European HIV Legal Forum

Access to HIV-and co-infection(s) treatment, care and prevention services for people who use drugs

A comparative 10-country report

European HIV LEGAL FORUM

LEGAL NOTICE

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LIST OF ABBREVIATIONS

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AAE	AIDS Action Europe
AIDS	Acquired Immune Deficiency Syndrome
DCR	Drug consumption rooms
ECDC	European Centre for Disease Prevention and Control
EHLF	European HIV Legal Forum
EMCDDA	The European Monitoring Centre for Drugs and Drug Addiction
GBMSM	Gay, bisexual and other men who have sex with men
HAT	Heroin-assisted treatment
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HVA	Hepatitis A virus
NSP	Needle and syringe exchange programme
OST	Opioid substitution therapy
PWID	People who inject drugs
PWUD	People who use drugs
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV / AIDS

EHLF PARTNERS

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INTRODUCTION

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The mission of AIDS Action Europe's European HIV Legal Forum (EHLF) is to develop effective means of improving access to HIV prevention, counselling and testing, treatment, care, and support for all those who have limited access to HIV services due to legal obstacles, through the united efforts of legal and policy experts with the aim of bringing into effect a rights-based approach to health as adopted by the European Commission.

In 2012, following growing interest within the AAE Steering Committee and the broader AAE network for mutual support and joint action on legal issues related to HIV, AAE developed the first steps towards the EHLF, which began with a pilot project initiated by five AAE member organisations (the "EHLF partners") in Hungary, Italy, Netherlands, Switzerland, and the United Kingdom.

The pilot focused on the legal situation affecting access to healthcare of migrants in an irregular situation (also known as "undocumented migrants") who are living with HIV since it was felt by all five EHLF partners that there was an urgent need to act on this issue. A survey was revised by the EHLF partners and rolled out in the partners' countries. The results provided valuable insights into differences in health systems in the five countries and its effects on access to treatment and services for irregular migrants. By documenting the legal situation, providing a comparative analysis of each country's laws and how they were applied, the survey report identified good practice and innovative solutions consistent with international human rights, acting as a catalyst for change where practice remains poor. Following the pilot phase, this EHLF was enlarged and the 2017 report covered 16 European countries legal situation and level of access to HIV- and co-infection services for migrants in an irregular situation.

In the project phase 2018-2019, EHLF partners with coordination from the AIDS Action Europe office produced a 10-country report on access to HIV-, viral hepatitis-, and TB- services for people in prison and other closed settings and a 10-country report on HIV-criminalisation in European Union, which expanded to a 20-country in 2022.

In the project phase of 2021–2022, EHLF focused on the topic of discrimination of PLHIV in healthcare settings and produced an 11-country report on discrimination of PLHIV in healthcare as well as a 6-country report on discrimination of PLHIV working in healthcare.
Following discussions with the AIDS Action Europe Committee and previous EHLF partners, it was decided that the next round of the EHLF (2022–2023) would focus on access to HIV- and co-infection(s) treatment, care and prevention services for people who use drugs (PWUD).

BACKGROUND

BACKGROUND

The Steering Committee of AIDS Action Europe identified tackling stigma and discrimination as a core thematic area that the network should address and work on in the 2022-2026 strategic period. For this strategic period, AAE members identified harm reduction services that are sensitive and responsive to the needs of women and other key populations who are left behind by traditional harm reduction services as a priority in the region and as a core thematic area that AAE should work on.

In the complex field of public health, the juxtaposition of drug use and communicable diseases, particularly HIV and its co-infections, has seen as a pivotal challenge. According to the European Centre for Disease Prevention and Control (ECDC), in recent years Europe has witnessed fluctuating trends in HIV incidences among people who use drugs, with Eastern Europe showing particularly high rates[1]. In 2022, the increased movements of Ukrainian refugees across Europe, and recovery of infectious diseases services after the COVID-19 pandemic resulted in (significantly) increased number of HIV diagnoses compared to the previous year[2].

The transmission of hepatitis C among people who use drugs also remains a substantial concern, highlighting the need for comprehensive co-infection management strategies. The current epidemiological scenario not only impacts individual health outcomes but also reflects broader public health implications, particularly in the light of targets set by international agreements like the Sustainable Development Goals, which aim for good health and well-being for all[3].

The provision of health services to people who use drugs is full of challenges. Stigmatisation and discrimination form a significant barrier, often leading to denied or inferior care[4]. The criminalisation of drug use exacerbates this stigma[5], creating a climate of fear and mistrust towards health services[6]. Furthermore, the lack of integration in health services, where HIV treatment, mental health support, and substance use therapy are often siloed, undermines the efficacy of interventions.

[1]European Centre for Disease Prevention and Control and World Health Organization, HIV/AIDS Surveillance in Europe 2021 : 2020 Data (LU: European Centre for Disease Prevention and Control, 2021), https://data.europa.eu/doi/10.2900/65321.

[2]European Centre for Disease Prevention and Control. and World Health Organization., HIV/AIDS Surveillance in Europe 2023: 2022 Data. (LU: Publications Office, 2023), https://data.europa.eu/doi/10.2900/08930.

[3]Department of Economic and Social Affairs United Nations, 'Sustainable Development Goals', accessed 15 January 2024, https://sdgs.un.org/goals.

[4]James D. Livingston, 'Structural Stigma in Health-Care Contexts for People with Mental Health and Substance Use Issues: A Literature Review', 2020, https://doi.org/10.13140/RG.2.2.21168.17929.

[5]Benjamin D. Scher et al., '"Criminalization Causes the Stigma": Perspectives From People Who Use Drugs', Contemporary Drug Problems 50, no. 3 (September 2023): 402–25, https://doi.org/10.1177/00914509231179226.

[6]Brandon Muncan et al., '"They Look at Us like Junkies": Influences of Drug Use Stigma on the Healthcare Engagement of People Who Inject Drugs in New York City', Harm Reduction Journal 17, no. 1 (December 2020): 53, https://doi.org/10.1186/s12954-020-00399-8.

In addition, harm reduction services, especially in central and southeast parts of Europe and in the EECA countries are systematically underfunded and thus disrupted. Moreover, there is not an adequate legal context for those services, resulting in continued and regular harassment of frontline workers by the police and municipal authorities.

Addressing these challenges necessitates a holistic approach, one that incorporates harm reduction as a cornerstone. Harm reduction strategies, which include needle and syringe programs and opioid agonist treatment, have shown effectiveness in curbing HIV transmission among people who use drugs[7].

The integration of harm reduction into broader health services is crucial for addressing the multifaceted needs of people who use drugs. This also includes the integration of these services with infectious diseases treatment and care, mental health support and broader social services.

Policy plays a pivotal role in shaping the landscape of drug use and communicable disease responses. There has been a gradual shift in Europe from punitive approaches towards more health-centred policies. This shift is evident in the increasing adoption of decriminalisation policies and a focus on harm reduction and health care services for people who use drugs. Such policies align with the 10-10-10 targets under the United Nations' political declaration on HIV /AIDS, which aims to reduce to 10% the proportion of countries with punitive legal and policy environments that impede effective HIV responses[8].

The goal of eliminating hepatitis C by 2030, as part of the World Health Organisation's global health sector strategy on viral hepatitis, further underscores the need for integrated approaches. Achieving this goal requires not only effective treatments but also robust harm reduction and prevention strategies, particularly in the context of people who inject drugs[9].

As we dive deeper into the various aspects of this issue, it becomes evident that addressing the needs of people who use drugs in the context of HIV and co-infection(s) is not just a health issue but also a matter of social justice and human rights. The pursuit of health equity, as enshrined in the SDGs, calls for a comprehensive approach that encompasses harm reduction, integrated care models, and supportive policies. This report aims to explore these dimensions in detail, offering insights into the challenges faced, the progress made, and the path forward in ensuring equitable access to health services for people who use drugs in Europe.

[7]World Health Organization, Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update. (Geneva, Switzerland: World Health Organization, 2016), https://www.afro.who.int/sites/default/files/2017-06/9789241511124-eng.pdf.

[8]UNAIDS, 'Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS.' (UNAIDS, 2021), https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf.

[9]World Health Organization, 'Global Health Sector Strategy on Viral Hepatitis 2016-2021. Towards Ending Viral Hepatitis' (World Health Organization, 2016), https://www.afro.who.int/sites/default/files/2017-06/WHO-HIV-2016.06-eng.pdf.

METHODOLOGY

METHODOLOGY

This study will cover the following 10 European Union Member States: Finland, France, Germany, Greece, Hungary, Italy, Lithuania, Portugal, Romania, and Slovakia.

These countries were chosen due to their differing epidemiological, political, geographical, and economic conditions, ensuring the diversity of contexts existing in the European Union.

EHLF partners from each country were chosen based on their previous and current work on the HIV-and co-infection(s) treatment, care and prevention for people who use drugs from the AAE membership.

The information in the country profile section was provided by the AAE member organisations via a standardised questionnaire and is based on public information and information requested from different relevant institutions, reflecting the situation during the data collection of April – August 2023.

THE QUESTIONNAIRE IS INCLUDED IN ANNEX 1 AND CONTAINED THE FOLLOWING INFORMATION SETS:

PART 1: General data

PART 2: Epidemiological overview

- Incidence among PWUD / PWID
- Main epidemiological trends
- Socio-demographic characteristics of people who use drugs and recent changes.

PART 3: Drug use patterns & trends

PART 4: Drug use & the law

PART 5: Harm reduction services: general issues

- General overview
- General access

PART 6: Harm reduction services: specific matters

- Prevention
- PrEP
- Treatment
- Naloxone and drug checking
- Needle and syringe programmes (NSP)
- Opioid agonist therapy (OAT) and Heroin-assisted treatment (HAT)
- Drug consumption rooms (DCRs)
- Chemsex services
- Prisons

PART 7: Good practice

PART 8: Priorities and ways for improvement.

In addition, desk research was undertaken, and interviews were conducted where relevant to collect complementary information allowing for produce a comprehensive overview of the situation in examined countries. A draft of each country profile was sent back to the participating AAE member organisations for review and verification of the information.

MAIN FINDINGS

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INFECTIOUS DISEASES EPIDEMIOLOGICAL SITUATION

The situation of infectious diseases among people who use drugs in Europe presents a concerning situation, marked by complex relationships. While there has been a general long-term decrease in new HIV cases attributable to injecting drug use, recently, an increase in HIV incidence can be seen in many countries (in some cases, affecting nationals, and in some attributed primarily to migration and an influx of refugees from Ukraine, e.g., in Finland and Germany). The issue of late-stage HIV diagnoses is a concern in France and Portugal.

People who use drugs remain a key population at risk for HIV and co-infections transmission, although the dynamics have evolved. While injecting drug use used to be a predominant mode of transmission, most new infections are now attributed to heterosexual contacts and sex between men. This shift underscores the need for tailored prevention and education efforts to address these changing patterns.

The prevalence of Hepatitis C Virus among people who use drugs is high in all countries included in this report. In contrast to HCV, the situation regarding Hepatitis B Virus is much less severe, with very limited prevalence.

DRUG USE PATTERNS

Drug use patterns in Europe are undergoing significant transformations of preferences and shifting of demographics.

One notable trend is the ageing of the population that has been traditionally the main clients of harm reduction services, that is, people who inject heroin. Ageing of this population was reported in Slovakia, and ageing of people who use drugs in general in Finland and France. Additionally, polydrug use seems to be on the rise, with many individuals using a combination of substances (e.g., heroin and cocaine or methamphetamine)

An important change in drug preferences is the shift away from heroin. In many European countries, there has been a marked decrease in heroin use and a corresponding rise in the consumption of (crack) cocaine (France, Italy), as well as other stimulants, including synthetic (Greece, Hungary). Younger individuals seem to prefer stimulants over opioids and less invasive consumption methods than injecting.

DRUG USE AND LAW

The countries included in this report exhibit diverse approaches to drug laws and policies. In Finland and France, a punitive legal approach prevails with strict sanctions on drug use, while Germany is in the process of evolving its regulations to potentially allow personal possession and cultivation of cannabis. Greece maintains nuanced drug laws that stipulate imprisonment for drug use but exempt individuals diagnosed with drug dependency from punishment. Hungary enforces a punitive policy criminalising drug use since 2013, often pushing casual cannabis users into unnecessary treatment programmes. Calls for drug policy reform and decriminalisation in Hungary have faced significant challenges. Italy distinguishes between personal use and trafficking, leaning towards administrative penalties rather than criminal sanctions. Discussions in Italy are ongoing regarding cannabis legalisation and decriminalisation.

Lithuania's legal landscape is characterised by penalties for drug possession under administrative law, with ongoing debates and challenges surrounding drug regulation and decriminalization. Portugal stands out for its progressive approach, having decriminalised the use and possession of drugs for personal use in 2001. However, drug trafficking and cultivation for personal use remain criminal offenses in Portugal. Legislative proposals are underway to legalise cannabis for adult use in 2024, reflecting the country's forward-thinking drug policy.

Romania has stringent drug laws that criminalise drug possession, with recent proposals aiming to increase penalties for such offenses. Slovakia also maintains strict drug-related policies where drug use itself is not, however, criminalised; still, severe penalties are imposed for drug possession under the Criminal Code based on the quantity and potential doses produced. Despite the stringent legal framework in Slovakia, there is a growing advocacy for reform, particularly concerning cannabis possession. A new draft of the Criminal Code is currently under consideration in parliament with the aim of recalibrating cannabis-related regulations to address quantities and associated penalties.

Each country's unique approach reflects a mix of punitive measures, evolving regulations, decriminalization efforts, and ongoing debates on drug policy reform within their respective contexts.

HARM REDUCTION SERVICES

Harm reduction plays a critical role in national drug policies across the European countries highlighted in the report, reflecting a commitment to addressing drug-related issues with a public health approach. Basic harm reduction services, including opioid agonist treatment and needle and syringe programmes, are available in all the countries examined.

However, other types of harm reduction services often face significant challenges. The distribution of naloxone remains – to a varying extent – limited in many countries, with take-home naloxone programmes being an exception rather than a rule.

Drug checking services and drug consumption rooms are often blocked by stringent legal regulations on drug possession. In extreme cases, such as Slovakia, even needle and syringe programmes operate in a grey zone, with their existence dependent completely on the political will and related interpretation of the law.

Geographical disparities in harm reduction service distribution are evident, affecting accessibilit for individuals in more rural areas. Their availability also varies between regions, especially in countries where regional authorities are responsible for implementation of harm reduction (e.g., Germany, Italy, Slovakia). Funding is a major concern for harm reduction organisations, with many struggling to secure stable financial support, leading to uncertainty and instability in service provision. Integration of harm reduction services with broader health and social services is generally insufficient, limiting the comprehensive support available to people who use drugs. Harm reduction is lacking in prisons.

INFECTIOUS DISEASES SERVICES

Access to preventive measures such as HIV and hepatitis testing is generally ensured across countries. The situation is more difficult with respect to confirmatory testing and treatment, where obstacles like stigma, formal requirements and geographical barriers can hinder some individuals from accessing care.

A positive trend is the increasing prevalence of systems where HIV and HCV treatment are not anymore contingent on drug abstinence, resulting in more equitable healthcare access. However, practical limitations within the healthcare system, including restricted service hours and geographical disparities, pose challenges to comprehensive coverage.

