year (2020). Data were verified and analysed by the report authors. The different chapters were revised by the respective thematic expert groups.

LIMITATIONS

Given the nature of this monitoring structure and the focus of the work of C-EHRN FP organisations, data in this report cannot claim to be representative of Europe or the nations in which FPs are based. Most FPs work locally, or regionally, and have an in-depth knowledge of how harm reduction is implemented on-the-ground. Respecting this experience was chosen over national representativeness to provide a more nuanced analysis of the implementation of harm reduction at the local level. A more complete account of the methodology and its limitations can be found elsewhere (8) and in specific chapters when concerning a particular topic.

REPORT STRUCTURE

The report consists of 7 chapters.

This first introductory chapter provides information on why a civil society-led monitoring of harm reduction is useful; an overview of the methodology used for the present monitoring and its previous reporting years; a profile of the C-EHRN FPs collecting data for this report; and the limitations of this monitoring.

Chapter 2 reports data about civil society involvement in drug policy and related decision-making processes in European countries. **Chapter 3** describes the state of essential harm reduction services in FP cities. **Chapter 4** describes experiences with the availability and accessibility of interventions that constitute the continuum of care for hepatitis C. **Chapter 5** describes the status of, the need for, and changes to, overdose prevention in the previous year at the local level in Europe. **Chapter 6** focuses on the perceived New Drug Trends in FP cities. Finally, **Chapter 7** discusses how the COVID-19 pandemic has affected harm reduction services and the lives of people who use drugs in different European cities.

5 www.correlation-net.org/monitoring/

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Correlation
European
Harm Reduction
Network

PARTICIPATION OF CIVIL SOCIETY ORGANISATIONS IN POLICYMAKING

2

INTRODUCTION

Civil Society's Organisations (CSOs) working with people who use drugs play a crucial role in the development and implementation of drug policies. They work directly for, and with, drug users and they often function as their first contact and entrance point. This close contact gives them a good insight on the users' daily needs, concerns and problems which are vital to develop effective policies addressing the negative consequences of drug use. Yet the meaningful involvement of civil society in policymaking is often missing in many European Countries [1].

This chapter analyses civil society involvement in policymaking in Europe through the lens of the C-EHRN FPs. Cooperation between CSOs and policymakers is evaluated by FPs at national and local levels in the cities and countries in which they work. More specifically, it aims to address how official mechanisms are implemented (or not) on-the-ground and reveals critical factors, challenges and needs. For data collection, we used the same questionnaire as in 2020 which allows us to compare the situation and draw conclusions on potential developments.

The indicators used in this questionnaire are those proposed by the code of good practice for civil participation in the decision-making process of the Council of Europe (Council of Europe, 2009) and the assessment for the meaningful involvement of civil society in the area of drug policy in Europe by the Civil Society Forum on Drugs (CSFD) [2]. New indicators were included to assess CSO contributions to data collection and reporting and participation in organised networks and national platforms. Due to differences of FPs reporting in 2020 and 2021, a comparison of data was unfortunately only possible to a limited extent. While 33 FPs responded to the civil society involvement (CSI) questionnaire in 2020, 34 responded in 2021. The FPs from Lithuania and Norway reported in 2020 but not in 2021 and the FPs from Malta and Montenegro only responded to the questionnaire in 2021.

COOPERATION BETWEEN CSO'S AND POLICYMAKERS

Cooperation mechanisms

The scope, level and quality of the cooperation and dialogue between policymakers and CSOs is different in countries and gives an idea on how the dialogue is organised and the extent to which CSOs can contribute in a meaningful way to the development of policies. At one end of the spectrum, cooperation is restricted to information exchange. At the other end, a solid partnership is established [3].

Following the definition of cooperative mechanisms of the Council of Europe [4], four different levels of cooperation can be considered:

- Information: This is a relatively low level of cooperation. It consists of a two-way process of information sharing and the provision of access to it between public authorities and CSOs;
- Consultation: This is an ad hoc mechanism through which public authorities ask CSOs for their expertise and opinion regarding a specific policy issue or development;
- Dialogue: This is a two-way communication mechanism built on mutual interests and potentially shared objectives to ensure a regular exchange of views; and,
- Partnership: This is the most comprehensive type of cooperation. This mechanism stipulates and articulates shared responsibilities for each step of the policymaking process: agenda-setting, policy drafting and implementation of activities.

COOPERATION AT THE NATIONAL LEVEL

The majority of FPs reported the existence of structural cooperation between CSOs and policymakers in the field of drug policy in their country (see Figure 1). Only FPs from Belgium, Italy, Poland, Spain and Sweden reported having no formalised national cooperation mechanism. In 2020, Belgium, Italy, Poland and Spain reported that there was cooperation between CSOs and policymakers in their countries. The reasons described for lacking cooperation can be seen below:

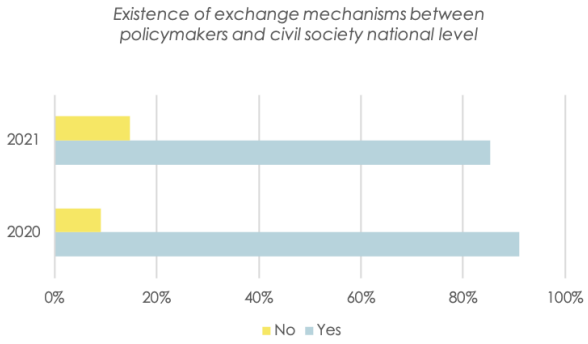
> *"Swedish drug policy is rigid and anti-harm reduction"*
> *(FP **Stockholm, Sweden**)*

> *"Only very big service providers are involved, HR organisations are not involved."*
> *(FP **Milan, Italy**)*

> *"Due to the epidemic and restrictions, all efforts were rather focused on the problems related to the continuation of activities so far."*
> *(FP **Krakow, Poland**)*

> *"Covid's pandemic has stopped a lot of programmes and initiatives."*
> *(FP **Barcelona, Spain**)*

Figure 1: Is there any structural information and exchange mechanism between policymakers and civil society organisations in the field of drug policy in your country, at the national level?

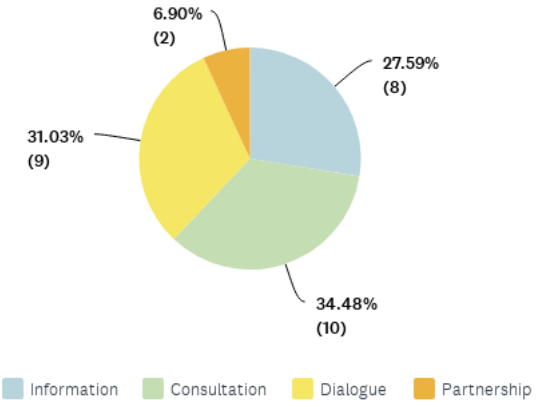


On the other hand, we also observed a change in the responses of Finland and Russia which now do report the existence of cooperation in their countries in comparison to last year. The reasons for these changes are unclear and cannot be retrieved from the collected data.

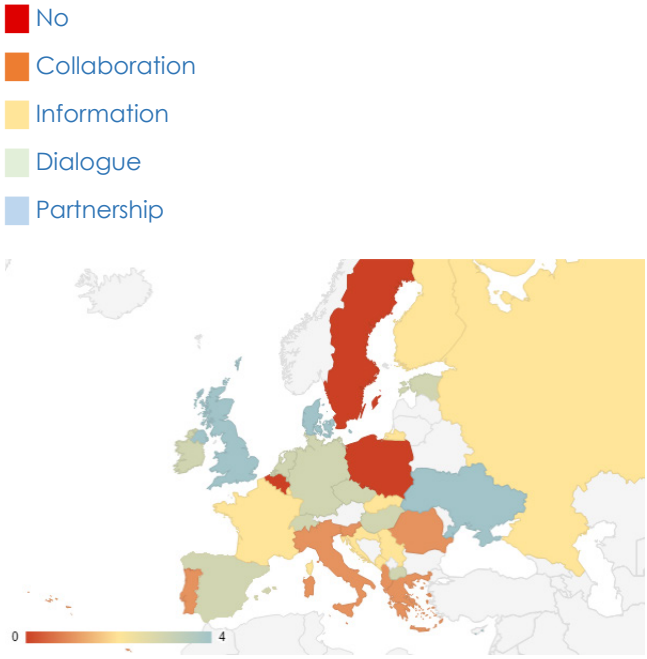
Types of national-level collaboration

While most of the organisations indicate some kind of exchange between policymakers and CSOs, only 6.9% of the FPs describe the cooperation mechanism in their country as Partnership. Consultation and Dialogue were the most cited types of collaboration (34.48% and 31.03%, respectively), while 27.59% of the respondents think their national cooperation mechanism is based on Information exchange only.

Figure 2: If yes, please choose one of the following levels (information, consultation, dialogue or partnership)



Map 1 portrays the highest type of collaboration mentioned at the country level by respondents in 2021.



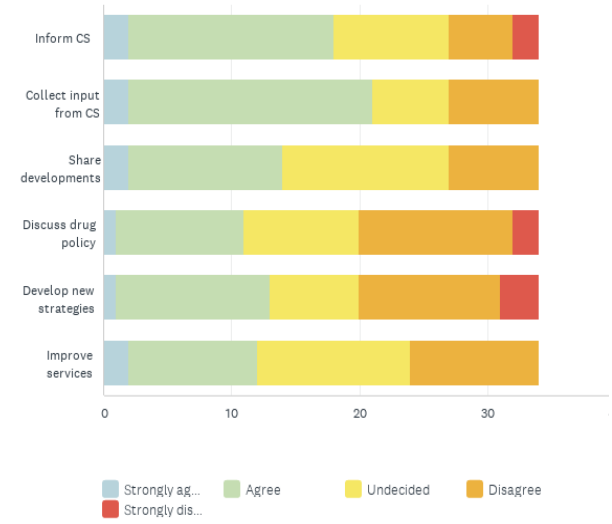
The aim of the exchange between government and CSOs

FPs were asked to indicate to what extent the following statements applied to their country context. The exchange between government and CSOs aims to:

- **Inform** civil society (CS) of new policy developments;
- **Collect** input and knowledge from CS at the grassroots level to learn more about new developments, trends and problems;
- **Share** developments, trends and problems from the field and the grassroot level;
- **Discuss** which kind of drug policies are effective, beneficial or harmful;
- **Develop** new strategies and approaches;
- **Improve** access to, and the quality of, services (health, social and drug-related services).

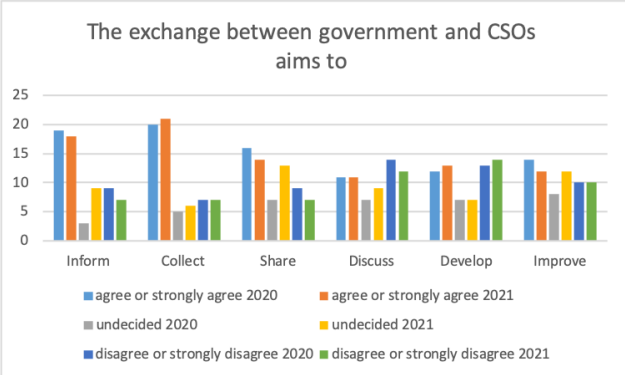
The 5-point scale for answering included the following options: strongly agree (1); agree (2); undecided (3); disagree (4); and strongly disagree (5). Figure 3 shows the overall results.

Figure 3: Please indicate how the following statements apply to the situation in your country. The exchange between government and CS aims to



Over 60% (21 FPs) agree or strongly agree that the exchange between governments and CSOs aims at collecting their input to learn more about new developments, trends and problems at the grassroots level. About 40% (13 FPs) agree or strongly agree that the aim is to share information about such developments and about 38% (13 FPs) think that the goal is to develop new strategies and approaches. More than half (18 FPs) believe that these exchanges aim at informing CSOs on new policy developments, while about 30% discuss policies and to improve services as the aim of these exchanges (11 and 12 FPs, respectively). According to these findings, most respondents look at the current civil society involvement mechanisms as a one-way information flow from the government to civil society, rather than an interactive and constructive exchange of ideas and views which informs future drug policy and practice.

Figure 4: Comparison between reported level of change between government and CSOs 2020/2021.



Some slight changes can be observed when comparing this data with previous years (Figure 4). For instance, in 2020, over 60% of FPs agreed that the main aim of the policy dialogue was to inform CSOs on new policy developments, while this applies for only 50% in 2021. In 2020, about 40% agreed that the main aim was to discuss policies, develop new strategies and approaches, and improve access to, and the quality of, services (health, social and drug-related services). In 2021 only 30% of FPs agreed to this statement. Nevertheless, when analysing findings from an holistic perspective, they appear to be in line with last year overall. This suggests that no improvement has occurred towards a more interactive and constructive exchange of perspectives between governments and CSOs.

Table 1 shows the answers per FP regarding the level of exchange existing between the government and CS in 2020 and in 2021. The 5-point scale for answering is represented as strongly agree (1); agree (2); undecided (3); disagree (4); and strongly disagree (5). It must be born in mind that the evaluations as to the aim of the exchange between government and CSOs are subjective and, thus, not easily comparable between countries and cities.

Table 1. Please indicate how the following statements apply to the situation in your country. The exchange between government and CS aims to:

Country	City	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021
		Inform		Collect input		Share		Discuss		Develop		Improve services	
Albania	Tirana	3	2	3	1	2	3	2	4	2	4	2	3
Austria	Vienna												
Belgium	Antwerp	4	3	2	3	2	3	5	3	5	3	2	3
Croatia	Rijeka	1	2	2	2	2	3	3	3	2	3	2	3
Cyprus	Nicosia	2	2	2	2	2	2	2	2	2	2	1	2
Czech Republic	Prague	2	2	2	2	2	2	4	4	4	4	5	4
Denmark	Copenhagen	2	2	2	2	3	3	2	2	4	2	4	2
England, UK	London	5	5	4	4	4	4	5	5	4	5	4	4
Estonia	Tallinn	2	2	2	2	2	2	3	2	2	2	2	2
Finland	Helsinki	5	2	4	4	5	4	5	4	4	4	4	4
France	Paris	2	2	2	2	2	2	2	3	2	3	2	3
Georgia	Tbilisi	2	2	3	2	3	2	5	2	3	2	4	2
Germany	Berlin	2	2	2	2	3	2	3	2	2	2	3	2
Greece	Athens/ Thessaloniki	3	3	2	2	2	2	1	2	2	2	2	1
Hungary	Budapest	4	3	4	2	4	2	4	4	4	4	3	3
Ireland	Dublin	3	3	3	3	3	3	3	3	3	3	3	2

Country	City	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021
		Inform		Collect input		Share		Discuss		Develop		Improve services	
Italy	Milan	4	4	3	4	4	4	4	4	4	4	4	4
Italy	Rome	1	4	2	3	1	4	1	4	1	4	1	4
Kyrgyz Republic	Bishkek	2		2		2		4		3		3	
Lithuania	Vilnius	2		2		2		2		2		2	
Luxembourg	Luxembourg		2		2		2		2		2		2
Malta	National level		2		3		3		3		5		3
Montenegro	Podgorica		3		3		3		3		2		2
Norway	Kristiansand			2		2		2		2		2	
Poland	Krakow	4	5	2	3	2	3	4	4	4	4	3	4
Portugal	Vila Nova de Gaia	4	2	4	4	4	4	5	4	4	4	3	4
North Macedonia	Skopje	2	3	2	2	2	3	2	4	3	3	3	3
Romania	Bucharest	4		2		3		3		4		4	
Romania	Bucharest		2		4		4		4		4		4
Russia	Saint Petersburg		3		4		4		3		3		3
Scotland, UK	Glasgow	2	1	3	1	3	1	3	1	3	1	2	1
Serbia	Novi Sad	2	3	2	2	4	4	4	2	2	2	2	4
Slovakia	Bratislava	2	4	4	4	4	3	5	4	5	4	5	4
Slovenia	Ljubljana	2	4	4	2	4	3	4	4	4	4	4	4
Spain	Barcelona	1	2	1	2	1	2	2	2	1	2	1	2
Sweden	Stockholm	4	1	4	4	4	3	4	5	4	5	4	3
Switzerland	Bern	1	2	1	2	1	2	1	3	1	2	1	3
The Netherlands	Amsterdam	2	3	1	2	1	2	2	4	3	4	2	3
Ukraine	Kyiv	2	2	2	2	3	1	3	2	3	2	3	2

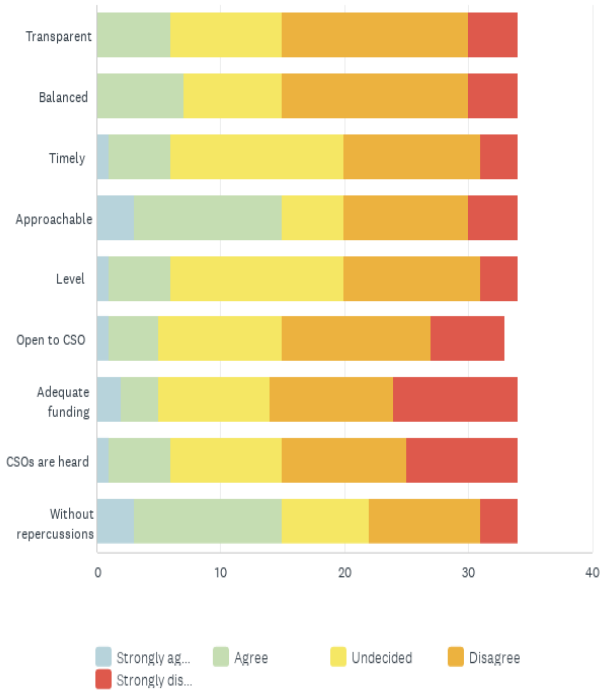
The nature of the exchange between government and CSOs

Another set of indicators that provide incites of the existing cooperation between CSOs and policy-makers on drug policy in their countries is the nature of these exchanges. These indicators are part of the assessment for the meaningful involvement of civil society in the area of drug policy in Europe by the Civil Society Forum on Drugs (CSFD) [2]. FPs were asked to indicate to what extent they agree with the following statements about the dialogue between government and CS in their country:

- It is organised in a **transparent** way (e.g. it is easy to follow the decision-making process).
- It is organised in a **balanced** way (represents different services well, communities, worldviews).
- It is organised in a **timely manner** (e.g. CS is informed in a timely way about any kind of new policy/development and the agenda of the meeting).

- Government officials are easily **approachable** by CSOs (e.g. they respond to emails/ phone calls).
- Decision-makers are represented at the **appropriate level** (e.g. those who make decisions are involved).
- The government is **open to civil society** initiatives (e.g. civil society initiatives are easily taken up by government).
- Adequate **funding** is provided (e.g. there is public funding for advocacy work).
- Civil society input is **heard** and taken into account when it comes to decision-making.
- Civil society can speak openly and frankly and criticise without facing **repercussions** or budget cuts.

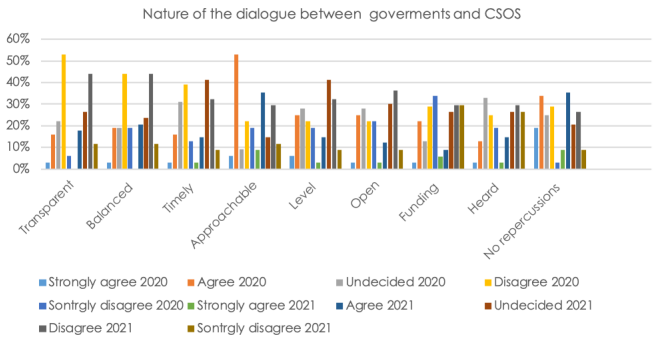
Figure 5: How much do you agree with the following statements about the exchange between government and CS in your country:



About 45% (15 FPs) agree or strongly agree that governments are easily approachable and civil society can criticise it without repercussions or budget cuts. Nevertheless, this number represents a slight decrease when compared to last year's results (see Figure 6) which might suggest that CSOs noticed changes from one year to another. Yet, as already mentioned, comparisons between the results of both years hould be made cautiously.

Most of the FPs (56%, 19) disagree or strongly disagree that the exchange between CSOs and governments is balanced and that it is organised in a transparent way; about 44% (15 FPs) that the representativeness of decisions makers is appropriate and that CS is informed in a timely manner about any kind of new policy/development and the agenda of the meeting. Conversely, half of the FPs disagree that the government is open to civil society initiatives and that governments hear and consider CS inputs when it comes to decision-making. Similar to 2020 (Figure 6), almost 60% (20 FPs) disagree that adequate funding is provided for their endeavours.

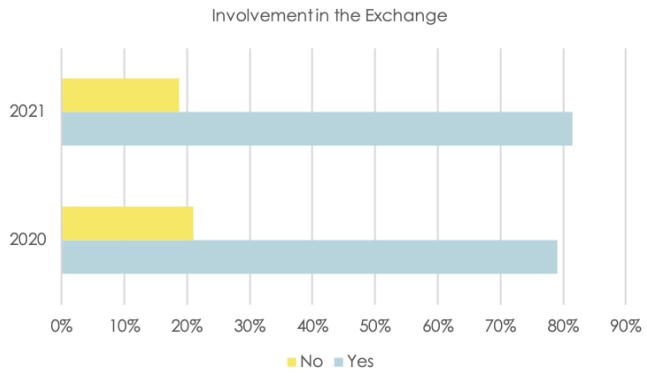
Figure 6: Comparison between reported aim of exchange between government and CSOs 2020/2021.



FP participation

About 81% of the FP harm reduction organisations are directly involved in structural cooperation around drug policy with national policymakers. This number is similar to the 79% reported last year.

Figure 7: Is your organisation involved in this kind of exchange?



Main forms of involvement

The main forms of involvement included consultation and partaking in discussion forums. To a lesser extent, FPs give feedback during the development of strategies and interventions, draft policies and guidelines, or provide information. Not all, however, feel that their suggestions are taken seriously. The main forms in which FPs are involved in cooperation exchange with policymakers are highlighted below, with examples given by FPs.

- Consultation on the draft of National Drug Strategy and/or other new policies; expert advice for drug use related services, including prevention and for harm reduction (e.g. FPs in London, England, UK; Podgorica, Montenegro; Paris, France; Rome, Italy; Rijeka, Croatia).

> *"Mainly through public consultations and briefing MPs but not the UK Government who are ideologically opposed to drug policy reform. Release also works closely with Public Health England."*
> *(FP **London, England, UK**).*

> *"There is no high degree of functionality and cooperation, except in participation through the Country Coordinating Mechanism (CCM) for implementing projects funded by GFATM and the National AIDS Commission, and the obligation for the Government to consult NGOs regarding potential new policies."*
> *(FP **Podgorica, Montenegro**)*

> *"During the first lockdown, we participated in weekly meetings with the French Ministry of Health (crisis reunions) in a cooperative way: we provided them with information about the issues the professionals would face and they would try to find solutions (i.e. we asked then for the extension of OST prescriptions and the Minister allowed it quickly). However, things changed since last September; our relations can be now qualified as consultation. We can feel that the Government is now preparing for the Presidential elections and things are getting more complicated regarding the drug policy."*
> *(FP **Paris, France**)*

> *"Consultation occurs mostly at regional level. Only very strong and "big" CSOs engaged in service provision have consultations at national level. A few best practice examples can be found at regional/local level, e.g. in Piemonte, Emilia Romagna, Umbria."*
> *(FP **Rome, Italy**)*

> *Red Cross: Member of the National Commission on HIV/AIDS; expert advisor to the CNIPH Drug Abuse Prevention Service (former Government Office on Drugs) for the Harm Reduction area; expert advisor of the Referral Centre for Drugs of the Republic of Croatia NGO "Susret": At the national level, we are familiar with most decisions. NGO "Vida" takes part every year in the focus group which is an evaluation of national strategies considering drug abuse and services."*
> *(FP **Rijeka, Croatia**)*

- Participating in drug policy-related forums or committees, including meetings with different ministries and experts, national agencies on drugs and national councils (e.g. FP in Luxembourg, Luxembourg; Amsterdam, The Netherlands; Bucharest, Romania; Barcelona, Spain; Kyiv, Ukraine; Dublin, Ireland; Budapest, Hungary; Novi Sad, Serbia; Berlin, Germany; Bern, Switzerland).

> *Through our funding relationship with the Ministry of Health, we have (at least) bi-annual meetings during which we report our data. Also, last year the national drug research institute started facilitating CSO consultations with the national ministry/ies. This is still in the developing phase, but Mainline is one of the partners involved. A similar structure exists on the international level, where several CSOs are in dialogue with the Ministry of Health, Ministry of Justice and Ministry of Foreign Affairs."*
> *(FP **Amsterdam, The Netherlands**)*

> *As the oldest service provider and with the highest coverage, ARAS is constantly participating in meetings called by the National Anti-drug Agency (ANA) both on policy formulation and funding. However, very few proposals made by ARAS have ever been incorporated into the drug policies."*
> *(FP **Bucharest, Romania**)*

> *Club Eney, PUD.UA (VOLNA): Active participation in National Council for HIV, participation in the civil society meetings with governmental stakeholders on some specific issues - for the Ministry of Social Policy and Ministry of Health. Director of Convictus, Evgeniya Kuvshinova, is a member of the National Council on TB and HIV/AIDS in Ukraine and Head of the Programme Committee."*
> *(FP **Kyiv, Ukraine**)*

- Direct involvement in drafting policies and/or guidelines related to drugs or related issues (e.g. HCV; FPs in Bucharest, Romania; Copenhagen, Denmark; Barcelona, Spain; Prague, Czech Republic).

> *We are involved in formulating guidelines for needle exchange, OST. Our organisation is also in communication with the National Board of Health and other organisations that are involved in the field."*
> *(FP **Copenhagen, Denmark**).*

- Providing information through annual reports as well as giving feedback regarding harm reduction activities, drug trends and on action plans and national drug strategies (e.g. FPs Athens, Greece; Tallinn, Estonia; Bratislava, Georgia; Tbilisi, Georgia; Ljubljana, Slovenia).

> *Positive Voice is part of a broader NGO coalition called, 'Platform of Civil Society for Psychoactive Substances', and representatives of that coalition meet with the National Coordinator for Narcotics and express their views and their feedback regarding street/outreach work, drug trends and drug scenes and the condition of the community. The same representatives shared their insights regarding the Action Plan and the National Strategy and they were taken seriously."*
> *(FP **Athens, Greece**)*

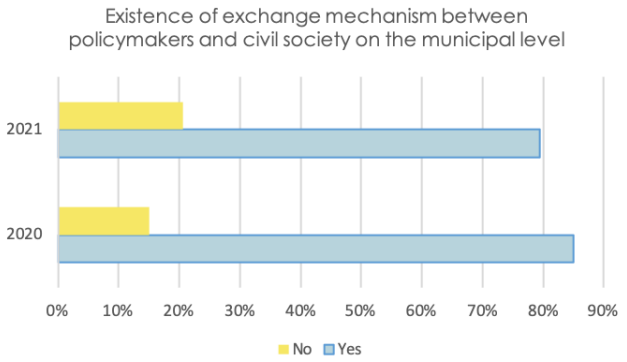
> *We are a member of EWS at the Ministry of Health who are once a year requesting information and statistics about our services for EMCDDA. We were also attending meetings regarding the new drug strategy and were able to put comments and new tasks, but our comments are rarely taken into consideration."*
> *(FP **Bratislava, Slovakia**)*

COOPERATION AT THE MUNICIPAL LEVEL

Evaluation

The majority of the FP's reported the existence of structural cooperation between CSOs and policymakers on drug policy with their municipalities.

Figure 8: Is there any structural information and exchange mechanism between policymakers and civil society organisations in the field of drug policy in your country, on the municipal level?



Cooperation

Like in 2020, the reasons given for a lack of structural collaboration at the municipal level, when it occurs, were related to the tendency of structural exchange mechanisms to be organised at the national level, or the restrictive posture of the government against drugs.

