



Regional Overview

2.3 Western Europe



WESTERN EUROPE

Table 2.3.1: Epidemiology of HIV and viral hepatitis, and harm reduction responses in Western Europe

Country/ territory with reported injecting drug use	People who inject drugs ⁽¹⁾	HIV prevalence among people who inject drugs (%) ⁽²⁾	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%) ⁽³⁾	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) ⁽⁴⁾	Harm reduction response		
					NSP ^{(6, 7)a} 	OST ^{(8) b} 	DCR ⁽⁵⁾ 
Andorra	nk	nk	nk	nk	nk	✗	✗
Austria	11,000-15,000 ⁽⁹⁾	10.5	51.3 (33.9-74.1)	1-44.1 ⁽⁹⁾	✓37	✓(B, M, O)	✗
Belgium	25,295 (17,638-35,699)	0.0-5.7	17.1-75.1 ^c	0.1.9	✓96	✓140 (B, H, M)	✗
Cyprus	291 (216-427)	0-1.6	43.1	0.9	✓1	✓2 (B, O)	✗
Denmark	12,754 (10,066-16,821) ^d	2.1	52.5	1.3 ^e	✓	✓(B, H, M)	5
Finland	15,611 (13,770-22,665) ^f	1.19 ^g	74 ^h	nk	✓40	✓(B, M, O)	✗
France	122,000 ⁱ	6.2 ^j	63.8 ^k	0.8 ^l	✓583	✓(B, M, O)	1 ⁽¹⁰⁾
Germany	94,250 (56,000-169,500) ⁽¹¹⁾	1.6-9.1 ^m	62.6-73 ⁿ	0.1-6.3 ^o	✓156	✓(B, H, M)	24
Greece	5,120 (4,209-6,303)	6.4-8.5	66.7-73.5	1.9-2.8	✓16	✓56(B, M, O)	✗
Iceland	nk	nk	63 ^p	nk	nk	✓(B, M)	✗
Ireland	6,289 (4,694-7,884) ^{(12)q}	6 ^r	41.5 ^s	0.5 ^t	✓143	✓721(B, M, O)	✗
Italy	326,000 ^u	30.1	54	12.1 ⁽¹³⁾	✓620	✓(B, M, O)	✗
Luxembourg	1907 (1,524-2,301) ^v	4.5	80.7-90.7 ^w	nk	✓8	✓(B, M, O)	1
Malta	1,524-2,301	0	14.7	1.8 ⁽¹⁴⁾	✓7	✓(B, M)	✗
Monaco	nk	nk	nk	nk	✓nk	✓1 ⁽²⁵⁾	✗
Netherlands	2,390 (2,336-2,444) ^x	0	66.7 ^y	0	✓175	✓(B, H, M)	31
Norway	8,145 (6,948-9,842) ^z	2.4	62.1	0.9 ^{aa}	✓33	✓(B, M)	1
Portugal	14,426 (12,732-16,101) ^{bb}	14.7	84.4	5.2	✓	✓(B, M)	✗
Spain	9,879 (7,971-11,786) ^{cc}	30.6 ^{dd}	nk	nk	✓1578	✓(B, H, M)	12
Sweden	8,021 ^{ee}	7.4 ^{ff}	96.8 ^{gg}	nk	✓6	✓110(B, M)	✗
Switzerland	31,653 (24,907-38,399) ^{(12)hh}	nk	nk	nk	✓	✓(B, H, M, O)	12
Turkey	nk	0.2	42.8	4.2	✗	✓(B)	✗
UK	122,894 (117,370-131,869) ⁽¹⁶⁾	1 ⁽¹⁶⁾	50 ⁽¹⁶⁾ⁱⁱ	0.2 ^{jj}	✓1,523	✓(B, H, M, O)	✗

nk = not known

^a Figure is based on total number of fixed sites (including specialist agency sites, vending machines, pharmacy-based services and prison-based services) combined with total number of mobile sites (outreach workers and services carried out by a van). Data is from 2014 unless otherwise stated.

^b (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine). Figures for the number of sites are often not available in Western Europe due to a variety of service providers which include general practitioners.

^c Estimate is based on sub-national data 2014.

^d Estimate based on Global State of Harm Reduction 2014 report. No new data available.

^e Year of estimate: 2007. See: reference 9.

^f Year of estimate 2012.

^g Estimate is based on sub-national data from 2014.

^h Estimate is based on sub-national data from 2014.

ⁱ Year of estimate: 1999.

^j Estimate is based on sub-national data from 2011/12.

^k Estimate is based on sub-national data from 2011.

^l Estimate is based on sub-national data from 2011.

^m Figure is based on sub-national data from 2013/14.

ⁿ Estimate is based on sub-national data from 2013/14.

^o Estimate is based on sub-national data from 2013/14.

^p Year of estimate: 1990-1993.

^q Year of estimate: 1996.

^r Year of estimate: 2010.

^s Year of estimate: 2010.

^t Year of estimate: 2010.

^u Year of estimate: 1996.

^v Year of estimate: 2009.

^w Year of estimate: 2005.

^x Year of estimate: 2008.

^y Year of estimate: 2014.