Barriers to access for infectious disease care usually also include requirements of identification documents and/or valid health insurance, which people who use drugs often do not have. Fragmentation of the system, the disconnect between harm reduction and other health and social services hinder the continuity of case as confirmatory testing and HIV / HCV treatment are provided exclusively in medical settings.

Finally, stigmatisation and discrimination of people who use drugs in health care settings is one of the most important barriers affecting access to care.

RECOMMENDATIONS

EQUITABLE SERVICE DISTRIBUTION

Ensure equal access to services throughout the countries. Develop targeted policy frameworks that addresses regional disparities in service provision. Prioritise the allocation of resources to areas with historically limited access, fostering a more equitable distribution of healthcare services for people who use drugs.

PROMOTE COMMUNITY-LED AND LOW-THRESHOLD SERVICES

Fostering an environment where individuals and groups of people who use drugs take ownership over addressing local challenges. Encourage grassroots initiatives by supporting local leaders, activists, and volunteers who wish to create or enhance existing services tailored to their needs. Advocate for removing barriers to exsisting services for people who use drugs.

HEPATITIS C TREATMENT EXPANSION

Formulate and execute a comprehensive strategy to expand access to Hepatitis C treatments. This includes exploring funding mechanisms, streamlining approval processes, and engaging in negotiations with pharmaceutical companies to secure affordable pricing, ensuring widespread availability of life-saving treatments.

DRUG CHECKING SERVICES

Initiate and promote drug checking services as a harm reduction strategy. This involves the establishment of supervised facilities equipped with advanced testing technologies, coupled with educational campaigns to inform individuals about dangerous substances emerging on the market.

DRUG CONSUMPTION ROOMS

Establish and scale up drug consumption rooms for safer drug use. Advocate for and support the creation of safer consumption spaces equipped with hygienic facilities and trained staff. These rooms provide a controlled environment where people who use drugs can engage in safer drug consumption practices, reducing the risks of overdoses and transmission of infectious diseases.

UNIVERSAL HIV TESTING ACCESS

Develop a robust network of HIV testing services accessible throughout the countries. This includes mobile testing units, community clinics, and partnerships with low-threshold harm reduction services. Continuous access to testing is essential for early diagnosis and treatment initiation.

LEGAL ADVOCACY FOR HARM REDUCTION

Engage in proactive legal advocacy efforts to challenge and reform policies hindering harm reduction services. Collaborate with legal experts, advocacy groups, service providers and people who use drugs to address legal barriers and create an enabling environment for the implementation of comprehensive harm reduction strategies.

ENSURE CONTINUITY OF CARE

Establish policies and collaborative frameworks to prevent disruptions in essential services for individuals who use drugs. Develop holistic care plans that transcend institutional boundaries, ensuring a seamless and patient-centred healthcare experience. Engage stakeholders to create a continuous approach to healthcare, reducing the risk of treatment interruptions and enhancing overall health outcomes for people who use drugs.

REGULATORY MEASURES IN PRISONS

Work closely with correctional institutions to establish and enforce regulatory measures supporting harm reduction. Provide necessary training for prison staff, allocate resources for harm reduction services, and create a supportive regulatory framework recognising the unique healthcare needs of individuals who use drugs in prison settings.

HUMAN RIGHTS-CENTRIC DRUG POLICIES

Lead efforts to advocate for a paradigm shift in drug policies, emphasising health and human rights over punitive measures. Collaborate with service providers, human rights organisations, and affected communities to craft policies that prioritise harm reduction and the protection of individual rights.

ELIMINATE PENALTIES FOR DRUG USE

Support legal reforms that eliminate penalties for drug use, ensuring that individuals seeking healthcare services are not subject to punitive measures. This policy aims to reduce stigma, improve access to treatment, and create an environment where individuals feel comfortable seeking help without fear of legal consequences.

FINLAND

INFECTIOUS DISEASES: EPIDEMIOLOGICAL OVERVIEW

Infectious diseases continue to pose significant health challenges worldwide, particularly among populations with high-risk behaviours. In Finland, the incidence rates among people who use drugs have shown variable patterns over the years.

Concerning HIV, recent observations have indicated an increase. In 2022, Finland reported total of 274 new HIV cases, marking a substantial increase from the prior year, with a prevalence of 4.94 cases per 100,000 individuals. Notably, over half of these cases emerged from the hospital district of Helsinki and Uusimaa. Importantly, most new HIV cases in Finland have been identified among foreign nationals, which is largely due to the influx of individuals fleeing the war in Ukraine.

During past years, infections among Finnish citizens have remained relatively low and stable and sex has been the main way of transmission. Between 2018 and 2022, a high rate of infections has been observed among people who inject drugs in Finland in the metropolitan area. The first case was detected in 2018. In 2022, 12 new cases were detected. In total, 23 cases have been reported that were related to the same cluster. Infections have been diagnosed mainly in Finns.

In 2022, 1 148 (21 / 100 000) new hepatitis C infections were reported to the Communicable Diseases Registry, which is the same as in previous years. 61% of infections were found in men. Male cases were concentrated in the 20-39 age group. Incidence rates were highest in the 20-24 age group (74/100 000) and in the 25-29 age groups (58/100 000). The majority (85%) of cases were found in persons of Finnish origin. The majority of these (87%) were infections contracted in Finland.

Injecting drug use was the most prevalent mode of transmission (40%) for HCV. Sexual contacts were reported as the mode of transmission in 8% of cases. The mode of transmission was missing in 48% of cases.

In 2020, four acute IgM antibody-positive cases were reported to the communicable disease register. Hepatitis B (incidence 0.07/100 000). One of the diagnosed persons was born Finland and three abroad. In all cases where the mode of transmission was sexual contact. In 2020, 160 cases of chronic hepatitis B infection were reported (incidence rate 2.89/100 000), which 32% less than in the previous year.

There was a slight increase in the number of TB cases compared to 2021. In 2022 189 TB cases were diagnosed (incidence rate 3.4/100 000). This was 22 (13%) more than in 2021, when there were 167 cases. Of all TB cases, 127 (67%) were pulmonary TB, of which 35 (28%) were cough smear positive, that is, infectious. There were 150 (79%) culture-confirmed TB cases, a higher proportion than in 2021 (74 %).

DRUG USE PATTERNS & TRENDS

The use of drugs, either occasional or more regular, traditionally skews toward younger adults aged 25–34. This demographic remains the most likely to report drug use at some point in their lives, with an especially high prevalence of 54.0% among males. Between 2018 and 2022, a notable shift has occurred with older age groups showing increased drug use prevalence, especially among men.

According to the data of the European Monitoring Centre for Drugs and Drug Addiction, in Finland, slightly over 26% of adults (ages 15-64) has ever used illicit drugs. Meanwhile, the recent drug use (last 12 months) was estimated at 8.7% and current (last 30 days) drug use at 3.7% of the adult population. The prevalence of drug use was significantly higher among young adults, with 16.5% and 6.7%, respectively.

In the year 2018, an estimated 300,000 individuals, integrated within societal structures, reported drug use within the past 12 months. A subsequent estimate in 2020, reflecting on data from 2017, suggested the number of problematic injecting drug users stood at approximately 25,000. Problematic drug use was defined through the aggregation and comparison of various registers, including those for drug use and drunk driving offenses, bringing the total to an estimated range of 31,000 to 44,000 individuals.

The Finnish Institute for Health and Welfare (THL) has documented substance use trends for decades. As of 2022, cannabis remains the most used drug, with its prevalence of lifetime use having seen a fivefold increase from 6 percent in 1992 to 29 percent in 2022. Although other drugs also witnessed an uptick in lifetime use, their proportions were significantly lower than those for cannabis. Stimulants such as amphetamine, ecstasy/MDMA, and cocaine had been tried by 7%, 6%, and 5% percent of the population, respectively.

Despite cocaine not ranking among the most used drugs in nationwide surveys, wastewater analyses, particularly in the southern cities, indicate its use. It is still less prevalent compared to the European average but represents a substantial portion of drug consumption in urban centres like the capital region, Helsinki.

The routes of drug administration are as varied as the substances themselves. Cannabis, for instance, is primarily consumed through smoking and eating. Amphetamine is ingested, snorted, and injected. Benzodiazepines and opioids follow similar patterns, with routes including oral consumption, snorting, and injection. The use of ecstasy mostly involves ingestion and occasional snorting, whereas buprenorphine is injected, and oxycodone is predominantly consumed orally.

DRUG USE AND LAW

In the Finnish legal system, the approach to drug use and possession is highly punitive, with a range of possible measures. According to Chapter 50 § 2 a of the Criminal Code, the illicit use, possession, or attempts to acquire even a small amount of an illicit substance can lead to fines or a maximum of six months' imprisonment. However, in practice, incarceration for drug use is not the norm; more commonly, the police exercise their authority through fines or warnings. Alternatives to criminal sanctions are available presented for those seeking treatment or those whose criminal offence is a consequence of drug dependency. Such individuals can undertake treatment and, if successful, avoid criminal punishment. However, in such systems where no tables of thresholds exist to guide the judiciary system, there is always a risk of non-uniform application of alternatives to criminal sanctions and geographical discrepancies emerging.

Notably, the Finnish legal system does not draw a distinct line between drug use and possession. On the other hand, proof of intent to distribute or the possession of substantial amounts of drugs can escalate the situation to a more serious drug crime.

On the political front, discussions around drug policy are currently on the horizon. The Finnish population is exhibiting shifting attitudes towards drug use. In a survey conducted by THL, nearly two-thirds of survey respondents support the idea of drug consumption rooms, and there is an increasing lean towards the decriminalisation of cannabis.

Despite these changing public opinions, the current right-wing government's stance is rather not reformative. The debate around decriminalisation does not seem to be a pressing issue in the current political climate, despite alarming trends of Finland witnesses one of highest prevalence of injecting drugs (the highest in 2019) and the highest rates of drug-related deaths among young people in Europe.

HARM REDUCTION FRAMEWORK

In Finland, the framework for addressing drug-related issues is rooted in a comprehensive drug policy that balances prevention, harm reduction, and legal enforcement. The country's policy emphasises the reduction of both the supply and demand for narcotics, the minimisation of harms associated with drug use, and the effective delivery of treatment services. The Finnish approach is codified in national policies and legal texts, such as the "Act on the Welfare of Substance Abusers", which mandates municipalities to provide welfare services for people who use drugs and their immediate social networks. These services encompass a spectrum of care ranging from outpatient to inpatient rehabilitation, complemented by support services, including those delivered by peers.

Harm reduction services in Finland are multifaceted, and include health counselling centres, which provide sterile injection equipment, health guidance, testing for communicable diseases, and comprehensive services for managing communicable disease among people who use drugs. These centres are a referral point for various services, including drug dependency treatment and detoxification. Additionally, opioid agonist treatment, accommodation through the housing first model, and provision of clean injection equipment through pharmacies are important elements of the Finnish harm reduction system.

The integration of harm reduction with sexual and reproductive health services, including interventions related to communicable diseases, further exemplifies the Finnish commitment to comprehensive care. These services not only distribute condoms and lubricants but also facilitate access to basic healthcare, including sexual and reproductive health rights. Innovative approaches, such as providing contraceptive implants at harm reduction centres without the need for an appointment, are also worth mentioning.

The connectivity between harm reduction services and other social services is established, with referrals to educational, employment, psychological support, family / child support, housing, and potentially other necessary services. However, as reported by HivFinland, the effectiveness of these connections is questionable.

Funding for harm reduction services in Finland is characterised as sustainable, though disparities exist in service availability and organisation. While services in Helsinki may be robust and well-coordinated, smaller cities and rural areas may face challenges in offering comparable levels of service, leading to limited access. For example, a service, although available, may be open only for several hours per week. This paints a picture of a country striving for a balanced and humane drug policy, and in a need for scaling up harm reduction responses to improve their accessibility.

HARM REDUCTION SERVICES

NALOXONE

In Finland, naloxone is available, but its accessibility is very limited. Naloxone is an element of equipment of emergency services. Despite the importance of naloxone in emergency medical situations, barriers to its broader accessibility persist. These include the requirement for a prescription and the cost of the medication (over 50 Euros), which is likely prohibitive for some individuals at risk of drug overdose or those who are in a position to assist them.

Currently, Turku is the only city where accessibility of naloxone is higher. This is due to the existence of a system where individuals can receive a document from NSPs and other low-threshold services which makes them eligible for reimbursement of naloxone purchased in a pharmacy. The reimbursements are covered by the (local) government. Such a solution is permissible in the Finnish legal system; however, its actual implementation depends on the will of local politicians and authorities.

DRUG CHECKING

When it comes to drug checking, legal constraints constitute a significant barrier, as the possession of drugs for the purpose of substance identification is not permitted, and there is no legal framework to apply for permit to establish such a service. An ongoing pilot project in Helsinki (finishing in 2024) has made some progress by examining drug residues, albeit with limitations. Samples can be left at select locations within the city, but the service does not examine concentrations and the analysis. In addition, the analysis takes place only once a month, leaving people who use drugs with no timely information.

NEEDLE AND SYRINGE PROGRAMMES

The accessibility of needles and syringes is evolving, albeit with some practical challenges. While there are no policy barriers impeding access to needle and syringe programmes, the accessibility varies across the country.

Currently, people who inject drugs can exchange their needles and syringes in the Health Counselling Centres or purchase STOP-bags (three needles and syringes for 3.30 Euros) from pharmacies. In addition, injecting equipment is available for sale through some online platforms. Despite the lack of policy barriers, the high cost of purchasing needles and syringes can be an impossible barrier for those in need. Coupled with geographical disparities, with no exchange programmes existing outside the major urban areas, this puts people who inject drugs and live in the countryside in an especially vulnerable situation with virtually no access to sterile injecting equipment.

Efforts to improve accessibility are underway, with plans to introduce vending machines, however only in Helsinki. As reported by HivFinland, there

is also a need for more locations that offer needle exchange services, along with extending opening hours to make them more accessible.

OPIOID AGONIST TREATMENT (OAT) AND HEROIN ASSISTED TREATMENT (HAT)

Regarding the opioid agonist therapy, methadone was more commonly used in the past, but with the introduction of injectable and pill-form buprenorphine, HivFinland reports a shift toward the latter. The shift, however, is not related to any regulatory document mandating a preference for one medication over the other.

OAT programmes are operated by a variety of institutions, including central hospitals, specialised social hospitals, municipal hospitals, health centres, drug dependency treatment units, or the healthcare units of correctional facilities, provided they meet the necessary conditions for such treatment.

To start OAT, the primary requirement is a diagnosis of opioid dependency. Once on the treatment, it is possible for clients to receive take-home doses, including provisions for traveling. Concerning the registration, names of individuals on OAT are officially recorded, which prohibits the possibility of anonymous service access. Nevertheless, HivFinland reports no indication that the lack of anonymity works as a deterrent to starting OAT.

Heroin-assisted treatment is not available in Finland.

DRUG CONSUMPTION ROOMS (DCRS)

DCRs are not available in Finland because of the Criminal Code regulations on controlled substances. As mentioned above, all drug-related activities, including use and possession, are criminalised, which makes DCRs a legal grey zone, blocking their establishment. Overcoming these legal barriers would likely require comprehensive policy reform.