The organisation of the cooperation

The cooperation between CSOs and policymakers is organised in different ways, via discussion forums, meetings with key policy makers to draft action plans and exchange information. Additionally, this cooperation is also extended to the implementation of programmes such as OAT, housing programmes for people experiencing homelessness and other services targeting people who use drugs.

Types of municipal-level cooperation

When there is cooperation between CSOs and municipalities, it mainly comes in the form of information (41% or 11 FPs). A few FPs mention consultation and dialogue as the next predominant forms of collaboration (26% or 7 FPs, and 22% or 6 FPs, respectively) and only about 11% (3 FPs) collaborate with municipalities at a partnership level.

FP participation

Around 72% of the FPs are directly involved in civil society dialogue with policy makers. This number is very similar to last year (75%) and slightly lower to the national figure.

Main forms of involvement

Similar to what happens at the national level, FP participation in exchange with the municipalities was described as participation in forums and meetings, dialogue and discussions with different stakeholders. Less mentioned practices included active participation in drafting protocols and programmes.

> *Exchange of opinions to find solutions for the housing of drug using people who are homeless. There has been an effort from our organisation to involve them in the process, although there is still a lot to do."*
> *(FP **Nicosia, Cyprus**)*

> *We are invited to give input when there are changes in the way OST is organised in Copenhagen. We also work with the municipality about issues regarding the target group."*
> *(FP **Copenhagen, Denmark**)*

> *Through meetings and policy planning initiated and organised by us or partner organisations."*
> *(FP **Podgorica, Montenegro**)*

> *Local governments exchange information with us, we have reached agreements regarding common clients and their needs."*
> *(FP **Tallinn, Estonia**)*

> *Free Clinic is one of the largest organisations in Antwerp with a lot of experience. Ad-hoc meetings occur at policy level on different subjects, meetings and collaboration with different stakeholders."*
> *(FP **Antwerp, Belgium**)*

> *Active participation in new protocols, programmes and working spaces."*
> *(FP **Barcelona, Spain**)*

CIVIL SOCIETY NETWORKS AND PLATFORMS

Most FP organisations are part of a civil society network or national platform in harm reduction, human rights and development aid (see Figure 9) which is in line with the results from 2020. These networks facilitate exchange with other CSOs, either at national or local level. The types of networks in which FPs are involved, as well as their main aims and purposes, can be seen in Table 2.

Figure 9: Is your organisation part of any kind of CS network or national platform (in the area of harm reduction, human rights, development aid) for exchange with other CSOs on the national and/or local level?

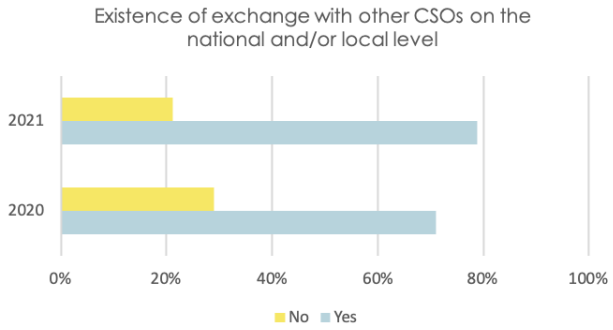


Table 2: Types, aims and purposes of networks in which FPs are involved

Types of networks	Aims and Purposes of the Networks
Taskforce networks focused on specific issues like the COVID-19 pandemic, HCV, HIV, TB, sexual health.	To advocate for harm reduction services as well as exchange information and good practices on specific diseases, improve cooperation and give specific inputs for policies. To develop activities at the community level in prevention, care, treatment, control, HR, psychological and legal support, reduction of stigma and discrimination.
European, national or local harm reduction networks and platforms, including networks on drug consumption rooms and drug checking	To increase communication and cooperation among harm reduction service providers, advocating for the sustainability of harm reduction services and for changes in drug policies and to improve practices.
Networks on drug trends, drug policy, justice security and crime, at the local, national and European levels.	To connect organisations involved in drugs, drug policy depedence, security, justice and crime, to cooperate in the interventions, practises and policies in drug-related issues.
Networks or associations of people who use drugs (including EuroNPUD and INPUD).	To defend and protect the rights of people who use drugs, make their needs visible, exchange knowledge and experiences, organise networks of people who use drugs (and others) that advocate for changes in drug policy and fight against stigma and discrimination.
Networks of services working with key populations, such as the homeless, sex workers, youth, or people in prison settings.	To exchange expertise and to network, helping to improve the quality of life and health of these key populations, while improving coexistence for all people in the cross-cutting fields.
Networks of drug service providers (including, but not exclusively focused on), harm reduction.	Advocate for harm reduction services and for the rights of people who use drugs.

CIVIL SOCIETY CONTRIBUTION TO DATA REPORTING

Most C-EHRN FPs (24 or 69%) are currently contributing to data reporting in their country (other than the present monitoring). In 2020, 24 FPs were also contributing to data reporting in their country.

For those working on data reporting, the main types of contribution include data related to their own service provision (number of people assisted, services distributed, treatment completion, etc.). The data is mostly shared with the EMCDDA national Reitox Focal Point, but sometimes is directly shared with local or national government. This means that CSOs are important sources of information and knowledge and that they significantly contribute to the data collection and reporting of the Reitox Focal Points.

For those not contributing, the reported reasons are lack of time and the fact that governmental organisations and other organisations are responsible for national data collection on harm reduction. As for the FP in London, Brexit is the reason behind their current non-contribution:

> *Drug reporting to the EMCDDA by the UK has ceased due to Brexit. We are not sure at present whether, as it has for Drug Reporting, reporting to the EMCDDA by the UK regarding HCV has/will cease (due to Brexit)."*
> *(FP **London, UK**)*

CHANGES IN CIVIL SOCIETY INVOLVEMENT

The FPs were asked if there was anything else they would like to share with us regarding civil society involvement, especially considering the changes that have occurred in comparison with the previous year. No changes were observed from two FPs. Three mentioned the development of a better relationship with policy makers, mostly due, and in relation, to the COVID-19 pandemic. Two other FPs noticed less willingness by the government to implement harm reduction measures, mainly for political reasons. Two respondents addressed the need for more civil society involvement in the development of policies and practices related to substance use.

> *We do not experience any change compared to previous years. There is perhaps a bit more talk of civil society involvement, but it has not resulted in noticeable changes."*
> *(FP **Copenhagen, Denmark**)*

> *In the face of the COVID-19 pandemic - harm reduction was centre stage. Working in partnership with State agencies, the pragmatism of many CS organisations, including street-level harm reduction NGOs, was very apparent; and this is to be commended."*
> *(FP **Dublin, Ireland**)*

> *An uncertainty in the funding of drug services, little support from the State in advocacy of the importance of harm reduction services, low efforts to inform the public, insufficient focus on voter-unattractive topics (problem of NIMBY, etc.)."*
> *(FP, **Prague, Czech Republic**)*

> *Unfortunately, there is a serious lack of grassroots organisations representing the voice of people who use substances. Only people in rehabilitation or families of people that died because of drug use are usually featured or consulted."*
> *(FP **Malta**)*

CONCLUSIONS

Most FPs are directly involved in structural cooperation with the government at the national, at the local level, or both. While at the local level most FPs still experience low levels of cooperation such as information exchange, at the national level dialogue was pointed out as being both at the level of consultation and information exchange, which indicates a higher level of cooperation compared to 2020. At both levels, these cooperation mechanisms happen mostly through discussion forums and meetings. Nevertheless, governments are more likely to engage in this exchange to inform policy changes, gather data and information to solve specific problems, than to jointly draft policies, protocols, programmes and guidelines.

Although most FPs continue to view government representatives as being approachable by CSOs, speaking openly and critically about the government without any repercussions is the most tangible aspect of exchange between civil society and government that we observe. Indeed, big challenges continue to be posed to civil society involvement, including a lack of balance in the representation of different services, communities and worldviews and the lack of transparency and adequate funding. Generally, these challenges - together with civil society not being informed in a timely manner about policy development or even agendas of meetings, the lack of openness to their initiatives, not having their input being considered in decision making - shows that civil society is not yet equally and meaningfully involved in drug policy decision making.

The important role of CSOs and HR services in the field of data collection needs more acknowledgement and should be reflected in cooperation with the government and the Reitox Focal Points.

In a nutshell, civil society involvement in the development and implementation of drug related policy making remains sub-optimal. Indeed, civil society involvement did not change much in the last year. Their role is still more as consultants and, as observed last year, even for cases whereby FPs do cooperate with policymakers, many of them feel like their contributions are not taken into consideration, both locally and nationally. The COVID-19 pandemic seems to have helped in developing cooperation mechanisms for civil society involvement. However, it remains unclear as to whether this will result in improvements in the development of policy making, per se. Greater efforts are needed to practically implement the voice of civil society.

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ESSENTIAL HARM REDUCTION SERVICES

3

The state of harm reduction services in 35 European cities[6] was assessed for the second time as part of C-EHRN monitoring. The assessment was undertaken from two angles: from the viewpoint of people using the services ('user groups') on the one hand and from different harm reduction service providers on the other. The FPs were also asked to estimate how their situation compares with the national situation and to name major needs of people who use drugs (PWUD) in their city.

DIFFERENCES BETWEEN SERVICES AND USER GROUPS

The first question in this part concerned the state of harm reduction services for different user groups. Altogether, 13 populations in need of services were named in the questionnaire. The 5-point scale for answering includes options (if the service providers are able to provide services for different groups): *to a great extent (5), somewhat (4), very little (3), not at all (2), not relevant to my city (1)*. It should be emphasised that the estimations on the extent to which services are available are subjective and, thus, not easily comparable between countries and cities.

As shown in Table 1, in most of the cities there are services provided to drug users who inject drugs (opioids, stimulants or NPS) and who experience homelessness. The overall picture is somewhat similar to 2020. The scarcest situation with regard to city-level harm reduction services are for people who use drugs intranasally or by smoking as well as for migrants and people in prison. However, for the latter two groups (migrants and prisoners), the city-level evaluations might not be the most relevant when it comes to providing services to them.

In some of the cities, there are generally insufficient harm reduction services, especially in Budapest (Hungary), Malta and Stockholm (Sweden). Harm reduction services for injecting drug users were assessed to have significantly improved in St. Petersburg (Russia); the situation is, however, very fragile. The responding organisation, the Charitable Fund Humanitarian Action, is fighting against the crackdown on harm reduction organisations: a court recently annulled the government decision to include them in the infamous foreign agent list[7].

6 *Compared to the countries and cities that answered the survey in 2020, in 2021 Oslo (Norway) and Vilnius (Lithuania) are missing, but there are also two new cities responding: Valletta (Malta) and Podgorica (Montenegro). As with previous years, there were two separate cities (C-EHRN focal points) taking part in the survey from the UK, one from Glasgow (Scotland) and one from London (England). This year, there were also two separate answers from Italy, from Rome and Milan. Thus, the number of respondent cities is 35, but as countries there are 33.*

7 *For more about this issue, please see:* https://drogriporter.hu/en/russian-harm-reduction-ngo-fights-foreign-agent-status-interview-with-alexei-lahov/

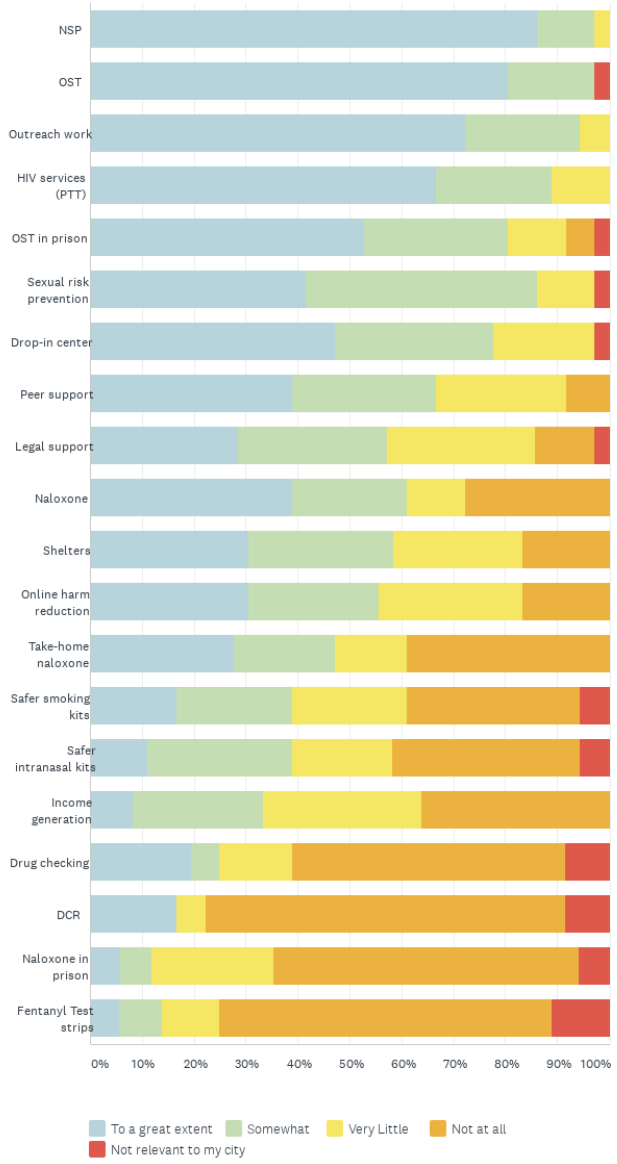
Table 1: Are harm reduction services in your city able to provide services for the following populations? (Year: 2021, n=35 cities)

	People who inject opioids	People who inject stimulants or NPS	People who smoke opiates	People who smoke stimulants or NPS	People who use intranasal stimulants	Sex workers	People experiencing homelessness	Women who use drugs	LGBQTI who use drugs	Young people who use drugs (< 18)	EU Migrants	Non-EU migrants	People in prison settings
Amsterdam	5	4	5	4	4	5	5	3	4	4	5	4	3
Antwerpen	5	5	5	5	5	4	5	5	3	4	5	5	3
Athens	5	4	5	4	4	3	4	3	3	4	3	3	3
Barcelona	4	5	4	4	4	4	4	5	4	3	4	2	4
Berlin	5	4	4	4	4	4	4	4	3	3	4	4	3
Bern	5	5	5	5	5	5	5	5	4	5	5	5	3
Bratislava	4	4	3	3	3	4	4	3	3	2	3	3	2
Bucharest	4	4	3	3	1	4	4	4	4	4	1	1	3
Budapest	3	4	3	4	3	3	3	3	3	3	3	2	2
Copenhagen	5	5	5	5	4	4	4	4	4	3	4	4	1
Dublin	5	5	4	4	4	4	5	4	4	3	4	3	4
Glasgow	5	5	5	4	4	4	5	4	4	4	3	3	5
Helsinki	5	5	4	4	4	4	4	4	3	4	4	4	3
Krakow	4	5	1	4	5	4	5	5	3	4	4	5	2
Kiev	5	5	3	3	3	5	3	4	4	5	3	3	4
Ljubljana	4	4	4	4	4	3	4	4	2	3	3	3	3
London	4	4	3	3	3	3	5	4	4	3	4	4	4
Luxemburg	5	5	5	5	5	5	5	4	4	4	3	3	5
Milano	4	3	4	3	4	4	4	4	4	3	4	4	3
Nicosia	4	4	4	4	3	2	4	4	2	2	4	4	3
Novi Sad	4	2	2	2	2	5	5	5	5	4	4	4	3
Paris	4	4	4	4	4	4	4	4	4	4	4	4	4
Podgorica	5	5	3	3	4	5	4	5	5	3	3	5	5
Porto	5	4	5	4	4	4	5	3	3	2	4	3	2
Prague	5	5	4	4	4	4	5	3	3	4	4	4	3
Rijeka (Croatia)	4	4	4	4	4	3	4	4	4	3	3	3	3
Rome	5	4	5	4	1	5	5	4	3	4	5	5	2
Malta	4	3	2	2	2	2	3	3	2	2	2	2	3
St Petersburg	5	4	4	4	4	5	4	5	4	3	2	2	2
Skopje	5	5	4	4	4	5	4	4	3	5	1	1	2
Stockholm	4	4	2	2	2	3	4	4	4	2	3	3	2
Tallinn	5	5	5	5	4	4	4	4	3	2	1	1	3
Tbilisi	5	5	4	3	3	5	3	5	4	3	2	3	2
Tirana	5	4	5	3	3	5	4	5	5	4	5	4	5
Vienna	5	5	4	4	5	4	5	5	5	5	5	5	2

(5=to a great extent; 4=somewhat; 3=very little; 2=not at all; 1=not relevant to my city)

When the first question was about groups in need of services, the second question (Table 1 and Figure 1) assessed the cities' situation concerning 20 different harm reduction services. Generally, most prevalent harm reduction services in the 35 European cities were needle and syringe exchange programmes (NSPs), opioid substitution therapy (OST) and outreach work. Much less prevalent services were drug consumption rooms (DCRs), fentanyl test strips and naloxone provision in prisons.

Figure 1: Are the following services available in your city for people who use drugs?



In the open answers, many respondents described the overall situations in their cities and countries. For instance, in Copenhagen there is generally good access to treatment and harm related services in most of the city. Shelters in general have a positive approach to harm reduction and all provide needle exchange. All staff are trained in overdose treatment with naloxone (FP from Denmark).

In the Kyiv region (Ukraine), harm reduction services are provided by both the city and community-based organisations. The State supports harm reduction programmes (FP from Ukraine).

In many countries, the COVID-19 pandemic has impacted harm reduction services. For example, in London the epidemic and related restrictions have considerably limited traditional drop-in facilities. The corresponding reduction in people's access to HR services generally - given unprecedented restrictions to movement - did prompt innovation in service delivery (including postal services, online support, peer-led initiatives, less restrictive OST prescribing). The FP from London also reported legal and policy barriers to DCRs and to paraphernalia outside of injecting equipment, meaning there are limitations to access a full range of harm reduction services. In relation to smoking and intranasal use of drugs, there is advice but no access to equipment (apart from foil). In terms of the impact of Brexit on EU-migrant service provision, Brexit (and the hostile environment this has created for migrants) has impacted service delivery for this population. Whilst there is no duty to inform authorities, there have been examples of housing organisations working with the Home Office over deportation back to the EU and non-EU countries, so whilst services exist, there are barriers to access (FP from London).

Paris is facing issues regarding crack consumption and how to deal with crack users, implemented in the north of the city. Harm reduction services are not sufficient, other services are required and at least a DCR for crack users. Paris also needs another DCR aimed at people injecting drugs (at the moment there is only one DCR) (FP from Paris).

Other underserved populations mentioned were the Roma ethnic minority which is disproportionally affected by problematic drug use due to segregation and social exclusion (FP from Budapest).

COUNTRY PROFILE: CROATIA

Zagreb, the capitol of Croatia, and Rijeka are both reported to have good coverage of harm reduction services. Harm reduction measures were accepted by the Croatian parliament in 1996. Since then, it has been an integral part of the national policy to combat drug abuse and funding for the programme has been provided by the Ministry of Health which controls the quality and standards of implementation of the Harm Reduction programme.

> *"Croatia's coverage of harm reduction activities is extremely good because all places where it is epidemiologically necessary and useful to have HR programmes have been achieved. At the moment, HR programmes are implemented in Croatia by associations: the Croatian Red Cross with programmes in Zagreb, Krapina and Zadar; Help, with programmes in Split, the islands, Dubrovnik; Porat, with a programme in Zadar; Terra, with programmes in Rijeka and its surroundings as well as in Pula, Istria and Porec Let, plus minimal work and programmes in Zagreb based on mobile teams (at the moment, they are practically not working).*
>
> *Harm reduction programmes are well received by the medical community. All public health institutes work well with associations in their areas. On a global scale, when it comes to the treatment of dependence, there is a "Croatian model", which is characteristically multidisciplinary. The success of HR in Croatia has been proven by epidemiological indicators - a stable population of HIV-infected PWUD, a stable number of PWUD infected with HCV and HBV.*
>
> *The Croatian Red Cross presented and introduced harm reduction programmes to the IFRC and is one of the founders of the Harm Reduction programme in the Red Cross movement. There is one drop-in center in Rijeka, open Monday to Friday from 10am to 5pm. Field work is organised in a way that covers the Primorje-Gorski Kotar and Karlovac counties. Part of the field work is performed by users-volunteers (peer support) who are in contact with people who have not yet contacted other organisations and know the gathering places of intravenous users, where they leave clean injecting equipment and collect infectious waste." (**Croatian** FP)*

Table 2: Are the following services available in your city for people who use drugs? (Year: 2021, n=35 cities)

	Outreach work	Peer support	NSP	Safer smoking kits	Safer intranasal kits	DCR	Drop-in center	Drug checking	Fentanyl Test strips	OST	OST in prison	Naloxone	Take-home naloxone	Naloxone in prison	Sexual risk prevention	HIV services (prevention, testing or treatment)	Specific employment opportunities/income generation for PWUD	Online harm reduction	Shelters	Legal support
Amsterdam	5	5	5	5	3	5	5	5	3	5	4	5	2	3	5	5	5	5	4	5
Antwerp	4	4	5	2	4	2	5	2	2	5	5	2	2	2	5	5	4	4	5	3
Athens	4	4	4	3	2	2	3	2	2	5	3	2	2	2	4	4	2	2	3	3
Barcelona	5	5	5	4	4	5	5	4	2	5	5	5	5	4	5	5	3	2	3	5
Berlin	5	3	5	4	4	5	5	2	2	5	4	3	3	2	4	4	4	3	4	4
Bern	5	5	5	5	5	5	5	5	1	5	3	5	4	3	5	5	5	5	5	5
Bratislava	5	4	5	3	3	2	4	2	2	4	2	2	2	2	4	3	2	3	3	2
Bucharest	4	3	4	1	1	2	4	2	2	4	4	2	2	2	4	4	2	3	3	2
Budapest	3	2	3	2	2	2	4	2	2	4	2	2	2	2	3	3	3	2	4	4
Copenhagen	5	5	5	4	2	5	5	4	4	5	5	5	4	2	4	4	4	5	5	3
Dublin	5	4	5	5	4	2	4	2	2	5	5	4	4	2	4	4	3	3	5	3
Glasgow	5	5	5	4	3	2	3	2	2	5	5	5	5	5	4	5	4	4	5	3
Helsinki	5	4	5	3	4	2	5	2	4	4	4	2	2	3	4	5	3	5	4	4
Krakow	5	3	5	4	2	2	5	2	2	5	4	5	2	1	3	5	4	4	5	5
Kiev	5	5	5	2	2	2	3	3	2	5	4	5	5	3	5	5	4	4	4	5
Ljubljana	5	3	5	4	4	2	5	5	2	5	5	4	4	2	3	5	3	3	4	4
London	3	4	5	2	2	2	3	3	2	5	5	5	5	3	4	4	2	5	5	4
Luxemburg	5	2	5	4	4	5	5	5	2	5	5	4	3	3	5	5	4	5	5	5
Milan	4	3	4	3	3	2	4	2	2	5	5	4	4	2	4	3	2	2	3	4
Nicosia	4	2	4	2	2	2	4	2	2	4	5	3	3	2	3	3	2	2	2	2
Novi Sad	5	4	5	2	4	2	5	2	2	5	5	2	2	2	5	5	2	5	2	2
Podgorica	5	5	5	2	2	2	5	2	2	5	5	2	2	2	4	5	2	5	2	3
Paris	5	5	5	5	5	3	5	5	2	5	5	4	4	3	4	5	3	5	3	1
Porto	5	3	5	3	3	3	3	3	3	5	3	2	2	2	5	4	2	3	4	3
Prague	5	4	5	3	3	2	4	2	3	4	3	4	4	2	4	5	3	4	4	4
Rijeka	4	4	5	2	3	2	4	5	5	5	4	4	2	4	4	5	4	2	3	3
Rome	5	4	5	5	5	2	5	3	4	5	5	5	5	3	5	5	3	4	4	4
Malta	4	3	5	2	2	2	3	2	2	5	4	3	2	2	4	5	2	3	4	4
Saint	5	5	5	2	4	1	3	1	1	1	1	5	5	1	5	5	3	5	2	4
Skopje	5	5	5	1	1	1	5	1	1	5	5	2	2	2	5	5	2	3	2	5
Stockholm	4	5	5	2	2	2	1	2	5	5	5	5	5	2	1	5	3	3	5	3
Tallinn	5	5	5	4	2	2	5	2	2	5	4	5	5	3	5	4	3	4	3	3
Tirana	5	3	5	5	5	1	4	1	1	5	5	3	3	2	5	5	2	3	3	4
Tbilisi	5	5	5	3	2	2	4	3	3	5	4	5	5	2	5	5	2	4	2	5
Vienna	5	3	5	3	4	2	5	5	2	5	5	4	3	2	5	5	4	4	5	5

(5=to a great extent; 4=somewhat; 3=very little; 2=not at all; 1=not relevant to my city)

Figure 2: Are harm reduction services in your city able to provide services for the following populations? (n=35)

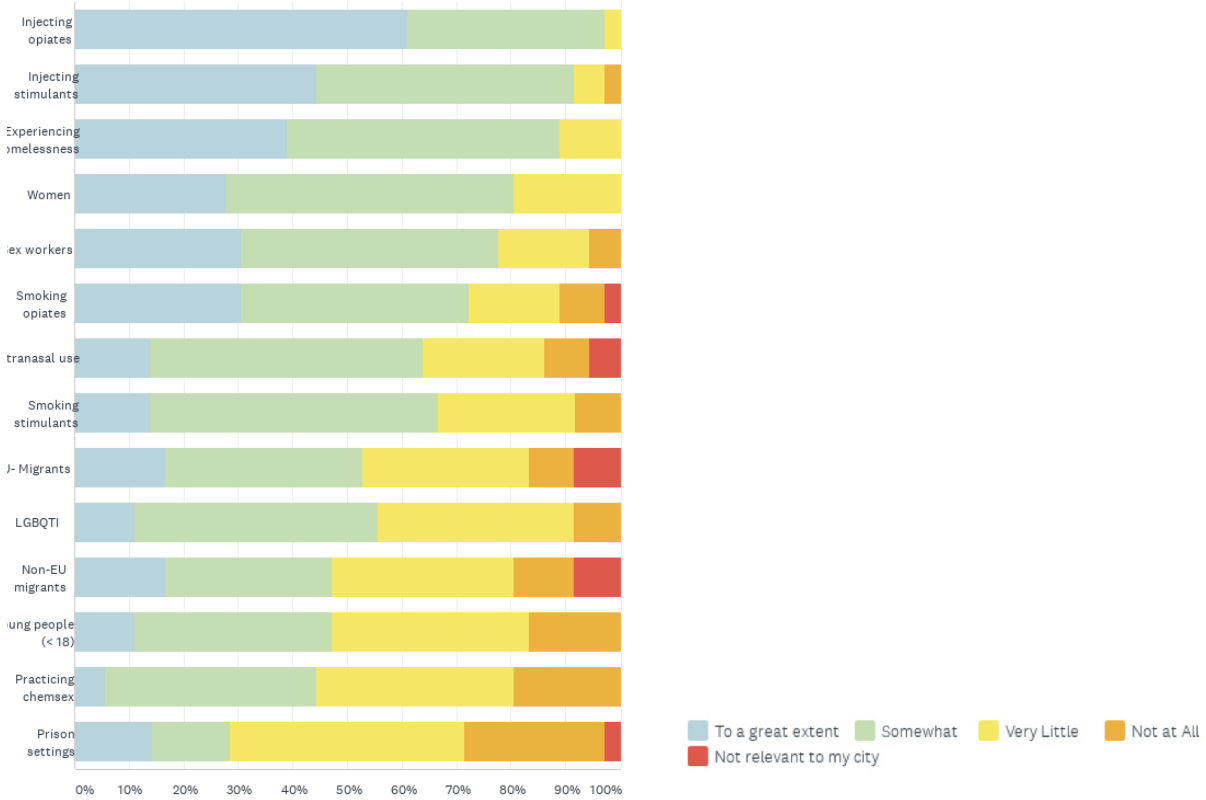


Figure 3: For the populations you have answered "very little" or "not at all", can you indicate to your knowledge why these populations are currently not being reached by harm reduction programmes?

