CIVIL SOCIETY MONITORING OF HARM REDUCTION IN EUROPE 2022

EXECUTIVE SUMMARY

Correlation
European
Harm Reduction
Network

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C-EHRN FOCAL POINTS

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Switzerland	**Bern**	Infodrog/Radix	Marc Marthaler	Scientific Collaborator
The Netherlands	**Amsterdam**	Mainline Foundation	Machteld Busz	Director
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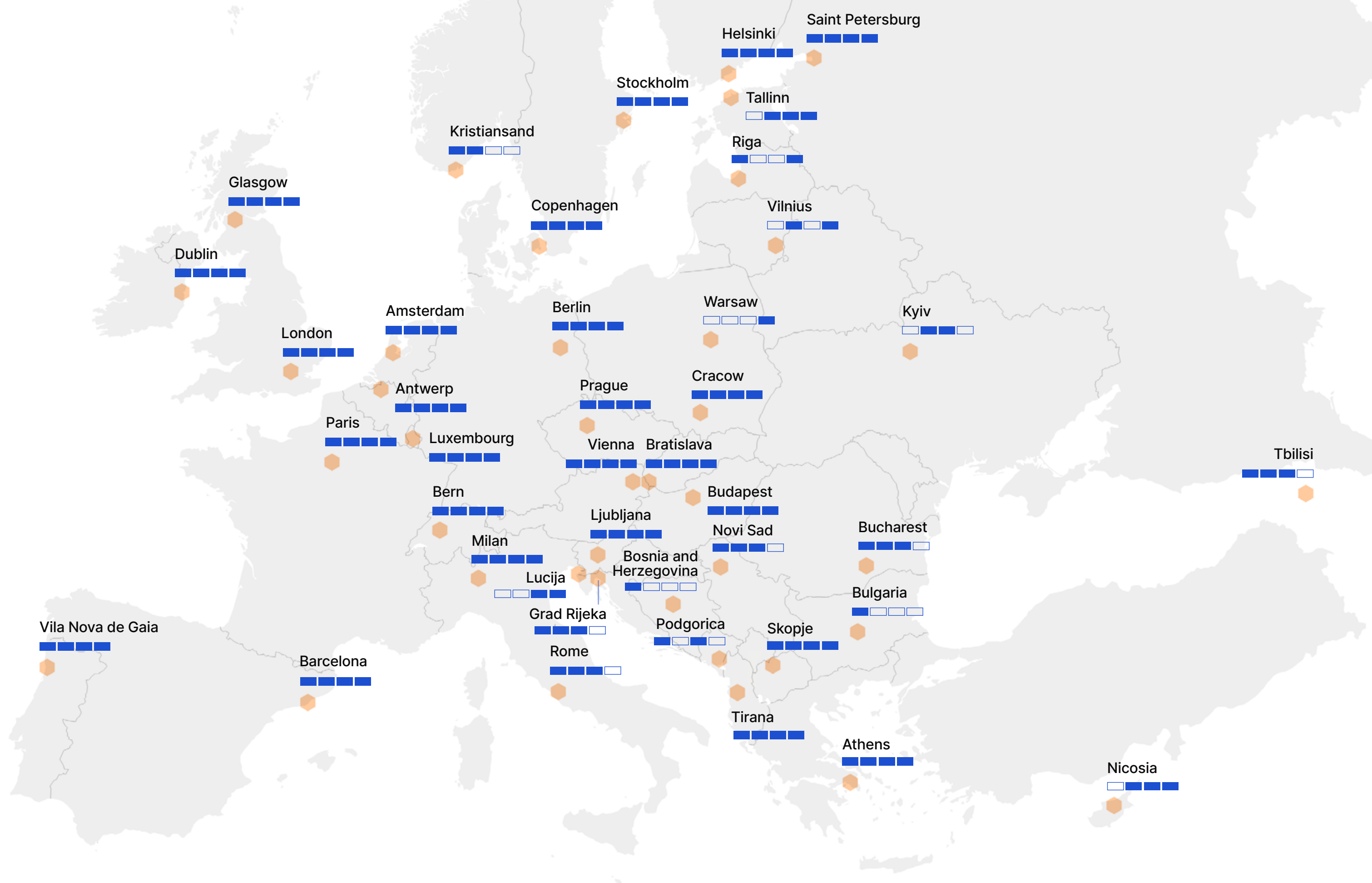
INTRODUCTION

Civil society-led monitoring and evaluation of policy implementation are the essential tools that allow for holding governments accountable. Such independent assessment also contributes to improving existing services and programmes to fit better the needs of people who use drugs. Finally, through reflecting on the experiences and knowledge of local harm reduction service providers, **C-EHRN monitoring also aims to improve knowledge and complement already existing data to support advocacy efforts and inform policy making**.