CHEMSEX SERVICES

In Finland, there are no services addressed and tailored to the specifically needs of people engaging in chemsex. The service offer to this community is the same as to other people who use drugs. Service providers trust that their services are LGBTQI+ friendly. However, this belief is not based on concrete evidence since individuals tend not to disclose their sexual orientation when accessing services.

HivFinland argues that the introduction of drug checking services could be a significant improvement in the field of harm reduction for people engaging in chemsex, offering them information on the specialised in intersections between substance use and sexual behaviours could ensure a more focused and effective support system for this community.

PRISONS

Harm reduction offer in Finnish prisons is extremely limited, with only OAT available.

HARM REDUCTION SERVICES: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND AFFORDABILITY

In Finland, low-threshold services, such as NSPs and rapid HIV testing, are freely accessible to all individuals over the age of 18 anonymously. However, other interventions, such as HIV or HCV treatment or OAT, are available only to people with valid identity documents. In practice, access to many services depends on a person's status in the country. Individuals without valid documents can stay in such a situation for 1-3 months, after which they receive help from social workers to regulate their status and get access to healthcare. The basic premise of the system is that everyone should be able to get treatment. HIV treatment is available universally, regardless of a person's legal situation.

In Helsinki, services operate in adequate hours that meet the needs of service users. Yet, the situation is very different elsewhere; in some smaller cities, services may be as limited as one hour every two weeks, making their accessibility extremely low.

According to HivFinland, youth are the main underserved population, alongside groups that historically have not been the focus of harm reduction services, such as LGBTQI+ individuals and undocumented migrants. Harm reduction services have been developed with people who inject drugs in mind, and the existing offer responds directly to their needs. Non-injecting people who use drugs and other sub-populations face a significant gap in service provision.

The COVID-19 pandemic changed the provision of harm reduction services. With closures and reduced operating hours, the accessibility of full services significantly decreased during the lockdown periods. Nevertheless, this was partially mitigated by an increase in outreach work. The story of harm reduction in Finland is thus a story of both progress and ongoing challenges, with a clear vision for future improvement aimed at equitable access for all, regardless of background, location, or way of substance use.

INFECTIOUS DISEASES SERVICES: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY, AND AFFORDABILITY

People who use drugs have formal and practical access to preventive services, including testing for HIV, HCV, HBV, STIs, and TB, as well as vaccinations, with only minor challenges. The provision of these services seems to function efficiently, as reported by HivFinland.

Pre-exposure prophylaxis is available and reimbursed, with national guidelines allowing people who use drugs to be

eligible for it. However, awareness of people who use drugs about PrEP is low, and information dissemination by service providers not really practiced. The latter issue is related to low general accessibility of PrEP (including other populations, like men having sex with men or sex workers), leading to services staff perception that informing people who use drugs about PrEP is not a priority if it cannot be immediately offered at harm reduction services.

When it comes to treatment, it seems that there are minimal barriers to access treatment programmes for HIV, TB, HCV, HBV, or STIs. Substance abstinence is not required, and there are no legal or practical barriers reported for people who use drugs to access antiretroviral therapy – services are available where people need them. However, funding is reported by HivFinland as a practical barrier for Hepatitis C treatment, indicating financial constraints as a hindrance to access.

CHALLENGES AND POSSIBLE SOLUTIONS

In Finland, addressing the uneven distribution of services for people who use drugs is crucial for enhancing their access to HIV and co-infection treatments, care, and prevention. Notably, there is a need to extend Hepatitis C treatments, establish drug checking services and drug consumption rooms, and make HIV rapid testing available around the clock across the country.

Such developments require a challenging yet necessary step of reforming the drug policy and legal regulations surrounding drug use. It is, however, a difficult and long-term endeavour that requires collective effort and advocacy actions. On a practical level, it is essential to set clear priorities and actively engage in dialogue about the needs and advantages of initiatives like consumption rooms. By fostering open conversations and awareness, practical steps can be taken to create a more supportive environment for these services.

KEY RECOMMENDATIONS:

- Address the unequal availability and accessibility of services throughout Finland.
- Expand the provision of Hepatitis C treatments.
- Introduce drug checking services as a harm reduction strategy.
- Establish consumption rooms for safer drug use.
- Ensure continuous access to HIV rapid testing services nationwide.
- Advocate for legal reforms that support harm reduction services.
- Prioritise and promote discussions on the necessity and benefits of harm reduction to garner wider support and understanding.

FRANCE

INFECTIOUS DISEASES: EPIDEMIOLOGICAL OVERVIEW

According to the latest comprehensive data, one can see a story of two intersecting epidemics in France. HIV, being once a grave public health issue, now constitutes a less severe but persistent problem within the community of people who inject drugs. According to the French Public Health Agency's 2021 report, among 5 013 total HIV incidents, a small yet significant 1% of new HIV infections were attributed to injecting drug use. A concerning aspect of this data is the high proportion of advanced-stage HIV diagnoses in this group (41% in 2021), suggesting the existence of testing barriers or delays in seeking care. The prevalence of HIV among people who injected drugs at least once in their lifetime the HIV prevalence reaches as high as 13%, with some regions estimating even higher proportions, up to 21%, mainly due to the presence of ageing and migrant people who use drugs. In 2016-2018, 72% of newly diagnosed individuals were migrants from Eastern Europe or outside of Europe. The incidence of HIV among people who inject drugs has not decreased since 2004, contrary to declining rates in the general heterosexual population, which suggests a need for more developed services targeting at-risk populations.

The situation is more concerning with respect to hepatitis C (HCV), where prevalence remains alarmingly high (still significantly lower than in some other European countries, although the data on the situation in France is somewhat outdated). The ANRS-Coquelicot 2011 survey revealed estimates of a 44% prevalence of HCV antibodies among individuals in contact with care harm reduction services. In a 2019 survey, Chronic HCV was estimated in 30% of people who regularly inject drugs (i.e., injected in the last month preceding the survey).

Hepatitis B, albeit with a lower prevalence, shows a significant variation based on the geographical endemicity of the birth country of individuals, with the prevalence of chronic HBV ranging from 0.7% to 7.6%, depending on the region.

Regarding the transmission modes for HIV, heterosexual contact and male-to-male sexual contact constitute most new infections in France (51% and 44%, respectively). Among people who inject drugs, the main concern is the large share of late diagnoses, suggesting persistent gaps in early intervention and testing outreach. Restricted access of this community to HIV services is further evidenced by the extremely high percentage of individuals who had never been tested for HIV prior to their diagnosis.

Demographically, the population of people who use drugs is ageing, with the average age of individuals accessing harm reduction services having increased by five years since 2006 and a more evident ageing among female individuals. A high proportion of people who use drugs live alone, and significant groups experience precariousness, unstable housing, and financial instability. These trends point to a population potentially accumulating years of risk, which may complicate treatment and care due to the emergence of specific needs.

DRUG USE PATTERNS & TRENDS

In France, understanding the patterns of psychoactive substance use is challenging due to methodological differences in studies and the absence of estimates of the total population of people who use drugs. According to the most recent data, in 2017, cannabis was the most experimented and regularly used drug (18 million - 44.8% and 1.5 million - 3.6% of the population, respectively), followed by cocaine (2.1 million – lifetime use; 600 000 – last year use), and MDMA/Ecstasy (1.2 million and 400 000, respectively). An estimated half a million people have ever used heroin. Cocaine use has been increasing annually, making it the second most-used illicit drug after cannabis.

The only available data on the number of people who inject drugs comes from the 2019 report by the OFDT that estimates their number at 110 000. However, according to AIDES, methodological concerns and questions arise about the data quality in connection to these estimates. According to AIDES, the numbers are significantly underestimated due to excluding people who inject drugs who had not sought help from the Centre for Addiction Prevention and Treatment. In addition, the data seems to be collected only for injecting use of traditional drugs, disregarding new psychoactive substances (such as cathinone) and some new practises like injecting practice (slamming) among people engaging in chemsex.

Recent qualitative reports have highlighted an increase in high-risk chemsex practices, such as slamming, while chemsex as such – despite being in the picture for some time already – has been addressed by public health

institutions only very recently. Other recent trends observed in France include the proliferation of psychedelic new psychoactive substances like NBOMe, affecting mainly psychonauts; a growing presence of ketamine in party settings and among diverse populations; and a rise in nitrous oxide use, especially among young men. The diffusion of NPS in the market is evident, with specific mentions of the prevalence of cathinones. Additionally, the issue of crack cocaine has intensified, especially in the northern parts of Paris, raising public health and security concerns.

DRUG USE AND LAW

In France, drug use and possession are treated with harsh legal consequences under the French Public Health Code and the French Penal Code. Drug use is a punishable offence with one year of imprisonment and a fine of 3,750 euros, regardless of the location of use (public or private) and irrespective of the substance used. A slight relaxation of the law and simplification of the proceedings occurred in 2019 when a fixed fine system for small-scale drug use without concurrent offences was introduced. In such cases, upon admission of guilt, a 200 Euros fine is imposed, and a criminal record entry is registered.

For drug possession, the legal framework is even more stringent, with a potential ten-year prison sentence and fines of up to 7.5 million euros. This severity extends to the conditions of imprisonment, eliminating the possibility of privileges such as parole or temporary leave.

The political climate regarding drug use remains predominantly repressive despite several instances of institutions advocating for decriminalisation or regulation. Still, the president and the prevailing political majority resist any drug policy reform. This attitude towards substance use was especially evident in recent crackdowns on people using crack in Paris and the restrictions on harm reduction, as the operation of only one low-threshold drug consumption room. Finally, the debate on drug use regulation has been fuelled by some high-profile incidents that reignited stigma towards people who use drugs and engage in chemsex. Despite some progressive voices, the current state of French law and political dialogue continues to favour a strictly punitive approach to drug use and possession.

HARM REDUCTION FRAMEWORK: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND AFFORDABILITY

In France, the development of harm reduction services began as a public health response to the escalating HIV crisis among people who inject drugs during the 1980s. This dire situation motivated the French government to collaborate with organisations and other key actors to implement policies designed to minimise the adverse health and

social consequences of sharing injection equipment. Adopting the harm reduction approach, arguing that people who use drugs can adopt safer practices and behaviours when given the opportunity, was formalised through several circulars and acts of law that establish the state's role in implementing harm reduction and outline operational guidelines. Harm reduction is precisely defined in France as a policy that aims to 'prevent health, psychological, and social harm, as well as the transmission of infections and overdose mortality associated with the use of psychoactive substances or substances classified as narcotics'.

The laws and policies regulating the implementation of harm reduction, however, coexist with the Penal Code criminalising drug use and possession, creating a paradoxical situation where public health objectives may clash with the criminal justice-focused approach. This dissonance can hinder harm reduction efforts, often placing health priorities behind punitive drug laws and thus impacting the welfare of people who use drugs.

Access to harm reduction services is facilitated by a system designed to be inclusive, with no formal preconditions such as proof of insurance or residency requirements. However, the scope and timing of services vary by provider, with gaps in service provision during evenings, nights, and weekends.

The legal framework ensures that services are anonymous and free; hence also, those uninsured or without valid documents can benefit from them. Support is available for referrals to health and social care systems, often including legal assistance.

Geographical accessibility remains a challenge, with many more services in larger cities. While outreach efforts extend into smaller towns and rural areas, disparities persist. Notably, specialised facilities like DCRs are limited to Paris and Strasbourg, illustrating regional imbalances.

Existing services are generally responsive to the needs of various inadequately served populations, such as women, LGBTQI+, and migrants, yet the reach may not be uniform across all demographics.

During the COVID-19 pandemic, harm reduction services showed noteworthy flexibility. No significant shortages of materials like naloxone, needles, or syringes were reported, and alternative distribution methods such as delivery and 'click and collect' were successfully implemented. Although drop-in centres closed, one-on-one services persisted, and some providers expanded operating hours to spread out client visits. Pharmacies continued syringe exchange programmes, even incorporating postal services, and CSAPA centres sustained essential care through in-person OAT and telephone services.

HARM REDUCTION SERVICES

Regarding more specific solutions, France offers a spectrum of harm reduction services, including medical-social centres (CSAPAs) and harm reduction centres (CAARUDs); harm reduction information, education, and counselling; distribution of sterile injecting equipment; and provision of naloxone to prevent overdoses. Drug analysis, disease screening, and social mediation are also crucial elements of the support provided. Yet, the harm reduction offer depends on the context and locality and can be less accessible or even not accessible at all in certain specific settings or geographical locations (e.g., rural areas, prisons, festival settings). However, specialised treatments like opioid agonist treatment or HCV treatment require the presence of professional medical staff and are offered primarily at medical-social centres.

Integration with other social services is established, with referrals for educational, employment, treatment, psychological support, and housing services. Domains like family or child support services connections still need to be covered.

The funding for harm reduction services mainly comes from government sources, including the Ministry of Health and Social Affairs. However, the level of this funding can be inconsistent, influenced by political, public health, and budgetary factors, which affects the ability of harm reduction services to meet the needs of people who use drugs fully.

NALOXONE

Naloxone is accessible during emergencies, in pharmacies, through community service providers, and for people who use drugs. Since 2017, naloxone in injectable form (Prenoxad®) and a nasal spray, Nalscue®, has been available without a prescription and distributed through community service providers like CAARUD. However, Nalscue® was removed from the market, and the alternative nasal spray Nyxoïd® is now available only as a prescription drug, leading to legal uncertainties about its distribution by community organisations.

DRUG CHECKING

A robust network of community service providers offers drug-checking services. However, AIDES argue that the main obstacle impeding the effectiveness of drug checking is a general lack of awareness among people who use drugs about the availability of such services. This knowledge gap can lead to the underutilisation of drug-checking resources, undermining their potential.

NEEDLE AND SYRINGE PROGRAMMES (NSPS)

The state of needle and syringe provision for people who inject drugs in France is characterised by uneven access and availability. Specialised

clinics, pharmacies, and community organisations offer sterile equipment in urban areas. However, in more remote regions, NSPs are scarce, with their availability limited by prohibition-focused law and policy, social stigma, and opposition from certain political actors.

OPIOID AGONIST TREATMENT (OAT) AND HEROIN-ASSISTED TREATMENT (HAT)

OAT provision is limited to specialist doctors in care, support, and prevention centres (CSAPA), hospitals, and the prison system, with primary care physicians also able to prescribe buprenorphine. The medications used in OAT include methadone and high-dose buprenorphine (HDB), with the latter having several formulations with varying times of working, such as Subutex®, Suboxone®, Buvidal®, and Sixmo®. Preferences towards one medication over another are informed by the client's treatment history and risk of misuse and are guided by the French High Authority of Health (Haute Autorité de Santé - HAS) recommendations. Methadone prescriptions are initially short-term, and transition to primary care is possible once stability is achieved. Buvidal® and Sixmo® require specialist handling.

Commencing OAT requires client willingness alongside medical, psychological, and social support structures. Age restrictions apply, with 15 as the minimum, except for injectable and long-lasting buprenorphine options (Buvidal® - 16+, Sixmo® - reserved for those on a stable sublingual buprenorphine dose).