^z Year of estimate: 2013.

^{aa} Estimate is based on sub-national data from 2012.

^{bb} Year of estimate: 2012.

^{cc} Year of estimate: 2013.

^{dd} Year of estimate: 2013.

^{ee} Year of estimate: 2008-2011.

^{ff} Estimate is based on sub-national data from 2012.

^{gg} Year of estimate: 2007.

^{hh} Year of estimate: 1997.

ⁱⁱ Estimate is based on sub-national data from 2014.

^{jj} Estimate is based on sub-national data from 2014.



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



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

Harm reduction in Western Europe

Overview

In much of Europe, HIV rates among people who inject drugs are reported to be stable or declining, with 1,236 newly reported drug-injection related HIV diagnoses in the European Union in 2014, the lowest number reported in more than a decade.⁽¹⁷⁾ A recent UNAIDS report estimates there to be between 719,000 to 914,000 people who inject drugs in Western Europe, with HIV incidence among this population estimated to be 0.8%.⁽¹⁸⁾ The low rates of HIV infection can be attributed to early scale-up of harm reduction measures in many countries.⁽¹⁹⁾ Localised outbreaks of new HIV infections among people who inject drugs have been documented, however, in Ireland, Scotland, and Luxembourg in 2015.⁽¹⁷⁾ In Ireland, data from 2014 indicated that among the 359 people newly diagnosed with HIV, 25 were linked to unsafe injecting, a rise from previous years.⁽¹⁷⁾ An epidemiological investigation has been launched to determine the reasons behind this increase.⁽¹⁷⁾

Changes in drug use patterns, particularly increased amphetamine-type stimulant (ATS) injecting, and high levels of marginalisation have been common factors in a number of the recent HIV outbreaks in Western Europe.⁽¹⁷⁾ Crystalline methamphetamine is reported to be increasing in availability, including in countries where methamphetamine use has not been commonly reported in the past. For example, according to the Federal Criminal Police Office in Germany, the number of first-time crystalline methamphetamine users increased by almost 7% in 2013.⁽²⁰⁾ The region has also seen a rise in the use of synthetic ATS substances such as mephedrone. Although first synthesised in 1929, mephedrone did not become widely available until 2007, and has now been placed under national legislative controls in a total of 31 countries.⁽²¹⁾ Since mephedrone was scheduled under Article 2 of the Convention on Psychotropic Substances and made an illicit drug, the United Kingdom has been the only country in Europe to conduct repeat surveys on mephedrone use. According to the Crime Survey for England and Wales (CSEW) 2011/12, mephedrone had the highest annual prevalence rate of any ATS, ranking fourth among the general population, and third among those aged between 16-24.⁽²⁰⁾ There are currently relatively few harm reduction programmes for people who use ATS. In light of this, in 2015, Harm Reduction International produced a report synthesising available data and programme

experience in this area, noting the ways in which harm reduction programmes can respond effectively to reduce the harms that can be associated with ATS use.⁽²²⁾

Although Western Europe is home to many of the strongest national harm reduction programmes in the world, with the vast majority of countries offering needle and syringe programme (NSP) provision and half of all opioid users accessing opioid substitution therapies (OST),⁽²³⁾ there are still important gaps in service provision. For example, access to hepatitis C treatment for people who inject drugs remains consistently low and new direct-acting antivirals (DAAs) continue to be priced out of reach. A myriad of factors, including criminalisation, stigma and inadequate medical and social services contribute to disproportionately high mortality and morbidity among people who use drugs in Europe, and overdose continues to be a major cause of death.

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

In Western Europe, NSPs operate in 19 of the 23 countries (please refer to Table 2.3.1), to greater or lesser degrees. In a few of the countries in the region, the annual number of syringes distributed per person who injects drugs per year approaches the UN recommended high coverage level of 200.^(25, 26) Since the *Global State* last reported, the number of NSPs has declined in Austria, Belgium, Finland, Germany, Luxembourg, and Norway, with a large decrease in service provision seen in Portugal (from 1,270 to 590) and Spain (from 2,386 NSPs to 1,578).⁽²⁷⁾

In Austria, syringes are available at 15 fixed sites, there are also 20 syringe vending machines located in five provinces, and five sites serviced by outreach workers. Syringe vending machines are also available in Luxembourg⁽²⁸⁾ and Germany, the latter having the highest number of syringe vending machines in the world (approximately 160 across nine of its 16 federal states).⁽²⁹⁾ Although Germany's NSP service currently spans 180 cities, there is still a need for increased investment, particularly in light of the declining numbers of NSP sites.⁽³⁰⁾ In the majority of countries in the region, needles and syringes can be also be purchased without a medical prescription at most pharmacies, which play



a vital role in providing NSP services.⁽³¹⁾ In the Flemish region of Belgium, annual evaluations of the needle and syringe programmes indicated that pharmacies play an important role, with almost two-thirds of people who inject drugs reporting purchasing needles through this medium as opposed to NSP sites.⁽³²⁾ Pharmacy provision often ensures that even where NSP sites do not cover a wide geographical area, sterile injecting equipment is still available to people. However, pharmacy staff are often not equipped with the expertise to provide harm reduction advice and will be unlikely to have had training in this area.