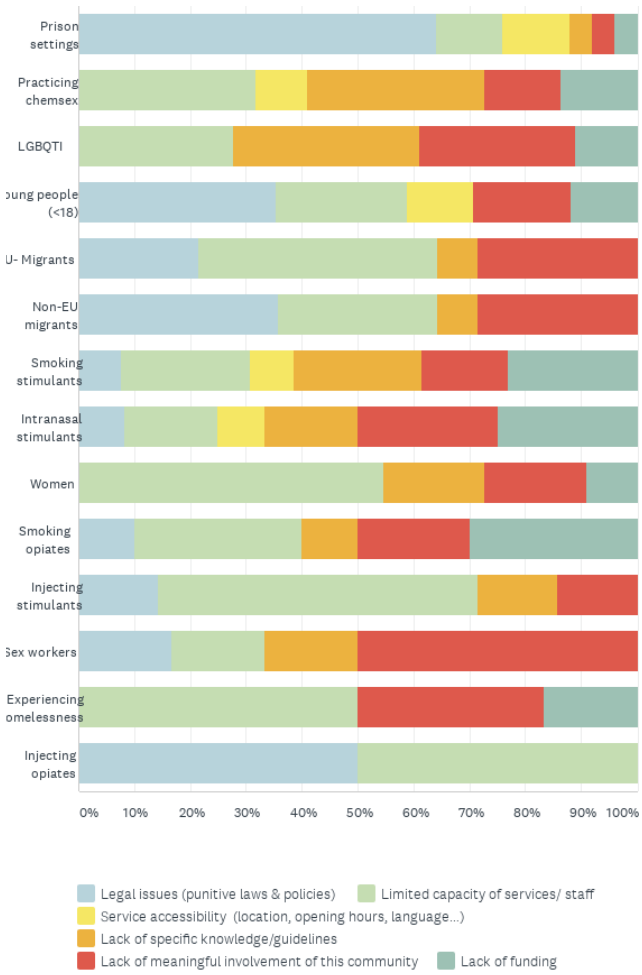
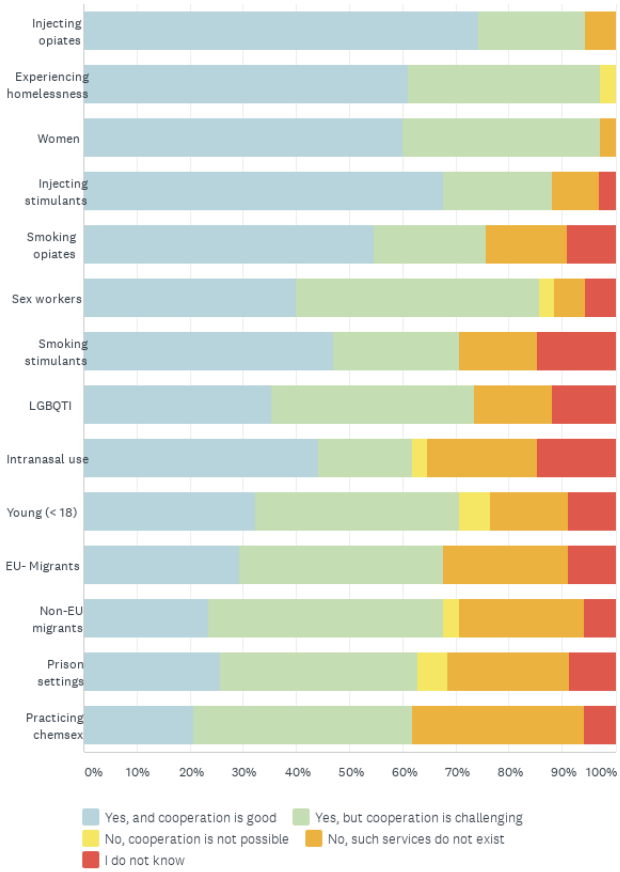


Figure 4: Do harm reduction services in your city cooperate with other services reaching the following populations?



HOW DO THE CITIES COMPARE WITH THE NATIONAL SITUATION?

The respondents were asked if the current harm reduction services in their city can meet the needs of PWUD: about 30% felt that the services do meet their needs, whereas the rest, about 70%, answered no. Still, compared to the national level, over 91% felt that the harm reduction service coverage in their city is better than the overall situation in their country (Figure X). Most of the cities in the survey are either capitals or other bigger cities

where both PWUD and harm reduction services are typically concentrated, more diverse and have better opening hours. The number of PWUD in smaller cities or rural areas are isolated and, thus, in a worse situation when it comes to harm reduction service availability and access.

In Romania, for example, harm reduction services are available only in Bucharest, not at all in other parts of the country. In Poland, a country with almost 40 million people, harm reduction programmes are operating only in Krakow, Warsaw and Wroclaw. In another big country, Italy, harm reduction services are more or less absent in the southern part of the country. Portugal has a similar situation: Porto and Lisbon have great coverage of harm reduction services but other cities have lower coverage or no services. Also in Austria, there are still federal districts which do not have either needle exchange or naloxone programmes.

In Cyprus, the only drop-in centre in Nicosia also provides some of its services to other cities via its mobile unit. Podgorica, the capital of Montenegro, has two drop-in centres for PWUD, one for sex workers and one for LGBTQI people. Outside the capital, there is just one drop-in centre in Bar and none in other cities in Montenegro.

In Hungary, Budapest has better services than the countryside but if you compare the prevalence of drug users in the capital, still, the coverage is not much better with areas where communities are not reached out at all. In Slovakia, the harm reduction service coverage has worsened since 2008 when the anti-drug fund was moved from the Ministry of Health; nowadays, there are only three harm reduction organisations in Slovakia in the western part of the country, whereas there used to be eight throughout the country. Two of the remaining programmes are in Bratislava and one covering three smaller cities. The rest of the country is not covered and there is also a lack of information about the situation in communities, the Slovakian FP reports.

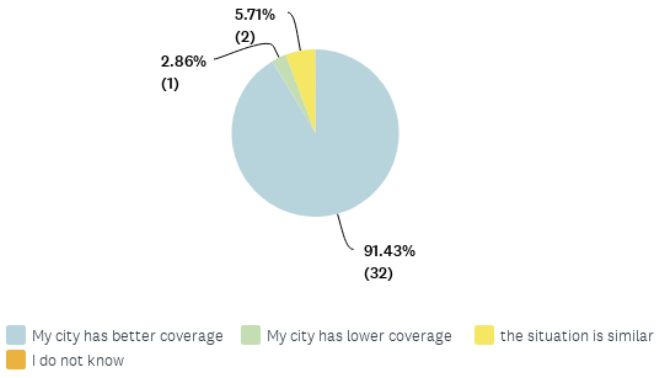
North Macedonia represents a more positive case. In Skopje, there are 2 drop-in centres and extensive outreach work and a further 11 harm reduction programmes operating in 11 cities.

In Estonia, most services are offered in Tallinn, Harju County and Ida-Viru County. In August 2020, a new harm reduction centre was opened in Tallinn in an area where there had been no services before.

Some cities report having specialised services, like Glasgow's WAND Initiative which involves Wound Care, Assessment of Injecting Risk, Naloxone and Dry blood spot tests. People are even paid to engage in these assessments.

Most countries that have DCRs have them only in a couple of cities. For example, Spain is composed of 17 regions and 2 autonomous cities, but DCRs are only in Catalonia and the Basque Country. In France, there are DCRs only in Paris and Strasbourg. Even in the Netherlands, a country with the most DCRs in Europe, they are offered only by a minority of the municipalities. Similarly, the drug checking services are also not offered in all municipalities. However, this service is not entirely up to the municipality but also decided upon by the Drug Information Monitoring Service (DIMS), the national coordinator of drug checking services. They make the final decision on whether additional service iare needed in the regions.

Figure 5: How does your city compare with the national situation in terms of harm reduction coverage?



PROFILE: DUBLIN, IRELAND

Dublin has the 'lion's share' of the drug problem in Ireland and, as a consequence, harm reduction services have developed over the past number of decades. That said, smaller cities, towns and villages across Ireland report significant problems with cocaine, cannabis, street tablets and other drugs; and all the attendant issues that come with drug use and engaging with drug markets.

One challenge is for harm reduction services to reach PWUD in rural areas, i.e. those people who are geographically isolated. It would be good for C-EHRN to consider how we can share good practice in this regard with member organisations."
*(FP from **Dublin**)*

IMPROVEMENTS NEEDED IN HARM REDUCTION SERVICES

When asked, "Do you feel the current harm reduction services in your city can meet the needs of PWUD?", 70% of FPs (cities) answered negatively. They were asked to freely describe the major needs PWUD might have in their cities and what is needed to improve the harm reduction services. The main needs and anticipated improvements mentioned by the 35 cities are as follows:

Amsterdam. User needs: (1) Affordable housing; problematic drug and alcohol use occurs relatively often among homeless and the marginally housed. Amsterdam and other cities in the Netherlands all struggle with a severe shortage of affordable housing, leaving people homeless and in shelters for too long. Stable housing/housing first helps people to recover in the broadest sense. (2) Access to non-biased and knowledgeable information about drugs and drug use as well as the services on offer through channels and in the tone of voice that fits the specific PWUD community. PWUD groups are very diverse and the younger groups are rather fluid; younger PWUD tend to identify less as PWUD but rather through other lifestyle aspects. The questions people have about drugs and the (social, mental, physical, drug use related, sexual) problems they encounter are equally as diverse. A lot can be found online and there is a lot of support possible, but it can be hard to access or even find the support you need sometimes. (3) Some additional specific needs: for chemsex PWUD, specialised integrated care addressing sexual and drug use related problems combined; for migrant PWUD, better access to care and support; for women and LGBTQI, more specialised understanding of, and specific services, addressing their particular needs. HR improvements needed: capacity to reach out to new vulnerable groups who use drugs, opportunities to collaborate with, and refer to, other services and vice versa. Also, PWUD could benefit from professionals with harm reduction expertise at sheltered housing facilities that know about opportunities, which is not always the case at present.

Antwerp. User needs: Drug consumption room, naloxone, drug checking. HR improvements needed: decriminalisation; change of drug law; more funding.

Athens. User needs: housing, naloxone availability, needle exchange programmes, and above all efficient psychosocial support. HR improvements needed: funding and peer involvement.

Barcelona. User needs: (1) shelter (there is only one in Barcelona for PWUD). (2) DCRs that are open 24/7. (3) DCR for smoking. HR improvements needed: Working directly with PWUD demands joint work between PWUD, politicians and CSOs, economic investments, visualising HR services and goals.

Berlin. User needs and HR improvements needed: take-home naloxone, drug checking, services for refugees and migrants.

Bern. User needs: Consumption rooms and drug checking services are distributed unequally in Switzerland and especially in the French and Italian speaking parts there is a lack of coverage. HR improvements needed: Better coverage of consumption rooms and drug checking services.

Bratislava. User needs: designated shelter for PWUD; low threshold centre with showers, washing machine; change in drug policy on drug possession (a lot of people are facing big and absurd criminal charges for possession of small amounts of drugs). HR improvements needed: the main problem is the stigma around HR and PWUD. There is the will on the side of the city and also on the side of HR service providers to create new services, but we are facing big problems with the local community. The city had to cancel the plans for a shelter for PWUD due to it and Odyseus also needed to leave new premises where there would have been a new low threshold centre for PWUD.

Bucharest. User needs: more clean injecting commodities and to reach a reasonable coverage; PWUD access to HIV, HBV, HCV treatment and better access by PWUD to OST. HR improvements needed: central and local authorities must prioritise disease prevention through their policies and act accordingly through the provision of constant funding for improving coverage (to at least 50%) and harm reduction service quality.

Budapest. Needs: adequate housing and income; access to social/health services; and avoid criminalisation/police harassment. Improvements: political leadership/will to support harm reduction; adequate funding mechanisms tailored to harm reduction; and the greater involvement of the community/drug user organisations.

Copenhagen. User needs: access to substitution treatment for migrants. HR improvements needed: smaller satellite DCRs in hotspots outside the open drug scene.

Dublin. User needs: Housing for PWUD and who are homeless; greater access to income generation for PWUD; drug consumption facilities. HR improvements needed: broadly, the removal of structural barriers (e.g. changing laws) and the prioritisation of implementing agreed harm reduction measures (e.g. supervised injecting; better access to Naloxone, etc.).

Glasgow. User needs: same-day access to prescribing; access to DCRs; choice in prescribing options including HAT (Heroin Assisted Treatment programme). HR improvements needed: DCRs.

Helsinki. User needs: drug checking; consumption rooms; better access to HCV treatment. HR improvements needed: political will.

Ljubljana. User needs: safe consumption rooms; housing first programme and specific employment opportunities. HR improvements needed: political will and taking harm reduction experts into account when deciding new public policies.

Paris. User needs: to use in a safe environment; to get accommodation; to get a job. HR improvements needed: more harm reduction facilities, especially for crack users; better cooperation between harm reduction services and community health services regarding chemsex users; more DCRs; more shelters and employment services aimed at homeless people and people who use drugs.

Podgorica. User needs: Naloxone is a priority since it is not available except in health institutions (NGOs are not allowed to provide free naloxone to clients); also there are no drug test kits, drug consumption rooms, shelters. HR improvements needed: increase in the availability of psychosocial support services, as well as the possibility of hiring experts from various fields in order to exercise the rights of persons who use drugs - such as free legal aid, but not only in terms of providing free legal aid related to counseling on individual legal matters but also the possibility of legal representation if necessary. Also, change in legal regulations regarding naloxone availability, as well as contemporary harm reduction measures available everywhere in the world.

Prague. User needs: (1) insufficient capacity of drop-in centres - at least one more is required. (2) OST programmes - insufficient capacity of programmes. Hundreds of people are not on OST that would profit from it very much. HR improvements needed: main problem is the division of political power between districts of Prague and the municipality of the whole of Prague. Funding and will of the city districts, problem of NIMBY. Adjustment of opening hours of NSPs.

Kiev and Kiev region. User needs: lack of community centres; social support for inclusion of OST; receiving harm reduction services at home during quarantine. HR improvements needed: there is a basic package of harm reduction services funded by government and available in the city, but there is the need to develop an expanded package of services that would address needs of the communities; improvement of working conditions for social workers during quarantine, possibility to move between cities of the Kyiv region when there is no transport connection; creation of a community hub for providing food and accommodation services, or a wider range of social services with the help of mobile brigades in Kyiv and the Kyiv region; access to medical services of family doctors through NGOs.

Krakow. User needs: drug consumption room, drug testing, finding the proper harm reduction strategy and offer for young drug users. HR improvements needed: legal changes, especially regarding the drug law (decriminalisation of drug possession); recognise harm reduction as a broader strategy to help drug users; identifying the backgrounds and needs of young people who regularly use drugs.

London. User needs: (1) DCRs; (2) drug checking; and, (3) paraphernalia for smoking/intranasal use. HR improvements needed: (1) legal reform in respect of the interventions described above or an increase in local agreements with police and public health to permit these activities; (2) greater funding – local authorities became responsible for funding and commissioning drug and alcohol services under the Health and Social Care Act 2012 while facing an estimated 37.3% reduction in central government funding between 2010/11 and 2015/16. As a result, "drug misuse treatment" faced more reductions in funding than any other public health area in 2016/17 with a 14% reduction in funding between 2015/16 and 2016/17. Net expenditure on adult drug and alcohol services has decreased by 19% in real terms between 2014/15 and 2018/19.

Milan. User needs: more mobile units and drop-in centres; attention is also needed to health issues (prevention, testing and treatment of HIV and hepatitis); drug-checking services and drug consumption rooms are absent. HR improvements needed: political commitment supporting HR strategies and services; major investments in financial and human resources.

Nicosia. User needs: (1) introduction of methadone substitution treatment; (2) shelters; and, (3) harm reduction in prison. HR improvements needed: (1) specialised training; (2) budget; and, (3) change of priorities in the political agenda regarding harm reduction issues.

Novi Sad. User needs: harm reduction programmes for speed (amphetamines); bigger syringes for injection of methadone; programmes for employment. HR improvement needs: additional training and funds.

Porto (answers on the national situation). User needs: HR services in prison settings; specific interventions for specific populations like LGBTI and women; services for homeless people (housing programmes adapted for PWUD/shelters with DCR included); drop-in DCRs. HR improvements needed: proper funding to extend the services and improve conditions; political/ideological changes to open more DCRs in new cities; peer Involvement and HR services promoted by peers; drug-checking and HR in party settings in new cities; HR shelters for homeless PWUD; making HR services permanent; regulation of HR responses; professional recognition for people working in HR.

Rijeka. User needs: Red Cross: All needs are covered by the system and NGOs which are implementing HR programmes. NGO Terra: Naloxone; additional utensils for intravenous drug consumption (citric acid - packaged in the dose required for a single injection; cooking utensils); the availability of drug-checking. NGO "Susret": availability of services; psychological help and detoxification. NGO "Porat": Clean injecting equipment; place for personal hygiene; legal and social assistance. NGO "Nada": Detoxification unit; living room for drug dependent people; legal aid. HR improvements needed: Red Cross: more funding; a stable financing system. NGO "Terra": financial resources for the procurement of additional material for distribution to intravenous drug users; changes in the legislation related to naloxone (at the State level); provision of financial resources for drug-checking. NGO "Susret": to increase funding for carrying out these types of activities. NGO "Nada": more empathy and concrete help. NGO "Porat": it would be necessary to open the living room (drop-in facility).

Rome. User and HR improvement needs: A proactive attitude towards harm reduction strategies as well as decriminalisation of drug use. Public drug treatment services are unattractive for NPS users; DCRs; need to implement HR in prisons.

Skopje. User needs: specific treatment programmes are needed, there is only OST; there is no treatment programme for children who use drugs; there are no programmes for women. Decentralisation of OST is needed as there are 3 centres in Skopje and in one of them, there are about 500 people. People on therapy need time to get to the OST centre and most of them have to take several buses. People need money and time to go for therapy and now the OST centre works from 7am to 2pm. HR improvements needed: smoking and intranasal kits; funding for opening programmes for people who use stimulants and NPS; and a programme for women.

Malta. User needs and HR improvements: (1) harm reduction principles should be applied to all substances; enact legislation to ensure the necessary legal safeguards to allow drug testing by users and in a more professional way by experts; (2) increase educational outreach that moves beyond prevention and the medicalisation of problematic substance use; and, (3) provide a fully decriminalised system for personal use of substances, ensuring persons that experience problematic use are provided with the necessary assistance and are no longer criminalised.

St. Petersburg. User needs: more services for people who use NPS; more services for chemsex users; and greater access to rehabilitation. HR improvements needed: funding; government support; relevant trainings.

Stockholm. User needs: (1) consumption rooms; (2) needle exchange programmes without ID and registration; and, (3) faster access to an OST programme. HR improvement needs: funding.

Tallinn. User needs: there is a great lack of mental health services; there are no rooms for safe use; there are no shelters for PWUD (the condition for admission to our shelters is that the person is sober). HR improvements needed: there is a need for greater cooperation with health care. More legal assistance for PWUD is needed. Information and knowledge are needed for drug users who use drugs in other ways than by injection. More State medical institutions for dependence treatment and closer to Tallinn.

Tbilisi. Sterile injecting equipment; naloxone; social support; and innovative approaches to develop online outreach as well as other models to support peer-to-peer interventions.

Tirana. User needs: employment opportunities for PWUD; more opportunities regarding re-integration into society; more treatment for HCV. HR improvements needed: more funding; more collaboration between CSOs and other stakeholders.

Vienna. User needs: (1) safer use measures in prison; (2) employment opportunities for PWID; (3) heroin substitution treatment; and, (4) DCRs. HR improvements needed: policy measures for the aforementioned measures.

CONCLUSIONS

Country-based monitoring reports tell if a given country has, or has not, a certain harm reduction service. To gain more insight into the state of harm reduction services, it is important to also go to local and regional levels and assess differences in service provision between cities and within the country and to assess which services are lacking in the city and if the existing services can meet the demand.

The overall picture of essential harm reduction services is that there is an insufficient number of available in almost all European cities and that in many cities the existing services are largely focused on, and limited to, PWID (especially NSP and OST). In most cities, the harm reduction services lack funding and political support. In many cities, the integration of harm reduction services with other parts of the health and social care system is still too weak.

In the big picture, there is a divide between Eastern and Western Europe when it comes to harm reduction. Generally, harm reduction services are better available and accessible in Western Europe, and less in Eastern Europe, but there are also exceptions. The other divide, in most of the countries, is between the service-provision in capitols and other big cities, and small towns and rural areas. In smaller places PWUD can be isolated and lack harm reduction services.

This section of the survey has at least two major limitations. While its main indicator is the existence and extent of the harm reduction service, the service coverage cannot be sufficiently assessed on the basis of the current questionnaire. The second limitation is that current data does not provide sufficient information on the quality of services. In the current version of the survey, the data provides quite limited and non-systematic information on service quality in the qualitative reports by respondents.

Correlation
European
Harm Reduction
Network

HEPATITIS C

4

INTRODUCTION

In 2016, the World Health Organization (WHO) set a global goal to eliminate viral hepatitis as a public health threat by 2030[8]. In Europe, people who inject drugs (PWID) account for the majority of new cases of hepatitis C virus (HCV) infections. In the WHO European region, an estimated two million PWID are living with active HCV infection, about 75% of whom are thought to live in Eastern European countries[9]. In 2021, the WHO Global Progress Report showed that in the WHO European region only 24% of people infected with HCV are aware of their infection and only 8% of those diagnosed have so far been treated[10]. However, the report also revealed immense inequities in HCV management.

Monitoring of progress in the HCV response for PWID related to the WHO 2030 HCV elimination goals in 35 European countries during two consecutivre years was performed by the Correlation-European Harm Reduction Network (C-EHRN) in the years 2019 and 2020. The results showed that despite progress reported by several countries, HCV testing and treatment for PWID remains insufficient and further improvements of the existing continuum-of-care interventions for PWID are needed.

In the spring of 2021, for the third year in a row, C-EHRN once again invited civil society organisations (CSOs) from European countries to complete a 27-item online survey on the availability of, and access to, interventions that constitute the HCV continuum-of-care that are specific for PWID. Consequently, this section consists of four parts: 1) the use and impact of national strategies and guidelines on accessibility to HCV testing and treatment for PWID; 2) the functioning of the continuum-of-care in different countries and cities; 3) potential changes in the continuum of services compared to the previous year; and, 4) the role of harm reduction services and PWID NGO's in this context.

The responses from the C-EHRN focal points were selected due to their expected capability to capture the national situation and their experience in harm reduction policy and practice. In what follows, the focus varies between national level situations and city level; this is to enable comparisons in progress to be made over the three consecutive years, 2019, 2020 and 2021. When making comparisons, however, it should be born in mind that there are some differences in participating countries and cities between 2020 and 2021. Compared to the countries (cities) that answered the survey in 2020, in 2021 Norway (Oslo) and Lithuania (Vilnius) are missing, but there are also two new responding countries (cities): Malta and Montenegro (Podgorica). As in previous years, there were two separate cities (C-EHRN focal points) taking part in the survey from the UK, one from Glasgow (Scotland) and one from London (England). This year, there were also two separate answers from Italy, from Rome and Milan. Thus, the number of respondents as cities is 35 but as countries it is 33.

8 *WHO (2016). Global health sector strategy on viral hepatitis 2016-2021. Towards ending viral hepatitis. Geneva; World Health Organization.* https://apps.who.int/iris/handle/10665/246177

9 *Maticic M, Pirnat Z, Leicht A, Zimmermann R, Windelinck T, et al. (2020). The civil society monitoring of hepatitis C response related to the WHO 2030 elimination goals in 35 European countries. Harm reduction journal, 17(1), 89.* https://doi.org/10.1186/s12954-020-00439-3; *Maticic M, Pirnat Z, Leicht A, Zimmermann R, Windelinck T, et al. The civil society monitoring of progress in hepatitis C response for people who inject drugs related to the WHO 2030 elimination goals in 35 European countries. INHSU Digital Conference 2021, on-demand presentation #VP68.*

10 *WHO. Global progress report on HIV, viral hepatitis and sexually transmitted infections, 2021. Accountability for the global health sector strategies 2016–2021: actions for impact. Geneva; World Health Organization, 2021.* https://apps.who.int/iris/bitstream/handle/10665/341412/9789240027077-eng.pdf

NATIONAL POLICY LEVEL

Firstly, respondents were asked to assess the summarised public information on HCV policy implementation per country on the EMCDDA website[11] about their country and whether it was up-to-date, or if something mentioned on the website had recently changed regarding new or updated hepatitis C policy.

For the majority of countries (20/34) the information on the EMCDDA website was up-to-date. Compared to previous years, in 2021 more respondents (9/35 in 2020, 12/34 in 2021) answered that the information provided on the EMCDDA website about their country needs to be updated. It must be noted, however, that Georgia, Montenegro, North Macedonia, Serbia and Ukraine, who also chose this answer, are not part of the EMCDDA's data gathering network.

Such Reitox Network[12] countries, whose information needs to be updated, include Austria, Belgium, Croatia, Ireland[13], Italy[14], Scotland[15] and Sweden. The information on the UK was also regarded as needing an update. The UK does not, however, belong to the Reitox network[16] anymore due to the withdrawal of the UK from the European Union at the end of 2020 ("Brexit").

NATIONAL GUIDELINES AND REAL-LIFE PRACTICES

One part of the C-EHRN monitoring survey assesses the use and impact of national strategies or guidelines on accessibility to testing and treatment for PWID. Respondents were asked to assess the use, and impact, of national strategies or guidelines on access to testing and treatment for people who use injectable drugs from the viewpoint of services working with PWUD.

Almost all countries use either their own national guidelines, EASL guidelines or other guidelines that include PWID (see Table x). Two countries, Poland and Russia, reported not having any HCV guidelines related to PWID. Last year, Cyprus was also among those countries, but this year they reported having WHO guidelines in use.

11 http://www.emcdda.europa.eu/publications/topic-overviews/hepatitis-policy_en#section4

12 https://www.emcdda.europa.eu/about/partners/reitox_en

13 https://www.hpsc.ie/a-z/hepatitis/hepatitisc/hepatitiscreports/hepatitisannualreports/Hepatitis C Annual Report 2019.pdf

14 *"In Dec 2020 the MoH issued a new plan for the screening of active HCV which foresees screening for HCV for all the population born from 1969 to 1989, people attending drug treatment services and prisoners" (Italian FP).*

15 *For this question, the number of countries is one higher (from 33 to 34) because Scotland was treated independently from the UK as it has its own HCV policy. The Scottish FP answered that their information on the EMCDDA website needs to be updated as, "there will be a sexual health BBV 'recovery' plan to be launched shortly".*

16 *Reitox is the European information network on drugs and drug dependence created at the same time as the EMCDDA. The abbreviation 'Reitox' is derived from the French '**R**éseau **E**uropéen d'**I**nformation sur les Drogues et les **Tox**icomanies'.*

Table 1: Which guidelines for hepatitis C testing and treatment of people who inject drugs (PWID) are used in your country? (n=33)

	n
No guidelines	2
EASL guidelines	8
National guidelines with PWID included	16
Separate national guidelines for PWID	2
Other guidelines (i.e. WHO)	5

Even if guidelines exist, they might have limited relevance in practice. Respondents were asked about the implementation of national HCV guidelines. A range of challenges - such as outdated guidelines and complicated testing and treatment systems - as well as a lack of services, the effects of COVID-19 on testing and treatment and other disparities between formal guidelines and reality were reported.