Travel for OAT patients is regulated; domestic or Schengen country travel requires regional health agency authorisation to receive an extended dose of the medication (up to 14 days for methadone and up to 28 days for Subutex). In case of foreign travel exceeding the maximum period, individuals need to seek local medical advice to ensure the continuity of treatment. National medicines safety agency approval is necessary to comply with international laws for journeys beyond the Schengen zone.

Doctors are key figures in managing individuals on OAT, needing to observe for misuse, relapse, or new substance use. In such cases, they should re-evaluate the client's condition and treatment plan, addressing underlying issues and providing additional support. The re-evaluation aims to optimise treatment outcomes and enhance client well-being. French guidelines for OAT management promote a comprehensive, multidisciplinary approach, enabling healthcare professionals to deliver optimal care for better treatment results and improved quality of life for people who use drugs.

Currently, heroin-assisted treatment (HAT) is not an option in France.

DRUG CONSUMPTION ROOMS (DCRS)

Drug consumption rooms operate as a part of a carefully monitored experiment under the Ministry of Health. The country has established two such facilities—one in Paris and another in Strasbourg. The DCRs run under stringent operational guidelines.

The path to implementing DCRs has been with significant legal and practical challenges. The Ministry of the Interior, along with advocates of security-focused and prohibitionist policies, has expressed opposition, pointing to legal barriers (penalised drug use and possession) to prevent the opening of additional facilities. Practically, the strict operational framework, strictly adjusted to the Parisian context, is unfit to generalise and transfer across different regions.

For people who use drugs, using DCRs is challenging due to their minimal availability. Access remains significantly limited, with only two DCRs serving the entire nation and without the capability to operate round-the-clock. The current infrastructure does not adequately address the need for continuous, accessible harm-reduction services across France.

CHEMSEX SERVICES

In France, harm reduction providers like AIDES are actively reaching out to individuals engaged in chemsex. In 2022, AIDES connected with 4 360 individuals via direct contact and digital services, compared to estimates suggesting that between 100,000 and 200,000 people in France participate in chemsex activities. Despite not being a new phenomenon, the formal integration of chemsex-related issues into public health policy and harm reduction strategies has been relatively recent. Existing harm reduction facilities and sexual health centres have yet to synchronise their efforts thoroughly. Moreover, their staff often needs more knowledge and skills to address chemsex and require additional training to support the community effectively.

Services are evolving to be LGBTQI+ friendly, inspired by community-based networks. Recommendations from reports like the Apaches study, conducted with the LGBTQI+ community and associations of people who use drugs, are shaping more community-oriented approaches. Yet, the available services – although adjusted to the community needs – are struggling to keep up with demand, particularly in urban centres where wait times for assistance are lengthy and in rural areas where physical services are scarce.

To improve the situation, a more robust, public policy-backed expansion of the harm reduction network is essential to enhance service capacity, reduce wait times, and ensure services are accessible beyond cities. Tackling the profound and pervasive stigma attached to chemsex—related to sexual practices,

identities, and substance use - is essential to improving service utilisation. A staggering 89% of participants in a study expressed a desire for safe spaces to discuss chemsex, with 48% feeling isolated because of engaging in chemsex.

Finally, the decriminalisation of drug use could significantly diminish stigma, thereby enhancing access to harm reduction services and enabling community spaces and event organisers to partake more actively in harm reduction efforts, creating a more inclusive and supportive environment for those involved in chemsex.

PRISONS

The “PRI2DE” survey of 2011 sheds light on the stark contrast in harm reduction service accessibility between prisons and the outside community in France. The survey reveals that despite national harm reduction guidelines, implementing these services in prisons is severely limited and inconsistent across the country.

A few facilities provide essential harm reduction tools, like sterile water and disinfectants, and even fewer offer materials, such as crack pipes and mouthpieces. The survey notes a particular challenge with straws for drug sniffing, often banned by prison authorities, thus preventing their distribution by associations active within enclosed settings.

The transition from prison to freedom is a vulnerable time for people who use drugs, particularly regarding the risk of overdose. In this light, the inadequate distribution of naloxone kits upon release - despite clear recommendations in the health roadmap for prison settings - is a significant concern. Moreover, the access to naloxone during the period of incarceration remains highly unequal from one prison to another.

The heightened risk of high-risk use and dependency and infectious diseases within prisons due to factors like overcrowding, social and economic instability, isolation, mental health issues, sexual intercourse and drug use emphasises the critical need for harm reduction measures. While some prison health units have seen doctors prescribing syringes, these efforts are sporadic. Concerns from prison guard unions about the potential use of needles as weapons and the lack of a necessary implementing decree have put a hold on the implementation of NSPs within correctional facilities.

French associations are particularly concerned by the serious and persistent lack of harm reduction services in prison despite the eight years-old health law which extended harm reduction to this setting. Efforts to establish a comprehensive harm reduction in prisons continue, with health and prison administration authorities drafting an updated health roadmap. The draft

decree necessary for executing harm reduction strategies is yet to be shared with relevant prison organisations for consultation, leaving a gap in service parity between community and prison-based harm reduction services.

INFECTIOUS DISEASES SERVICES: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY, AND AFFORDABILITY

In the French healthcare landscape, services are designed to be public, inclusive, and devoid of prerequisites for general service access. Yet, the access is not without challenges. In the case of people who use drugs, stigmatisation, isolation, and geographical barriers persist, undermining access to essential interventions, including HIV, HCV, HBV, STI, and TB prevention, testing, information dissemination, condom distribution, and vaccination programmes.

PrEP is available and reimbursed under national health provisions. The Morlat 2018 report acknowledges various high-risk groups, including people who use drugs, as eligible for PrEP on a case-by-case basis. However, awareness of PrEP among people who use drugs remains low, likely contributing to an underutilisation of this preventative option, especially outside the gay community.

As for treatment, the French approach is non-discriminatory and follows the harm reduction principles. Therefore, drug abstinence is not a precondition for enrolment into or continuity of treatment for conditions like HIV, TB, HCV, HBV, and STIs.

Access to antiretroviral therapy and treatments for Hepatitis C and B, TB, and STIs is legally and practically available to people who use drugs without explicit barriers. Non-governmental organisations play a crucial role in this system, facilitating referrals and providing support to medico-social structures or hospitalisation according to clients' needs.

CHALLENGES AND POSSIBLE SOLUTIONS

On the way to enhancing access to HIV and co-infections treatment, care, and prevention for people who use drugs, France faces several national challenges, such as insufficient focus on effective harm reduction strategies, particularly in prisons, fragmented care and stigma and discrimination that impedes access to health-improving interventions.

Legally, there is room for improvement. Although the 2016 healthcare system modernisation law stipulates harm reduction services in prisons, the anticipated regulatory measures for implementing needle exchange programmes in prisons have yet to materialise. Further, a thorough reform of the country's drug policies, which have been criticised for their repressive

nature since 1970, is needed to shift the focus from punitive responses to health-centred approaches. A movement led by several associations, including AIDES, is advocating for legislation to eliminate penalties for drug use, a step that could reduce discrimination and improve access to care.

Practically, AIDES has been at the forefront of harm reduction in France since 2013, providing education on injection-related risks, which has demonstrably reduced both risky practices and injection-related complications among people who use drugs. However, the establishment of drug consumption rooms remains a challenge; despite policy advancements, no new facilities are opening, and the strict regulations make them impossible to implement by CAARUD. Collaborative efforts with various organisations are underway to urge public authorities to inaugurate new consumption rooms.

KEY RECOMMENDATIONS INCLUDE:

Implementing regulatory measures to provide effective harm reduction services in prisons.

Reforming drug policies to focus on health and human rights rather than punitive measures.

Abolishing penalties for drug use to decrease discrimination and enhance care access.

Expanding harm reduction information, education, and counselling services to further reduce harm among people who use drugs.

Opening new consumption rooms with accessible specifications to support harm reduction efforts.

GERMANY

INFECTIOUS DISEASES: EPIDEMIOLOGICAL OVERVIEW

In the area of infectious diseases, particularly among people who use drugs, the incidence of HIV, Hepatitis C, Hepatitis B, and Tuberculosis paints a complex picture. The recent insights drawn from the Epidemiological Bulletin (Epidemiologisches Bulletin) by the Robert Koch Institute illuminate a shifting landscape.

In 2021, 320 individuals were newly diagnosed with HIV through intravenous drug use, underscoring the persistent challenges faced by this demographic. Notably, the overall trend in Germany portrays a nuanced narrative. Between 2020 and 2021, there was a 9% reduction in newly diagnosed HIV cases (from 2 468 to 2 258), but a subsequent surge of 43% occurred between 2021 and 2022, with 3 239 cases reported by May 1, 2023. This surge is attributed, in part, to refugees from Ukraine, with 22% of the 'new' diagnoses linked to this group. Even considering this, however, the data still shows some increase in the number of 'domestic cases of new HIV infections.

Further nuances emerge when we consider demographic patterns. In 2021, among GBMSM, 68% indicated Germany as their country of origin, compared to 56% of people who use drugs and 33% among individuals who contracted HIV through heterosexual contacts. These variations underscore the diverse dynamics in HIV transmission risks among different population groups.

Shifting focus to HCV, 673 incidents were reported in 2021. The route of contraction was only known for 21% of the total of 4 714 cases reported in 2021. Among these known cases, injecting drug use accounted for a substantial 67% of HCV transmissions, underlining the significant role of intravenous drug use in the spread of the virus.

In the case of HBV, 8 353 new infections emerged in 2021. The route of transmission was identified for 320 cases (3.8%), with intravenous drug use contributing to 106 infections (33% of cases with known infection routes), including instances within prison settings. The DRUCK study conducted

between 2012-2016 showcased HBV prevalence among people who inject drugs ranging from 5-33%, emphasising the diverse landscape of HBV prevalence in different locations, with 0.3-2.5% of chronic HBV infections.

This epidemiological overview outlines dynamic shifts in the area influenced by the intrinsic nature of infections and global events, like migration patterns. The situation in Germany is a good example illustrating the need to adopt comprehensive and adaptable public health strategies that consider the multifaceted nature of infectious disease transmission.

DRUG USE PATTERNS & TRENDS

Regarding drug use patterns and trends in Germany, one finds a dynamic landscape shaped by evolving preferences and administration methods.

Regarding the general population, estimates suggest that 9.3% of the adult population (15-64 years old) and 18% of young adults (15-34 years old) engaged in drug use recently (in the last 12 months). Breaking it down further, cannabis leads the list, with 8.8% of adults using it in the previous year, followed by cocaine (1.6%), amphetamine (1.4%), and NSPs (1.3%).

Delving into 'problem drug use,' the year 2020 saw nearly 100 000 individuals estimated to be involved in opioid use, paralleled by a similar number engaging with stimulants in the last 12 months.

As of 2016, approximately 165 000 individuals engaged in the use of illicit opioids. While specific data on injection use is not up to date), the last attempts to grasp the landscape of injecting drug use in Germany date back to 2016. The DRUCK Study unveils the prevalence of different substances use among people who inject drugs, with 74% opting for heroin, 50% for benzodiazepines, and 79% for cocaine.

A noteworthy shift in drug use patterns emerges, particularly in the mode of administration. According to Deutsche Aidshilfe, the transition from injecting to inhaling opioids and cocaine marks a significant trend. In 2021, data from 11 drug consumption rooms in North Rhine-Westphalia revealed inhalation as the predominant method, constituting around 59% of consumption events. Intravenous use followed closely at approximately 38%, with nasal administration making up a modest 3%.

This narrative unveils a nuanced perspective on the intricate and evolving landscape of drug use in Germany, guiding our understanding of trends and preferences within this demographic.

DRUG USE AND LAW

In Germany, the legal landscape surrounding drug use is nuanced, reflecting a balance between prohibition and an evolving approach that leans towards treatment rather than punishment.

The acquisition, possession, and distribution of drugs are explicitly prohibited, constituting criminal offences. Notably, according to the German Federal Narcotics Act, drug consumption itself is not treated as a criminal act. Instead, the focus lies on prohibiting the possession and purchase of controlled substances. The legal system embraces the principle of prioritising treatment over punishment, allowing for alternative measures, particularly for minor possession cases. The specifics of penalties depend on individual and social factors.

A pivotal development in 2023 involves the regulation of cannabis use. Under specific conditions, the use of cannabis has been made legal. This signals a notable shift in policy, reflecting ongoing debates and a potential evolution in the legal regulations surrounding drug use. In February 2024, the Parliament (Bundestag) passed a bill aiming to permit personal possession of a defined amount of cannabis, cultivation of a limited number of plants, and the purchase of cannabis within the framework of non-profit cannabis social clubs. The bill still has to be approved by the Federal Council (Bundesrat), which has the authority to delay but not completely block its rollout. This bill marks a significant step in shaping the legal landscape and demonstrating a growing political will to reconsider certain aspects of drug regulation in Germany.

HARM REDUCTION FRAMEWORK: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND AFFORDABILITY

In Germany, harm reduction is integral to the national drug policy, aligning with the comprehensive 4-pillar model that encompasses prevention, treatment and counselling, and harm reduction next to drug supply reduction. Enshrined in the German National Strategy on Drug and Addiction Policy since 2012, harm reduction is viewed as a crucial element of the policy that acknowledges drug dependency as a ‘disease’ and leans more towards health-focused solutions.

The legal framework is notably permissive, accommodating interventions including opioid agonist treatment, needle and syringe programmes, take-home naloxone initiatives, and drop-in centres. Germany stands out in Europe for offering a broad spectrum of harm reduction services, including a network of drug consumption rooms and heroin-assisted treatment. Notably, the scope of these services extends beyond harm reduction, facilitating referrals to educational, employment, vocational training, treatment, recovery, family and child support, and housing services.

Harm reduction services maintain a low-threshold approach, ensuring accessibility without preconditions, even for individuals without insurance, such as undocumented migrants. Notably, treatment services, including

drug-free treatment and opioid agonist treatment, have specific requirements, such as health insurance. Despite general accessibility, challenges exist, particularly in rural areas where services are perceived as insufficient. The service availability, including extended hours and needle and syringe vending machines, is more pronounced in urban areas than in the countryside. Funding for harm reduction services is decentralised, relying on the discretion of state- and city-level authorities. While Deutsche Aidshilfe indicates that funding is generally sufficient to provide essential services, limitations may arise, impacting the distribution of essential items like needles and syringes.

Inadequately served populations include individuals without ID cards or health insurance and those in prison settings. The COVID-19 pandemic significantly impacted harm reduction services, leading to the closure of many facilities during this period.

HARM REDUCTION SERVICES

From initiatives such as naloxone training programmes and drug consumption rooms to heroin-assisted treatment, Germany's harm reduction field reflects a commitment to inclusivity, acknowledging the diverse needs and challenges faced by people who use drugs. This multifaceted approach highlights the country's dedication to public health, aiming not only to prevent harm but also to provide essential support and resources for those seeking help.

NALOXONE

Naloxone availability in Germany is contingent upon a prescription, limited to people who use drugs or are enrolled in OAT. The indication for naloxone extends exclusively to these populations, constituting an existing barrier preventing social workers, family members, or friends from obtaining naloxone prescriptions from doctors. While naloxone is accessible in drug consumption rooms, its availability is not extended to other harm reduction services.