C-EHRN monitoring reports have been published annually since 2019. The data collection builds on the network of C-EHRN Focal Points (FPs). Hence, information is collected from harm reduction service providers (and, indirectly, service clients) at ground level. Since 2020, the data collection has focused on the local (city) level, with 31 FPs from 30 countries participating in the monitoring in 2022, as shown in the map below. The 2022 monitoring report, for the first time, includes more in-depth data collected via interviews and focus group discussions with FPs and experts, besides the usual online survey.

The map below shows cities involved in the C-EHRN monitoring in 2019-2022.

> ***“Most (70%) of C-EHRN FPs 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.”***



2019 2020 2021 2022

Yes

No

Map: C-EHRN Focal Points location & contribution years. Source: C-EHRN Monitoring Report 2022

ESSENTIAL HARM REDUCTION SERVICES

Overall, harm reduction services seem insufficient in the vast majority of cities participating in the monitoring. Although almost all FPs (except for FP Malta) reported some level of services meeting the needs of people who use drugs, only five (16%) reported a great extent of meeting those needs.

In comparison, 10 (32%) reported an extent below moderate.

In 2022, harm reduction services were delivered to the greatest extent to people who inject or smoke opioids, inject stimulants or NPS, and people experiencing homelessness. The groups that services can reach to the least extent were young people who use drugs (under 18 years old); people in prison settings; people who practice chemsex; and undocumented migrants using drugs. Lack of funding and legal issues (punitive/ restrictive laws and policies) are the dominant

barriers affecting reaching out to specific populations. Between 2020 and 2022, the ability to provide services notably decreased for sex workers, people experiencing homelessness, and women who use drugs.

In terms of prevalence, in 2022, the services most available to people who used drugs were, in descending order, HIV treatment, NSP, HIV prevention, OST, HIV testing, and outreach work. In contrast, extremely low availability was reported for (in ascending order) fentanyl test strips, NSP in prisons, drug consumption rooms, naloxone in prisons, and drug checking. In 2020 and 2022, we can observe notably decreasing availability of peer support and increasing availability of safer smoking kits and intranasal kits.

Harm reduction organisations in all FPs cities collaborate with other services and institutions to reach at least some target populations. In 2022, the cooperation was good in the case of people injecting opiates, experiencing homelessness, injecting stimulants, and smoking opiates. Collaboration was the most challenging (including sometimes non-existent) in the case of undocumented migrants, youth, people practising chemsex, LGBTQI+, and people in the prison setting. Changes in 2020-2022 include a deterioration of cooperation in the case of people who inject stimulants or NSPs, people who practice chemsex, women who use drugs, LGBTQI+ who use drugs, and young people who use drugs.

Harm reduction doesn't seem to be a policy priority, with little political will and funding supporting its implementation. Precarious financing is one of the significant problems in the field, having severe consequences for the services' operation, including staff shortage and harm reduction professionals experiencing uncertainty, lack of job security, difficult working conditions, overworking and burnout.

The availability of services is higher in Western European countries than in Central-Eastern Europe, both in terms of the types of services available and the number of existing services. However, it is characteristic for most countries that harm reduction services are concentrated in large cities (often capitals). In 2022, only one FP reported the coverage of harm reduction services in their cities as lower than in the rest of the country, and only two FPs reported similar coverage.

According to the data, even in 'more developed' Western countries, harm reduction's momentum seems to be over, with decreasing intravenous use and opiate use. The data shows that although the availability of safer smoking and intranasal kits seems to improve slightly, the change in the mindset of the decision-makers doesn't catch up with the changes in the drug market and drug use patterns to a sufficient extent. Harm reduction services are still highly focused on intravenous (and) opiate use, while services for people using stimulants, using through inhalation and intranasally, are scarce. Innovation seems to be in shortage.