Respondents (whose country has guidelines) were then asked to assess how these guidelines impact access to HCV testing, treatment and other services for PWID in their city (See Figure X). Overall, many respondents (24/33) saw a positive impact of the guidelines, while in 4/33 cities (Amsterdam, Bratislava, Bucharest, Tallinn) the impact was considered negative and in 5/33 cities (Budapest, Dublin, Milan, Novi Sad, Rome) the guidelines were reported to have no impact. In 19/33 cities, respectively, better access to HCV testing and treatment was reported as the positive impact of the guidelines (see Table 2).

Figure 1: Do you think these guidelines impact accessibility to hepatitis C testing and treatment of people who inject drugs (PWID) in your city? (n=33)

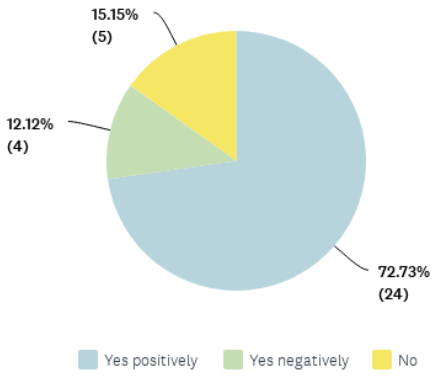


Table 2: In which areas did you notice that guidelines had better impact on access to hepatitis C testing, treatment and other services for people who inject drugs (PWID)(n=23[17])

ANSWER CHOICES	RESPONSES	
Better access to HCV testing	82.61%	19
Btr access to HCV treatment	82.61%	19
Btr access to information	69.57%	16
Better access to CSO services	56.52%	13
Btr acs to spec. services	56.52%	13
Other	13.04%	3

17 Out of 24 who answered the guidelines had a positive impact, one (Cyprus) did not specify the impact.

Problems and shortcomings

The respondents were asked to freely describe any other vital issue that is missing from their guidelines, or otherwise comment on the guidelines and their implementation. They provided plenty of comments and additional information on the state of art in their cities and countries:

> **Georgia (Tbilisi):** *"Due to the COVID-19 pandemic, online treatment interventions for PWID should be added into the guidelines. Self-testing for HCV should be adopted."*

> **UK (London):** *"The devolved regions – Scotland, Wales and Northern Ireland – have either a national plan or an elimination strategy. Although England does not yet have an elimination strategy, elimination is driven centrally by NHS England and treatment networks are specifically required to focus on the PWID cohort where prevalence is highest. NICE also offers guidance for HCV testing and treatment specifically for those who inject drugs. NHS England has entered into a Hep C tender deal with industry - who have contracted with the Hep C Trust and drug services to deliver Hep C testing and treatment. It is a weighted procurement of tenders costed against numbers needing access to testing and treatment. The number of people treated is not limited and it aims to provide treatment to all those who need it. The pharmaceutical industry has entered into deals with drug treatment providers to provide testing and treatment with the Hep C Trust, offering a peer service. This approach has been received positively and progress towards elimination is being made."*

> **Romania (Bucharest)**: *"Treatment for non-insured individuals (being the case for many vulnerable people) is not covered by the national health insurance house. The network of public diagnosis and treatment services is complicated and takes from days to weeks, therefore it requires a lot of navigation and support from the staff of harm reduction services. Services are not patient-friendly, especially for vulnerable populations. Patients who acknowledge drug use while in treatment are removed from treatment due to the fact that cost of hep C treatment is covered by the national health insurance house only if the patient finalises treatment and can prove a negative viremia, otherwise the doctor is charged with the entire cost of treatment for that respective patient. So, current guidelines discourage doctors from enrolling active drug users onto HCV treatment."*

> **Finland (Helsinki):** *"The municipalities do not follow the guidelines as is; PWUD are still being sent to specialised services rather than being treated in basic healthcare units."*

> **Montenegro (Podgorica):** *"The guidelines contain one restriction on the admission of people who use drugs. Namely, the person using drugs must abstain for at least 3 months in order to be included in treatment or to be included in OST."*

> **Estonia (Tallinn):** *"HCV treatment is available only for people who have health insurance. Estonia has no new clinical guidelines for HCV treatment. According to the Gastroenterology Association, EU guidelines are in use in Estonia."*

> **Portugal:** *"Some cities/hospitals still deny treatment for people who use drugs."*

> **Ukraine (Kyiv):** *"There are complicated registration procedures for patients to start treatment. Additional costs are needed to pay for expensive tests to start treatment. Also, there is a high level of stigma and discrimination from health professionals towards PWID."*

> **Ireland (Dublin):** *"Difficulties in accessing treatment if not on OST at a clinic or on the panel of an OST prescribing GP - a special case must be brought to a clinical advisory group for individual approval."*

> **Czechia (Prague):** *"We are currently facing a problem of migrants (EU and non-EU) who live in Czechia and do not have health insurance. There are missing strategies on how to treat HCV in this target group."*

> **Slovakia (Bratislava):** *"The current national guidelines form a bad approach to testing and treatment for these patients: twelve months of abstinence confirmed every three months by toxicological examination and no access to treatment if person has debts on health insurance."*

AVAILABILITY OF, AND ACCESS TO, NEW DRUGS (DAA'S)

As in 2020, in 2021 the new drugs for HCV treatment (direct-acting antivirals (DAA's)) were available in all countries[18]. However, there was still a range of reported restrictions to DAA access. DDA's were accessible without restrictions in 22/35 (63%) of the cities (74% in 2020) and with restrictions in 13/35 (37%) of cities (24% in 2019). A list of reported restrictions is presented in Figure 3.

Figure 2: Are the new drugs for the treatment of hepatitis C (direct-acting antivirals, DAAs) accessible in your city? (n=35)

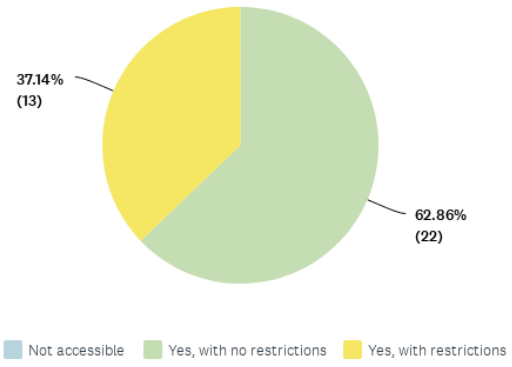
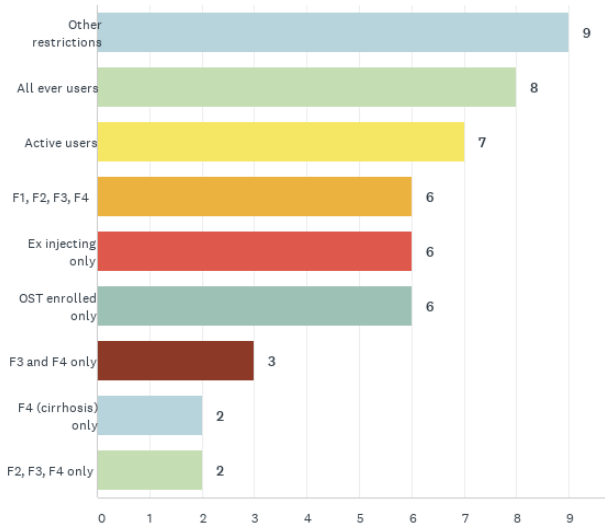


Figure 3: Reported restrictions applied in hepatitis C treatment for PWID (n=13)



Restrictions to access DAA's could be related to the fibrosis stage of the person (e.g accessible only to those in F4 stage; F3 or F4 stage; F2, 3, or 4; or F1,F2,F3,F3) or to the behavior of injecting drugs (accessible to ex injecting only, OAT enrolled only, or to those currently injecting).

The largest group (9/35 cities) reported "other restrictions" which includes the following:

- **Amsterdam (The Netherlands)**: "No restrictions for PWID, but for people who are in prisons and those in nursing homes HCV treatment is not automatically reimbursed. There are problems with reimbursement at prisons, there is another health insurance from the Justice Department taking over health coverage when individuals enter prison. Often this insurance scheme does not want to cover the costs of treatment. Regarding nursing homes, each client has a set budget per year and covering the costs for DAA might exceed their total annual budget[19]."

18 Still in 2019, DAA's were not available in North Macedonia but are now available.

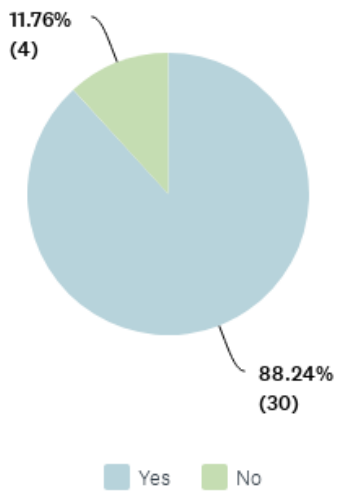
19 https://hcvrichtsnoer.nl/Indicatie-voor-behandeling/

- **Antwerp (Belgium)**: "Only people with social security can get reimbursement. People without papers need a special approval for urgent medical care."
- **Bratislava (Slovakia)**: "PWID patients, twelve months of abstinence confirmed every three months by toxicological examination" (the same as in 2020).
- **Bucharest (Romania):** "Available only for insured individuals; only for genotype 1 and 4. Genotype 3 is prevalent among PWID. Pangenotypic treatment will hopefully be available starting autumn 2021".
- **Dublin (Ireland)**: "Geographical restrictions: rural locations have sparse treatment access, leading to travel and financial requirements for clients."
- **Krakow (Poland**): "In Krakow, Hep C treatment is provided by few medical centres and they do not have standardised accessibility criteria. Officially, the restrictions apply to people who are actively dependent on psychoactive substances. In practice, at least in Krakow, such restrictions are not applied. All people in contact with Krakow DROP-IN who decided to be treated with HCV received such treatment."
- **Moscow (Russia)**: "DAAs are accessible to people co-infected with HIV".
- **Tirana (Albania)**: "It costs a lot. There are not very many places available to get treatment. The capacity to provide treatment is very low."
- **Vienna (Austria)**: "DAAs are reimbursed only when a prescription comes from a specialised hepatological centre" (the same as in 2020).

ARE DAAS USED ACCORDING TO OFFICIAL POLICY?

The great majority of respondents reported that in their countries DAA's are used according to the official policy (see Figure 4), but there were also 4/34 citiies where there is a discrepancy between policy and practice. In Bucharest (Romania), "the current policy discourages doctors from enrolling vulnerable populations onto treatment"; in Novi Sad (Serbia), "the national guidelines do not discriminate PWID but, in practice, the DAAs are given to very few people, so those priorities do not include drug users; in Helsinki (Finland), "people are still being sent to gastroenterologists even though their APRI-values are under 1"; in Milan (Italy), "they should be offered to all people with HCV, but some doctors in practice discriminate active drug users because they have doubts about their adherence to treatment and think they might get re-infected."

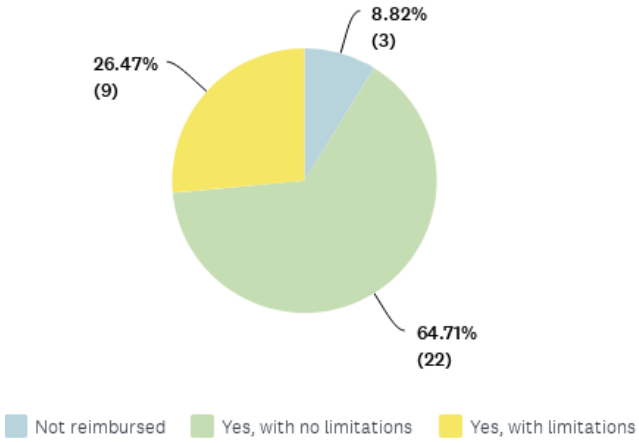
Figure 4: In practice, in your city, are the direct-acting antivirals (DAAs) used according to the official policy? (n=34)



WHO IS PAYING FOR HCV TREATMENT?

HCV treatment with DAA's was reported to be reimbursed by health insurance or the public health service in most of the cities/countries (31/34). Treatment with the new drugs is reimbursed with no limitations in 22/34 cities/countries (65%) and with limitations in 9/34 cities/countries (26%). In 3/34 countries (Albania, Montenegro, Ukraine) hepatitis C treatment with DAA's is not reimbursed. The North Macedonian FP did not answer this question.

Figure 5: Is treatment with the new drugs for hepatitis C (DAAs) reimbursed? (n=34)



Limitations in reimbursement of DAA treatment costs were reported by 9/33 countries, as follows:

- **Austria:** "It is covered by personal health insurance."
- **Belgium:** "People need to have social security, so people without papers need special approval for urgent medical care."
- **Czechia:** "In the case of HCV reinfection, it is difficult to obtain the DAA treatment twice. It depends on the type of insurance company and also on the genotype of the virus (if it is the second HCV infection) caused by the same genotype of the virus as for the first time, there are many more obstacles to get the DAA treatment again."
- **The Netherlands:** "The only limitation is that every individual has to pay the first couple of hundred Euros within their health insurance, the so-called 'own risk'. However, this is not DAA-specific but applies to almost all health costs and can be reimbursed through governmental subsidies."
- **Poland:** "Patients must have health insurance. In the case of Polish citizens, obtaining health insurance is not a problem. In the case of people from outside the EU, this is a big problem."
- **Romania:** "Only for insured individuals and those patients who complete treatment."
- **Russia (St. Petersburg)**: "There is a city programme that covers 50% of expenses. The other 50% patients should cover by themselves."
- **Serbia:** "It is reimbursed only for 70 people per year."
- **Slovakia:** "The condition for paid treatment for drug-dependent patients is proof of at least 1 year of abstinence, evidenced by the findings of a psychiatrist and the results of toxicological examinations (during treatment at three-month intervals). Reimbursed treatment is subject to the prior consent of the health insurance company. Also, persons who want to get reimbursement for treatment cannot have a debt with health insurance."

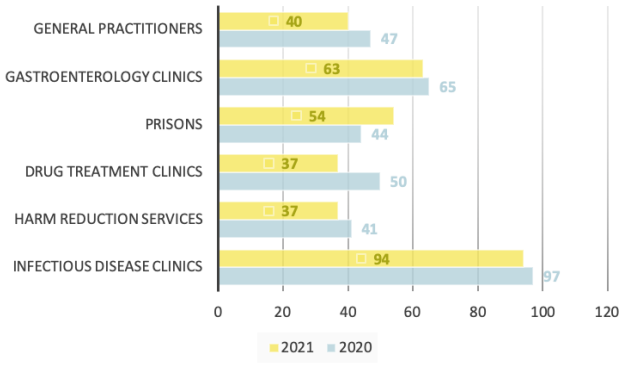
CHANGES IN THE CONTINUUM OF-CARE

A well-functioning continuum-of-care, including provision of low threshold and harm reduction services, is important for accessibility and impact of HCV testing and treatment. It is crucial to improve the low uptake of HCV testing and treatment among PWID by including the harm reduction and drug user organisations in the continuum of services that provide HCV management within every European country. C-EHRN monitoring contained a pattern of questions asking how the continuum-of-care is functioning in different countries and regions.

Most cities (29/35, 83%) reported that PWID can have a rapid test for HCV (see Figure 6) in low threshold settings at harm reduction services. According to the respondents, rapid tests are also quite commonly available in drug treatment (20/35, 57%) and at infectious disease clinics (20/35, 57%). PWID can get tested by a general practitioner in 12/35 cities (34%) which is less than in previous years (44% in 2020; 51% in 2019). Rapid testing for PWID at pharmacies has remained very rare (only in 4/35 cities).

Similar to last year, confirmatory blood testing for HCV RNA is most commonly available for PWID at infectious disease clinics (33/35, 94%) and gastroenterology clinics (22/35, 63%) but, compared to last year, their availability seems to have decreased at drug treatment clinics (13/35, 37%; 50% in 2020 and 35% in 2019) and remained at the same level at harm reduction centres (13/35, 37%; 41% in 2020; 26% in 2019) (see Figure 7). Similarly, non-invasive tests (Fibroscan) are most commonly performed at infectious disease clinics and gastroenterology clinics (see Figure 8).

Figure 6: Proportion of cities performing hepatitis C testing for PWUD at various settings in the years 2020 and 2021 (n=35)



As in 2019, PWID are most commonly treated for hepatitis C at infectious disease clinics (30/35, 88%; 90% in 2020) and gastroenterology clinics (22/35, 65%; 65% also in 2020). In 12/35 cities (35%; 32% in 2020), treatment was provided at harm reduction services or community centres (see Figure 9). In most countries, DAAs can be legally prescribed by infectious disease clinics (31/34), gastroenterologists (28/34) and general practitioners (10/34).

> *In Vienna, we have built a powerful HCV Treatment Network, with a specialised hepatological centre, drug treatment centres, pharmacies, shelters and the Viennese health authority". FP from* ***Vienna, Austria.***

> *There is an expansion of access to treatment of viral hepatitis C for all categories of the population on the basis of infectious disease clinics. The drugs and basic diagnostics are more available. But the problem remains with specific diagnostics necessary for the treatment prescription (fibroscan, quantitative and qualitative tests) which is expensive and made at the expense of patients."*
> *FP from* ***Kyiv, Ukraine.***

> *The Antwerp model is a good-practice model in HCV management. Strong cooperation between specialist, drug service, NSP and C-Buddy (peer project). This is the only city working with this kind of network. There is a need to start HCV management in every city based on their own context."*
> *FP from* ***Antwerp, Belgium.***

Point-of-care testing increases HCV testing and linkage to care. There are still big differences within Europe as to where, and how, PWID can undertake a HCV test and inequities in access exist across European countries and cities.

It is important that facilities offering testing are able to offer both HCV testing and treatment. However, from the results obtained, it can also be concluded that the integration of testing and treatment at the same location is still too rarely the case.

> *"Testing procedures need to be simplified. Also, testing needs to be made more accessible, that people at increased risk can access testing more easily. That includes ongoing community testing services, as well as support in funding this type of service. Since our law is such that no medical procedures (such as blood sampling for analysis) are allowed outside of medical facilities, it should be changed in that part so that testing can be conducted in the community."* FP from ***Podgorica, Montenegro***.

> *"It is essential to attend to the social situation of PWUD during the HCV treatment (before and after too, of course). It is important to generalise the way of work of "TEST and TREAT". It is a basic approach to facilitate access to treatment into HR services."* FP from ***Barcelona, Spain.***

Table 3: Where can people who inject drugs (PWID) be tested for hepatitis C using a point-of-care rapid test (detection of antibodies to HCV in oral swab or finger prick)? (n=35)

ANSWER CHOICES	RESPONSES	
Harm Reduction Services	82.86%	29
Infectious Disease Clinics	57.14%	20
Drug Treatment Clinics	57.14%	20
Prisons	54.29%	19
At Gastroenterology Clinics	40.00%	14
General practitioners	34.29%	12
Other	31.43%	11
Self-testing	20.00%	7
Pharmacies	11.43%	4
Total Respondents: 35		

Figure 7: Where can people who inject drugs (PWID) perform a confirmatory blood test for HCV RNA? (n=35)

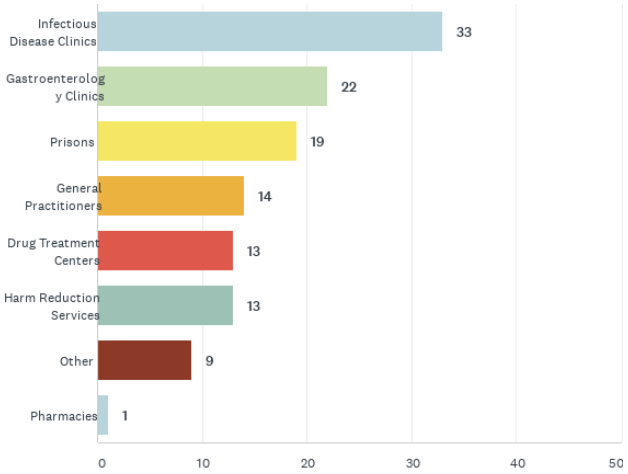


Figure 8: Where can HCV-infected people who inject drugs (PWID) perform a non-invasive diagnostic procedure for the evaluation of the stage of liver disease (i.e. Fibroscan®)? (n=35)

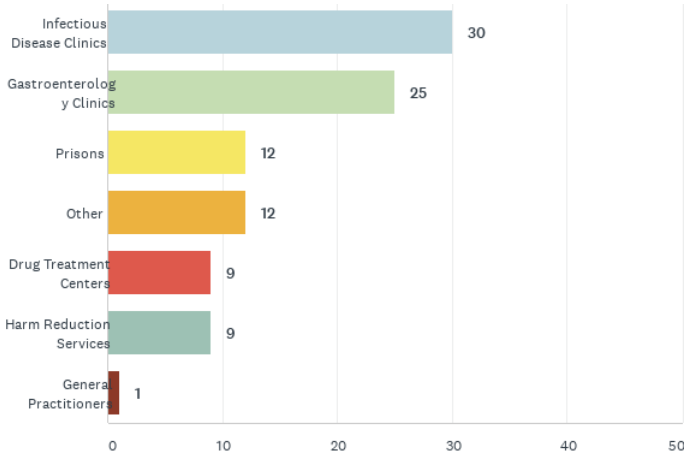


Figure 9: In cases where DAAs are accessible to people who inject drugs (PWID), where are they treated for hepatitis C? (n=34)

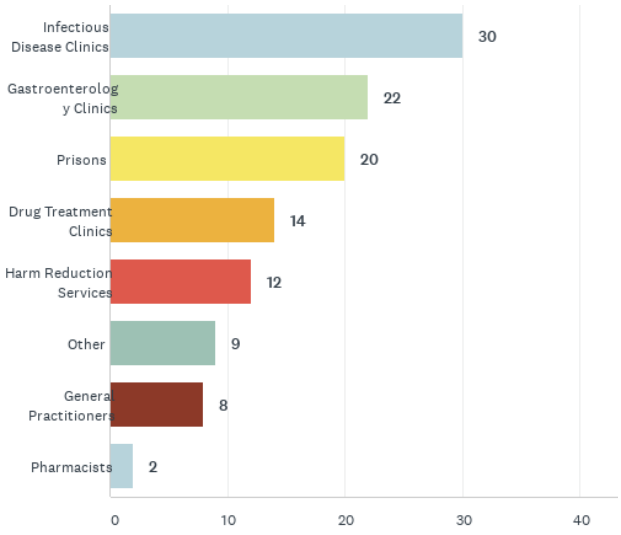
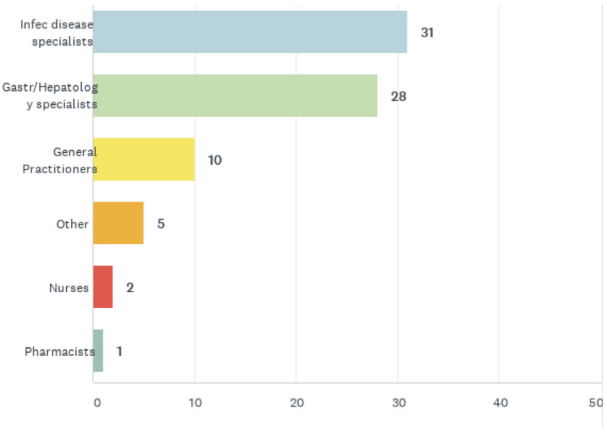


Figure 10: Who can legally prescribe direct-acting antivirals (DAAs)? (n=34)



ARE THERE WRITTEN GUIDELINES FOR LINKAGE-OF-CARE?

Respondents were asked if linkage-to-care for PWID is achieved by a written protocol or guide-line (see Figure 11). More concretely, they were asked to assess if there is, for instance, an agreed

protocol to refer clients from harm reduction services to other treatment and care systems. Respondents from 13/35 cities answered that linkage is achieved, but in the majority of cases (16/35 cities) linkage was regarded as not achieved. Respondents of 3/35 cities could not make an assessment.

Figure 11: Is linkage-to-care for people who inject drugs (PWID) achieved by a written protocol / guidelines? (n=35)

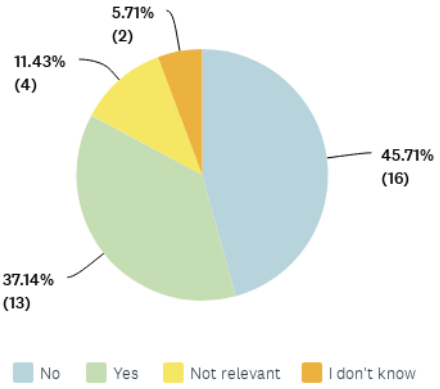
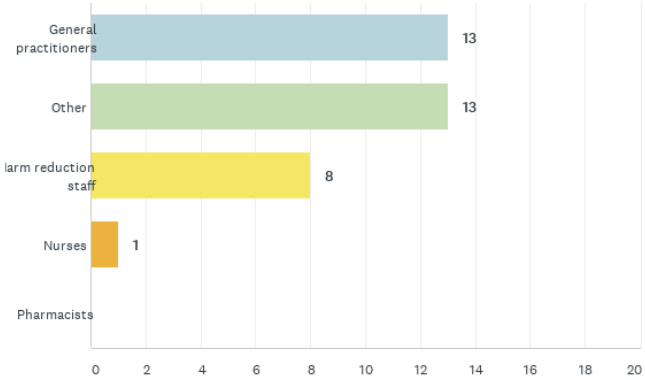


Figure 12. Who can link (refer) HCV-infected people who inject drugs (PWID) to further hepatitis C care? (n=35)



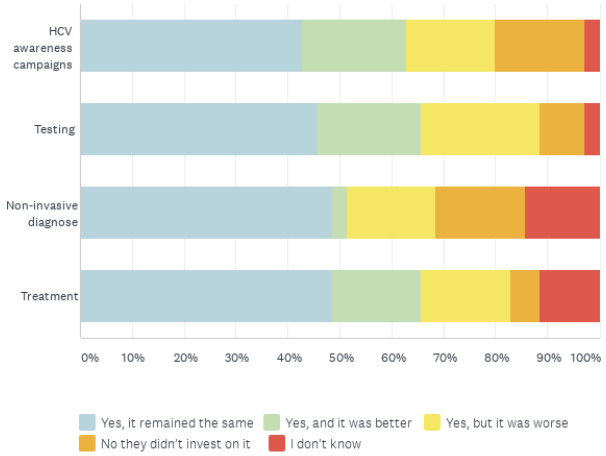
MORE OR LESS ACTION AND COORDINATION ON HCV?

Focal points were also asked to compare the changes in HCV activities between 2019 and 2020. If PWID service providers in their country invested more or less attention to HCV awareness campaigns, testing at their own location and treatment at their own location? Most commonly, these activities were reported as having either remained at the same level or improved.

There was, however, an alarming number of cities/countries where the situation had worsened. *HCV awareness raising* was reported to have become worse in Bratislava (Slovakia), Bucharest (Romania), Budapest (Hungary), Glasgow (UK), Portugal, Tbilisi (Georgia) and Stockholm (Sweden). *HCV testing* has become worse in Budapest (Hungary), Glasgow (UK), London (UK), Milan (Italy), Portugal, Rijeka (Croatia) and Stockholm (Sweden).

Furthermore, *non-invasive assessment* of the liver fibrosis stage among HCV-infected PWID was reported to have become worse in Budapest (Hungary), Glasgow (UK), Milan (Italy), Portugal, Rijeka (Croatia) and Stockholm (Sweden). *HCV treatment* has become worse in Budapest (Hungary), Dublin (Ireland), Glasgow and London (UK), Portugal, Stockholm (Sweden) and Tbilisi (Georgia).