To address this limitation, take-home naloxone programmes have been launched, focusing on training people who use drugs in harm reduction services on naloxone use. After completing the training, individuals approach a doctor to acquire the medication. While this initiative demonstrates progress, a distinct barrier arises concerning access for those without health insurance. Individuals with insurance benefit from a reimbursement system, paying a nominal five Euros for the prescription, whereas uninsured individuals incur a 40 Euro cost for naloxone.

The impact of the training projects is clearly visible in the substantial increase in the number of trained individuals receiving naloxone, rising from 100-200 per year to 1 500-2 000 following the project's launching. A broader government-funded project seeks to

train 800 social workers in drug service organisations to obtain a trainer license, enabling them to provide training and short interventions for people who use drugs. The overarching goal is to have 10 000 individuals equipped with naloxone within three years. However, challenges remain, with scepticism among German doctors who argue that naloxone may foster a false sense of security, potentially leading to riskier drug use.

DRUG CHECKING

The availability of drug checking in Germany is limited. Only two NGO-operated projects with low barriers exist (one in Berlin and another in the state of Thuringia), while pharmacies pose high barriers, mainly due to financial constraints. The process involves sending substances to laboratories, resulting in delays of several days for results. However, a recent legal change in May 2023 has paved the way for drug checking, with individual states now responsible for implementing these services.

NEEDLE AND SYRINGE PROGRAMMES (NSP)

In Germany, access to needles and syringes for people who inject drugs is facilitated through various channels. The country has 150 vending machines, but no syringe exchange programmes exist in prisons, except for one female prison in Berlin. People who inject drugs can obtain needles in many drug services, and purchasing is also possible at pharmacies.

Regarding the needle and syringe programmes, with an average of 119 syringes and 156 needles distributed per person per year, Germany achieved the WHO recommendations for 2020 and is on the way to achieving the recommended 300 needles-syringes per year per person by 2030. Significantly, funding for NSPs varies across states, impacting the quantity of needles and syringes distributed in different locations.

OPIOID AGONIST TREATMENT (OAT) AND HEROIN-ASSISTED TREATMENT (HAT)

Opioid Agonist Treatment (OAT) in Germany operates through two primary models. The first involves engagement with general practitioners specialised in OAT provision. The second model entails OAT centres with a capacity of two to three hundred people, predominantly existing in larger cities. Notably, OAT services at GP offices are available nationwide, though in some regions more than in others.

OAT is available with all medications accessible, and no specified preference is outlined in documents – the choice of medication is at the doctors' discretion. Requirements for OAT initiation include a history of opioid use. Individuals receiving OAT can get up to 30 days supply of their medication to take home. Violent behaviour is mentioned by Deutsche Aidshilfe as a premise for

discontinuing the treatment, with other possible reasons being stipulated in individually tailored contracts between clients and doctors.

A notable access barrier exists as general practitioners often face a patient limit 50 for OAT treatment in their offices. This limitation is not rooted in exclusion or discrimination but rather is imposed to ensure the quality of care provided, acknowledging that treating more than 50 individuals by a single doctor might compromise the effectiveness of the treatment.

Heroin-assisted treatment (HAT) is available in 14 specialised services in Germany, but a high threshold of services hinders access. Registration of individuals' names in OAT and HAT databases is mandatory, potentially posing a barrier to some individuals.

DRUG CONSUMPTION ROOMS (DCRS)

Germany has 28 fix-site DCRs and three mobile services, all legally defined and compliant with drug-related laws at the federal level. The establishment of DCRs is hindered by the requirement for states to pass special laws, and only 9 out of 16 states have done so.

CHEMSEX SERVICES

In Germany, the availability of chemsex services is more prominent in organisations with a specific focus on GBMSM. Harm reduction services typically do not include interventions targeting the chemsex community.

To improve the current situation, the Deutsche Aidshilfe suggests exploring decriminalisation of drug possession, indicating a need for a shift in policy to address the needs of people engaging in chemsex users more comprehensively.

PRISONS

Access to harm reduction services in prisons in Germany differs from outside of prison. Specifically, there are no needle and syringe programmes available within prisons. However, HIV and HCV treatment, as well as opioid agonist therapy, are offered in this setting.

INFECTIOUS DISEASES SERVICES: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY, AND AFFORDABILITY

No significant barriers exist for individuals with health insurance seeking infectious disease services in Germany. Access to testing services is facilitated through harm reduction centres working with people who use drugs. Although not uniformly existing across the country, approximately 50 counselling and testing services operate in Germany. The absence of a medical professional during testing is permissible, and in the event of a positive result, individuals can seek treatment from a qualified doctor. Essential to this process is possessing health insurance, as treatment costs are a significant barrier, rendering the service exclusive to those with insurance coverage.

Healthcare coverage in Germany is predominantly provided by the government or employers, with over 90 percent of the population benefiting from health insurance through these channels, according to the Deutsche Aidshilfe. Exceptions exist for those without health insurance, such as undocumented migrants or individuals burdened by health insurance debts.

For individuals lacking health insurance, a specialised service of health insurance clearinghouses exists, dedicated to integrating individuals into the health insurance system. Many cities host such clearinghouses, signifying their vital role in the healthcare system.

While this approach occasionally proves successful, some individuals without insurance still face challenges securing treatment for infectious diseases.

People who use drugs also have straightforward, free, and full access to HBV / HVA vaccines, both formally and in practice.

PrEP is generally available and reimbursed in Germany. People who use drugs are eligible for PrEP under national guidelines, although awareness among them might be limited, and service providers may not consistently offer information on PrEP.

Crucially, the treatment for infectious diseases does not depend on drug abstinence. On the contrary, guidelines for infectious disease treatment explicitly affirm that individuals using drugs are eligible for Hepatitis or HIV care. This inclusive approach aligns with a commitment to equitable healthcare access, recognising the diverse circumstances of those seeking treatment for infectious diseases.

CHALLENGES AND POSSIBLE SOLUTIONS

Germany faces specific challenges in ensuring equitable access to harm reduction and infectious disease services for people who use drugs. The federal structure, with cities and states responsible for drug policy, results in varying levels of service availability and quality. This disparity must be addressed to standardise services and ensure that the scope of help is not dependent on one's location.

Germany has a diverse and effective service system, but the issue of regulating or legalising drugs has not been addressed in a comprehensive manner. A political initiative is needed to address the negative effects of criminalisation and draw the right conclusions from the experiences of other countries.

GREECE

INFECTIOUS DISEASES: EPIDEMIOLOGICAL OVERVIEW

In the field of public health, the incidence of infectious diseases among people who use drugs and, more specifically, among people who inject drugs presents a critical area marked by both enduring challenges and dynamic shifts. According to the data provided by various sources, including the Greek Centre for Disease Control (CDC) and the Greek Reitox Focal Point, epidemiological trends among these populations are complex and multifaceted.

HIV has been tracked in Greece since 1983, revealing a total incidence of 2 377 cases of infections attributable to injecting drug use up to 2022.
In 2022, there were a total of 565 HIV incidents, with 67 (11.9%) attributed to injecting drug use, a slight decrease from the preceding year, where 86 out of 526 new cases (16.4%, the highest rate since 2014) were identified as such. People who use drugs are at a high risk of infections, with 6% of individuals accessing treatment or harm reduction services in 2020 being HIV positive. The rate increased to 11% of HIV prevalence in central Athens, according to the focused research from the snowball project Aristotelis-Alexandros conducted between 2018 and 2020.

In the context of hepatitis C, the data specifically for people who inject drugs is not available. In the case of a broader group of people who use drugs, the numbers oscillate, with 46 cases identified in 2021, 54 in 2020, and a peak of 119 in 2019. The Greek Reitox Focal Point for the EMCDDA provides an additional perspective, indicating that 65% of individuals entering drug treatment in 2020 were hepatitis C positive.

The data on hepatitis B virus (HBV) also offers insights into the situation of people who use drugs. Data from 2021 reveal that 17.4% of people who inject drugs entering treatment for substance use problems had antibodies against the hepatitis B core antigen (anti-HBc), indicating prior exposure to the virus. Further details about the demographic revealed those over 34 years of age, primarily using opioids,

with a history of longer-term injecting and incarceration, as more frequently anti-HBc positive. The infection rate (HBsAg) stood at 1.7%, with slight variation across demographic lines. An alarming information comes from the data highlighting that more than half of the individuals (57.0%) have neither been diagnosed nor vaccinated against HBV, indicating a significant gap in preventive measures among this vulnerable population.

A closer examination of the main epidemiological trends draws attention to the sharing of drug use paraphernalia—not limited to needles—as a predominant route of the transmission of HIV and other bloodborne infections among people who use drugs. Beyond needle and syringe sharing, less apparent behaviours such as cooker and cotton sharing, pipes for methamphetamine, and communal straw use for snorting are potential risks.

DRUG USE PATTERNS & TRENDS

In Greece, the landscape of drug use and its epidemiology presents a complex and evolving challenge. An estimated 12 351 adults (15-64 years old) using opiates high-risk have been identified, predominantly male, with a notable concentration in Athens. However, according to Positive Voice, this figure is likely underestimated due to the methodology used for estimation. A significant segment remains unaccounted for, particularly within the western suburbs of Athens.

Among people entering treatment, the most used drugs are opioids, predominantly heroin, followed by cannabis and cocaine or other stimulants. While opioids have traditionally dominated the treatment entries, over the last decade, there has been a distinguishable shift; more individuals entering treatment have reported using stimulants and cannabis, while the number of those reporting heroin use has been continuously decreasing. As Positive Voice reports, recently, the market has seen a decline in the availability of traditional brown heroin, replaced by cheaper and more accessible synthetic substitutes sold as heroin. One such synthetic opioid, known as thai is injectable and varies in composition, while a tar-like, cheap substance prevails in the outskirts of Athens. Moreover, low-grade crystal methamphetamine, referred to as shisha, is widely sold in the Athenian centre.

The evolution of drug use patterns in Greece can be traced back to post-2004, after the Olympic Games and the onset of austerity measures. The influx of unemployed undocumented migrants into central Athens marked the beginning of a more organised and accessible drug market, offering services around the clock. This period also saw stimulants like cocaine becoming available on the streets, causing a shift in drug use patterns from non-

injecting use of heroin to intravenous use of cocaine. The intersection of these developments with budget cuts in frontline services contributed to an HIV outbreak among people who use drugs between 2011-2013.

The year 2010, marked by implementation of austerity measures, introduced the abovementioned shisha and thai to the streets. Over a decade later, the impact of these substances is profound, with shisha, exceptionally detrimental to people's mental health, now being a prevalent choice among users, often combined with heroin and benzodiazepines. Together with injectable stimulants misrepresented as cocaine being increasingly common, these changes indicate a shift of the market from opioids towards stimulants.

Within the gay community, problematic use of high-quality crystal meth, distinct from street-sold versions, is rising without targeted support services. Cocaine use, not the street variety but rather that obtained through dealers, is also on the rise, as evidenced by wastewater analysis.

The epidemiology of drug use in Greece tells the story of shifting patterns influenced by socioeconomic trends, evolving markets, and the complex interplay between public health measures and the accessibility of substances. The trend towards stimulants and the emergence of synthetic drugs reveals a drug use landscape in flux, one that requires continuous monitoring and tailored interventions.

DRUG USE AND LAW

In the current Greek legal framework, delineated by Criminal Law 4139/2013, drug use and possession are penalised with nuance. In general, any acts of use, cultivation, possession, or procurement of drugs for personal use can lead to imprisonment for up to five months. However, there is an allowance for judicial discretion; if a court deems the drug-related act occasional and unlikely to repeat, it can acquit the individual.

Conversely, those diagnosed with drug dependency, demonstrated through certification by state-run drug institutions or healthcare professionals, are exempt from punishment for drug use. This demarcation within the law underscores a distinct approach towards people who use drugs depending on their dependency status.

There is no debate within the Greek political scene regarding any reforms of drug laws and policies. Discussions on decriminalisation or any form of legalisation, even for recreational cannabis, are notably absent from the political agenda. The absence of debate suggests a rigidity in the current legislative approach to drug use and its associated activities.

HARM REDUCTION FRAMEWORK

In Greece, harm reduction interventions are incorporated within the national legal framework and policy documents, albeit mainly in an implicit way. The law does not explicitly reference harm reduction either in the context of opioid agonist treatment (OAT) provision or within the mission statement of OKANA, a state-run organisation responsible for frug-related services in Greece. It is, however, referenced in the context of drug consumption rooms, indicating a legal acknowledgement of harm reduction in these specific facilities.

The Greek government adopts a predominantly medical approach to harm reduction, with state-run entities dominating the landscape of harm reduction services and peer-led and civil society initiatives being traditionally marginal and hardly funded. Still, civil society organisations (CSOs), particularly in the wake of the HIV outbreak in Athens from 2011-2013, have progressed, ensuring their frontline workers with relevant training, and learning opportunities from colleagues abroad, altering the harm reduction landscape.

The legal domain surrounding harm reduction services, such as HIV/HCV testing, needle and syringe distribution, or drug checking, is ambiguous, with CSOs operating in a sort of grey area. Recent advancements in Greek legislation have sought to address some of these issues, including the regulation of drug consumption rooms and the legalisation of naloxone for use in cases of opioid overdose by doctors and nurses, street workers, shelter workers, other professionals across various settings and the public (the law is still waiting for the approval by a Ministerial Decree of The Ministry of Health). The current framework allows the access and use of naloxone only by state-recognised entities approved to provide 'dependency treatment'.

The legal framework outlines the structure of national coordination for drug policy through the Inter-ministerial Committee for the National Action Plan against Drugs, led by the Prime Minister. The National Strategy and Action Plan for 2021-2026 is in the process of approval, although past strategies have seen delays and non-implementation.

The Organisation Against Narcotics (OKANA) retains the exclusive right to provide OAT, as described in Law 4139/2013. This law stipulates the state's monopoly over the production and distribution of controlled substances for medical use. It outlines strict licensing procedures for producing, transporting, and distributing such substances. The provision of other harm reduction services, like needle and syringe programmes, is not explicitly supported or recognised, creating uncertainty for non-governmental service providers in this area.

In the landscape of service provision, a distinct contrast emerges between state-funded and civil society organisations. The former typically enjoy the stability of a sufficient budget, secured through public funding, which supports both the financial and human resource needs. On the other hand, CSOs often find themselves in a perpetual struggle to secure resources. Not only do they face financial constraints, but they also deal with limitations in human resources, which are equally crucial for their operation and survival. This disparity highlights the ongoing challenge for CSOs to establish a position in a domain where state-supported entities prevail due to their stable and ample funding.

In summary, the Greek approach to harm reduction is predominantly medicalised, with a state monopoly on most services like OAT and a complex legal environment for CSOs operating in the harm reduction space. Despite legal advancements and recognition of certain harm reduction facilities, challenges still need to be addressed in fully integrating and implementing a comprehensive and supportive harm reduction strategy at the national level.