NSP service delivery varies widely across Western Europe. In Belgium in 2014, approximately 926,000 syringes were distributed through 51 specialised agencies and 14 sites serviced by outreach workers, coordinated by the Free Clinic in the Flemish community and by Modus Vivendi in the French community.⁽³²⁾ In Portugal, the National Commission for the Fight Against AIDS (Comissão Nacional de Luta Contra a SIDA), in cooperation with the National Association of Pharmacies (Associação Nacional de Farmácias), implements the national needle and syringe programme “Say No to a Second-Hand Syringe”, which was established over twenty years ago to prevent HIV transmission among people who inject drugs. The programme involves pharmacies, primary care health centres and NGOs, and includes several mobile units.⁽³³⁾ In 2012, a mobile medical care unit was launched in Luxembourg as an additional service to the five fixed sites and three vending machines, and facilitated the provision of primary medical care at low-threshold harm reduction centres.⁽²⁸⁾ It is reported that most of those registered as people who inject drugs in the country^{kk} were then able to obtain syringes from specialised agencies as well as pharmacies. Drug services in Luxembourg are decentralised and most commonly provided by state-accredited NGOs financed by the government. Many of the specialised agencies providing NSP have signed agreements with the Ministry of Health which guarantee their annual funding.⁽²⁸⁾ However, civil society organisations report that there have been problems with harm reduction funding for measures such as NSPs.⁽³⁴⁾

Even in countries with relatively good levels of NSP coverage, important gaps exist. Reaching migrant communities, especially undocumented migrants, is difficult and many services still do not allow the provision of needles for people under the age of 18, which is now an explicit recommendation within UN technical guidance.⁽³⁵⁾ In Greece, an urgent priority to respond

to the needs of the refugee population is reported to have affected mobile NSP provision. In 2015, 368,000 syringes were distributed, a decrease from 2014 figures, even though a further two sites had been initiated. This decrease was attributed to a re-focusing of three out of four mobile sites to the needs of refugee.⁽³⁶⁾

Opioid substitution therapy (OST)

There were an estimated 644,000 people who use opioids receiving OST in Western Europe in 2014, equating to about half of all people using opioids in the region.⁽²³⁾ Coverage rates vary widely across the region, however, from low coverage in Cyprus, for example, to high coverage in countries such as France and Portugal. Methadone remains the most commonly prescribed form of opioid substitute, received by 61% of those receiving OST.⁽²³⁾ OST in the region is prescribed from various sites, including healthcare centres, specialist treatment facilities, via general practitioners, and outreach services. Due to this dispersal of prescription sites, the actual numbers of OST sites in countries within the region are often difficult to determine.

In some countries, national OST coverage may reach UN-recommended levels, while at the local level there may be some regions or some populations in those countries for whom coverage remains inadequate. In Germany for example, although OST is estimated to be received by 30-50% of people who inject drugs,⁽³⁷⁾ regulations for prescribing are reported to be overly bureaucratic, serving as a deterrent in attempting to access OST. In 2016, with pressure from prescribing doctors and NGOs, the barriers regarding access were considered by the Federal Ministry of Health in Berlin, and amendments have been made in order to attract a greater number of doctors as OST prescribers.⁽³⁰⁾

In Greece, the Greek Organisation Against Drugs (OKANA) is the only organisation which has legal permission to establish, operate and monitor OST. According to latest available estimates from 2014, a total of 10,266 people who use drugs received OST, with buprenorphine-based treatment being the most predominant substitute. In the Attica region of Athens, where the majority of opioid users are situated, waiting lists to initiate OST still average three years,⁽³⁶⁾ highlighting the inadequacy of harm reduction provision in this area, despite a large scaling-up process which started after the HIV outbreak in 2011.

In Cyprus, OST was introduced in 2007 and is currently only available from two specialised drug treatment service units (one hospital and one private clinic). OST is

^{kk} Réseau Luxembourgeois d'Information sur les Stupéfiants (RELIS) is a multi-sectoral drug monitoring system.

prescribed in the form of oxycodone, dihydrocodeine, buprenorphine, and methadone, but the latter is only used for detoxification purposes. In 2014, 178 people were receiving OST in Cyprus.⁽³⁸⁾ Similarly, Turkey introduced OST in 2009, with buprenorphine and naloxone licensed for use for both detoxification and substitution since 2010. Prior to 2014, OST was only prescribed by psychiatrists, but since 2014 all drug treatment centres licensed by the Ministry of Health have been able to implement OST provision.⁽³⁹⁾

Drug Consumption Room (DCRs)

Alongside other effective harm reduction approaches such as OST⁽⁴⁰⁾ and NSP⁽⁴¹⁾ provision, several countries in the region operate drug consumption rooms (DCRs).⁽⁴²⁾ These are professionally supervised healthcare facilities where people can consume drugs in safe conditions.