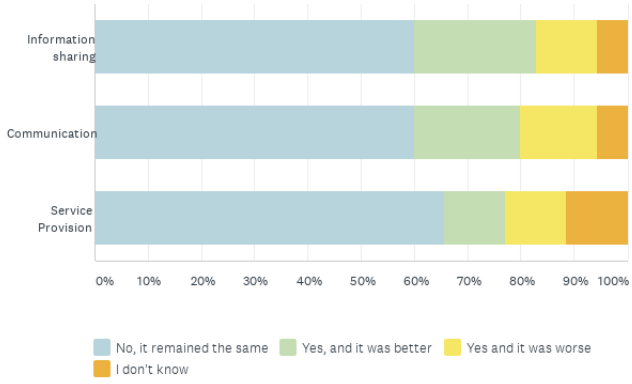
Figure 13: Compared to 2019, have service providers for people who inject drugs (PWID) in your city invested attention in 2020 to the following? (n=35)



When asked about progress in coordination between health care and social care providers (especially NGOs and harm reduction services), in most of the cities and in all dimensions (information sharing, communication, service provision) the situation was reported to have remained the same or improved (see Figure 14). For a small proportion of respondents, the situation has worsened and this also concerned all categories.

Negative progress was reported by 4/35 cities with regard to *information sharing*: Ireland, Italy, North Macedonia and Portugal; *communication* had become worse in 5/35 cities: Croatia, Italy, North Macedonia, Portugal and Serbia; and *service provision* had become worse in 4/35 cities: Italy (Milan), Portugal (national level), UK (London) and Ukraine (Kyiv).

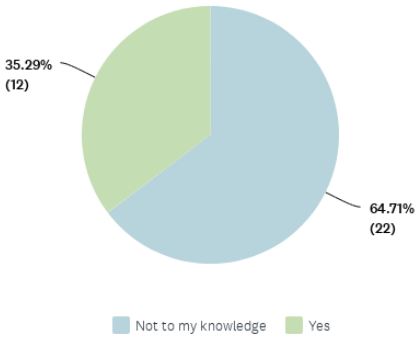
Figure 14: Compared to 2019, did the coordination regarding hepatitis C between health care providers (general practitioners, clinics) and social service providers (like non-governmental organisations, harm reduction services) change in 2020?(n=35)



THE ROLE OF HARM REDUCTION AND DRUG USER ORGANISATIONS

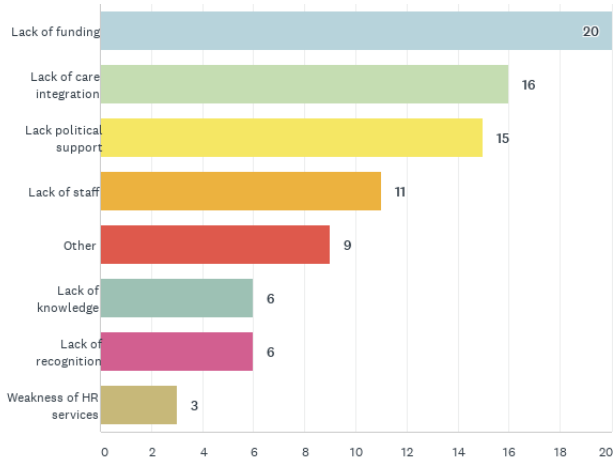
In countries with progressive HCV treatment policies, drug user interest groups have had a pivotal role in raising the issue with the public through awareness and in advocating for the right of PWID to low threshold HCV testing and treatment. In 2020, the question was addressed at the city level whereas in 2019 it was at the country level (see Figure 15). In 2021, there were active user organisations in 12/35 cities (16/36 cities in 2020; 15/35 countries in 2019).

Figure 15: Are drug user groups active for (political) awareness with regards to hepatitis C in your city? (n=34)



The focal points were asked if there are limitations for the harm reduction organisations in addressing HCV in their cities. Altogether, 27/35 cities reported limitations which are listed below in Figure 16.

Figure 16. Limitations for harm reduction organisations in addressing HCV (n=27)



NEGATIVE IMPACT OF COVID-19

Many cities reported on the negative – but also some positive – effects of the COVID-19 pandemic. The COVID-19 effects are also dealt with separately in Chapter 7 of this report. Below are descriptions of the changed situation from 6 countries.

In the UK, services were negatively impacted on by the pandemic. There are limitations regarding self-testing: self-testing is being piloted for PWID in some areas. There are regional/local differences in terms of where HCV-infected PWID can perform the non-invasive diagnostic procedure for the evaluation of the stage of disease (i.e. Fibroscan), but in the main it is available. The main focus is peer outreach with mobile scans. Of note, in 2020 arrangements to have Fibroscan® equipment in place improved, but pandemic-related restrictions and national lockdowns meant that, naturally, this was not widely accessed. GPs can legally prescribe DAAs but, in practice, this does not happen due to the arrangements detailed above.

Re-infections are starting to present and could be a possible barrier towards HCV elimination. Several research bodies have started to investigate, but it is believed that disinvestment in the harm reduction sector could be a major factor. It is also believed that lack of access to traditional service delivery (due to the 2020 COVID-19 pandemic) will also have had a negative impact. The Hepatitis C Trust welcomes the approach taken by NHS England regarding HCV elimination, specifically its engagement with patient groups and their voice in designing service delivery.

In Ireland, the lack of consistent screening and testing has been an ongoing problem. The impact of COVID-19 has provided a rationale for pushing HCV discussions to the back of the room, stated the FP from Dublin.

COVID-19 also had a negative impact on HCV elimination in **Georgia**. It limited the number of HCV cases detected and treatment initiation.

Also, in **Czechia**, HCV interventions were affected by COVID-19, which had both positive and negative impacts. Thanks to cooperation between physicians and NGO staff, it was possible to reduce the number of visits to HCV treatment centres to a minimum and also to obtain HCV pharmacotherapy for all two (or three) months to avoid the risk of an interruption of the HCV treatment caused by possible hospital collapse. On the other hand, the COVID-19 situation had a negative impact on HCV interventions in terms of reducing the number of opportunities for face-to-face interventions and prioritising to testing for COVID-19 infection.

In **Denmark**, due to COVID-19, there has been a significant decline in outreach. Already before that, since 2019, all previously diagnosed patients have been contacted and point-of-care testing has been increasingly moved to more substitution treatment centres.

Italy reported a lack of national directives and guidelines specifically dedicated to addressing HCV awareness activities, testing and treatment for PWUD that translates into a lack of definition of roles, tasks and responsibilities between service providers (healthcare providers and social service providers/community organisations). The COVID-19 pandemic affecting infectious disease units of hospitals (the same units treating HCV) further complicated the situation during 2020.

CONCLUSIONS

HCV infection is preventable and curable, but still there is a high prevalence of HCV among people who inject drugs in Europe. On the basis of the C-EHRN monitoring of the situation in European cities and countries in 2018-20, as well as other information sources, it is evident that HCV testing and treatment for PWID has remained insufficient: despite some progress, further improvements of the existing continuum-of-care interventions for PWID are needed. The overall picture has not changed much from that of the 2020 monitoring report: in many European countries, much more support is needed to increase access to testing and treatment, using effective practices and developing the cascade-of-care. PWID are in an unequal position and often deprived of HCV interventions. Harm reduction organisations lack funding and political support.

The problem does not lie in the lack of proper guidance: almost all countries have either their own national guidelines or EASL guidelines that include HCV management for PWID. Only Cyprus and Poland do not have such guidelines.

The new drugs for HCV treatment (DAA's) are available in all countries. However, in practice, there remain restrictions for PWID to access DAA's in some countries. Treatment also remains quite centralised and available in some key settings, such as prisons. For testing of hepatitis C, barriers remain. The worsening of some harm reduction aspects could be due to the impact of COVID-19 rather than other impacts. The effects of COVID-19 can be read in chapter 7.

In many European countries, CSOs are engaged in promoting HCV awareness, testing and treatment for PWID. Major shortfalls in provision of these services remain. CSOs have an important role in strategic planning for the HCV continuum-of-care and monitoring progress towards elimination goals.

Correlation
European
Harm Reduction
Network

OVERDOSE PREVENTION

5

INTRODUCTION

This chapter focuses on mapping the state, the needs and changes to overdose (OD) prevention in the last year at the local level in Europe. When possible, comparisons are made with the previous year of monitoring (2020). As in 2020, data for 2021 focused on policy implementation and experiences at the city level. 35 C-EHRN focal points collected information on:

- What is desirable regarding OD prevention guidelines;
- The context in which overdoses are occurring (drugs involved and characteristics of overdose cases);
- Challenges and desired improvements regarding OD prevention on-the-ground;
- The state of trainings and campaigns for OD prevention;
- The state and needs regarding naloxone access; and,
- The state and needs regarding OAT (Opioid Agonist Therapy[20]) access.

OD PREVENTION IN OFFICIAL POLICIES

In 2021, 26 of the 35 FPs partaking of the survey affirmed that OD prevention was mentioned in at least one official policy document in their countries. Most guidelines were set at the national level, either as specific OD prevention guidelines or included in the national drug strategy. FPs located in Austria, Belgium, Hungary, Malta, Montenegro, Poland, Romania, Slovenia and Sweden mentioned that OD prevention is not yet featured in any official policy documents. In 2020, the lack of OD prevention in official policies was also mentioned by Belgium, Hungary, Poland, Romania, Slovenia and Sweden and in addition by Croatia and Portugal.

WHAT IDEAL GUIDELINES SHOULD CONTAIN

In an open question, C-EHRN FPs were asked to mention important issues missing in existing guidelines for OD prevention and features that ideal guidelines should address. 16 of the 35 FPs provided an answer with very similar results when compared to last year. They call attention to the need for guidelines to address:

- The provision of naloxone and take-home naloxone;
- Low-threshold access to OAT;
- Continuous training for OD prevention, including naloxone and low threshold OAT for service providers and people who use drugs;
- OD prevention for non-opioids (such as stimulants and synthetic cannabinoids);
- Provision of first aid in case of OD;
- Provision of drug consumption rooms; and,
- OD risk assessment and screening.

> *"Until this year, there were no take-home naloxone programmes in the Czech Republic. We are "lucky" that the most used opioid is buprenorphine with ceiling effect, so we report no fatal ODs regarding this. And we have very little fentanyl on the scene, but it can change any time."* *(FP **Prague, Czech Republic**)*

20 Also called OST (Opioid Substitution Therapy).

> *"There are precise guidelines for the prevention of opioid overdoses, but there are no specific guidelines for the prevention of other psychoactive substance overdoses that harm reduction could follow."*
> *(FP **Tallinn, Estonia**)*

> *"Ideal guidelines should be part of the national drug strategy and include overdose prevention counselling, first aid training and dispensing of naloxone in all government facilities that provide health and social services to the public (social services, hospitals, drug treatment facilities and others)."*
> *(FP **Kyiv, Ukraine**)*

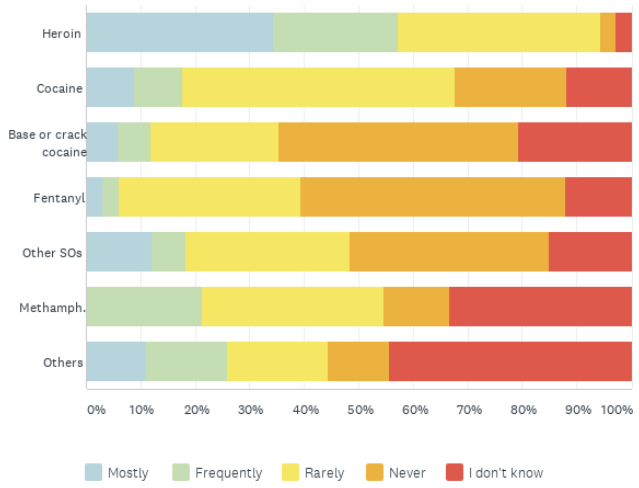
> *"Around half of fatal ODs occur amongst those who have not been in contact with treatment services in the last five years and the various guidelines do not specifically address this issue. Services often have high thresholds in relation to accessing OST. with many requiring people to remain on daily/ supervised consumption for prolonged periods which is a significant barrier to accessing OST. Some services across the UK still see a positive drug test as a reason to abruptly stop an OST script, leaving a person out of treatment and vulnerable to OD. We need education for key workers and clinical staff to help them to understand that, from time-to-time, drug users will use drugs and to reduce or withhold a script is only adding to the heightened risk of OD."*
> *(FP **London, UK**)*

OVERDOSES CONTEXT

Drugs involved in ODs

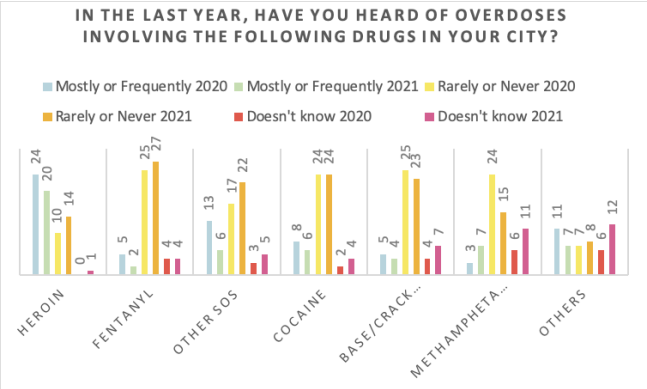
FPs were asked how frequently they have heard of overdoses involving a list of specific drugs in their city in the last year. All 35 FPs answered the question and results can be seen in Figure 1.

Figure 1: Overdoses FPs have heard of involving the following drugs in their city last year (n=35)



As in 2020, most overdoses that FPs had heard of involved opioids, with heroin being the most frequently mentioned and, to a lesser extent, fentanyl's and other synthetic opioids. Stimulants, such as cocaine and crack cocaine, were mentioned as being frequently involved in overdoses by around 15% of respondents, while methamphetamine was mentioned by slightly over 20%. Other drugs mostly mentioned were combinations of benzodiazepines with alcohol, methamphetamine, amphetamine, methadone (illicitly used and/or in combination with other drugs), ketamine and MDMA (in some cases, pills were reported via drug checking services as high strength, 240mg–400mg per pill). Other less mentioned substances were gabapentin, pregabalin (gabapentinoids), mephedrone, alpha-pvp, synthetic cannabinoids, 4-methylmethcathinone, GHB/GBL, synthetic cathinones, hallucinogens, (unknown) fentanyl derivatives and alcohol mixed with other 'downers'. As in 2020, the combined use of multiple drugs was often mentioned as being involved in the overdoses reported by FPs. Figure 2 presents comparisons between 2020 and 2021.

Figure 2: Overdoses FPs had heard of involving the following drugs in their city last year



Characteristics and circumstances of OD victims

In an open question, FPs were asked to describe the typical characteristics of OD victims that they know of, and the circumstances of their deaths. Results are very similar to 2020, only with a stronger emphasis on changes in the drug market and more unknown drug contents in 2021. The most frequent characteristics related to ODs known to C-EHRN FPs in 2021 were:

- Using drugs alone (in public toilets, parks, abandoned buildings, or private settings, or having been left by companions after using in a group;
- Engaging in polydrug use;
- Not having access to naloxone;
- Being in a situation of homelessness and deprived of good levels of nutrition and sleep;
- Changes in the drug market (new dealer, changes in drug quality);
- Not knowing the content of substances consumed; and,
- Being recently released from prison, drug treatment or other health treatment involving drug abstinence (such as in detoxification units in hospitals).

> *"Last year, cases were in deserted buildings around the Athenian centre or in the surrounding hills of the city. Heroin injected in combination with benzos was the lethal cocktail."*
> *(FP **Athens, Greece**)*

> *"Usually, ODs happen within victims' homes or injecting sites (houses where PWID gather to use drugs). When OD happens, other PWID do not have naloxone to provide help since naloxone is available only in clinical centres and ED and until the ambulance arrives it might be too late for a person to recover."*
> *(FP **Podgorica, Montenegro**)*

> *"Overdose victims often use street methadone or mix different psychoactive substances. People don't know the quality of the drug and they can buy fentanyl thinking it's methadone. Often, they use alone and have no other people to help. In case of an overdose, people are afraid to call an ambulance. Often, they do not have naloxone with them."*
> *(FP **Kyiv, Ukraine**)*

> *"Mostly we had heroin OD cases, but the death is reduced among them significantly because of naloxone distribution."*
> *(FP **Tbilisi, Georgia**)*

CHALLENGES AND DESIRED IMPROVEMENTS IN OD PREVENTION ON-THE-GROUND

Challenges in OD prevention

In an open question, C-EHRN FPs were asked about the main challenges regarding OD response in their cities in the last year. As in 2020, FPs described that the main challenges relate to lack of access to life saving overdose prevention programmes, information and medications:

- Lack of access to naloxone and take-home naloxone, also for those who are not enrolled in harm reduction programmes or other care settings;
- High threshold to access naloxone, e.g. only with a physician's prescription or in emergency units or by medical professionals;
- Hesitancy of pharmacies to sell naloxone due to stigma and discrimination;
- Lack of access to harm reduction programmes such as DCRs, OAT, Heroin Assisted Treatment (HAT) and substitution treatment for stimulant drugs;
- Not knowing the content of substances consumed, also due to a lack of (sufficient) drug checking services; and,
- Poor or non-existent OD prevention in prison and upon release.

> *We need to] make naloxone available at pharmacies. Some of them don't order naloxone because they don't want opioid users to come."*
> *(FP **Paris, France**)*

> *Pharmacies don't want to sell naloxone without a prescription, despite it being officially allowed. Most of the pharmacies do not order naloxone, so for PWUD it is problematic to get it easily."*
> *(FP **Kyiv, Ukraine**)*

> *There is no availability of naloxone to frontline workers, to drug users and their families."*
> *(FP **Athens, Greece**)*

> *Only a few services distribute naloxone and there is scarce knowledge of naloxone, even if it is possible to buy it as an over-the-counter drug in pharmacies. naloxone is not distributed upon release from prison."*
> *(FP **Milan, Italy**)*

> *Administering naloxone within NGOs is a violation of the law and so is take-home naloxone. Naloxone is available only in the clinical centres and ED. NGO Juventas is trying to put this issue in the spotlight by marking World Overdose Awareness Day, appearing in the media to attract more attention to this topic, recording and publishing videos about OD. We hope that in future we will be able to amend the law so that naloxone will be available to NGOs for distribution to clients and then more lives can be saved."*
> *(FP **Podgorica, Montenegro**)*

> *Drug users do not know what they are using. They think they are getting one substance, in fact it is something else, or mixed with something."*
> *(FP **Tallinn, Estonia**)*

> *"There is no drug checking, very few harm reduction programmes among the most marginalised communities where these overdoses are rampant, and repressive drug policies generate an even more dangerous black market by banning new drugs and forcing people who use drugs into hiding. Social exclusion is also worsening."*
> *(FP **Budapest, Hungary**)*

As in 2020, access to naloxone, DCRs and other harm reduction services were mentioned by FPs as protective factors against overdose. FPs called for (increased) peer-distribution of naloxone and also dispensing of naloxone in other care settings than hospitals (primary health care, harm reduction programmes, CSOs, pharmacies). FPs from Ljubljana and Krakow mentioned current movements to try to open Drug Consumption Rooms in their cities.

The COVID-19 pandemic brought an added difficulty for some FPs in 2021 related to a greater distance between service providers and (groups of) people who use drugs due to restrictions in services during lockdowns:

> *"In the past year, some services temporarily closed (e.g. drug checking) or had limited accessibility. Hence, it was harder to reach various PWUD groups. Among MSM, the official campaign was "not now", stimulating MSM to temporarily stop having sex. This worked for some, but those who continued to engage in chemsex did so behind closed doors and became harder to reach. When overdose incidents occurred during chemsex parties, the threshold to call the emergency services was higher than before. At present (June 2021) services have reopened, but often still with (accessibility) restrictions and some PWUD remain out of sight."*
> *(FP **Amsterdam, Netherlands**).*

Also, access to DCRs became restricted in many cases due to lockdowns or measures to decrease the number of visitors. Nevertheless, FPs mentioned that both clients and facilities adjusted as much as possible to assure overdose prevention. In Copenhagen, Denmark, for instance, it meant that some people would use their drugs close to the DCR even when due to the restricted number of visitors (COVID-19 measures) they could not be inside. In this way, DCR staff could quickly assist with naloxone in case an OD occurred.

Overdose prevention campaigns

As in 2020, in 2021 the number of campaigns directed towards OD prevention were also low in FPs cities. Over 60% of the FPs mentioned the non-existence of a campaign in the last year. When present, campaigns were either general or focused on opioids only. Only one FP mentioned the presence of overdose prevention campaigns directed, respectively, to stimulant drugs (Kyiv), synthetic opioids (Paris) and NPS (Amsterdam). Fewer OD prevention campaigns have taken place in FPs cities in 2021 in virtually all areas as compared to 2020 (see Figure 3 and Table 2).

Table 2 compares OD prevention campaigns in the different cities of FPs partaking in the monitoring in 2020 and 2021. In at least 14 (out of 35) cities, FPs reported no overdose prevention campaigns in the last two years.

Figure 3: Comparison of overdose awareness campaigns in the city in the past year (2020/2021)

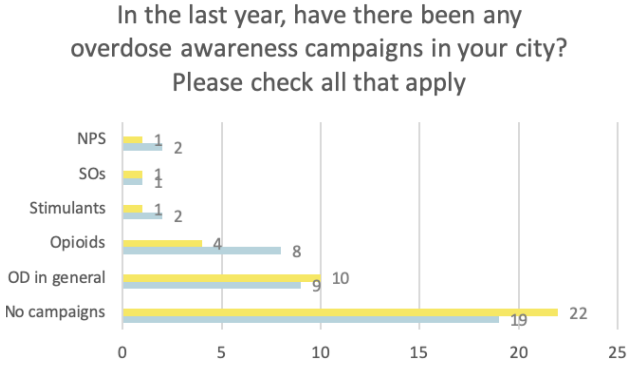


Table 1: Overdoses awareness campaigns in the city (comparison 2020/21)

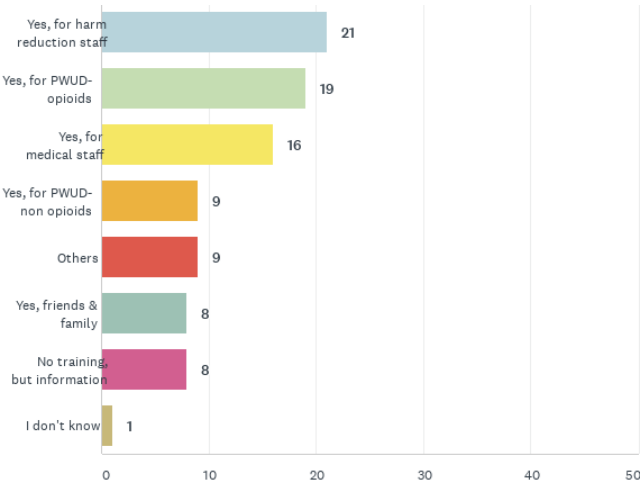
Country	City	2020					2021						
		OD*	OP	ST	SO	NPS	No	OD	OP	ST	SO	NPS	No
Albania	Tirana						x	x					
Austria	Vienna						x						x
Belgium	Antwerpen						x						x
Croatia	Rijeka						x						x
Cyprus	Nicosia	x						x					
Czech Republic	Prague						x						x
Denmark	Copenhagen		x						x				
Estonia	Tallinn						x						x
Finland	Helsinki						x						x
France	Paris		x						x		x		
Georgia	Tbilisi	x	x	x		x		x					
Germany	Berlin		x										x
Greece	Athens		x										x
Hungary	Budapest						x						x
Ireland	Dublin						x						x
Italy	Milan		x		x								x
Italy	Rome		x		x			x					
Lithuania	Vilnius						x						
Luxembourg	Luxembourg						x						x
Malta	National level												x
Montenegro	Podgorica							x					
North Macedonia	Skopje	x											x
Norway	Kristiansand	x											
Poland	Krakow	x											x
Portugal	Vila Nova de Gaia	x						x					
Romania	Bucharest						x						x
Russia	St. Petersburg						x	x					
Serbia	Novi Sad	x						x					
Slovakia	Bratislava						x						x
Slovenia	Ljubljana						x						x
SPAIN	BARCELONA		x	x		x							x
Sweden	Stockholm						x						x
Switzerland	Bern						x						x
The Netherlands	Amsterdam						x					x	
Ukraine	Kyiv	x	x					x	x	x			
United Kingdom	London						x	x	x				
UK (Scotland)	Glasgow	x											x
TOTAL		**9**	**9**	**2**	**2**	**2**	**19**	**10**	**4**	**1**	**1**	**1**	**22**

* OD (overdose); OP (opioids); ST (stimulants); SO (Synthetic opioids); NPS (New Psychoactive Substances); NO (no campaign)

Overdose prevention training

Out of 35 FPs, 27 confirmed the existence of some form of overdose prevention training in their cities in the past year (1 FP skipped the question).

Figure 4: Is overdose response training available in the city? (n=35)



Most training is available for harm reduction staff (in 21/35 cities), for people who use opioids (19/35) or medical staff (16/35). People who use drugs other than opioids, and family and friends of people who use drugs, are also targeted for training but to a lesser extent. Other groups receiving training included police in Kyiv and a wide range of professionals in the Netherlands, where first aid training covers resuscitation techniques which can be applied in an overdose situation (which is widely available for teachers, police, fire brigade and employees of companies with more than 15 people).

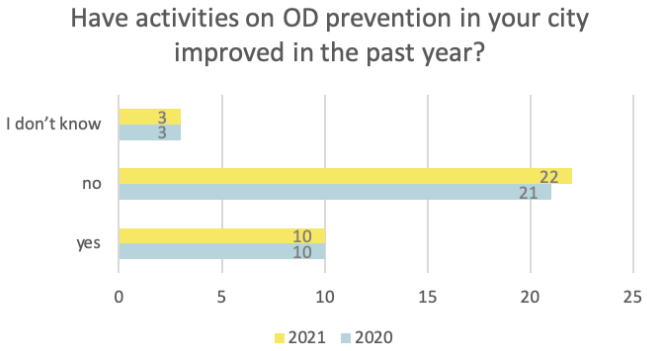
In at least 8 cities (Tirana, Rijeka, Athens, Budapest, Podgorica, Skopje, Novi Sad and Bratislava), no OD prevention training was reported, although information on OD is available. In 2020, FPs from the same cities (except from Skopje and Bratislava) also reported the absence of OD prevention training in their cities.

Overall, results are similar to those of 2020, with slightly less OD training in general (8 FPs reported no training in 2021 against 5 in 2020) and less training reported for medical staff (22 FPs in 2020 against 16 in 2021) and people who use opioids (21 FPs in 2020 against 19 in 2021).

Desired improvements in overdose prevention

As with 2020, most FPs responding to the survey in 2021 (63%) reported that activities on OD prevention have not improved in the past year in their cities (Figure 5). In 2021, 35 FPs responded to this question, against 34 in 2020.

Figure 5: Comparison of improvement of OD prevention (2020/2021)



In an open question, FPs described the main changes in OD prevention activities that they would like to see happening in their cities. The main points mentioned were:

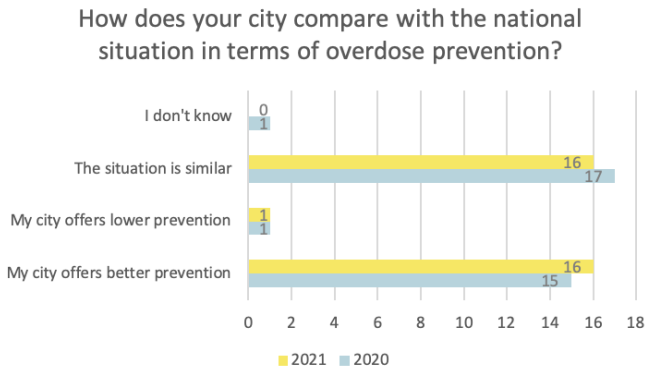
- **Increasing the availability of naloxone**, including the removal of legal barriers for distribution and the need for prescriptions to acquire it. Naloxone could also be widely available by being increasingly sold in pharmacies and upscaling/setting up take-home naloxone programme;
- **Increasing the provision of OD prevention training**, including family and friends of people who use drugs, care and law enforcement workers and people who use drugs and are outside drug treatment settings. OD prevention training should also include training for applying naloxone. Providing OD training for non-opioids, especially stimulants, was also mentioned;

- **Upscaling/setting up DCRs and drug checking services,** also including the availability of fentanyl test strips;
- **Meaningful involvement of the community of people who use drugs**, including more peer-led (and properly funded) services; and,
- **Providing safe supply**, including Hero-in Assisted Treatment and safe supply for non-opioid substances.