HARM REDUCTION SERVICES

Regarding services provided, Greece offers a range of harm reduction interventions, some of which are available through medical centres (e.g., OAT – in hospitals). In contrast, others are provided on-site and through outreach by governmental and non-governmental organisations, e.g., HIV/HCV testing, DCR in Athens, low-threshold drop-in centres, needle-syringe exchange and distribution, naloxone provision, and shelters for people who use drugs experiencing homelessness.

NALOXONE

A significant advancement was made with the passage of new legislation by the Greek Parliament in March 2023, which improves the accessibility of naloxone. Previously, only state-recognised drug treatment services could provide naloxone. Still, now, the law permits its free distribution to a broader range of professionals, including civil society organisations, people who use drugs, their relatives, and the public. However, the implementation awaits a ministerial act to ratify the law entirely.

Currently, naloxone is legally accessible during emergencies and through community service providers.

DRUG CHECKING

On a different note, drug-checking services, which are essential for identifying substances and reducing harm, are virtually absent in Greece. The practice exists in a legal grey area and is not addressed by Greek law. Nevertheless, Generation Act, a grassroots organisation dedicated to harm reduction in nightlife, has been independently implementing drug checking with colorimetric tests. This initiative continues without formal legal recognition, suggesting a need for legislative action to support and regulate

drug checking in the country. Laboratory-quality drug checking is only performed within the only drug consumption room existing in Greece.

NEEDLE AND SYRINGE PROGRAMMES (NSPS)

In Greece, while needle and syringe programmes are established and operational, they face challenges related to accessibility and distribution. Legally, they are in a grey zone as there is no regulation explicitly permitting civil society organisations to operate NSPs. A license from the municipal authorities is required, and without it distributing sterile equipment by CSOs is illegal.

The programmes do exist in the country, signalling a recognition of the importance of harm reduction strategies. However, the availability of these essential services is concentrated primarily in urban areas like Athens and Thessaloniki. Even within these cities, however, NSPs are not available through vending machines or pharmacies - a notable gap, especially in Athens, where pharmacies often do not supply paraphernalia to people who inject drugs.

A majority of needle and syringe distribution occurs via street outreach and drop-in centres, as well as through the recently opened drug consumption room. While no significant policy barriers impede access to NSPs, the practical challenges lie in their limited number and the hours of operation, which are restricted mainly to mornings. Additionally, the geographical spread is inadequate, with services clustered in city centres, leaving suburban areas underserved. This situation emphasises a pressing need for a more extensive, evenly distributed network of NSPs to ensure better access for all individuals in need across the region.

OPIOID AGONIST TREATMENT (OAT) AND HEROIN-ASSISTED TREATMENT (HAT)

In Greece, opioid agonist therapy is available and includes medications such as methadone in liquid form, buprenorphine (Subutex), and the combination of buprenorphine/naloxone (Suboxone). The choice between methadone and buprenorphine for treating substance use is based on treatment access, patient history, safety assessments, and individual preferences. Currently, buprenorphine is more commonly prescribed to new clients unless contraindications incline clinicians to apply for a switch to methadone. Factors like patient response, drug interactions, side effects, treatment accessibility, and transition ease between therapies are considered when both options are available.

As mentioned above, OKANA monopolises the provision of OAT as mandated by Greek law. As a state-funded public entity under the Ministry of Health, OKANA is the sole provider, indicating a centralised approach to OAT services.

Individuals seeking opioid agonist treatment must meet specific criteria, including being over 20 years old, demonstrating a significant opioid dependency, and, for those under 22, an unsuccessful treatment attempt elsewhere. Additionally, written consent to treatment terms is required. For take-home doses during travel, special documentation is provided within Greece and for up to 30 days abroad, detailing the individual's identity and treatment specifics, with an option to receive treatment in the destination country after coordination.

OKANA's Operational Framework outlines rules for OAT programmes, emphasising retention in treatment. However, involuntary discharge may occur because of behaviours that threaten programme integrity, such as violence, illegal activities, or severe non-compliance with rules. A step-by-step approach with warnings and support to change behaviour is applied before discharge.

While clients' names are recorded for safe and personalised treatment management, this has arguably not posed a barrier to treatment access due to strict confidentiality and ethical standards protecting personal data and rights to treatment.

Heroin-assisted treatment is not available in Greece and is considered a non-viable option within the current political landscape, as it was only suggested by a political party that failed to secure parliamentary representation in the recent elections.

DRUG CONSUMPTION ROOMS

In Greece, there is one drug consumption room offering services to people who use drugs. The legal framework that allows for the operation of this DCR has been adjusted from previous legislation that led to the closure of an older facility. The current law accommodates the existence of the DCR within the broader context of the country's drug policy.

One of the notable legal challenges the DCR faces is the ambiguous status of drug testing, which is not performed on the premises due to its classification as a legal grey area. Additionally, there is an informal understanding with local law enforcement to avoid the harassment or arrest of people who use drugs around the DCR, indicating a delicate balance between the facility's operation and policing practices.

CHEMSEX SERVICES

In Greece, state-run harm reduction organisations do not currently offer harm reduction services for chemsex users. Instead, Positive Voice, a community-based organisation, stands alone in providing support specifically for those engaging in chemsex. The organisation, deeply rooted in the LGBTQI+ community, operates with a focus on peer empowerment and offers services

adjusted to the unique needs of the community, including those provided by an openly queer clinical psychologist.

Despite Positive Voice's efforts, the overall recognition of chemsex as a public health issue needs to be improved. The main state entities responsible for forming the national drug strategy and action plan do not acknowledge the topic. The current situation calls for substantial improvements. Advocates argue that awareness campaigns, strategic lobbying with key stakeholders, and educational seminars for treatment professionals are critical to changing the status quo. These measures aim to break the silence surrounding chemsex, thereby preventing the rise in infectious disease transmissions and other harms associated with unsafe practices within this community.

PRISONS

In Greek prisons, harm reduction services are markedly different from those available to the public. Access to OAT is highly restricted, and there are no needle and syringe programmes or any other harm reduction initiatives within the penal institutions. People in prison settings are primarily directed towards abstinence-based treatment programmes.

Efforts by organisations such as Positive Voice and Prometheus (the Greek Liver Patient Association) to introduce needle and syringe programmes in prisons have been unsuccessful. Even measures as basic as condom distribution, which were once implemented, have been discontinued. Some civil society organisations continue to provide some level of support through educational seminars about HIV, Hepatitis C and B, and other sexually transmitted infections, as well as empowerment sessions. Still, these efforts are significantly constrained by the prevailing attitudes and policies within the prison system. This narrative underscores the challenges harm reduction advocates face in extending essential health services to populations deprived of liberty in Greece.

HARM REDUCTION SERVICES: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND AFFORDABILITY

In the context of harm reduction services in Greece, access varies significantly depending on the type of service and provider. Frontline services like drug consumption rooms, drop-in centres, needle and syringe programmes, and some housing services have minimal entry requirements, often expecting only a form of identification such as an ID or a release document from prison. However, other services, including additional housing options and OAT clinics, have a higher access threshold, requiring a (temporary) social security number and proof of asylum refugee status (or a document certifying applying for such status).

Operating hours for harm reduction services do not consistently meet the needs of service users. While outreach services, shelters, and HIV/HCV testing facilities offer wider availability, DCRs, drop-in centres, and NSPs have limited hours. OAT programmes work only in the mornings, which does not align well with clients' lifestyles, impacting their employment opportunities and daily routines. Access to naloxone is insufficient, especially during off-hours and in less central locations, due to a lack of access for people who use drugs and their relatives.

Undocumented migrants can access frontline services but are excluded from OAT, specific shelters, and sometimes HIV and HCV treatment due to documentation requirements. This exclusion presents a paradox as many abstinence-based treatment options are accessible to them.

Geographic accessibility is a significant issue, with the centralisation of services in Athens and their complete absence in rural and island areas. Smaller cities and rural regions not only lack NSPs and drop-in centres but there is also intense stigmatisation of people who use drugs, further impeding access.

Services are predominantly designed for the demographic of white, heterosexual, Greek males using heroin, leaving women, LGBTQI+ individuals, Roma communities, and migrants often inadequately served. There is a severe shortage of harm reduction services tailored to the needs of these diverse groups, and law enforcement presence in service areas mainly affects refugees and migrants.

The COVID-19 pandemic had a disruptive effect on harm reduction services, altering modes of operation, reducing the capacity of residential treatment programmes, and affecting the distribution of syringes and access to care. However, some positive developments emerged, such as the opening of shelters for people who use drugs and experience homelessness and the legal framework for naloxone provision. Despite initial setbacks, civil society organisations played a critical role in continuing services, and the pandemic catalysed the establishment of new initiatives like shelters for people who use drugs and experience homelessness.

INFECTIOUS DISEASES SERVICES: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY, AND AFFORDABILITY

In the field of prevention and treatment for infectious diseases among people who use drugs in Greece, several systemic barriers emerge that restrict their access to essential health services.

One of the significant challenges faced by people who use drugs is related to the accessibility of testing, with very few services offering free, confidential

testing in an environment free from judgment and discrimination. Access to vaccinations, a critical preventive measure against diseases like HBV and HAV, is only possible with a social security number—a requirement that most vulnerable populations, including people who use drugs, do not meet. Additionally, specific harm reduction services, such as the distribution of safer injection kits and condoms, are insufficient to meet the needs of the community. The pervasive stigma and discriminatory behaviours against people who use drugs at most services in Greece further exacerbate their marginalisation.

Regarding PrEP, the situation remains complex. The availability of PrEP is limited to unofficial channels or abroad, without reimbursement, and there are no national guidelines regulating this area. This situation is further complicated by the Greek scientific community's ongoing debate regarding the efficacy of PrEP in preventing non-sexual transmission of HIV. Consequently, service providers rarely inform people who use drugs about PrEP as an option for prevention, leading to a negligible demand for PrEP among this group.

When examining treatment accessibility for diseases like HIV, TB, HCV, HBV, and STIs, legal and policy barriers, such as the necessity of a social security record or equivalent for foreigners, present significant obstacles. Practically, the lack of acceptance of HIV clinics towards people who use drugs impedes their access to ART. In the cases of Hepatitis C and B, the primary practical obstacles are the community's lack of awareness and misinformation, which can lead to severe health complications due to untreated conditions.

Assessing the linkage to treatment from community-based services, it is evident that while services may exist formally, the real-world implementation is filled with barriers, leading to a significant gap between policy and practice, thus failing to address the needs of people who use drugs adequately.

CHALLENGES AND POSSIBLE SOLUTIONS

In Greece, the national challenge of enhancing access to treatment, care, and prevention services for people who use drugs is underscored by the alarming findings from the Aristoteles 2 and Alexandros projects. These studies have revealed a gloomy reality: Greece has the highest drug user mortality rate among developed nations, with a mortality rate of 3.5 deaths per 100 users annually. The data, presented officially at the 10th Panhellenic Meeting on AIDS, Hepatitis and Emerging Diseases in 2022, point to a pressing need for intervention.

Despite the availability of free healthcare services such as HAART, OAT, and DAAs for hepatitis C, the mortality rates remain distressingly high. The research

indicates that the COVID-19 pandemic has not significantly influenced these figures. Experts predict around 100 deaths in 2022 among the participants of the Aristoteles and Alexandros programmes alone, representing a broader crisis within the national PWUD community.

It is argued the lack of widely accessible naloxone for overdose prevention, significant stigma deterring engagement with health services, and the abandonment of HIV-positive people who use drugs all contribute to the extremely high mortality rates. The figures show that a significant proportion of people who use drugs in Athens are not connected to any treatment or rehabilitation services, and preventive measures like syringe distribution and HIV testing are highly insufficient.

KEY RECOMMENDATIONS FROM EXPERTS TO ADDRESS THESE ISSUES INCLUDE:

- Adopt a law facilitating the provision of OAT within hospitals, including HIV clinics, to ensure patient retention and prevent untreated discharges.
- Protect people who use drugs in treatment from arrest for past misdemeanours to ensure the continuity of treatment, thus supporting their individual health and public health.
- Simplify legal procedures for people who use drugs and are undergoing treatment, recognising them as clients with special health needs and ensuring access to treatment in case of arrest.
- Distribute naloxone directly to peers and educate them in its use and harm reduction strategies (such as the principle of 'Never Use Alone').
- Conduct educational seminars for police officers and healthcare professionals to combat stigma against people who use drugs.
- Establish grassroots organisations to bridge the gap between the affected community and health systems.
- Deploy municipal mobile drug consumption rooms and provide nasal naloxone.
- Improve housing structures and support civil society organisations working in harm reduction, including involving them directly in the design of drug policies.
- Establish 'One-stop shops' providing integrated services, including OAT, ART, DAAs, and other necessary treatments, to cater to the lifestyle and needs of people who use drugs.

HUNGARY

INFECTIOUS DISEASES: EPIDEMIOLOGICAL OVERVIEW

The situation of HIV and co-infection prevalence among people who use drugs in Hungary reflects broader social, economic, and health-related trends.

In 2018, the national coverage study revealed an extremely low HIV incidence among people who inject drugs, with only one new infection in this group (0.2%). This number increased to three incidents (3%) recorded in 2019 in a regional survey. Hepatitis C (HCV), however, paints a more concerning picture, with a prevalence rate of 43.5% in 2018.

The Hungarian epidemiological landscape has been characterised by significant changes over recent years. Initial seroprevalence surveys among people who inject drugs showed the first instances of HIV positivity in 2014. Regarding HCV, before 2010, the highest prevalence was observed among people injecting opiates. However, by 2011, prevalence among people injecting stimulants had spiked (to 30%), which was likely tied to the frequent injection and associated sharing and reuse of injecting equipment. Between 2010 and 2014, the prevalence of HCV among people who inject drugs doubled and reached 49%.

Moreover, the closure of the two largest needle and syringe programmes in Budapest in 2014 and the resulting deterioration of service accessibility and connection to people who use drugs have played an essential role in the rise in HCV prevalence, highlighting the crucial role these services play in the prevention of infectious diseases. In 2019, a 5% increase in HCV prevalence was observed in Budapest, compared to 2018, while other cities noted a 4% rise compared to 2015 data.

It must be emphasised that the data from Budapest and, consequently, at the national level faces significant comparability issues. This is because the two largest NSPs closed in late 2014 were key recruitment sites for the National Centre for Epidemiology's HIV/HCV seroprevalence surveys from 2006 to 2014. After 2015, a gap followed

until 2018, when a new national HIV/HCV study was conducted; however, the methodology only partly overlapped with the original one. Moreover, this study could not involve the population of people who inject drugs reached in the earlier surveys, rendering the data incomparable. It is likely that the seroprevalence of HIV and HCV in Budapest, and hence in the entire country, is somewhat underestimated.

The situation of infectious diseases among people who use drugs in Hungary is a complex one, with intertwining factors of drug use patterns, service provision, and social policies creating a dramatically shifting landscape. While the HIV prevalence remains low in this community, the disproportionately high rate of HCV is alarming and calls for sustainable and targeted public health interventions.

DRUG USE PATTERNS & TRENDS

Concerning the general population, the 2019 National Survey on Addiction and Public Health (NSAPH) estimates that nearly 8% of adults (18-64) and 14% of young adults (18-34) have used illicit drugs at some point in their lives. Among this group, every fourth person used illegal substances in the last year, which constitutes 2% of the adult population of the country, while current use (previous month) was estimated at 1.2%, with more men than women engaging in drug use.