The first supervised drug consumption room was opened in Berne, Switzerland in June 1986.⁽⁵⁾ In subsequent years further facilities were established in Germany, the Netherlands, Spain, Norway, Luxembourg, Denmark, Greece, and France.⁽⁵⁾ Currently, there are 87 DCRs operating across eight countries in Western Europe: Denmark, Germany, Luxembourg, Netherlands, Norway, Spain, Switzerland and France.⁽⁵⁾ In 2014, the only DCR available in Greece was closed due to policy makers' failure to adopt the necessary legislative amendments. Both Norway and Luxembourg are preparing to open a second DCR but these may not be in operation until 2018. In January 2016, France approved a six-year trial of drug consumption rooms, with facilities opened in Paris in October 2016.⁽⁵⁾ Switzerland is also planning to open a further DCR in the near future,⁽⁴³⁾ and Ireland is planning to introduce supervised injecting facilities during 2016.⁽⁴⁴⁾

There is often political resistance to DCRs. For example in Bavaria, Germany, despite the high rates of drug-related deaths, the regional government did not issue the required regulation for operating DCRs.⁽³⁰⁾

Viral hepatitis

Although Western Europe has good harm reduction practices and programme provision when compared to the rest of the world, access to hepatitis C treatment for people who inject drugs is still low.^(45, 46) With hepatitis C (HCV) antibody levels among national samples of people who inject drugs between 14-84% in 2012/13, five of the ten countries with national data reported HCV prevalence rates in excess of 50%.⁽¹⁷⁾ In Western Europe, as in the rest of the world, there is a significant gap in data relating to HCV prevalence and access to testing

and treatment for people who inject drugs. However, the limited available data suggest an increasing epidemic among people who inject drugs in the region. Among countries with national trend data for the period 2006-2013 declining HCV prevalence among people who inject drugs was only reported in Norway, whilst six other countries observed an increase.⁽¹⁷⁾

Deaths from HCV related to end stage liver disease and liver cancer doubled during the last decade in the UK, with the majority of people who died being from marginalised and under-served groups in society such as people who inject drugs.⁽⁴⁷⁾ In England and Wales, 50% of people who inject drugs are believed to have contracted HCV, with lower levels in Northern Ireland (23%) and higher levels in Scotland (57%).⁽⁴⁷⁾ In response to this, Scotland has in place a well-funded hepatitis C programme, which makes testing available in low-threshold settings and provides treatment to people who inject drugs.⁽⁴⁸⁾ In France, 344 anonymous screening centres operate and screen for infectious diseases such as HIV and HCV, but as far as the *Global State* is aware, they do not offer treatment options for HCV.⁽⁴⁹⁾

One of the primary barriers in achieving HCV viral suppression is the cost of treatment. A revolution in treatment came about via the approval by the European Commission in January 2014 of direct-acting antivirals (DAAs). However, these new DAAs are expensive when compared to older medicines. In a survey of 21 European Union countries, the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) found that the average cost of three months treatment was around €60,000, whereas treatment with HCV medicines from the previous generation of drugs cost between €17,000 - €26,000.⁽²³⁾ It is clear from Table 2.3.1 that the need for HCV treatment for people who inject drugs is considerable, and that addressing this gap is imperative.

Tuberculosis (TB)

Findings of a report undertaken by the EMCDDA in 2011 suggested that TB in Europe is predominantly concentrated among high-risk groups, such as migrant populations, homeless people, people who use drugs and people in prison.⁽⁵⁰⁾ People who are living with HIV and who inject drugs are two to six times more likely to develop TB than non-injectors, and commonly have co-morbidities with hepatitis B and HCV infection. Despite these facts, data on TB prevalence and treatment access among people who inject drugs in Western Europe continues to be limited. Globally, TB-related deaths among people living with HIV have fallen by 32% since 2004,⁽⁵¹⁾ and in 2014, the percentage of identified HIV-



positive tuberculosis patients who started or continued on antiretroviral therapy (ART) reached 77%.⁽⁵¹⁾

Antiretroviral therapy (ART)

As noted in the overview of this chapter, HIV prevalence rates among people who inject drugs are reported to be stable or declining.⁽¹⁷⁾ In Belgium, for example, only 11 people newly diagnosed with HIV reported injecting drug use as the probable mode of transmission in 2014.⁽⁵²⁾ In the UK, there were an estimated 2,160 people who inject drugs living with HIV in 2014, with approximately 150 new HIV diagnoses believed to be as a result of sharing injecting equipment.⁽¹⁵⁾ The Netherlands has also witnessed a decreasing trend in the annual number of new HIV diagnoses among people who inject drugs.⁽⁵³⁾ Similarly, Greece reported a 12.9% decrease in new HIV diagnoses among people who inject drugs in 2014,⁽⁵⁴⁾ although recent reductions in funding for harm reduction have begun limiting the provision of HIV prevention interventions among this group.