FP context compared to national context

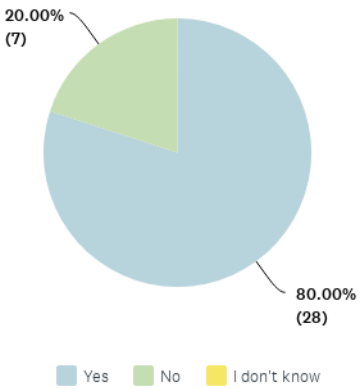
As in the previous year, roughly half of the participants assessed that OD prevention in their cities is comparable to the national situation in their respective country in 2021. The other half evaluated that their city offers better OD prevention when compared to the national context. 34 FPs answered this question in 2020 against 33 in 2021. As with last year, the OD prevention context described by C-EHRN Monitoring seems to be in good part based on the best examples available in a country. Since most FPs are based in a metropolis or a large city, it can be assumed that the current data might not reflect the context of smaller cities and rural areas, as it was already seen as essential for harm reduction services in general.

Figure 6: Comparison of national and FP city situation in terms of overdose prevention (2020/2021)



OD PREVENTION FOR OPIOIDS

Naloxone availability



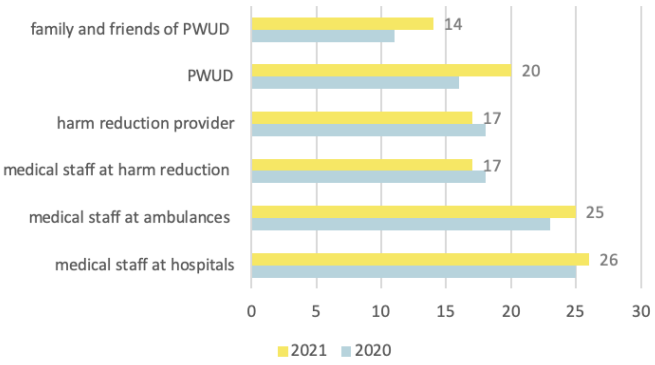
As in 2020, in 2021 the majority (80%) of FPs declared that naloxone is available in their cities. Yet, in at least 7 cases, the life-saving drug was reported as not available. As in 2020, FPs in Antwerp, Budapest, Bucharest and Helsinki declared a lack of naloxone availability. Furthermore, Montenegro, North Macedonia and Luxembourg also declared a lack of the drug in 2021. According to the EMCDDA, naloxone is included in the pharmacopoeia of all European countries, although in many cases only in injectable form and requiring a medical prescription or it may not be available outside the first responder's system. Lacking practical availability might be the reason why FPs mention naloxone as not being available in their cities.

To whom is naloxone available?

For those 28 FPs reporting the availability of naloxone, the drug is mostly available to medical staff at hospitals (93% of cases) and ambulances (89% of cases), similar to last year's results. In 2021, availability for people who use drugs as well as to their family and friends was reportedly higher. In 2021, 20 FPs (or 71%) mentioned that naloxone is available directly to people who use drugs, against 16

FPs (or 57%) in 2020. While in 2020 only 40% of cases (11 FPs) was naloxone available to family and friends of PWUD, in 2021 this rose to 50% (14 FPs). Availability for medical staff in harm reduction services and non-medical harm reduction staff remained at around 60%. Figure 8 compares who has access to naloxone in FPs cities in 2020 and 2021. 27 FPs responded to this question in 2020 against 28 FPs in 2021.

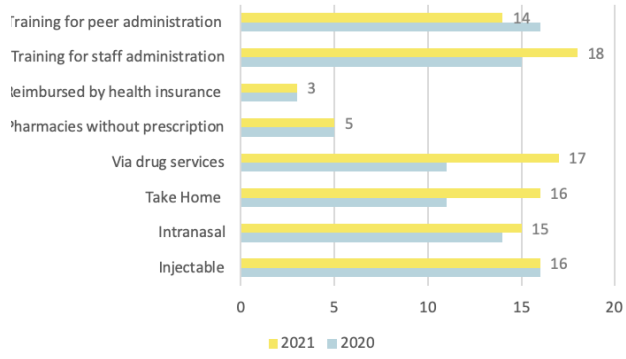
Figure 8: If naloxone is available in your city, who has access to it?



How naloxone is available

Figure 9 compares how naloxone was reported to be available by C-EHRN FPs in 2020 and 2021. 27 FPs responded to this question in 2020 against 26 FPs in 2021.

Figure 9: If naloxone is available in your city, how does that happen?



In the cities of the 28 FPs where naloxone is available, the drug is mostly found in its injectable form (61% or 16 cities in 2021 and 2020). The reported availability of intranasal naloxone slightly increased in 2021 (58% or 15 cities) when compared to 2020 (50% or 14 cities). The reported availability of take-home naloxone, and by distribution in drug services, showed the largest increase: 60% or 16 FPs reported having take-home naloxone in their cities in 2021 against 11 FPs or 54% in 2020. This may possibly reflect the COVID-19 pandemic regulations affecting services (lockdowns and restricted number of visitors). Nonetheless, distribution by drug services also increased from 54% (11 cities) in 2020 to 65% (17 cities) in 2021.

Only in 5 of the FP cities is naloxone available in pharmacies without prescription (Bern, Paris, Kyiv, Milan and Rome in 2021) as was the case in 2020. Reimbursement by health insurance also remains rare: only 3 cities (Paris, Stockholm and Rijeka) reported this was possible in 2021, as with 2020.

Training is most common for staff administration (70% or 18 cities) than for peer administration (53% or 14 cities). These numbers were slightly different in 2020: 15 cities had training for staff and 16 for peers.

Challenges in naloxone availability

In an open question, FPs reported on the main reported challenges for naloxone availability in their cities in the past year. These include:

- Administration by medical staff only;
- Need for a medical prescription;
- Naloxone is available only for those enrolled in drug treatment or for medical emergencies and, thus, not for all PWUD;
- Lack of insurance coverage for naloxone;
- Lack of funding for naloxone;
- Lack of political support to organise and/or simplify purchase and distribution; and,
- No offer of naloxone at prison release.

Examples of such challenges given by C-EHRN FPs include the following:

> *The challenges in London are the same as the rest of the country[21]. If you are not in treatment, you are not likely to get access to naloxone in 2020 owing to services primarily operating out of 'brick buildings' and having no assertive outreach approach to take naloxone and overdose prevention advice and guidance to people who are not in treatment."*
> *(FP **London, UK**)*

> *Naloxone use and the relevant training should not be doctors and nursing staff privilege but a human right of the directly affected community and the peer workers in harm reduction."*
> *(FP **Athens, Greece**)*

> *It is not accessible and distributed in the community or with vulnerable groups, therefore a person is administered naloxone only upon arrival in hospital. This 'waste of time' could be fatal for the person."*
> *(FP **Malta**)*

> *Take-home naloxone is available but is not taken in charge by the health insurance and so it is not frequently used."*
> *(FP **Bern, Switzerland**)*

> *The main barrier was the political will but also the lack of will and help of key decision- makers at the Ministry of Health, etc. The process took many years of advocacy. Additionally, it was complicated to get a naloxone preparation. The process was very complicated and time consuming because the naloxone nasal spray is not officially registered in our country and does not have a leaflet with usage information in the Czech language. Its import from abroad was also very problematic. In the end, we managed to obtain a limited number of sprays for the Czech Republic and distribute them to our clients, peers and colleagues (under the supervision of the Government council for drug policy coordination and the National monitoring centre for drugs and dependence)."*
> *(FP Prague, **Czech Republic**)*

> *Naloxone is a prescription medicine in Estonia, it can only be dispensed by a medical professional. People must have and display ID to be issued with naloxone."*
> *(FP **Estonia, Tallinn**)*

> *In Ireland, accessing naloxone requires a trained keyworker to initially conduct a risk assessment and to educate the client about naloxone and train them,or their relatives, on how to administer either or boththe nasal and injectable forms of naloxone. Once this is completed, the client requires a doctor (usuallytheir own GP, a GP working in specialised homeless services or an OST dependence prescriber) to issue a prescription for the naloxone. Due to theschedulingof naloxone in Ireland, the person to whom it is prescribed must not give the naloxone to anyone else to hold for them"*
> *(FP **Dublin, Ireland**)*

> *There is no availability of naloxone for drug users, except through the emergency medical service at the intervention."*
> *(FP **Rijeka, Croatia**)*

21 See report on naloxone in England and Wales published by Release in 2018. https://www.release.org.uk/naloxone-2017-18

Desired changes in naloxone policy

C-EHRN FPs were also asked to openly comment on the main changes regarding naloxone availability in their cities. These include the following:

- It must be increasingly available through peer distribution;
- It must be available for friends and relatives of PWUD;
- It must be available for take home;
- It must be available at prison release;
- It must be available in pharmacies;
- It must be free of charge;
- Access must not require a medical prescription;
- Legal barriers for administration by non-medical staff and PWUD peers must be removed;
- Government must also campaign for naloxone, not only CSOs; and,
- Funding for naloxone must be provided.

> *"More funding, more peer-to-peer initiatives, wider legal definition of who can supply with possible reclassification from prescription only to at least pharmacy supply or over-the-counter (but the latter may have funding implications in that the State may not pay for it). More broadly, there should be a presumption to supply to reach as many people who need it[22]. Remove the discriminatory approach of stating people having to be 6 months "clean" (drug free) to volunteer as naloxone peers. This approach shuts the door to experts by experience/current drug users from becoming naloxone Champions."*
> *(FP **London, UK**)*

> *"Changes in legislation to allow distribution through the network of harm reduction services; funding for it!"*
> *(FP **Bucharest, Romania**)*

> *"Increased accessibility to naloxone through being given directly to individuals. Should also be available to friends and family members."*
> *(FP **Nicosia, Cyprus**)*

> *"We need basic funding for naloxone and training for people outside the treatment system and we need a strategy longer than 6-12 months."*
> *(FP **Copenhagen, Denmark**)*

Policy change in process

As in 2020, most C-EHRN FPs reported not being aware of any policy change in process to increase access to naloxone in their city (see Figure 10). 27 FPs responded to this question in 2020 against 28 FPs in 2021.

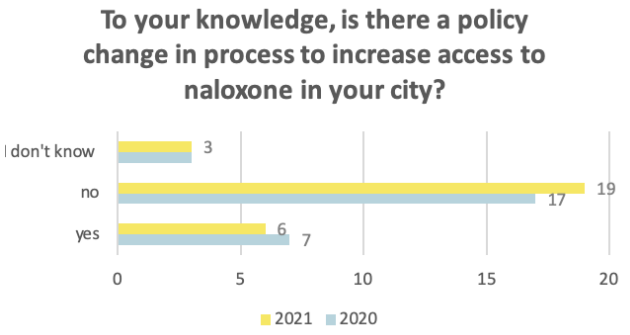
Those reporting policy changes in process in 2021 were in Glasgow (Scotland), Nicosia (Cyprus), Malta (national level), Vienna (Austria), Portugal (national level) and Prague (Czech Republic). In Glasgow, there was an increase in availability from non-specialist services. In Portugal, harm reduction teams are waiting for the national drugs agency to buy nasal naloxone and make it available to them. In Malta (national level) and Prague, despite the positive changes, FPs see room for further improvement.

> *"The forward to the National Report on the Drug Situation (2020) by Minister Michael Falzon, Minister for Social Justice and Solidarity, Family and Children's Rights proposed the introduction of nasal naloxone. However, unfortunately, no further information is provided, especially with regard to accessibility, privacy and pricing."*
> *(FP **Malta**)*

22 See Release's Good Practice Guidance on Supply of naloxone. https://www.release.org.uk/publications/saving-lives-best-practice-guidance-provision-naloxone-people-who-might-experience-or

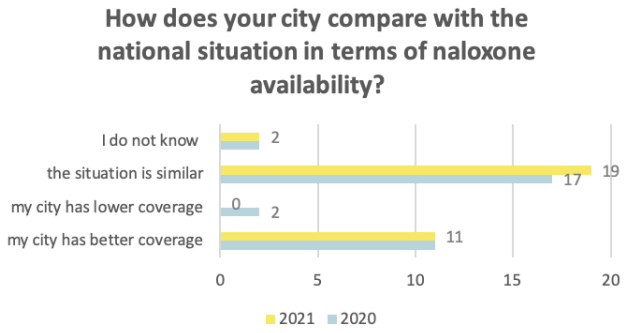
> *"The pilot project of naloxone distribution has been launched; however, we do not have relevant outcomes yet. And the future of the project is also unsure."*
> *(FP **Prague, Czech Republic**)*

Figure 10: Comparison - policy change in process to increase access to naloxone



FP context compared to national context

Figure 11: Comparison between FPs and national context regarding naloxone availability



As in 2020, in 2021 more than half of respondents assessed that naloxone availability in their cities is comparable to the national situation. 34% think that their city offers better coverage when compared to the national context and 6% that it offers lower coverage. Similar to general OD prevention, the context described by C-EHRN Monitoring for naloxone availability is in good part based on the best examples of availability in a country and, thus, current data might not reflect the context of smaller cities and rural areas.

OPIOID AGONIST THERAPY (OAT)

Medications available for OAT

Figure 12 compares the OAT medications reported to be available by C-EHRN FPs in 2020 and 2021. 33 FPs responded to this question in 2020 against 35 FPs in 2021.

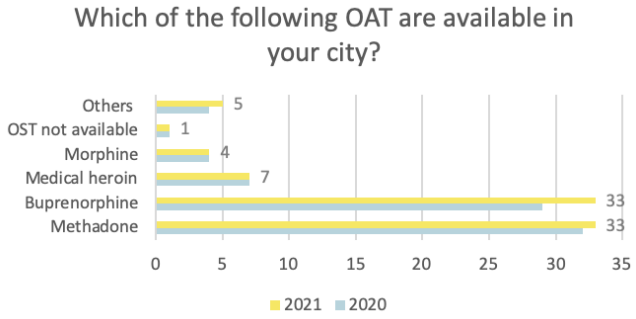


Figure 12: Comparison OAT availability in FPs cities 2020/2021

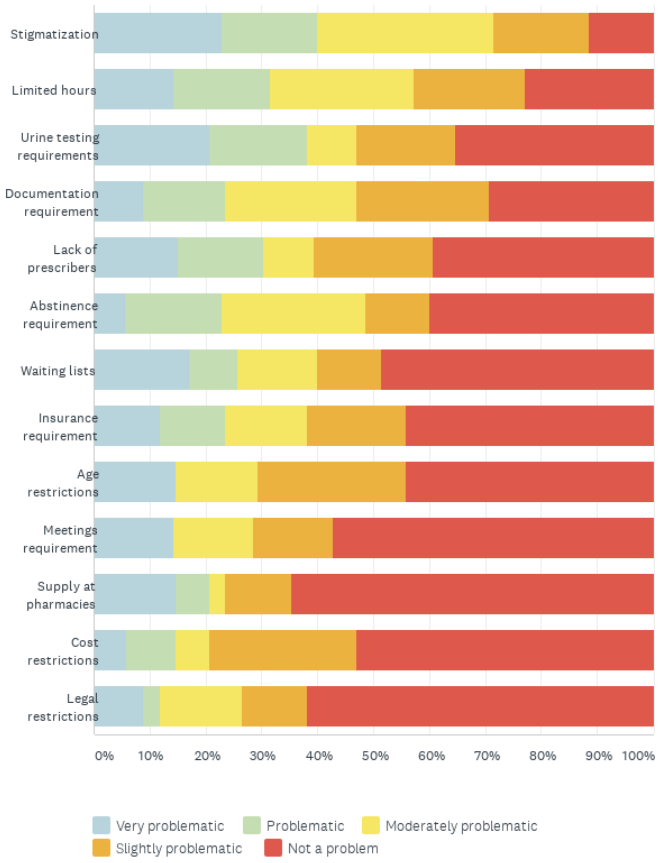
As in 2020, most C-EHRN FPs reported to have both methadone (97% or 32 FPs in 2020 and 94% or 33 FPs in 2021) and buprenorphine (88% or 29 FPs in 2020 and 94% or 33 FPs in 2021) available for OAT in their cities. Medical heroin (17%), morphine (11%) and diamorphine (14%) complement the availability of methadone and/or buprenorphine. Medical heroin is available in Amsterdam (Netherlands), Bern (Switzerland), Glasgow (Scotland), Berlin (Germany), Copenhagen (Denmark) and Luxembourg, as it was in 2020. Since 2021, it is also available in Rijeka (Croatia). Morphine is available only in Berlin, Copenhagen, Vienna and Rijeka (the last since 2021). As in 2020, OAT is prohibited in St. Petersburg (Russia).

Suboxone was also reported by FPs in Nicosia and Ljubljana. Although not OAT, methylphenidate for people who use methamphetamine was reported by the FP in Prague (Czech Republic).

Factors limiting access to OAT

Figure 13 shows how FPs rated several pre-selected barriers to OAT access as reported in 2021. As reported in 2020, the main limiting factors remain stigmatisation of PWUD and the high threshold to enter, or remain in, treatment. The thresholds considered most problematic are urine testing, limited hours of service delivery, long waiting lists and lack of OAT prescribers. The requirement that people abstain from using illegal drugs, the need for documentation, as well as requirements for social coverage or medical insurance and a requirement that people participate in meetings, are also barriers. Legal and age restrictions, an inadequate supply at pharmacies and the costs of treatment, are considered the least limiting factors.

Figure 13: What factors limit OAT access in your city? Please rate them according to the level of the barrier they represent to achieving sufficient OAT coverage (n=35)



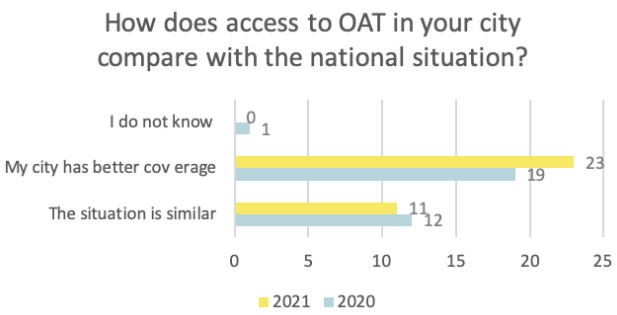
FP context compared to national context

As in 2020, most FPs consider that their city has better OAT coverage when compared to the national situation (see Figure 14). The number of FPs mentioning that their city had better coverage was slightly higher in 2021 (23 FPs) when compared to 2020 (19 FPs). In 2020, 32 FPs answered to this question, while 34 answered in 2021.

The main reason mentioned for the best coverage is that FP cities are bigger and might also have a higher number of people who use opioids, thus, count more services. In smaller and rural areas, OAT coverage, as well as the availability and coverage of other harm reduction services, is lower.

FPs' city situation was regarded as similar to the overall national situation for OAT coverage in 11 cases: Croatia, France, Georgia, Italy (for both Rome and Milan), Poland, Spain, Switzerland, the Netherlands, the UK and Russia (where OAT is forbidden throughout the country).

Figure 14: Comparison of OAT access in FP context and nationally 2020/2021



What needs to improve regarding OAT?

C-EHRN FPs were asked to openly comment on the most needed improvements regarding OAT access in their cities. Their main responses include:

- Lower threshold to start and continue treatment;
- Maintain the practice of take-home doses which was increased during the COVID-19 pandemic;
- Maintain or establish outreach work as a form of starting and continuing OAT, bringing it to where people who use drugs are;
- Increased OAT coverage, especially in smaller cities;
- Explore safe supply for other substances, such as stimulants and benzodiazepines;
- Increase the number of prescribers and OAT providers; and,
- More attention to counselling and social support during treatment.

According to some FPs, improvements in OAT in the past year occurred due to adjustments made in response to the COVID-19 pandemic. These related to a lower threshold to enter and to continue treatment, such as having shorter waiting times to start treatment, enhanced outreach work and more flexibility for take-home doses. FPs would like to see such achievements maintained. Some examples can be seen below:

> *"Due to the COVID pandemic, less restrictive prescribing is occurring which we hope will remain."*
> *(FP **London, UK**)*

> *"COVID opened for OST outreach for Danish citizens. Access to treatment was extended to home-delivery and initiation of treatment was made possible via outreach. This is a major improvement."*
> *(FP **Copenhagen, Denmark**)*

> *"During the pandemic, the demand to enter the OST programme increased. Entrance to treatment has been faster and more effective, in 48 hours maximum before the first demand."*
> *(FP **Barcelona, Spain**)*

> *"Due to COVID-19, PWUD on minimal dose of methadone could take home a methadone supply for the next day, so instead of going every day they needed to go just 2-3 times a week. Before, this was just possible for people who don't use any illegal drugs and are just on methadone therapy - there were urine tests."*
> *(FP **Bratislava, Slovakia**)*

> *"Due to COVID-19, the take home methadone has improved both in length and in people who are eligible."*
> *(FP **Rome, Italy**)*

CONCLUSIONS

As compared to the previous year of monitoring, no significant number of guidelines for OD prevention seem to have been developed in C-EHRN FP's countries or cities in 2021. In at least 10 FP's countries, overdose prevention is not yet mentioned in any guideline. Existing guidelines also need to be updated, above all for the inclusion of providing naloxone, lower threshold access to OAT and overdose prevention for drugs other than opioids.

As in 2020, the combined use of multiple drugs was often mentioned as being involved in the overdoses FPs had heard of in 2021. Opioids (and especially heroin) are still involved in most overdoses FPs had heard of, but mention to stimulants showed a slight increase in 2021 compared to 2020. The typical circumstances of ODs mentioned by FPs were similar to 2020: using drugs alone, combining multiple drugs, not having access to naloxone and having poor health conditions (homelessness, poor nutrition). In 2021, however, FPs brought a stronger emphasis on changes in the drug market with more unknown drug contents when compared to 2020.

Challenges for overdose prevention in 2021 remained similar to the previous year: lack of (low threshold) access to naloxone, lack of access to harm reduction programmes such as DCRs, OAT, Heroin Assisted Treatment (HAT) and agonist treatment for stimulant drugs and not knowing the content of substances consumed, also due to the lack of (sufficient) drug checking services. A positive development was the reported increased in access to naloxone for PWUD and their family and friends in 2021 when compared to 2020 data.

Attention to overdose prevention campaigns in FPs cities have decreased in the past year, perhaps due to the increased attention to prevention campaigns against COVID-19. In 23 FP cities (out of 37), there were no OD prevention campaigns during 2021 and, in at least 14 cities, FPs reported no overdose prevention campaigns in the last two years. When occurring, campaigns mostly focus on traditional opioids, leaving aside stimulants, synthetic opioids, other New Psychoactive Substances and drug combinations.

The most developed form of OD prevention in FP cities and countries concerns opioid OD prevention. OAT and naloxone are available in most cities of FPs reporting to this Monitoring. Nonetheless, access by people who use opioid's to both is still challenging. For OAT, the main limiting factors remain (as in 2020) the stigmatisation of PWUD and the high threshold to enter, or remain in, treatment. For naloxone, main limiting factors relate to the need for a medical prescription and/or medical staff to administer the drug. Desired changes emphasise peer distribution of naloxone, take-home programmes and removal of legal barriers for administration by non-medical staff and peers. For OAT, suggestions for improvement include maintaining and/or establishing lower threshold practices that had increased during the COVID-19 pandemic: take-home doses, facilitated start of treatment and outreach delivery. Exploring safe supply for other substances, such as stimulants and benzodiazepines, is also recommended. Finally, countries and cities not yet offering OAT must take responsibility in providing care for people who use opioids.

HIGHLIGHTS IN NEW DRUG TRENDS

6

INTRODUCTION

The continued appearance and use of New Psychoactive Substances (NPS) on the global and European markets remains a major concern for policy-makers, law enforcement officers and CSOs working in the field. International agencies have warned of potential health risks for quite some time [1-5]. Indeed, the number of new drugs entering the market every year remains high (in 2020, 46 NPS were identified for the first time within the EU). Although the body of knowledge regarding NPS is growing, essential information about most of these novel substances is still lacking, e.g. regarding effects, side-effects, risks, etc.

Given that CSOs work closely with PWUD, they are in principle among the first to observe and detect the emergence and use of new substances by their target groups and, thus, be able to gather essential information about these new substances, information which is difficult to gather by, for example, scientists, or law enforcement officials. New approaches in this field are needed to regularly update existing data on new drug trends and drug use patterns. Harm reduction and community organisations working closely with PWUD must play a pivotal role in identifying new drug trends. Therefore, it is considered important, and of significant added value, to establish a mechanism to identify, monitor and report on emerging drug trends at a much more rapid pace. The fact that the data collected by C-EHRN may be anecdotal, small-scale, or is appearing for a short period of time, is considered not as a limitation, but as complementary to other data sources. In this regard, we are reminded of the often referred to quote from Albert Einstein, "Everything that can be counted does not necessarily count; everything that counts cannot necessarily be counted." Prompt feedback from CSOs on drug trends is useful intelligence. This is intelligence which has been identified and responded to locally; intelligence which may, or may not, have been fed up through national structures; and intelligence which, in time, can be compared and contrasted with empirical data from official sources.

This chapter looks at the emergence of new substances on the local markets of the cities where the C-EHRN Focal Points (FPs) are located, but also at other developments regarding the use of ('traditional') drugs, e.g. new patterns of drug use, new routes of administration, the use of known substances by a different group of PWUD, or the combined use of different substances (new and/or known). So the focus of this activity includes a broader field than just the use of new drugs, e.g. NPS.

2020 RESULTS

METHODOLOGY

Questionnaire

For this years' data collection, the same questions were used as last year, consisting of seven closed questions with room for additional information per question on developments at city level regarding new drug trends. C-EHRN's new drug trends monitoring led to 36 completed questionnaires, of which 2 FPs skipped all questions related to new drug trends. The report below is, therefore, based on the responses of 34 FPs unless stated otherwise.

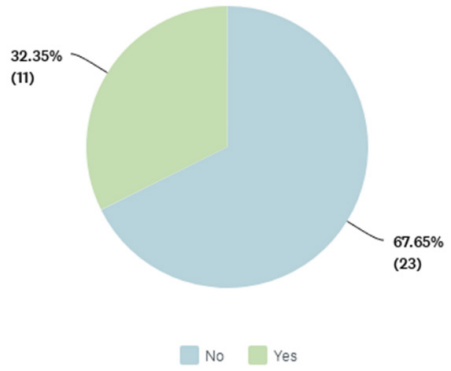
Piloting focus groups

Additional information was gathered via 2 focus group meetings (FP Vienna and FP Dublin). Both FPs completed the questionnaire and conducted a focus group discussion. Initially, introducing focus group discussions as a means of data collection was scheduled for 2020's data collection; however, due to restrictions in all FP countries due to the COVID-19 pandemic, it was deemed not possible to conduct this type of discussion face-to-face. Topics discussed in the focus groups were very similar to those in the questionnaire. Local stakeholders from various backgrounds were invited to the focus groups by the respective FPs. The focus group in Austria was led and conducted by the Viennese FP, whereas the (online) Dublin focus group discussion was led and conducted by the coordinator of the New Drug Trends expert group.

Both focus group discussions were recorded, then the content was transcribed and relevant information was added to the content of this chapter.

Below are the highlights gained from the monitoring of New Drug Trends in 2021.

THE EMERGENCE OF A NEW SUBSTANCE ON LOCAL DRUG MARKETS



Q63: Changes in drug use in your city. In the previous year, have you witnessed any new developments regarding the use of drugs in your city amongst your target group(s): a. The emergence of a new or unknown substance?