The closure of major NSPs in Budapest had severe consequences, pushing people who inject drugs underground, consequently compromising the accuracy of trend and population size estimations. The most tangible impact of the closure was seen as NSP client numbers dropped from 4 624 in 2013 to a mere 567 by 2020. Besides, the remaining harm reduction facilities observe a decline in the prevalence of injecting and a diversification in drug use methods towards foil inhalation, snorting, and smoking, notably synthetic substances.

From the perspective of specific substances themselves, cannabis tops the list as the most used drug, with prescription relaxants, often in pill form, following. Inhalants, synthetic cannabinoids, and MDMA are other prevalent substances, each with their preferred methods of consumption, from inhaling to ingesting pills. A concerning phenomenon is the injection and snorting of synthetic cathinones and amphetamines alongside the traditional snorting of cocaine. The list extends to LSD, GHB, magic mushrooms, and nitrous oxide, with heroin and methamphetamines closing the list with the lowest prevalence.

The most significant trends, although not that recent, include the shift post-2010, marked by a decline in traditional drugs like heroin and amphetamine and a surge in synthetic cathinones and cannabinoids. These newer psychoactive substances have established their position, particularly among the most marginalised

groups, such as people experiencing homelessness, people in prison settings, and residents of impoverished neighbourhoods. Although the rise of new psychoactive substances reached its zenith in the mid-2010s, there has been a noticeable decline in injecting stimulant use since 2016. On the other hand, service providers report an increase in polydrug use and diversified methods of consumption, highlighting a public health concern that extends beyond simple prevalence rates to the complexities of patterns of drug use. The data on the current situation in Hungary indicates the need for the development of a robust harm reduction service network and a more nuanced understanding of the evolving drug use patterns.

DRUG USE AND LAW

In Hungary, the legal system surrounding drug use is marked by punitive measures and an absence of progressive reform. Since 2013, following a stringent amendment to the Criminal Code, not only the possession but also the use of drugs has been criminalised, reflecting a shift towards a more repressive drug policy regime after decades of penalising only possession.

The consumption or possession of a small amount of drugs - a quantity precisely defined by the weight of the substance's active ingredient - can lead to up to two years imprisonment. Yet, enforcement of this penalty is rare in practice. Individuals arrested for the first time are typically offered a six-month drug counselling programme as an alternative to criminal proceedings. This is accompanied by the burden of court procedural costs, which, if unpaid, can lead to incarceration. Recidivism within two years rules out the possibility of such a diversion, often leading to fines or warnings first and imprisonment for repeated offences.

The current practice coerces mostly casual cannabis users into treatment programmes they often do not need, causing overutilisation of the counselling services and clogging them. Hence, those seeking voluntary treatment face considerable waiting lists. Additionally, those arrested for possession of new psychoactive substances unavoidably face fines, as the opportunity for alternative sanctions is not extended to them.

Politically, Hungary has leaned towards increased repression in drug regulation since 2010, with no signs of decriminalisation or substantive legal reforms on the horizon. Civil society's calls for amendments, mainly to allow the diversion of people using new psychoactive substances away from the criminal system, have so far been unsuccessful. The second Orbán government's Criminal Code amendments in 2013 and subsequent procedural changes in 2018, affecting mainly the more vulnerable individuals with drug dependency, reflect an entrenched resistance to reform. Notably, modern addiction science's view of relapse as a natural recovery phase contrasts sharply with the Hungarian legal system's punitive response.

Hungarian drug policy is stringent, punitive, and resistant to evidence-based approaches that consider dependency and drug use as complex social and health issues rather than merely criminal acts.

HARM REDUCTION FRAMEWORK

In Hungary, the concept of harm reduction has been included within the national policy framework; however, it is not recognised as such but understood under the term of low-threshold services, which are defined in the relevant professional guidelines as 'interventions aiming at reducing the individual and macro-level health, social and economic harms of drug use'.

According to the Rights Reporter Foundation, in 2021, 32 public organisations and 32 non-governmental organisations were operational, offering needle and syringe programmes. Peer-led organisations were notably absent from the roster, suggesting a potential area for growth and inclusivity in service provision.

However, the connection seems to be relatively weak when it comes to integrating harm reduction with other social services. While there are elements of psychological support, family and child aid, and housing assistance, these services are limited and reliant on referrals rather than being directly available on-site. This suggests that while there is an acknowledgement of the need for comprehensive support structures around harm reduction, the implementation is fragmented and could benefit from a more integrated approach.

The financial situation of harm reduction services paints a picture of precariousness. Funding is organised through a competitive tender process overseen by the Slachta Margit Nemzeti Szociálpolitikai Intézet (Margit Slachta National Institute for Social Policy), which dispenses fixed-term grants from the central state budget. Despite a nominal increase in the fixed annual funding for low threshold services in recent years, the available funds fall short of meeting even the basic salary requirements of staff, revealing a dissonance between the pressing need for these services and the financial support provided. Additionally, discontinuing specific annual grants in 2021 exacerbated the financial instability, forcing organisations to seek alternative sources to maintain their operations. It is an open secret that the terms harm reduction or needle and syringe must be omitted from public grant proposals, as their inclusion risks disqualification from funding.

In conclusion, Hungary's harm reduction landscape is challenged by financial insufficiency, punitive policies, lack of political will, and an underdeveloped integration with broader social services.

HARM REDUCTION SERVICES

The active organisations deliver a range of essential harm reduction services, from drop-in centres to needle exchange programmes and HIV and Hepatitis C testing and counselling. Furthermore, some organisations work to promote harm reduction within nightlife environments.

NALOXONE

Access to naloxone is severely restricted. This life-saving drug is legally allowed only within medical emergency settings, where only licensed doctors have the authority to administer it. The availability of naloxone is limited by its non-prescription-possible status, resulting in no access through pharmacies or community service providers and no access for people who use drugs. This strictly regulated access outlines Hungary's conservative stance on overdose prevention.

DRUG CHECKING

Illustrating the challenges in harm reduction efforts, drug-checking services are not available either. The Criminal Code classifies such services as facilitation of drug use – a criminal offence. The barriers to implementing drug checking are firmly rooted in a lack of political will, with no indication of the government's intention to grant special permissions for harm reduction services to implement such interventions.

NEEDLE AND SYRINGE PROGRAMMES

Needle and syringe programmes are facing a critical shortage. The current situation reveals a massive deficit in the distribution of sterile needles, with an average of fewer than ten needles per person per year being provided, falling significantly short of the World Health Organization's minimal recommendations.

Accessibility of NSPs is further restricted by a sparse presence of vending machines—limited to just two in smaller towns—and the absence of pharmacy-based NSPs. Although most pharmacies do sell sterile needles, this possibility by people who use drugs is not always guaranteed due to stigma and discrimination. The network of service providers has suffered significant setbacks, particularly with the closure of the two largest NSPs in Budapest in 2014. These closures, attributed to political hostility and funding deficits, removed critical support services for people who inject drugs, leading to a substantial decrease in sterile needle distribution and a concurrent inability to monitor infectious diseases among this population effectively.

Geographical coverage of NSPs remains inadequate despite approximately 30 operating programmes, as many offer minimal distribution and are predominantly fixed-site operations, with only a few offering outreach

services. The number of sites does not translate into broad access, with some regions entirely lacking NSP presence.

Complicating the scenario further are the policy and practical barriers erected by a government ideologically opposed to harm reduction. The closures of key NSPs in the face of political protests orchestrated by the governing party exemplify this antagonism.

OPIOID AGONIST TREATMENT AND HEROIN-ASSISTED TREATMENT

Opioid agonist therapy is mainly characterised by very limited coverage. Methadone, primarily provided in liquid form, is the most accessible OAT medication due to full health insurance coverage. However, its dispensation is restricted to specialised OAT clinics, with varying conditions for collection and consumption, some requiring daily attendance and others permitting a week's take-home dosage. Despite this coverage, the obstacles to initiating treatment are significant, with few new patient slots and no prescription capacity outside clinics.

Suboxone seems to be a preferred alternative among psychiatrists due to its perceived lower potential for misuse. Nonetheless, it remains financially inaccessible to many, as it is not subsidised by health insurance, resulting in only a quarter of clients opting for Suboxone over methadone. This preference is not governed by any overarching document but is left to the discretion of individual doctors.

The process of entering OAT is governed by arguably outdated national protocols dating back to 2008 and is executed by local professional guidelines. The decision-making power lies within a specialised working group at each treatment centre, which makes decisions considering the patient's health and social circumstances. Only 577 individuals were enrolled in OAT in 2021, suggesting a coverage rate of a mere 22% among people who use heroin.

The guidelines on take-home OAT are not explicitly outlined, leaving the general recommendation of 60 to 120 mg per dose as the only reference. Furthermore, the current protocols do not stipulate specific violations that would lead to the discontinuation of OAT.

Heroin-assisted treatment is not available in Hungary.

DRUG CONSUMPTION ROOMS

Drug consumption rooms are non-existent, marking a significant gap in the harm reduction landscape. The country's Criminal Code starkly opposes the operation of such facilities, outlawing the use and facilitation of illicit drug consumption, with no political inclination to favour the necessary exemptions that would legalise DCRs. The absence of DCRs is rooted in a legal framework that

harshly criminalises drug-related activities, compounded by a pronounced lack of political will to shift the status quo.

Besides legal obstacles, funding is a formidable barrier, as current harm reduction programmes already struggle with financial constraints; establishing DCRs would command even more significant economic resources. Moreover, local communities' engagement and support are crucial yet unattainable, requiring a level of political leadership and advocacy that no local officials seem willing to take in the prevailing political climate.

CHEMSEX SERVICES

Services tailored to the needs of individuals engaging in chemsex are virtually non-existent. Despite recognising the growing presence and concerns related to chemsex, mainly in Budapest, the support framework is underdeveloped. The beginnings of dialogue on this issue were marked by an inaugural conference held in January 2022, signalling the start of a collective effort to address this emerging phenomenon.

One of the few possibilities for people engaging in chemsex is a self-help group formed under the auspices of Háttér, an NGO advocating for the rights of gay men in Hungary. It represents a grassroots effort to bring together scattered knowledge and awareness among service providers and government entities. However, the absence of dedicated funding severely impedes the expansion of these initiatives.

PRISONS

In Hungarian prisons, the situation of harm reduction services sharply contrasts with what is available outside the correctional system. While OAT is theoretically available, implementation is virtually non-existent, and there are no records of individuals receiving OAT within the criminal justice system. Instead, those suffering from withdrawal are transferred to the National Institute for Forensic Observation and Psychiatry for medical care, which generally does not include methadone. The primary approach to drug dependency within prisons is centred around abstinence-only programs. These units offer improved conditions for inmates who consent to random drug testing, which highlights a preventative rather than therapeutic model of care.

Regarding the prevention of infectious diseases like HIV, Hepatitis C, and B, prisons have seen some intervention in the form of testing campaigns, notably funded by pharmaceutical entities. One significant initiative was a nationwide testing program from September 2018 to May 2019, which included a substantial portion of the prison population and staff. Out of those tested, a considerable number were identified as HCV-positive. However, the number of individuals who commenced and completed treatment was relatively modest.

Treatment for infectious diseases within prisons is available to those with confirmed diagnoses. Specifically, for HIV, there is a dedicated unit in the Tököl prison hospital providing antiretroviral therapy. The latest available data from 2019 indicates that several individuals received treatment for HIV, tuberculosis, and Hepatitis B and C. However, the treatment reach for HCV was limited by a variety of factors, including lack of consent, health-related treatment exclusion, or interruption due to release from prison.

HARM REDUCTION SERVICES: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND AFFORDABILITY

In Hungary, various formal and informal factors shape access to harm reduction. While some services like outreach, needle and syringe programmes, and drop-in centres offer assistance without requiring identification or legal documentation, the situation becomes more complex regarding OAT.

Service hours are constrained, often limited by funding shortages. This means that certain locations only witness outreach services sporadically throughout the week. While larger cities typically have low-threshold services available, the distribution and timing of these services are not always aligned with the needs of the communities they aim to serve.

Geographical accessibility presents a mixed picture. Most larger cities provide some level of service, but certain groups find themselves particularly underserved, even in urban areas. The suspension of the only program dedicated to women who use drugs due to financial constraints leaves a notable gap in care for this sub-group. Similarly, Roma communities and LGBTQ+ individuals have faced a virtual absence of services addressing their needs.

The COVID-19 pandemic, while a disruptor, did not completely halt the provision of harm reduction services. Many providers were flexible and remained operational, and OAT programmes adapted through telemedicine and take-home distribution. Although this flexibility was not preserved post-lockdown, the pandemic catalysed a shift toward increased online client engagement, suggesting a lasting transformation in service delivery models.

INFECTIOUS DISEASES SERVICES: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY, AND AFFORDABILITY

Infectious disease services face significant practical barriers, notably since the closure of Budapest's two largest needle and syringe programs. This shutdown has led to a troubling invisibility of thousands of people who use drugs. Results of a 2019 study corroborated this crisis, revealing reduced access to critical health

screenings, vein care, and social services. The resulting social isolation is profound, with people who use drugs have fewer opportunities to connect with social workers or even find a place for rest. During the COVID-19 pandemic, the HepaGo outreach initiative emerged, targeting marginalised people who use drugs, mostly experiencing homelessness, with testing, counselling, and linkage to treatment. However, reliant on private funding, HepaGo's future without stable government support remains uncertain.

Further complicating is the lack of free hepatitis B and hepatitis A virus vaccines at most harm-reduction sites. PrEP is available, but not without cost, and many people who use drugs remain uninformed about PrEP, partly because service providers lack awareness, likely influenced by the treatment's non-reimbursable status.

As for treatment accessibility, past requirements of drug abstinence for HCV treatment have been lifted, reflecting a policy evolution. However, the main obstacle remains the insufficient reach of harm reduction services to facilitate testing, counselling, and assistance for people who use drugs to initiate treatment. Although antiretroviral therapy and treatments for HCV, HBV, and tuberculosis are available, they are characterised by geographical limitations and potential stigma and discrimination among medical staff against people who use drugs.

Collaboration between harm reduction providers and hepatologists notably exemplifies the bridge from community-based services to treatment. HepaGo stands out as the best practice example in Budapest, with a dedicated multidisciplinary team guiding the most marginalised PWUDs towards treatment.

CHALLENGES AND POSSIBLE SOLUTIONS

Improving harm reduction services to meet international standards is Hungary's foremost national challenge in improving access to treatment, care, and prevention services. This includes enhancing needle and syringe programmes and opioid agonist treatment availability, which is integral for improving HIV treatment access. Crucially, this requires not only increased but also sustainable funding. Government policies should expand the fixed annual funding to genuinely reflect the operational costs of these services, reinstating annual grants and eradicating the societal stigma and discrimination against people who use drugs and harm reduction services.

Tailored services are also required to address the unique needs of various

key populations, such as the LGBTQI+ community, ageing and young people who use drugs, women, and people in prison settings. Additionally, integration of harm reduction into broader health and social care services, particularly those for HCV and HIV treatment, is vital. Establishing a robust connection between mental health services and drug services is urgent, ensuring those with dual diagnoses receive evidence-based and compassionate support. A stronger collective voice for people who use drugs is essential, backed by harm reduction organisations, to involve impacted communities directly in decision-making processes.