ART is available in principle in all countries in Western Europe, however, in a recent report by the European Centre for Disease Prevention and Control (ECDC) and the EMCDDA, Spain, Greece, Portugal and Sweden all reported people who inject drugs experiencing difficulties in accessing treatment, care and support. Spain also noted a reluctance by service providers to prescribe ART for people who inject drugs due to a lack of services to support adherence to treatment.⁽⁵⁵⁾ Late presentation (where people learn their HIV status at the point when their immune system is already significantly compromised) is often much more common among people who inject drugs,⁽⁵⁵⁾ and late diagnosis was reported in more than half of HIV cases acquired through injecting drug use in Austria (61%), Belgium (57%), Greece (75%), Ireland (56%), Italy (61%), Portugal (59%) and Spain (55%).⁽⁵⁵⁾

Although the information available on the level of access to ART among people who inject drugs is only partial in Western Europe, data continues to suggest that improvements may be needed in social and adherence support for people who inject drugs to ensure ART is made more easily available.

Harm reduction in prisons

Since Portugal decriminalised drugs for personal possession in 2001, there has been a trend towards reducing the likelihood of imprisonment for minor offences related to use and personal possession of drugs in Western Europe.⁽²³⁾ Some countries such as Spain and Italy only apply non-criminal sanctions (e.g. a

fine) for offences relating to drug use and possession,⁽²³⁾ while Ireland recently announced its intention to decriminalise substances including heroin, cocaine and cannabis in the near future.⁽⁵⁶⁾ Despite these positive developments, most western European countries still treat drug use and possession as a criminal offence. In fact, the majority of drug law violations in the region currently relate to use or possession for use, which has resulted in a very large proportion of the prison population comprising of people who use and inject drugs.⁽²³⁾

Injecting drug use in prisons in the region is common. At last count, between 5% and 38% of prisoners in Europe had ever injected drugs,⁽⁵⁷⁾ and between 2% and 31% of prisoners in the European Union, depending on the country, reported having ever injected drugs while in prison.⁽⁵⁸⁾ At the same time, prevalence estimates for HIV (4.6%) and HCV (15.5%) in Western Europe remain considerably higher among the prison population than the broader community.⁽⁵⁹⁾ These figures highlight the need for quality harm reduction services in the region's prisons.

Availability of OST is improving, with all countries apart from Andorra, Cyprus, Iceland and Monaco now providing the service in some or all prisons. Since the *Global State* last reported in 2014, pilot OST programmes have been introduced in two prisons in Greece,⁽⁵⁴⁾ with indications that this service could be scaled up in the future.⁽⁶⁰⁾ OST coverage in prisons is considered high in Austria, France, Ireland, Spain, the UK and Luxembourg,^(61, 62) however there remains considerable room for improvement in terms of accessibility and the quality of the service in many countries in the region. In Finland and Malta, for example, OST is mostly available to prisoners who were receiving it prior to incarceration,^(63, 64) while in the UK, OST is available in all prisons and can be newly initiated, but accessibility is restricted due to time-limited prescribing.⁽⁶⁵⁾ In Portugal and Greece, long waiting times act as a serious barrier to access for many prisoners,^(60, 66) while in Ireland, quality is said to vary by institution.⁽⁶⁷⁾ In Germany, access to, and quality of, OST in prisons varies by region.⁽³⁰⁾ In the German region of Bavaria, for example, OST is not available to prisoners at all. This was very recently the subject of a European Court of Human Rights case, where Germany was ultimately found to be in violation of the prohibition of cruel, inhuman and degrading treatment for denying the applicant access to OST while in detention.⁽⁶⁸⁾

Provision of prison-based NSPs continues to be inadequate in Western Europe, with the service only

available in Spain (22 prisons),⁽⁶⁹⁾ Luxembourg (both prisons),⁽⁶²⁾ Germany (one female prison in Berlin)⁽³⁰⁾ and Switzerland (three prisons).⁽⁴³⁾ An important legal development in France, however, is reason to remain optimistic that this service will soon become more widely available in prison settings in the region. In December 2015, the country enacted a new law (*Loi Santé*), which includes a specific section on compulsory compliance with the principle of equivalence specifically in relation to the provision of harm reduction in prison settings. The law provides that harm reduction services that are available in the broader community, including NSPs, must also be available in prison settings.⁽⁷⁰⁾

Condom provision in Western European prisons varies by country and/or prison. In Spain, for example, condoms are available and easily accessible in all 72 prisons, while in all Belgian and approximately 85% of Swiss prisons, condoms can be accessed discreetly through machines.^(43, 61) Condoms are only available on request at medical services or the prison health service in Finland, Portugal, the Netherlands and France, while in Austria and Denmark, female condoms are only available in approximately half of the prisons detaining female prisoners.⁽⁶¹⁾ In the UK and Germany, condoms are reportedly not available in all prisons,^(30, 65) whereas in Italy and Cyprus, condoms are not available in prisons at all.^(71, 72)

Availability, accessibility and quality of diagnostics, treatment and care for HIV, HCV and TB in the region's prisons also vary. For instance, HIV-related services are reportedly not available to female prisoners in Cyprus,⁽⁷²⁾ while ART is only available in 89% of Italy prisons.⁽⁷¹⁾ In Switzerland, HCV testing and treatment are only available in 85% of prisons,⁽⁴³⁾ while in Finland and Ireland, HCV treatment is only provided to prisoners who use drugs if they are either stable on methadone or have achieved abstinence for a period of time.⁽⁶¹⁾ This type of variable standard of care contravenes international human rights law and standards relating to the treatment of prisoners. Measures must urgently be taken to ensure that all prisoners have equal access to the same quality of services available to the broader community.