This question had 34 responses, 2 FPs skipped the question. Yes: 10 FPs (29%).

10 out of 34 FPs[23] reported the emergence of a new substance on the local market. 6 out of those 10 FPs mentioned a synthetic cannabinoid as a new substance. This is in line with last year's monitoring where synthetic cannabinoids were also most often mentioned. In most of the FPs cities, cannabis users did not intentionally use this synthetic cannabinoid; this synthetic cannabinoid was found in substances mis-sold as other substances (especially as cannabis) through their chemical analyses, e.g. by drug checking services identifying this substance (MDMB-4en-PINACA) in samples sold as cannabis [6]. A number of other FPs mention a synthetic or benzimidazole opioid.

> *"Cannabis users didn't know they were using it. MDMB-4en-pinaca was found in samples from different sources and from different areas. We found it in samples from street dealers but also from 'coffee shops'. Therefore, it's hard to pinpoint a specific group. It seemed that it could potentially affect all cannabis users."*
> *(FP **Amsterdam, the Netherlands**)*

Besides this phenomenon, others choose deliberately to use synthetic cannabinoids which are usually much more potent than regular cannabis and, therefore, much stronger in their effects [7]. When taken deliberately, reasons include its easy availability, because of the effects and to escape from reality.

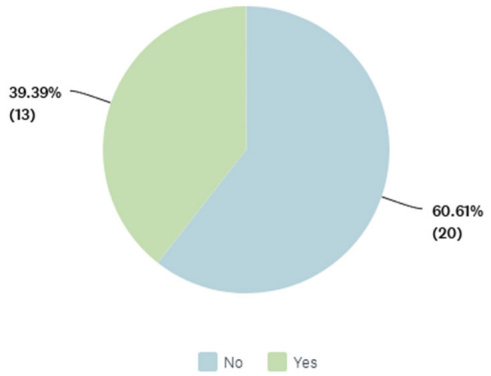
Part of the questionnaire was an open question that meant to provide FPs the opportunity to add relevant information about any of the questions on the questionnaire. From this 'other remarks' section, it was noted that also in Tallinn, Estonia, a new substance was identified on the market:

> *"In the beginning of summer of 2021, we received information about several cases of unknown novel synthetic psychedelics, possibly NBOMe-type drugs, being sold as LSD. It is possible that these drugs have been on the market and sold as LSD for quite some time and that their presence was only discovered due to drug checking at a dance music festival."*
> *(FP **Tallinn, Estonia**)*

23 *Actually, there were 11 positive responses but 1 FP did not share any further information, so the response was excluded from the analysis.*

This finding is line with the mis-selling of LSD at Portugal's Boom Festival in 2017 where an on-site drug checking service identified this worrying practice [8].

KNOWN SUBSTANCES NEWLY USED BY YOUR TARGET GROUPS



Q67: In the previous year, have you witnessed any new developments regarding the use of drugs in your city amongst your target group(s): b. The emergence of a known substance but used for the first time among (one or more of) your target group(s) in your city (e.g. GHB use among people who traditionally only used heroin)? (Please mention only the most remarkable or worrying changes).

This question was answered by 33 FPs, 3 FPs skipped the question; Yes: 13 FPs (39.9%).

13 FPs mention changes in substances used by their target groups, 20 mentioned no changes and 3 FPs skipped this question. 6 FPs mentioned two known substances being used for the first time by their target group, of which 2 also mentioned a third substance. 1 FP mentions 4 substances to be now used by a specific subgroup (chemsex).

Substances newly used by target groups of the FPs include GHB (4 times mentioned), e.g. by a group that substitutes alcohol with GHB (FP Copenhagen, Denmark); by younger people (FP Stockholm, Sweden); by groups that use different type of drugs (FP Rijeka, Croatia); or by groups engaging in chemsex (FP Antwerp, Belgium and Switzerland)). Other substances mentioned included methamphetamine (mentioned by FPs London, UK; Bern, Switzerland; Stockholm, Sweden); 3-MMC (FP Amsterdam, Antwerp and Switzerland); and speed by people who previously injected heroin (FP Novi Sad, Serbia); heroin by migrants (FP Copenhagen, Denmark); alpha-PVP with people who were caught while driving intoxicated (FP Helsinki, Finland); cocaine by people who were previously heroin users (FP Podgorica, Montenegro); fentanyl by users of street methadone (FP Kyiv, Ukraine); ketamine and cannabis edibles by young people (see also below, FP London, UK); oxycodone tablets by buprenorphine users (FP Helsinki, Finland); MDMA/ecstasy by young people engaging in chemsex (FP Rome, Italy); snus and rivotril (FP Paris, France); or the combination of GHB and stimulants in the chemsex scene (FP Antwerp, Belgium).

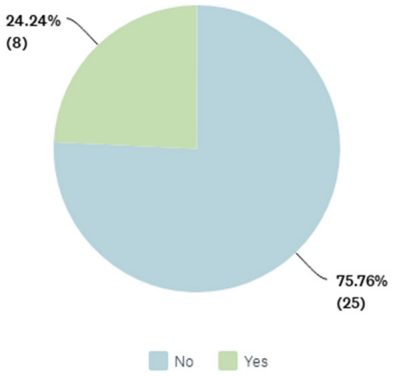
> *"GHB has become a bit more widespread as a substitute for alcohol / benzo when it is not available or not able to drink. It is used to prevent withdrawal."*
> *(FP **Copenhagen, Denmark**)*

An increase in use of 'laughing gas', but not by their target groups, was reported during a focus group discussion by the FP Dublin, Ireland.

> *"There is a concern about nitrous oxide. The levels of drug-related litter (discarded whippets) and anecdotal feedback suggests that 'doing balloons' is commonplace amongst recreational / non-problematic drug users. Another concern is that it is being used in combination with other drugs, e.g. alcohol, MDMA, etc."*
> *(FP **Dublin, Ireland**)*

In comparison with last year, no major changes were witnessed, albeit that some substance use was now reported by the target groups of other FPs and in which substances newly used differed.

NEW OR DIFFERENT ROUTE OF ADMINISTRATION OF SPECIFIC SUBSTANCES



Q71: In the previous year, did you witness in your target group(s) the emergence of a new or different route of administration of specific substances?

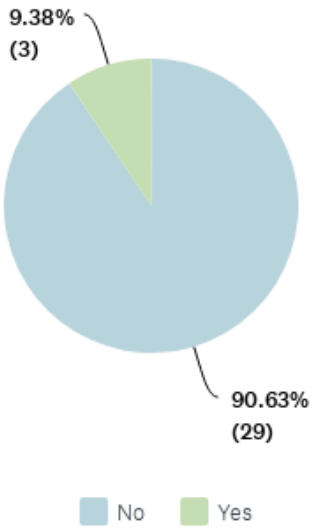
This question was answered by 33 FPs; 3 FPs skipped this question. Yes: 8 (24.24%).

25 FPs mentioned that no new or different routes of administration (RoA) were seen. 8 FPs mentioned a new or different RoA of a specific substance used by (one of) their target group(s). But the RoA of a substance differs largely among FP cities, varying from young people starting to use cannabis edibles (FP London) to the injection of cocaine (FP Podgorica) or oxycodone (FP Helsinki) by users that previously snorted these substances. The reasons for these shifts also vary. In Rijeka, buprenorphine is increasingly snorted by OAT patients as it would supposedly have a stronger effect, while in Helsinki the temporary unavailability of buprenorphine may have led to the injection of oxycodone.

> *"Young people start using cannabis edibles…Potentially due to (anecdotal reports) that it reduced the likelihood of detection when using (i.e. no visible smoke/ smell), innocuous packaging."*
> *(FP **London, UK**)*

In comparison with previous years, the use of cannabis edibles by young people was mentioned for the first time.

NEW COMBINATIONS OF SUBSTANCES IN TARGET GROUPS



Q75: In the previous year, did you witness in your target group(s) new combinations of substances?

32 FPS answered this question, 4 FPs skipped this question. Yes: 3 (9%).

FPs in Paris, Rijeka and Antwerp reported new combinations of substances used by their target groups. More specifically, FPs mentioned the combined use of rivotril (clonazepam) with MDMA in Paris by 'unaccompanied' minors from North Africa, 'alcohol with everything, everything with everything' by younger people and people suffering from dual diagnosis in Rijeka, and GHB and stimulants within the chemsex scene in Antwerp.

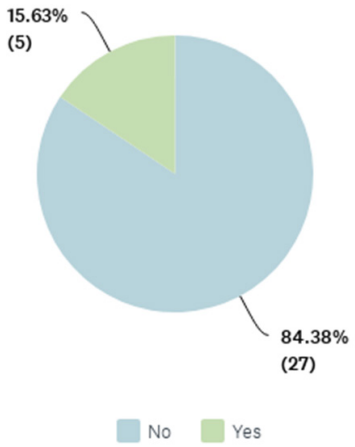
For the 'other remarks' section, it was noted that some PWUD shifted from the use of buprenorphine to a mix of alcohol and benzodiazepines.

None of the reprted combination of substances were mentioned last year.

> *"The main substances are meth and buprenorphine. Due to the small capacity of OST, we have more clients among ageing drug users that are switching to easier obtainable combinations of alcohol and benzos, which is much more dangerous than buprenorphine."*
> (FP ***Prague, Czech Republic***)

> *"For a few years, GHB and stimulants are used together in the chemsex scene orally or through 'slamming' (injecting in chemsex slang). It is used to enhance sexual performance, but a known risk is GHB overdosing."*
> *(FP **Antwerp, Belgium**)*

CHANGES IN THE EXISTING TARGET GROUPS?



Q79: In the previous year, did you witness any changes in the existing target groups you provide services for (e.g. younger, new immigrant groups)?

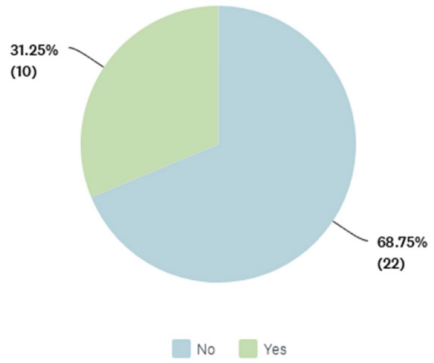
32 FPs answered this question, 3 FPs skipped this question. Yes: 5 (16%).

5 FPs reported changes in the existing target groups of their services. These changes mainly relate to changes in substances used (e.g. St. Petersburg: increase in alpha-PVP use; or a decrease in heroin users in Rome; the increased use of several substances together in Stockholm; or increase of groups engaging in chemsex in Amsterdam and Antwerp). From the 'other remarks' section, it was noted that in Budapest the chemsex scene is also growing.

> *"The chemsex scene has been growing in Budapest for several years now and there are very few professionals who help."*
> *(FP **Budapest, Hungary**)*

Similar to last year, changes in existing target groups refer mainly to changes in substances used.

SERVICES INITIATED FOR NEW TARGET GROUPS



Q83: In the previous year, did you start providing services for any new group(s) of PWUD?

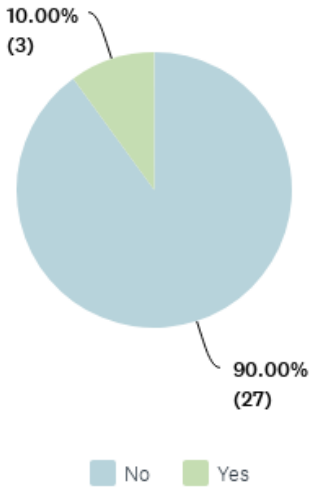
This question was answered by 32 FPs, 4 FPs skipped the question. Yes 10 (31%).

10 FPS reported to have started providing services for new target groups. These groups include people from chemsex communities (FP Amsterdam, FP Antwerp); young people (FP Helsinki; FP Podgorica; FP Ljubljana, Slovenia); people having fought in the first Russo-Ukrainian war (FP Kyiv); and immigrants from either Southern Asia or from Arab-speaking countries and Somalia (FP Nicosia, Cyprus, FP Helsinki, FP Stockholm). The services offered concern predominantly harm reduction services including needle exchange, self-support groups, peer-to-peer outreach work or services targeting specifically PWUD from chemsex communities.

> *"In Kyiv, harm reduction services were initiated for 'combatants' engaging in risky behaviour. This group of clients injects street methadone. They are active military personnel who were sent home temporarily (for a vacation) and they come to harm reduction programmes for services. Many of our old harm reduction clients went to the military to serve under a contract and they come for services too. Also, in the Kyiv region, there are military units and some clients come from there (they are not participating in the military actions)."*
> (FP ***Kyiv - also based on personal communication***)

As was also the case last year, a third of all FPs that answered this question reported the provision of services to new groups and, similarly this year, services were also provided to PWUD in chemsex communities and immigrants. New is the group of PWUD that have fought in the first Russo-Ukrainian war.

NEW GROUPS OF PWUD FOR WHOM NO SERVICES ARE YET PROVIDED



Q87: In the previous year, did you come across any new group(s) of PWUD for whom your organisation, or any other organisation, are not currently providing any services?

This question was answered by 30 FPs, 6 FPs skipped the question. Yes: 3 (10%).

3 FPS report to having witnessed new groups of PWUD for whom no services are yet provided: FP Stockholm (young Afghan immigrants); FP Kyiv (homelessness among many people including PWUD); and FP Amsterdam (women engaging in chemsex).

> *"People are experiencing homelessness. Because of poverty in the country and the military conflict, many people from vulnerable groups, including PWUD, have a decreased quality of life and have lost their homes."*
> *(FP **Kyiv**)*

CONCLUSIONS

Since its start in 2019, monitoring of new drug trends by grassroot organisations within the framework of C-EHRN has been a challenge and was basically regarded as a 'learning-by-doing' exercise. Monitoring drug trends requires some specific expertise that is not commonly present among harm reduction staff.

Rich, additional information

However, it appears that these limitations were less predominant than in previous years. Instead, the information received may be richer, especially while most of the data received are more or less in line with the monitoring results of previous years and in line with trends reported by other sources (such as the increase in the use of specific NPS in some countries; the increase in people engaging in chemsex; and the appearance of cannabis containing synthetic cannabinoids on local markets reported by a number of FPs). As a result, CSO monitoring of new drug trends deepens the information available from national or international agencies (whose reports usually target national overviews that by nature are more general).

Timely reporting?

However, 23 of the FPs report that no new substances entered the market since last year, which might indicate that changes to local drug markets do not come overnight and that the timeframe of monitoring is too strict and, perhaps, we should use intervals of 2 or 3 years rather than just 1 year. The fact that the EMCDDA reports roughly one new substance per week somewhere in the European Union (in 2020) could indicate that its appearance throughout the territory of the EU can take quite some time, if at all.

It is also very much possible that most of the FPs do not report new substances in a timely manner because the absence of low-threshold drug checking services means there is no way of knowing what is actually on the market.

Focus groups

This year's edition of the data collection included 2 focus group discussions. Besides completing the questionnaire, data collection by the FP in Dublin and the FP in Vienna also included focus groups. We can conclude that focus groups are an attractive alternative to the questionnaire for both FP and C-EHRN staff. More than ever, people are now used to meeting online and technical issues are easily solved. As such online meetings are very time efficient (no travel), as well as cost efficient (often takes less time compared to a face-to-face meeting, e.g. travel time and expense). An even more important benefit of focus group discussions is that it may add to the quality of the data since, within focus groups, consensus is a more common outcome than if the questionnaire was filled out by, for example, 1 or 2 people that also may be working with the same organisation. Finally, focus group discussions may also improve the quality of the data collected as these group discussions allow for asking additional questions for clarification to get a better understanding of the local markets. Therefore, it is recommended that further monitoring activities by grassroots organisations be developed using focus groups as an alternative to the lengthy questionnaire. As such, it would be of great help should there be a reliable computer package that can automatically transcribe the online focus groups.

Drug checking

This year's data collection holds the same limitations as described in previous editions of the monitoring report (such as issues in interpreting the data and the reliability of some of the data received and the fact that in most cities the appearance of a new substance on the local market is based on assumptions, not on laboratory tests. Therefore, it is strongly recommended that at city level throughout the EU, drug checking services are implemented. Drug checking services have proven to be an essential tool for EMCDDA's Early Warning System. Drug checking services are at the forefront when it comes to identifying new, mis-sold or adulterated substances, as examples in this chapter have shown. Drug checking services also allow for quick responses, such as warning campaigns, aimed at preventing unintentional consumption of mis-sold substances or of adulterated substances that may have serious adverse health consequences.

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Correlation
European
Harm Reduction
Network

COVID-19 AND HARM REDUCTION

7

INTRODUCTION

The COVID-19 pandemic has not ended but, after enormous collective efforts since the beginning of 2020 and a rise in vaccination, European countries are entering a phase of less restrictions. Up until now, European countries implemented a variety of virus containment strategies, such as border closures, lockdowns, increased police presence, as well as diversion of sterile supplies and staff to hospitals, as well as service reductions [1]. All of these measures affected both people who use drugs and harm reduction services in Europe [2-4].

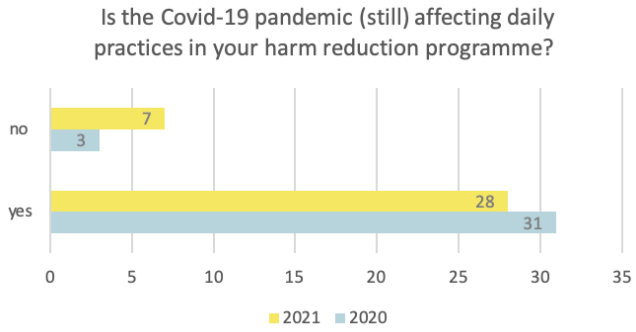
To map these effects as well as the new challenges and opportunities for harm reduction service providers, C-EHRN monitoring added a section about the impact of COVID-19 in its 2020 report [5]. Results, collected from May to July 2020, showed that the pandemic had affected daily harm reduction practices for most FPs, creating challenges for services providers and service users. Unexpectedly, the pandemic also brought opportunities for advancing a few harm reduction practices. Opioid Agonist Treatment gained lower threshold regulations and practices in several cities, with increased take home doses, outreach delivery and online consultations. An increased availability of housing and shelters for people who use drugs and who are in situations of homelessness could also be seen.

To follow up on new developments, our 2021 Monitoring report collected data via ten questions focused on the COVID-related impact on harm reduction services and their clients, the extent to which positive changes were sustained and vaccination policies and uptake. Results can be seen in the following pages.

CHALLENGES FACED BY HARM REDUCTION SERVICES

C-EHRN FPs were asked whether their harm reduction services were still having their daily practices affected by the COVID-19 pandemic. 35 FPs answered the question in 2021, compared to 34 in 2020, and Figure 1 compares both reporting years.

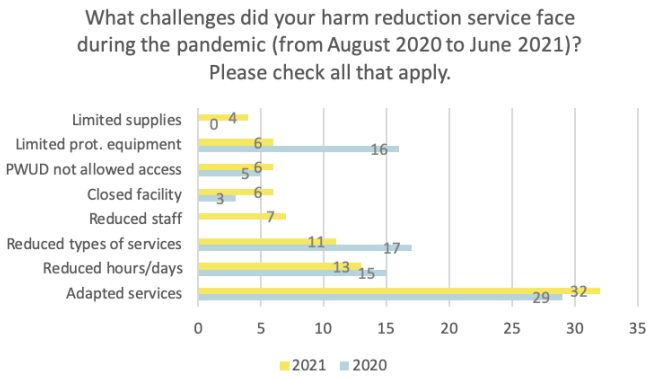
Figure 1: COVID-19 pandemic and harm reduction practices - comparison 2020 (n=34)/2021 (n=35).



As in 2020, most FPs partaking of the monitoring in 2021 reported that their activities were still being influenced by the pandemic, but numbers decreased in 2021. Cities reporting no longer being affected by the pandemic in 2021 were London (UK), Novi Sad (Serbia), Copenhagen (Denmark), Paris (France), Rome (Italy), Tirana (Albania) and Saint Petersburg (Russia).

FPs were then asked which challenges their services had faced during the last year (the period from August 2020 to June 2021). Figure 2 compares results from 2020 and 2021. 33 FPs responded to this question in 2021 against 30 in 2020.

Figure 2: Challenges for services - comparison 2020



(n=30)/2021 (n=33).

In 2021, fewer services struggled with limited COVID-19 protective equipment for staff and users and there were less reductions in the types of services when compared to 2020. Yet some facilities still had to close and could not allow people who use drugs to reach care. Reduced number of staff became a problem for some facilities, both due to COVID-19 cases and burnout. Virtually all services in which FPs work have adapted their activities in 2021, as was the case in 2020. Only FP organisations not providing direct harm reduction services reported not having to adapt due to pandemic regulations. These were, for instance, organisations providing helplines, doing research or advocacy work.

In an open field for comments, some FPs explained the challenges faced and the adaptations made:

> *PWUD were not allowed in the cars of outreach workers. HIV and HCV testing was not in use in Spring 2021."*
> *(FP **Helsinki, Finland**)*

> *We provided all services, but clients were not able to come inside the Drop-in Centre and consultations were provided online or by telephone and this significantly raised our number of daily contacts (counselling). We added lunch package services for 50 most-in-need clients and their families and provided such service for 8 weeks of the epidemic."*
> *(FP **Podgorica, Montenegro**)*

> *Closure of facilities refers to our inpatient services, not the outpatient services."*
> *(FP **Malta**)*

> *Employees were sick and services were less than planned. There was no possibility to travel to work or for many clients to come for services because public transport wasn't working or was only available for essential workers who had to have a special pass. It took some time to obtain those for NGO social workers."*
> *(FP **Kyiv, Ukraine**)*

> *Limited access to day care and personal hygiene services."*
> *(FP **Nicosia, Cyprus**)*

> *We run a range of tailored groups in each local area focusing on harm reduction, relapse prevention and peer education and support. COVID-19 has had an impact on the delivery of low threshold group work. We provide groups and one-to-ones in prison. We also provide community-based support to people leaving prison. COVID-19 has had an impact on the delivery of work inside the prisons."*
> *(FP **Dublin, Ireland**)*

> *We primarily reach people through outreach on location; this was hardly possible during the lockdown as our outreach staff were not welcome at most services and it was too cold for PWUD to hang in public spaces. Moreover, many low-threshold services closed their facility for PWUD who are not homeless which resulted in reduced visibility of, and contact with, PWUD. For several months, most of our outreach work happened by phone. Finally, because our office was closed, we had to organise our chemsex support groups online and no longer offered drug checking and needle exchange from the office (but a few times we did offer it on location)."*

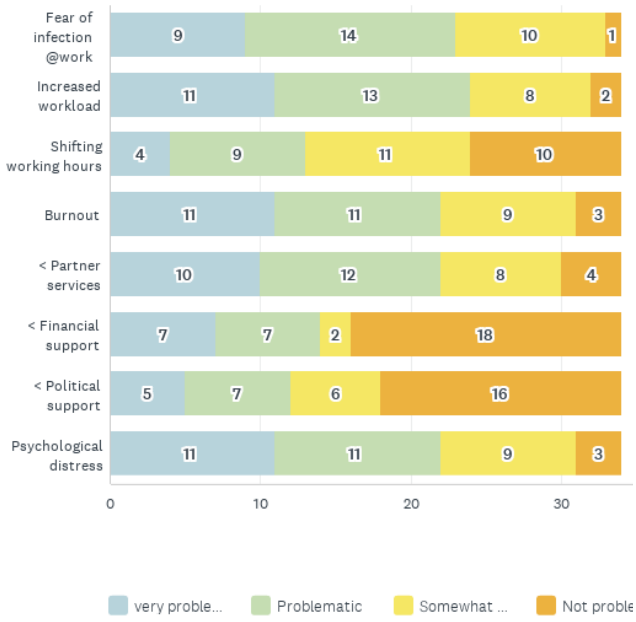
> *(FP **Amsterdam, the Netherlands**)*
>
> *NSP, OAT and other Free Clinic activities were never closed, only adaptation of service. Safensound, on the other hand, closed, gave out limited HR supplies and there was a reduction of HR services."*
>
> *(FP **Antwerp, Belgium**)*
>
> *The start of COVID at the beginning of 2020 was the most difficult time, later on we adapted our service and ensured sustainable services."*
>
> *(FP Tallinn, Estonia)*
>
> *The programmes took place all the time with strict application of protective epidemiological measures - wearing masks, social distance, hand disinfection, a limited number of people indoors."*
>
> *(FP **Rijeka, Croatia**)*
>
> *The staff is currently encouraged to vaccinate users though there's not a clear protocol on how to do it."*
>
> *(FP **Barcelona, Spain**)*

CHALLENGES FACED BY HARM REDUCTION STAFF

In recent years, several of us faced new forms of pressure and stress due to a long-term pandemic and the regulations and consequences attached to it. To try to capture these additional challenges, the 2021 Monitoring added a question related to the challenges that harm reduction staff had to face due to the pandemic, based on a fixed list. FPs were asked to rate it according to difficulty and were offered a space to comment and suggest other challenges which had not been listed.

As Figure 3 shows, the main difficulties reported were fear of being infected with COVID-19 at work (23 out of 34 FPs found it either very problematic or problematic) and an increased workload (24 FPs). Burnout and psychological distress were also high on the list of main difficulties, along with a decreasing number of partner services to refer users to (22 FPs each). Shifting working hours (13 FPs) and decreased financial and political support were the lowest on the list, although at least one FP commented that the lack of financial and political support was usual and not something new occurring with the pandemic.

Figure 3: Which are the main difficulties that harm reduction staff must face in your city during the coronavirus pandemic? Please rate how important these difficulties are. (n=34)



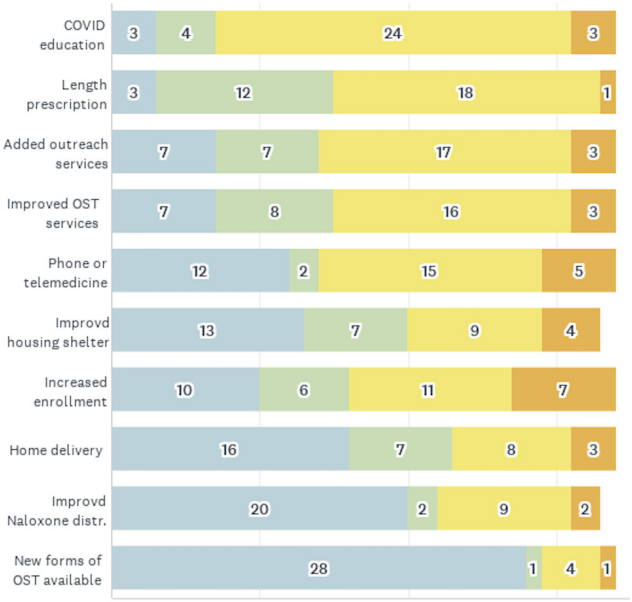
POSITIVE CHANGES AND INNOVATIONS DURING THE PANDEMIC

Despite the many hardships for people who use drugs and harm reduction services, the COVID pandemic has also provided a unique opportunity for innovative practices, as well as a few positive changes. Last year's Monitoring [5] mapped changes around increased health education and promotion activities, increased OAT length of prescription and take-home doses, telemedicine, increased availability of housing and shelter for those experiencing homelessness and increased distribution of both OAT and naloxone via outreach.

This year's Monitoring survey had a dedicated question to check to what extent such changes have been maintained. Figure 4 shows the results. 34 FPs answered this question.

Education around COVID occurred and was maintained in most (24 of 34) FP services and discontinued in a few (4) cities. A lower threshold for accessing OAT was also maintained in several cases, although discontinuity also happened, especially for increased length of prescription of OAT. Increased length of OAT prescription was maintained for 18 FP cities but discontinued for another 12. Added outreach services were maintained in 17 FP cities but discontinued in 7. Improved OAT services were maintained in 16 FP cities but discontinued in 8. Phone or telemedicine was, so far, the most maintained lower threshold OAT activity: maintained in 15 FP cities and discontinued in 2. Home delivery of medicines and/or material for drug use was maintained in about half of the cases (8 maintained, 7 discontinued). Improved naloxone distribution had occurred only in 11 FP cities but was maintained in 9 of those. Improved housing or shelter was maintained only in about half of the cases.