HEPATITIS C

Most countries taking part in the 2022 monitoring use some guidelines for Hepatitis C response among people who inject drugs, with 11 countries using their national guidelines, ten countries using EASL guidelines, and six countries using other guidelines. Five countries reported no HCV guidelines related to people who inject drugs. Still, even where appropriate frameworks are in place, some challenges, such as outdated guidelines; complicated testing and treatment systems; lack of services; effects of COVID-19 on testing and treatment; and other disparities between formal guidelines and reality can be seen.

Despite the challenges, Focal Points (FPs) reported a generally positive impact of guidelines, with better access to HCV testing and treatment mentioned by all of them and improved availability of information and services mentioned by 16 and 13 FPs, respectively. On the other hand, nine FPs also reported a negative impact of guidelines, namely, a situation where HCV treatment is prescribed only by specialists or in specialized health care units. Regarding prescribing DAAs, infectious disease specialists are the most common, followed by gastroenterologists and general practitioners.

In 2022, new drugs for HCV treatment (Direct Acting Antivirals, DAAs) were available in all cities, including no-restrictions availability in 19 cities. In nine cities, DAA treatment was reported to be accessible in practice only for people presenting liver fibrosis or cirrhosis.

In case the guidelines allow the use of DAAs for people who inject drugs, this applies to people on OAT (24 cities), people formerly injecting drugs and not on OAT (23 cities), people who ever injected drugs (21 cities), and people currently injecting drugs (19 cities).

In 2022, 18 FPs reported free HCV testing in general, and nine countries only at specific testing sites, such as harm reduction services, drug treatment clinics or community services. In North Macedonia, free testing is not available and requires a prescription. Confirmatory blood testing for HCV RNA and treatment for HCV for people who inject drugs were primarily available at infection disease clinics (73%, compared to 94% in 2021) and gastroenterology clinics (67%). However, integrating testing and treatment at the same location is still rarely the case. Each year, PWID have been most commonly treated for hepatitis C at infectious disease and gastroenterology clinics. In 2022, treatment provided at harm reduction services or community centres decreased significantly.

The great majority of respondents reported that in their countries DAA's are used according to the official policy, and two FPs reported discrepancies between official policy and practice. In 2022, HCV treatment with DAAs was reported to be reimbursed by health insurance or the public health service in most countries, including with no limitations in 16 cities/countries and with restrictions in nine cities/countries. In addition, HCV treatment was also reimbursed for PWID without insurance in nine cities/countries and with some limitations to reimbursement in six. In 10 cities/countries, HCV treatment was not refunded for PWID without insurance. Stigma and

discrimination were monitored and addressed in only six cities participating in the survey. Roughly one-third of the FPs did not know if such activities existed in their cities.

Agreed protocols governed the linkage of care in roughly 37% of cities, with referrals possible by general practitioners in 61% and by harm reduction staff in 36% of cities. In 2022, 16 FPs reported limitations for the harm reduction organizations in addressing HCV in their cities, including lack of funding, care integration, political support, and staff. Monitoring schemes for post-diagnosis follow-up and monitoring of PWID with HCV were in place in 47% of cities; however, the same proportion of FPs did not know if such mechanisms existed.

NEW DRUG TRENDS

The overall conclusion of this year's monitoring exercise is that most FPs report no changes in the use of substances, user groups or services rendered, or demand for services for unmet needs of people who use drugs in the last 12 months. This is in line with previous years' results; however, the number of responses indicating changes seems lower now than before.

As we noticed in previous years, this year's monitoring also showed that these limitations become less predominant year by year. Instead, the information received may be richer, especially since most of the data obtained are roughly in line with the monitoring results of previous years and with trends reported by other sources (such as the increase in the use of crack cocaine in some countries and the increase in people engaging in chemsex).

Only 5 FPs reported that a new or unknown substance entered the market last year and was used by a known target group. This might indicate that changes to local drug markets do not come overnight and that the monitoring timeframe should perhaps include two or three-year intervals rather than just one year.

This year's edition of the data collection included two focus group discussions, which are an attractive and time and cost-efficient alternative to the questionnaire for both FPs and C-EHRN staff. Focus group discussions may also improve the quality of the data collected as this form of data collection allows for asking additional questions for clarification, hence for a better understanding of the local markets.

A recurring issue that seriously limits the ongoing data collection by CSOs is that in most cities, the appearance of a new substance on the local market is based on assumptions rather than on laboratory tests. Therefore, it is strongly recommended that at the city level throughout the EU, drug-checking services are implemented.

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