Since the *Global State* last reported in 2014, the UK has been implementing a programme across the country that aims to achieve a higher and more uniform standard of care in prisons. The universal 'opt-out' blood born virus (BBV) testing programme, which is expected to be fully implemented in all prisons in England by the end of 2016-17, offers prisoners the chance to be tested for infections near reception and at several time points

thereafter by appropriately trained health care staff. A preliminary evaluation of the programme undertaken in 2015 revealed a near doubling of BBV testing only 6 months after it was introduced.⁽⁷³⁾

Despite people who inject drugs being at particular risk of overdose following release from prison, take-home naloxone kits are still not widely available to prisoners either during their incarceration or following release in Western Europe. In Spain, for example, naloxone is reportedly only available to prisoners in Madrid.⁽⁶¹⁾ As far as we are aware, naloxone is only available in some prisons in Norway, and all prisons in England, Wales and Scotland.⁽⁶¹⁾ Scotland's National Naloxone Programme, which began in 2011 and supplies naloxone kits for home leave and/or on release to those identified as being 'at risk' while in prison, has been recognised as a model of good practice. A recent evaluation of the programme found that it was associated with a 36% reduction in the proportion of opioid-related deaths that occurred in the 4 weeks following release from prison.⁽⁷⁴⁾

“Improving Prison Conditions by Strengthening Infectious Disease Monitoring”, an HRI led project

HRI's two year, EU co-funded project, “Improving Prison Conditions by Strengthening Infectious Disease Monitoring” came to an end in September 2016. Led by HRI and implemented with partners in 7 European countries, this project aimed to improve prison conditions and reduce ill treatment of prisoners by strengthening HIV, HCV, TB and harm reduction monitoring in prisons.

The project mapped HIV, HCV, TB and harm reduction in prisons and current monitoring practices on these issues in Catalonia (Spain), Greece, Ireland, Italy, Latvia, Poland, and Portugal. In each of these countries, rates of HIV, HCV and TB inside prisons were higher than rates in the general population, particularly in Latvia. While each country was found to provide a wide range of harm reduction services in the broader community, the majority failed to provide these same services, or the same quality of these services, in prison settings. Where harm reduction services had been available and easily accessible in prison settings for some time, such as in Catalonia, better health outcomes were observed, including significantly reduced rates of HIV and HCV incidence. A scarcity of systematic and

ⁱⁱ Correct numbers are always difficult to pin down. In 2014, the *Global State* reported that NSPs were available in 38 prisons in Spain based on a UNODC document. This year, we relied on the most recent *Secretaria General de Instituciones Penitenciarias'* annual report (2014, published in 2015), which indicated that only 22 prisons provided the service.



comprehensive monitoring of HIV, HCV, TB and harm reduction in prisons was observed at the national level in all countries surveyed. Overall, the provision of harm reduction in each of these countries' prisons varied considerably, but certain key themes and lessons were distilled, including around features of an enabling environment for harm reduction, resource allocation, collection of data, and accessibility of services.

The project also charted existing European and international public health and human rights standards relating to HIV, HCV, TB and harm reduction, as well as monitoring practice in relation to these issues. This research found that United Nations human rights bodies and the European Court of Human Rights are increasingly finding that issues relating to disease transmission in detention – including the denial of harm reduction services and the inadequate prevention, care or treatment – can contribute to, or even constitute conditions that meet the threshold of ill treatment. In spite of this, however, HIV, HCV, TB and harm reduction are not adequately monitored in the current European and International approach to the prevention of ill treatment in prison settings.

Finally, based on this research, a user-friendly, human rights-based tool was developed, in consultation with an Expert Committee, to generate better informed, more consistent, and sustained monitoring of HIV, HCV, TB and harm reduction in prisons by national, regional and international human rights-based monitoring mechanisms.

For more information on the project, or to access all reports and the monitoring tool, please visit: <https://www.hri.global/prison-project>.

Overdose

Overdose continues to be a major cause of death among people who use drugs in Western Europe, with more than 6,000 deaths among this population each year, many involving opioids.⁽²⁴⁾ In 2012, the six highest national mortality rates associated with drug overdose in Europe were reported by countries located in the north (in descending order): Norway, Ireland, Sweden, Finland, Denmark and the UK.⁽²⁴⁾ The overdose mortality rate in Norway, for example, is comparable to or higher to the overdose mortality rates in the 1990s prior to the introduction of harm reduction measures.⁽²⁴⁾ In the UK, there has been a 64% increase in drug-related deaths

linked to heroin and morphine from 2014-2016, the highest ever recorded in the country.^(65, 75)