Figure 4: In the first period of the pandemic, a series of positive changes or innovations occurred in harm reduction services. Have these changes been maintained? Please check all that apply. (n=34)

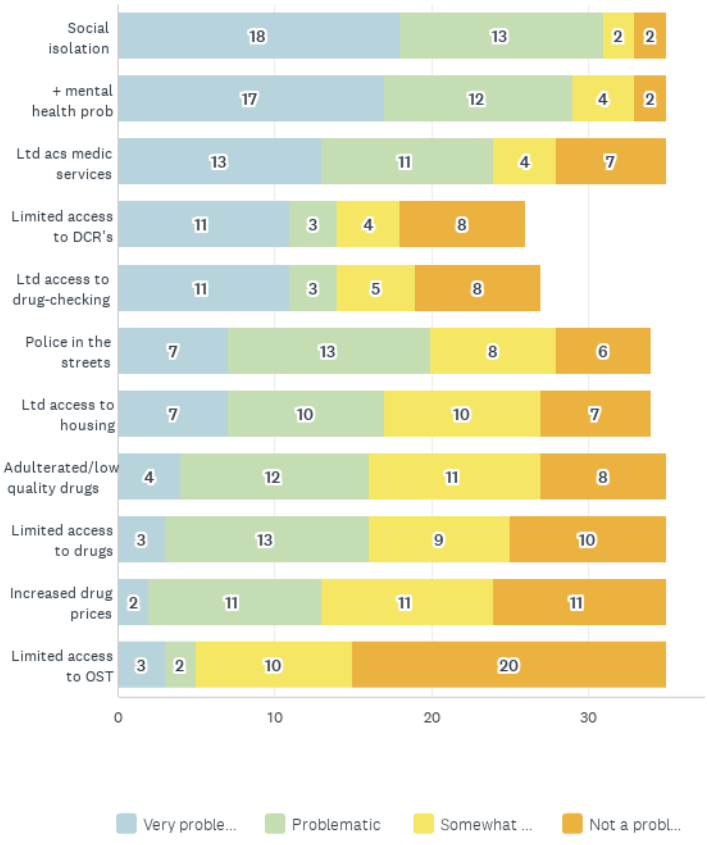


In an open field for comments, some FPs mentioned that online services were also generated from the pandemic and have been maintained. That was the case for Novi Sad (Serbia), Helsinki (Finland), Tallinn (Estonia) and Antwerp (Belgium). The FP from Podgorica (Montenegro) mentioned that provision of food packages for clients and their families have been continued by some organisations. In Barcelona (Spain), people who use drugs have free access to COVID-19 vaccination since May 2021. Also, in Bratislava (Slovakia), the organisation Odyseus was able to provide COVID antigen testing for clients and, in 2021, in cooperation with Ministry of Health, organised several COVID vaccination days in its Drop-in Centre.

CHALLENGES FACED BY PEOPLE WHO USE DRUGS FROM THE PERSPECTIVE OF SERVICE PROVIDERS

FPs were asked to identify (based on a given list of options) potential difficulties faced by people who use drugs in their countries during the pandemic and to rank them according to difficulty.

Figure 5: Which are the main difficulties that PWUD faced in your country during the coronavirus pandemic? Please rate how important these difficulties are. (n=35)

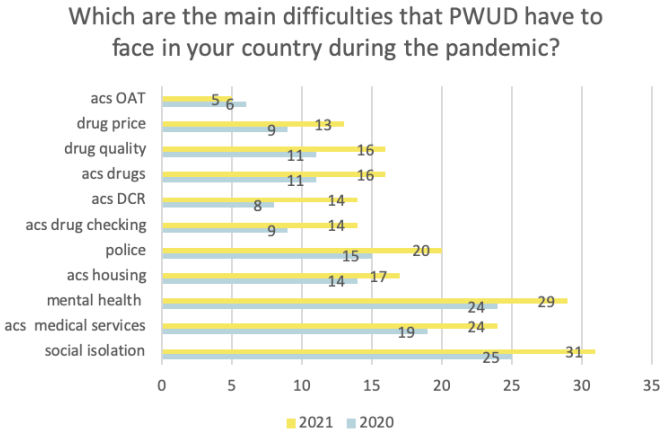


Social isolation and increased mental health problems were rated as the most problematic, along with limited access to medical and harm reduction services such as DCRs and drug checking. Increased police on the streets was also one of the 5 top problems. Access to OAT was the least problematic, along with access to drugs.

31 out of 35 FPs rated social isolation as either very problematic or problematic and 29 rated increased mental health problems in the same way. Limited access to health services (24 FPs) and limited access to DCRs and drug checking (both 14 FPs) were in 3rd and 5th place, respectively. Increase in police on the streets were seen as (very) problematic by 20 FPs, being considered by service providers the 3rd main problem people who use drugs have faced during the pandemic.

Figure 6 compares the difficulties seen as either very problematic or problematic by C-EHRN FPs in 2020 and 2021. It shows that virtually all challenges, except for access to OAT, were rated as presenting higher difficulties in 2021.

Figure 6: Challenges for people who use drugs - comparison 2020 (n=33)/2021 (n=35).



In an open field for comments, some FPs offered additional explanation for the problems faced by people who use drugs in their country. Some also included non-listed problems such as difficulty to find food and earn money due to pandemic measures and the spread of myths around COVID-19.

> *There are legal and policy barriers to DCRs. Police stop and search (of which over 60% of searches under the main police powers are for drugs) reportedly increased over the first UK national lockdown (at least in London and possibly beyond). The increase is clear from published monthly search rates of searches conducted by the Metropolitan Police Service and was also reported by people purchasing drugs in Release's coronavirus drug purchases impact survey – whereby respondents reported experiencing more contact with police since the pandemic compared to their experiences before the pandemic."*
> *(FP **London, UK**)*

> *There was a difficulty in finding food due to the quarantine measures (people living temporarily in rooms with no kitchen available). The harm reduction programme (TARGET) provided food to this population daily."*
> *(FP **Nicosia, Cyprus**)*

> *People without housing were lacking possibilities for hygiene and in the winter without a warm place and people were not allowed to hang out in public places." (FP **Helsinki, Finland**)*

> *Lack of ability to move around the city and the region due to inoperable public transportation in the strict stages of the quarantine. Lack of opportunity to seek medical services due to overcrowded hospitals. Inability to undergo vital examinations and receive treatment (HIV, tuberculosis, hepatitis) during a strict quarantine in 2020."*
> *(FP **Kyiv, Ukraine**)*

> *The financial situation of PWUD, the lack of tourism and thus the lack of financial resources were very problematic. The lack of information in the PWUD population and the spread of various myths about COVID-19 were also problematic. Some PWUD were afraid to go for Covid testing due to fears of quarantine and withdrawal symptoms. NSPs have largely substituted general medical care. The attitude of the police was mostly unproblematic in our city. However, some steps followed led to the significant changes in the Prague drug scene, especially in the way of moving the black market from the city centre to other city districts. Due to the national state of emergency, PWUD were also more at risk of arrest for a property cr ime."*
> *(FP **Prague, Czech Republic**)*

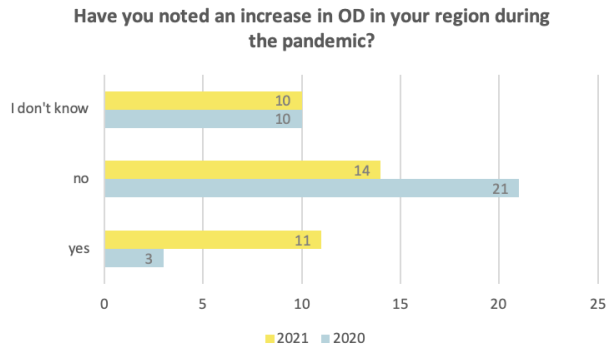
> *Access to earning money in public spaces has limited the seasonal migrant population."*
> *(FP **Copenhagen, Denmark**)*

IMPACT ON OVERDOSE

Harm reduction focal points were asked about whether they noted an increase in overdose (OD) during the pandemic. This was hypothesised by many experts early in the pandemic to be a potential risk due to more PWUD using alone, less access to naloxone and an increase in adulterated substances [1].

Figure 7 compares results for 2020 and 2021. Clearly, more FPs noticed an increase in ODs in their region in 2021 compared to 2020. In 2020, only 3 FPs (in Kyiv, Novi Sad and Stockholm) reported increased rates of OD during the pandemic. In 2021, the same 3 FPs again noticed an increase in OD and, in addition, another 8 FPs also did so: Budapest, London, Helsinki, Athens, Saint Petersburg, Ljubljana, Prague, and Bern.

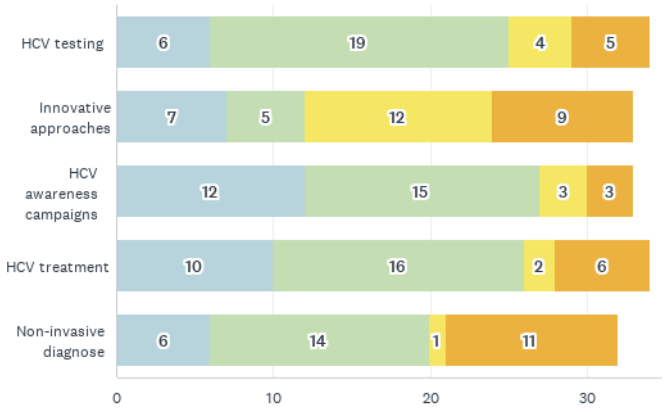
Figure 7: FPs perceived increase of OD during the pandemic – comparison 2020/2021.



IMPACT ON HCV CARE

During the pandemic, it became visible for both service providers and researchers that the focus on COVID-19 was detrimental to other types of care, especially regarding HIV and HCV testing and treatment for people who use drugs. 34 FPs answered this question (2 skipped). As Figure 8 shows, a negative impact was perceived by several FPs. The highest negative impact was perceived in HCV testing (19 FPs or 56%), HCV treatment (16 FPs or 47%), HCV awareness campaigns (15 FPs or 46%) and non-invasive diagnoses (14 FPs or 43%).

Figure 8: Were the following services impacted by COVID-19 in your city? (n=34)



In a comment box, some FPs offered more details:

> *"New HCV treatment pilots were delayed by COVID."*
> *(FP **Helsinki, Finland**)*

> *"During the COVID-19 pandemic, especially during the first wave, all specialist appointments were cancelled or delayed due to the overflow of COVID cases, including fibro scan and admitting new people to HCV therapy."*
> *(FP **Podgorica, Montenegro**)*

> *"The overall negative impact due to the congestion of the medical system was that services other than COVID treatment were unavailable. The use of innovative approaches (i.e. telemedicine) was increased but the clients (for example, OST clients) were not satisfied with the quality of these services compared to traditional face-to face consultations."*
> *(FP **Bratislava, Slovakia**)*

These disruptions perceived by C-EHRN FPs are in line with the results found in other surveys in Europe as well as further afield. A 2020 survey of 173 syringe service programmes in the United States found there had been a decline in the availability of testing and treatment services for HIV and HCV [6]. A survey assessing the impact of the pandemic on testing services for HIV and viral hepatitis across 34 countries in the WHO Europe region had 95% of its respondents (n=98) reporting a more than 50% decline in testing compared to expected numbers between March and May 2020. Numbers remained low in the months of June through August when restrictions would have eased in most countries [7]. In England, provisional data published by Public Health England found a reduction in testing for viral hepatitis in drug services and prisons between March and May of 2020. In those same months, there was a reduction in HCV treatment initiations, diagnosis of viral hepatitis as well as of HIV. Of 136 PWID surveyed in the same report, 22% had difficulties accessing HIV and/or hepatitis testing and 11% (10/87) experienced disruptions to their HCV treatment [8].

A few FPs also reported to have seen a positive impact from the pandemic in HCV care for people who use drugs. The major positive impact related to innovative approaches made possible by the COVID-19 pandemic (12 FPs or 36%). A few other FPs saw a positive impact of COVID-19 on HCV testing (4 FPs or 12%), awareness campaigns (3 FPs or 9%), HCV treatment (2 FPs or 6%) and non-invasive diagnoses (1FP or 3%). Similar to what happened to OAT treatment during the pandemic, the changes seen as positive in the case of HCV related to facilitated online consultations and increased length of take-home medication.

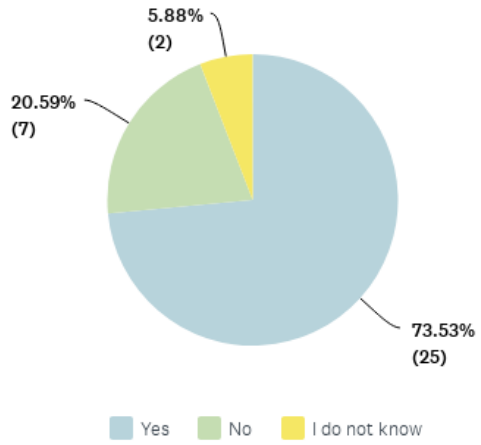
> *"Before the pandemic, there were very few online services (online consultations, etc.) in Tallinn, but this time it showed us that these services online are needed. Harm reduction started more actively testing clients via rapid testing for HCV."*
> *(FP **Tallinn, Estonia**)*

> *"In the first wave of the pandemic, the impact on HCV testing was negative due to the limitation of the face-to-face interventions. In further months, all these interventions resumed. The HCV treatment has the same quality as before, however it was simplified - the number of visits to the doctor decreased and medicines were dispensed for a longer period."*
> *(FP **Prague, Czech Republic**)*

COVID-19 VACCINATION

2021 saw the arrival of vaccinations against COVID-19 in all European countries. The set-up for priorities when receiving the vaccinations varied across countries, with certain professions being considered essential, having service provision continued during the pandemic and, therefore, receiving priority for vaccination. Several harm reduction providers kept their doors open and activities running throughout lockdowns, but not in all cases were they considered essential workers and had facilitated access to vaccinations.

Figure 9: Where health care professionals in drug treatment and harm reduction services considered essential workers and have been, or are in the process of being, vaccinated? (n=34)



In most (75% or 25 out of 34) of the C-EHRN FP countries, health care harm reduction staff were considered essential workers and were in the process of being vaccinated in the period when data was collected (May-July 2021). Even among these cases, however, harm reduction staff who were social workers, psychologists or outreach peers were sometimes not considered essential like their health colleagues. In 7 other cases (20%), harm reduction staff were not considered essential and did not have priority for vaccination. This occurred in Portugal, North Macedonia, Finland, Sweden, Slovenia, Luxembourg and the Netherlands. FPs in Tbilisi (Georgia) and Novi Sad (Serbia) where not aware of the situation.

A few examples where harm reduction staff were prioritised for COVD-19 vaccinations:

> *"All harm reduction staff had priority to COVID-19 vaccination."*
> *(FP **Bucharest, Romania**)*

> *We were identified as a priority group and had access to vaccination early in the process."*
> *(FP **Krakow, Poland**)*

> *Staff in communities were vaccinated significantly later than staff in hospital systems."*
> *(FP **Copenhagen, Denmark**)*

> *Health workers were vaccinated among the first categories, but HR professionals were not recognised as a high risk category, so people from HR services were vaccinated on their own. (Our organisation managed to organise vaccination for all employees)."*
> *(FP **Podgorica, Montenegro**)*

> *Health care professionals were vaccinated at the beginning of 2021, harm reduction staff in the Spring of 2021."*
> *(FP **Tallinn, Estonia**)*

> *Teams of HR services (professionals, volunteers, peers) were vaccinated in Febraury 2021."*
> *(FP **Barcelona, Spain**)*

> *Medical and social services staff were prioritised."*
> *(FP **Milan, Italy**)*

> *After a long time!!!!!! Finally, at the beginning of this year, there was a general vaccination for health care workers. Subsequently, people working in social services were also vaccinated - mainly in response to the spread of the infection among the homeless."*
> *(FP **Prague, Czech Republic**)*

> *IHR workers were vaccinated in the first round along with doctors and nurses in january 2021"*
> *(FP **Antwerp, Belgium**)*

> *Our organisation was able to get the vaccine at the beginning of vaccination in January with health personnel."*
> *(FP **Bratislava, Slovakia**)*

Below are a few examples of countries where harm reduction staff were not prioritised.

> *Once we have received the vaccines, the health care professionals are first vaccinated. People involved in harm reduction services asked to be vaccinated but we did not receive a response from the authorities. There are enough vaccines in this period, so anyone can get vaccinated."*
> *(FP **Skopje, North Macedonia**)*

> *Professionals in drug treatment were considered essential, but not the HR professionals."*
> *(FP **Portugal**)*

> *We were vaccinated in the first wave."*
> *(FP **Rijeka, Croatia**)*

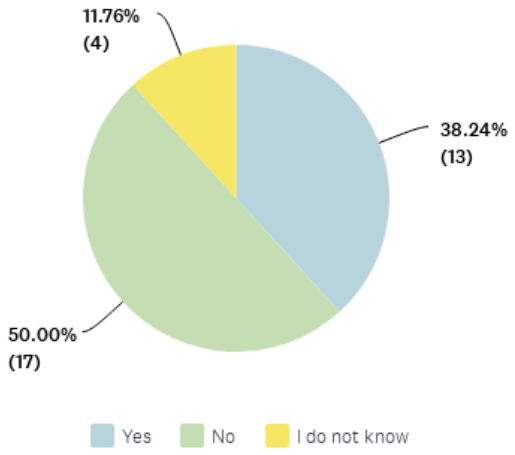
> *Only nurses had been vaccinated but not psychologists, social workers or others."*
> *(FP **Luxembourg**)*

> *Health care professionals were one of the first groups to receive vaccination. However, staff working in low-threshold facilities, such as drop-in centres, are not considered to be a priority group. That said, pretty much everybody above 18 can plan a vaccination appointment now."*
> *(FP **Amsterdam, the Netherlands**)*

Vaccinations for clients of harm reduction programmes are also of extreme importance given the vulnerability of many among the assisted groups. Some studies predicted [9] there would be a low uptake of the COVID-19 vaccine in the population of people who use drugs based on the suboptimal Hepatitis A and B virus vaccination rates observed within this group in the past. Suggested reasons for these low rates include perceived difficulties in delivering health promotion messages to the community; the perceived distrust by PWUD of health professionals; gap(s) between schedules which may add a layer of complexity and increase the risk of individuals not seeing the schedule through to completion.

Harm reduction services can offer low threshold access to vaccination for people who use drugs in a place where they are used to frequent, and have developed trustful, relationships with staff. C-EHRN FPs were asked whether harm reduction services in their cities have been involved in the national vaccination strategies to reach people who use drugs. Only in 13 out of 34 cities this was reported to be the case: Nicosia (Cyprus), Copenhagen (Denmark), Helsinki (Finland), Stockholm (Sweden), Vienna (Austria), Barcelona (Spain), Paris (France), Portugal, Bratislava (Slovakia), Dublin (Ireland), Luxembourg, Antwerp (Belgium) and (Bern) Switzerland.

Figure 10: Have harm reduction services in your city been actively involved in the national vaccination strategies to reach PWUD? (n=34)



In an open box, FPs were asked to comment on harm reduction and impact on PWUD of the COVID pandemic (between August 2020 and July 2021), especially considering the modifications that occurred when compared to the previous period covered by the monitoring. The picture is mixed, bringing several challenges but also a few gains due to the pandemic.

The FP in Copenhagen explains their participation on vaccination for people who use drugs:

> *"After an outbreak in December 2020 – January 2021, there was a significant rise in interest from the local hospital region and the national board of health which led to the delegation of vaccination procedures and access to vaccines to the city outreach team and DCR staff. We have been involved in direct vaccination or helping PWUD to get vaccinated locally at a vaccination centre close to a DCR and more than 1,100 homeless and PWUD has been vaccinated twice."*
> *(FP **Copenhagen, Denmark**)*

FPs in Helsinki, Podgorica, Tallinn, Kyiv, Bratislava, Albania, Prague and Antwerp talk about the adaptations made in their services, including many times the extension of services to better reach the population during lockdowns and restrictions. Challenges for organisations include the lack of funding and medicines, as well as staff stress and burnout. Challenges the pandemic brought to clients include mental health strain and worsening health conditions:

> *"We had an increase in networking for advocacy and co-operation, but also less customer places for low threshold services which led to people having to wait outdoors in the winter."*
> *(FP **Helsinki, Finland**)*

"At no point since the first case of the COVID epidemic has occurred has our organisation stopped providing services to categories at increased risk. What we had to do was adjust the working hours in relation to the health measures that were issued by the State. During the first wave of the COVID epidemic, we expanded the already existing laundry and drying service because the very focus of the fight against COVID was focused on enhanced personal hygiene. Also, due to the impossibility of socialisation or establishing contacts with the social network by clients as usual, we found that there was an increased need for support, especially psycho-social, so in addition to such support within the Drop-in Centre and in the field, we began to provide it through online platforms and telephone counseling, which has been of paramount importance to our clients. Also, during this period we managed to establish another new service, temporarily, during the first 8 weeks of the epidemic in our country and these are lunch packages that we distributed every week, for a period of 7 days for the 50 most vulnerable clients and their families. Regarding clients and their practices during the COVID-19 epidemic, we have noticed that due to the availability of cocaine, the use of this substance has increased, by injection less often by taking it by snorting. Also, combining alcohol with prescription tablets as well as tablets bought on the black market has become common."
*(FP **Podgorica, Montenegro**)*

"The situation has improved compared to the beginning of 2020. Services are more accessible and opening hours are clearer. However, there are still problems with clients' mental health, providing help/support is difficult, because queues to see a psychiatrist are very long, etc. We regularly come into contact with clients who have mental problems or dual diagnoses and it is very difficult to provide help. As a result, many harm reduction workers experience exhaustion and burnout."
*(FP **Tallinn, Estonia**)*

"Since 2018, our country has been implementing the Transition Plan, according to which the Government of Ukraine provides a transition from funding for TB and HIV/AIDS programmes by the Global Fund to ensure the implementation of these programmes with the State budget funding and public administration of these programmes. In mid-2019, an active phase of this process began – the State procured a basic package of HIV prevention services and services for the care and support of people living with HIV. For Ukraine, this is an unprecedented success in ensuring the sustainability of HIV/AIDS programmes, a demonstration of the State's readiness to invest in maintaining of the results achieved during international assistance. At the same time, for non-governmental organisations that have been implementing prevention programmes on-the-ground for years, and for Convictus Ukraine, this has become a time of new challenges. In 2020, Ukraine and the whole world faced the global challenges of the COVID-19 pandemic. The Ukrainian health care system went on a stress test and the continuity of services for the prevention, treatment of HIV/AIDS and tuberculosis has become important. Quarantine restrictions have completely reformatted lifestyles and communication models. Our Organisation was forced to react quickly, to make decisions on models of providing services to most-at-risk populations in order to prevent their interruption. We managed to ensure the full operation of programmes for prevention and access to HIV treatment for most-at-risk populations in Kyiv Oblast. The implementation of a unique model on the basis of our organisation in Kyiv – a testing room and instant registration and provision of

ARV therapy – has played a key role in ensuring the access of the most-at-risk populations to medical examination and treatment of HIV. Thus, in the difficult conditions of the pandemic, the Organisation ensured the unimpeded registration of clients for dispensary enrolment and provision of ART."
*(FP **Kyiv, Ukraine**)*

"*There was a cut in funding from the Ministry of Health in 2021; this grant is the only grant from government for HR services and it's for HR material. Right now, we are in the process of advocating for the re-opening of the grant scheme. We have a verbal yes from an official from the Ministry of Health but are still waiting for the grant to open."*
*(FP **Bratislava, Slovakia**)*

"*There was a shortage of methadone because of lack of transportation available for a period of 30 days between 25 June 2020 and 21 July 2021."*
*(FP **Albania**)*

"*Rough times indeed. The number of distributed syringes, needles and paraphernalia increased significantly in the last year. In an effort to reduce the number of contacts during a pandemic, it was possible to supply more injection sets per visit than we were used to before. It also seems that the health condition of our clients has got worse, they have asked for nursing and other medical services more often. For many PWUD, the pandemic was an opportunity to find some kind of accommodation – many disused hostels have offered their capacity to NGO's and to the homeless people. SANANIM also provided OST in an accommodation facility for COVID-19-positive homeless people. Harm reduction services have proven to be very flexible."*
*(FP **Prague, Czech Republic**)*

"*For PWUD at the Free Clinic, things did not change a lot, services were open, more day shelters, no change in availablitity or big changes in prices for dope. Nightlife: We expect that the tolerance of substance use will be different as we think that most PWUD in nightlife haven't used drugs at the same amount as they did before COVID. As Safe 'n Sound isn't that big of an organization, they have to select which events they will attend in the last part of the year 2021 and which did not. Safe 'n Sound is the only organisation in Flanders that provides peer support, information and harm reduction in nightlife. Together with Quality Nights (a charter that events, clubs and bars signed in order to provide services to make their nightlife space a safe space for trained staff, information about alcohol and other drugs, free earplugs, condoms, free water, safe transport, etc.) they can decrease the risks due to partying or using (illegal) partydrugs. More funding for prevention, harm reduction and peer support in nightlife would change lives and reduce the harm allied to nightlife and using drugs in nightlife."*
*(FP **Antwerp, Belgium**)*

CONCLUSIONS

In the period from August 2020 to June 2021, most C-EHRN FPs reported that the COVID-19 pandemic was still affecting their daily practices, although that was happening in less cities when compared to the previously reported period (up to July 2020). In 2021, less services struggled with limited COVID-19 protective equipment for staff and users, but reduced numbers of staff became a problem for some facilities, both due to COVID-19 cases and burnout. Harm reduction staff had to cope with an increased workload, less partner services to refer clients to, and the fear of being infected with COVID-19 at work. This, together with the overall challenges related to the pandemic, led to burnout and psychological distress being at the top of the list of the difficulties harm reduction staff had to cope with.

Psychological distress was regarded as also one of the main challenges to cope with for people who use drugs, at least in the perspective of C-EHRN FPs. This included social isolation and increased mental health problems, besides limited access to medical and harm reduction services such as DCRs and drug checking. This shows that it is possible that a return to group and social activities in existing services, as well as increased psychosocial and mental health support, may be needed. A lack of DCRs and drug checking services were also pointed out by FPs when evaluating the availability of essential harm reduction services in their cities and countries, as well as when assessing overdose prevention activities.

In the evaluation of C-EHRN FPs, the COVID-19 pandemic affected both overdose and HCV care service provision. In comparison to the previous reporting period, more FPs saw an increase in overdose due to the pandemic in 2021. Regarding HCV, the highest negative impact was reported to be in HCV testing, treatment and awareness campaigns.

Fortunately, the pandemic also brought opportunities for positive innovations in the harm reduction field. In the first reporting period (up to July 2020), C-EHRN FPs reported an increase in the length of OAT prescriptions and take-home doses, telemedicine, increased availability of housing and shelter for those experiencing homelessness and increased distribution of both OAT and naloxone via outreach. In 2021 (up to July), some of these changes had been maintained, notably a lower threshold for accessing OAT, including lower waiting times to start treatment and telemedicine and increased access to naloxone in the few places that this occurred. The increased length of OAT prescriptions, added outreach services and home delivery of OAT were only partially maintained, showing that more advocacy and research on the results of lower threshold access to OAT may be needed. Another area in need of attention is housing or shelter for those experiencing homelessness, maintained in only about half of the cases.

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C-EHRN envisions a fair and more inclusive Europe, in which people who use drugs, including other related vulnerable and marginalized people, have equal and universal access to health and social services without being discriminated against and stigmatized.

We advocate for a harm reduction approach that is based on solid evidence and on human rights principles, and addresses both health and social aspects of drug use.