The reasons behind these rises in fatal overdose are unclear but a number of factors may be involved including: increased heroin availability and prevalence of its use, higher purity, the increased levels of morbidity linked to an ageing cohort of drug users, as well as changing consumption patterns, including the use of highly potent synthetic opioids and medicines.⁽²³⁾ Overdose is predominantly reported among older opioid users (35-50) but increases in overdose deaths are also seen among the under-25s in some countries (for example, Sweden) warranting closer scrutiny.⁽²³⁾ Whilst heroin remains the most commonly used opioid, synthetic opioids are increasingly used and there has been a rise in the number of countries reporting synthetic opioids as the primary drug used by those entering treatment. Synthetic opioids used in substitution treatment (e.g. methadone, buprenorphine) are also regularly found in toxicology reports and these substances are associated with a substantial share of drug-related deaths in some countries (e.g. Ireland, France, Finland and the UK).⁽²³⁾

In its 2014 *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*, the World Health Organization recommends that people likely to witness a drug overdose (including people who inject drugs and their families and friends) should have access to naloxone and training on how to use it. Naloxone, a highly effective opioid antagonist, often continues to be blocked by administrative barriers in the region, being available by prescription or medical personnel only, rather than for peer-distribution. However, Scotland is the first country in the region to have a nationwide take-home naloxone programme, initially piloted in 2007. The naloxone distribution system targets people who have been in contact with drugs services, including NSP and OST programmes.⁽⁷⁶⁾ Scotland now also distributes naloxone to people who inject drugs at the end of their prison sentence. The Scottish Government's 2014 assessment of the first three years of this programme estimated that over 500 overdose deaths had been averted, and 90% of people who participated said that the programme had helped them to better understand the causes of overdose.⁽⁷⁷⁾ In Italy, naloxone is available over the counter from pharmacies, and take-home naloxone is also distributed through drop-in centres and outreach programmes in the country.⁽⁷⁸⁾

In the spring of 2014, a trial project of nasal naloxone sponsored by the Norwegian Ministry of Health and

care Services was launched in Oslo and Bergen. Within this project, staff working in low-threshold services were trained and overdose response kits distributed to people who use drugs. The project is now being expanded to train police and security staff, staff at detoxification centres, emergency health centres and prisons.⁽⁷⁹⁾ In October 2015, legislative changes were introduced in the UK to increase the availability of naloxone, making this specific drug exempt from prescription-only medicine requirements when it is supplied by drug services commissioned by a local authority or the National Health Service.⁽¹⁶⁾ Overdose prevention remains a relatively neglected issue in much of Western Europe and there is a need for continued advocacy for political and financial support for cost-effective and proven overdose prevention measures such as take-home naloxone programmes⁽⁸⁰⁾ and drug consumption rooms. There is great potential for valuable lessons and experiences to be taken from Scotland and Italy in implementing take-home naloxone programmes to be shared with other countries in the region, and elsewhere.

Policy developments for harm reduction

In comparison to some other regions, Western European HIV policy frameworks have specifically addressed and acknowledged harm reduction as a central component of the HIV response. At the regional level, harm reduction is noted in the European Union Action Plan on HIV/AIDS in the EU and Neighbouring Countries: 2014-2016,⁽⁸¹⁾ which is harmonised with the WHO-led European Action Plan for HIV/AIDS 2012-2015,⁽⁸¹⁾ in which harm reduction is also covered. Attention to harm reduction in European drug policy frameworks is also improving. The EU Drugs Strategy (2013-2020)⁽⁸²⁾ and EU Drugs Action Plan (2013-2016) addresses harm reduction, human rights, civil society engagement and transparency more than in previous European Union drug policy documents. Advocacy and policy work by civil society had a positive impact on support for harm reduction in these processes.

As harm reduction services have become widespread in the region, increasing focus has been placed on service quality, culminating in the adoption of 'Minimum quality standards in drug demand reduction in the European Union' by the EU Council of Ministers in September 2015. Sixteen standards for prevention, treatment, harm reduction and social reintegration set minimum quality benchmarks for interventions. These newly adopted standards represent a major development at the EU

level, and serve to facilitate the sharing of best practice at a European level.⁽²³⁾

During several important international policy processes, the European Union championed harm reduction both regionally and through individual member state support. In April 2016, during the United Nations General Assembly Special Session (UNGASS) on the drugs in New York, Italy, Finland, Norway, Sweden, Germany, the Netherlands, Lichtenstein, Portugal, Greece, Austria, Cyprus, Malta and Belgium all made statements in explicit support of harm reduction.⁽⁸³⁾ The European Union's common position also stated that harm reduction, as a proven effective measure in preventing overdose and the transmission of blood borne diseases, should be further promoted and implemented.⁽⁸³⁾ During the UNGASS roundtable on health and drugs, a Scottish National Party (SNP) Member of Parliament (MP) also made the case for increased investment in harm reduction.

Following the UNGASS, in June 2016, a United Nations General Assembly High-Level Meeting (HLM) on Ending AIDS was held, and a new Political Declaration adopted by United Nations Member States, which charts a course to end AIDS as a public health threat by 2030. This meeting gave governments the opportunity to elaborate on how they intended to meet the target of ending AIDS by 2030. Greece, the UK, the Netherlands and Switzerland explicitly supported harm reduction in their national statements during the HLM. Several other countries including Denmark, Liechtenstein, Germany, Sweden, Norway, Finland, Luxembourg and the EU referred to the need to target interventions towards key populations, with several mentioning people who inject drugs specifically. (See the Global Overview section of this report for more analysis of the outcome for harm reduction within recent high level political processes).

Civil society and advocacy developments for harm reduction

Civil society organisations continue to play a significant role in mobilising and advocating for harm reduction in Western Europe, both at national and regional levels. The European Civil Society Forum on Drugs, modelled after Europe's Civil Society Forum on HIV, is a diverse group representing civil society organisations engaged in service provision and advocacy relating to the prevention of drug use, drug-related treatment, social support services and harm reduction.



The meaningful involvement of people who use drugs in policy development and service delivery is often aided by civil society harm reduction networks, and/or networks of people who use drugs. The European Network of People who Use Drugs (EuroNPUD) was founded in 2011 within the framework of a European Commission-supported project to form the European Harm Reduction Network.⁽⁸⁴⁾ The network was relaunched in 2013 during a side meeting at a peer workshop on HCV and drug use. EuroNPUD is now comprised of an Executive Committee with representation from across the European Region and has identified a number of key thematic areas for focus including NPS, HCV and overdose prevention.⁽⁸⁵⁾

The European Harm Reduction Network lost funding at a regional level in 2014, leaving an important gap remaining for a strong and funded regional harm reduction network. However, a number of other networks continue to progress and have undertaken projects focusing on various aspects of harm reduction. The Correlation network⁽⁸⁶⁾ established the 'Hep C and drug use initiative' in 2013, the purpose of this platform is to reduce the burden of HCV among people who use drugs by promoting universal access to HCV prevention, treatment and care through collaborative activities including research, advocacy and civil society strengthening.⁽⁸⁷⁾ The 'NPS in Europe' is a multi-partner project aiming to increase knowledge and understanding of the risks associated with the use of new psychoactive substances and effective harm reduction responses. This project is undertaken by APDES (Portugal), CUNI (Czech Republic), Rainbow Group (Netherlands), Praxis (Greece), Carusel (Romania), Sananim (Czech Republic) and Monar (Poland).⁽⁸⁸⁾

At national level the existence of harm reduction networks varies across the region. There is no national harm reduction network in Switzerland, however, there are two regional networks on harm reduction in the German and the French parts of Switzerland.⁽⁴³⁾ In the UK there are a number of coalitions, including the National Needle Exchange Forum, UK Harm Reduction Alliance and the Harm Reduction Network. The Naloxone Action Group has also been recently formed to place pressure on local commissioners to pay for naloxone and for amendments to be made in prescribing regulations. This group includes civil society, activists and drug treatment providers.⁽⁶⁵⁾ Germany also has a national network on harm reduction, Akzept, with many smaller state level civil society organisations operating at the local level. Alongside this Germany also has JES, its national network of drug user rights groups, which is one of the oldest in

the world.⁽⁹⁰⁾ National harm reduction networks are also in existence to some extent in Italy, Portugal and France.

Funding: developments for harm reduction

This region contains some of the earliest adopters and long-term implementers of harm reduction and as such, Western European countries are among those globally that invest most heavily in harm reduction. However, there remains much variety in the levels and sustainability of harm reduction funding between and within countries. Limited political support for harm reduction still hinders investment in some countries and austerity measures brought in following the financial crisis continue to affect the sustainability of services in the region.

In 2015 and 2016, HRI and EHRN coordinated an EC funded project called 'Harm Reduction Works!' that aimed to fill a knowledge gap on harm reduction funding across EU member states and build the capacity of civil society to call for strategic investment into harm reduction.^{mm} In many countries surveyed, civil society identified the need for greater transparency of harm reduction investment. Spending on key harm reduction interventions such as NSP and OST was challenging in all countries surveyed and gaps in knowledge remain. However, the research did indicate that several countries have seen harm reduction funding cuts in recent years, for example, as a result of national austerity measures. The resultant impact on service provision in Greece, for example, has been marked and there are concerns that the potential for another sharp increase in HIV among people who inject drugs is now apparent. In some countries it was reported that challenges to sustainable, adequate financing for harm reduction were faced at the local level, despite endorsement of the approach in national policies. Six out of twenty Italian regions currently have no harm reduction services in place, for example, while others with supportive local governments have well-functioning harm reduction services.⁽⁷⁸⁾ In the UK, this was also highlighted as an issue, with the expectation that some parts of England will see dramatic cuts to services in the near future.

Most countries in the region cover the majority of the harm reduction investment without external support. While some countries have received international donor support, for example from the Elton John AIDS Foundationⁿⁿ and the European Commission,^{oo} much of this support has decreased or stopped in recent years.

^{mm} A report summarising the research findings is due to be published in the coming months.

ⁿⁿ Elton John AIDS Foundation (EJAF) for example, provided support to the roll-out of a nationwide pharmacy NSP programme since 2011.

^{oo} European Commission funds supported harm reduction scale up in Greece in 2011/2012, in response to the rapid increase in HIV infection among people who inject drugs, but this funding has now stopped.

There are concerns from civil society in many countries that the need for a well-funded harm reduction response is more pressing than ever, with drug use trends changing and NPS and stimulant use increasing. In order for harm reduction approaches in Western European countries to adapt to these new trends, adequate funds and political support is required.



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