Legally, decriminalising drug use, or at least expanding and refining alternatives to punitive sanctions, is essential to address small-scale drug offences with appropriate responses. Eliminating systemic discrimination within health and social care systems, exploring alternative drug policies, and establishing a legal framework for supervised drug consumption rooms and other harm reduction services are imperative steps towards improved prevention of infectious diseases. Moreover, reconstructing the institutional framework, such as re-establishing the Ministry of Health and the Ministry of Social Affairs with dedicated drug coordination departments, is a crucial element of the reform. The reformation of a National Drug Prevention Institute and a National Centre of Epidemiology, alongside creating a new national drug strategy and an HIV strategy accompanied by adequate funding, monitoring, and evaluation, is another recommended necessity. Restoring constructive dialogue and partnerships with civil society organisations in drug policy formulation is vital.

Addressing the scarcity of trained professionals in harm reduction is a challenge that must be urgently overcome. Improving the working conditions and attractiveness of the field for young professionals, including medical, psychological, and social work personnel, is essential. This could be facilitated by integrating drug and HIV issues into general training, providing specific courses on harm reduction and HIV, and fostering an environment of de-stigmatisation and sensitivity towards drug use. In addition, ensuring mental health support to prevent burnout and sustainably funding advocacy work are also crucial.

KEY RECOMMENDATIONS:

- Scale up harm reduction services to align with international guidelines backed by sustainable funding.
- Establish specific services to reach key populations, ensuring integration into broader health and social care frameworks.
- Decriminalise drug use and improve access to alternatives to criminal sanctions and eliminate systemic discrimination in health and social systems.
- Develop a legal framework to support harm reduction services and reinstate drug coordination structures and strategies.
- Enhance the training and working conditions for harm reduction professionals and support the advocacy work of civil society organisations.

ITALY

INFECTIOUS DISEASES: EPIDEMIOLOGICAL OVERVIEW

The situation of infectious diseases among people who use drugs, particularly those who inject, represents a complex and dynamic epidemiological challenge. Understanding these infections' incidence and transmission trends is critical for implementing effective public health strategies and interventions.

In the case of Italy, it is pretty evident that one of the severe challenges is the availability of data. The most recent information from the National Health Institute (Notiziario dell'Istituto Superiore di Sanità) does not include specific incidence numbers for most infectious diseases among people who use drugs, except HIV. According to this data, in 2021, 74 newly diagnosed HIV cases were identified among people who inject drugs, which constituted 4.2% of all incidents that year. The main route of infection was heterosexual contact, with 44% of the incidents identified as such. Meanwhile, the proportion of new infections attributed to GBMSM was 39.5%.

Information on other infectious diseases can be found in the national drug report. However, this includes only data about roughly 120 000 individuals in public drug treatment services. In this context, a significant proportion of people who use drugs were tested for major blood-borne infections in 2021 (28% for HIV and 22% for HCV and HBV). The prevalence of HIV in this group was 4.3%, while the prevalence of HBV and HCV was 2.1% and 39%, respectively .

The high prevalence of HCV among people who use drugs (likely higher in the entire population than among individuals in treatment) highlights the enduring risks associated with injecting practices. Despite improvements in HIV prevention, the transmission dynamics of Hepatitis C require attention and tailored strategies focused on harm reduction.

DRUG USE PATTERNS & TRENDS

In Italy, the current situation of drug use and its patterns is not clear due to the absence of comprehensive and up-to-date estimates of people who use drugs at a national level. The last

estimates from 2017 show that the lifetime prevalence of any illicit drug use in Italy was 33.3%, while recent use (last year) and current use (previous month) were 10.6% and 5.6% among the adult population, respectively. The recent and current use was roughly twice as prevalent among young adults (15-34) than in the entire adult population.

The more recent insights come from the data concerning those who seek treatment. In 2021, 123 871 individuals were enrolled in public drug treatment services. Within these services, the use of opiates, cocaine, and cannabis stands out, shedding light on the trends of substance use among Italians.

The landscape of drug dependency has been evolving, with distinct trends emerging among new and long-term service users. A large majority (63.8%) of those in treatment are experiencing opioid dependence, reflecting a continuous challenge for the public health care system. Interestingly, this figure drops to only 26.3% among people entering treatment for the first time. Cocaine, on the other hand, has emerged as the primary substance for 43% of new entrants into treatment programmes, contrasting with 20.4% of the longer-term service users. These data suggest a clear shift in drug preferences that aligns with the dynamic observed in other countries.

The ways of drug administration are equally diverse and indicative of deeper substance use narratives. Among the established clients, the practice of injecting drugs is notable (being the main route of consumption for 32% of individuals), though even more of them opt for smoking or inhaling (36.6%). New clients, however, exhibit a markedly different pattern, with over half favouring smoking or inhaling and a mere 6.4% using injections. Snorting is a common alternative across both cohorts, with one in five individuals preferring it.

DRUG USE AND LAW

In Italy, the legal framework distinguishes between personal use and possession and trafficking, with a strong inclination towards administrative rather than criminal penalties for people who use drugs.

In 2014, Law 309/1990 was reintroduced (as amended by the popular referendum which had taken place in 1993), as the new law 49/2006, which in 2006 had introduced harsher penalties for personal use was abrogated by the Constitutional Court. Personal consumption of drugs has been decriminalised and is no longer a penal offence. Instead, it is seen through the lens of administrative misconduct that cannot result in applying punitive or rehabilitative instruments. Those found using drugs are subject to administrative consequences but spared from criminal proceedings and records. Administrative sanctions are however noted in the police index records kept by the Ministry of Interior, which are consulted in case

of police controls for drug possession. Information about previous sanctions and behaviours remain available with obvious consequences on police' attitudes and stigmatisation of people who use drugs.

Similarly, possession is not criminally punishable when intended for personal use, though administrative sanctions may apply. The law distinguishes personal possession from possession with intent to distribute. It is up to the judge to evaluate drug possession on a case-by-case basis, considering both the substance quantity (established according to criteria set by jurisprudence) and other circumstances. Current legislation does not eliminate the risk of transforming a user into a dealer, mainly because evaluations are made based on active ingredient quantities, often unknown by people who use drugs. For such reasons, a certain number of individuals who are not dealers end-up in prison.

Exceeding the substance quantity threshold shifts the legal perception from personal use to potential trafficking (especially in specific circumstances like possessing many small portions of substances and/or weights), which carries severe criminal implications, including substantial fines and extensive prison sentences from six to twenty years.

In recent years, Italian society has witnessed a lively debate regarding drug regulation, with a particular focus on cannabis. Advocacy groups, including various professionals and citizens, have sparked discussions toward more liberal policies, including legalisation and broader decriminalisation efforts. These discussions reached momentum with a significant push for a referendum in 2022, rallying over 600 000 signatures in pursuit of legalising cannabis. However, the movement encountered a judicial barrier—the Constitutional Court declared the referendum inadmissible.

In sum, the Italian legal landscape tells a story of a society in flux, with prevailing legal regulations founded on a compromise between punitive measures and progressive attitudes towards drug use.

HARM REDUCTION FRAMEWORK: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND AFFORDABILITY

In Italy, harm reduction is an integral part of the national approach to public health challenges, specifically in the context of HIV prevention among people who use drugs. This approach is demonstrated within the National AIDS Plan, which recognises harm reduction interventions as essential in this context. These interventions are not just suggested but are enshrined in the country's 'Essential Assistance Levels' (2017), reflecting a commitment to align with international standards and recommendations.

Notwithstanding this important recognition, the situation is still poor and contradictory. Harm reduction as part of the national Essential Assistance Levels remains a reality only on paper, as since 2017 no steps forward have been made by the Ministry of Health to implement harm reduction interventions in a concrete and cogent way. There is no reference to harm reduction in the National Action Plan on Drugs that has not been updated since 2010. As health policy is a regional competence – in line with national guidelines and Essentials Assistance levels – harm reduction is well developed only in one-third of the 20 Italian Regions, where a few good practices are in place; the rest of the country has no sufficient coverage of harm reduction services.

Where harm reduction is implemented, it is not confined to specific drug prevention and treatment services; recognition is devoted to the need to integrate it into the broader healthcare system. Such embedment is presently only limited to drug treatment and psychological counselling, with room for improvement in the areas of housing, family support and employment.

Funding for harm reduction services is provided by the regional health departments, yet it falls short of the actual needs and is not uniformly distributed across the Italian regions. The South of Italy, in particular, faces a scarcity of harm reduction programmes. Furthermore, the sustainability of all services in this field is jeopardised by the precarious nature of the funding, which is neither guaranteed nor consistently provided year after year.

Although in Italy, the framework of harm reduction services highlights a commitment to health equity, it is not without its areas of tension. The country's universal health system is founded on the principle of health care as a right, not a privilege. Following this principle, Italy ensures the provision of low-threshold harm reduction services that are accessible without any preconditions. This approach facilitates anonymous access, catering to those who might otherwise avoid seeking help due to stigma or other reasons.

Nevertheless, there are severe limitations in service accessibility. Due to inadequate funding, harm reduction services cannot operate with the scope needed to adequately meet the needs of service users, particularly in terms of working hours and days of operation. This shortfall presents a significant barrier to individuals in need of continuous support.

While legal frameworks do not inhibit access, practical implementation does. Geographic accessibility remains a challenge, with a significant disparity between the northern and central regions (where the services are available) and the rest of the country (where the services are scarce). Even in

the areas with more developed harm reduction, however, one can clearly see a concentration of services in bigger cities, leaving individuals in smaller towns or more remote areas disadvantaged.

Moreover, while inclusive practices are in place, specific inadequately served populations such as women, the LGBTQI+ community, Roma and Sinti, and migrants find the current services insufficient. Although some projects addressing these groups exist, they are small in scale and unable to fully handle the nuanced needs of these diverse groups.

The COVID-19 pandemic further complicated the landscape. While mobile outreach services demonstrated resilience by maintaining operations, indoor services faced significant disruptions. The imposition of restrictions, the need for appointments, and limitations on client numbers restricted the accessibility of harm reduction during an unprecedented global health crisis.

HARM REDUCTION SERVICES

The range of harm reduction services offered in Italy is relatively comprehensive but needs more innovative interventions. Opioid agonist treatment is available through public drug treatment services, while non-governmental harm reduction service providers facilitate needle and syringe programmes, condom distribution and harm reduction education; these intervention by NGOs are anyway supported by public financing. Naloxone is also widely accessible through pharmacies and harm reduction service providers.

NALOXONE

In Italy, naloxone is available without a prescription, making it legally accessible over the counter in pharmacies nationwide since the middle 90s. Accessibility, however, is affected by the lack of awareness among pharmacists and the public regarding its availability, effects, and the legal framework governing its distribution. Although this knowledge gap may hinder access to naloxone, its non-prescription status makes Italy a positive exception in the European landscape.

Naloxone is not limited to pharmacies; it extends to community service providers and is available for use in emergencies. However, there remains a notable gap in direct access to naloxone by people who use drugs. This situation points to a need for the development of take-home naloxone programmes and education that could bridge the information gap and ensure broader and more effective dissemination of naloxone.

DRUG CHECKING

On another front, the state of drug-checking services in Italy presents a more complex picture. Some pilot programmes are in place, suggesting an acknowledgement of the potential

benefits of drug checking as a harm reduction tool, but they are available in very few Regions.

Some initial legal barriers have been overcome also thanks to the involvement of Public Drug Units and public analysis laboratories and the support of the Ministry of Health; some rules have been established and need to be respected by professionals (e.g. to avoid handling the clients' doses).

NEEDLE AND SYRINGE PROGRAMMES

In Italy, the situation for accessing needles and syringes by people who inject drugs shows a dichotomy between availability and practical accessibility. While there are various channels through which a person can procure needles and syringes - including vending machines, pharmacies, and online ordering options - these options require payments.

Harm reduction services providers offer distribution of needles and syringes at no charge via street work or drop-in centres. However, such programmes have limited geographical coverage, being predominantly accessible in larger cities. The absence of NSPs within reachable distances poses a significant challenge, restricting access for people outside major urban areas. There is a pressing need for a more equitable distribution of NSP services to ensure that all people who inject drugs in Italy have easy access to them.

OPIOID AGONIST TREATMENT (OAT) AND HEROIN-ASSISTED TREATMENT (HAT)

Opioid agonist treatment is a critical component of the healthcare system's response to opioid dependency. Methadone and buprenorphine are the primary medications available for OAT, with the choice between them depending on individual medical history and therapeutic needs. The decision-making process for medication selection does not appear to be regulated by any specific document but is left to the discretion of healthcare professionals based on each patient's unique situation.

The operation of OAT is the task of public drug treatment services and some private ones accredited by the regional health departments. These institutions are also responsible for managing take-home OAT protocols, which include providing written authorisation for clients to carry or transport their medication to accommodate the needs of travelling patients.

To initiate OAT, individuals must obtain official documentation of their dependency status from public drug treatment services. Continued participation in OAT is contingent upon adherence to the treatment regimen. Documented non-adherence can result in the discontinuation of therapy.

The names of individuals on OAT are officially recorded by the treatment services, raising concerns about it acting

as a deterrent for some individuals. However, the data is treated with high confidentiality and is not leveraged against the individuals in treatment.

Heroin-assisted treatment remains illegal and thus inaccessible in Italy, drawing a clear line between the accepted forms of opioid agonist therapy and other potential treatment modalities.

DRUG CONSUMPTION ROOMS

There are currently no drug consumption rooms in Italy. However, their absence is not a result of explicit legal prohibitions but rather a lack of political will. This absence of a legislative blockade suggests that, theoretically, the path to establishing DCRs is open, awaiting the appearance of motivated and favouring policymakers.

The primary practical challenge in launching DCRs involves securing the necessary space and obtaining funding from local or regional health or social institutions. These elements are essential to support the operation of DCRs.

To navigate these challenges, a robust advocacy campaign is needed, highlighting the success of DCRs in international contexts. Presenting evidence-based research demonstrating their efficacy in preventing overdoses and enhancing the well-being of people who use drugs could gather some support. The deadlock caused by a lack of political motivation might be overcome through strategic efforts to inform and persuade.

In 2006-2007 a campaign in favour of DCR implementation was carried on in the city of Turin: a municipal commission discussed the proposal, which was stopped by the government. Since 2022, some cities of the network ELIDE (cities for innovative drug policies), with the support of CSOs have been working towards a protocol to implement DCRs.

CHEMSEX SERVICES

There is a notable gap in service provision in this context. Presently, specific services for people engaging in chemsex are limited and tend to be offered primarily through checkpoints and NGOs focused on preventing HIV, hepatitis and STIs. These organisations, however, while not explicitly targeting chemsex participants, often serve key populations that include them, such as men who have sex with men. They do not focus their work on people who use drugs.

Despite the existence of these services, there remains a substantial unmet need within the chemsex community. To provide better care to these individuals, an evolution in the approach of harm reduction providers is necessary. This includes expanding training for both harm reduction service providers and public drug treatment services. With improved training, professionals would be better equipped to provide tailored counselling and support specifically designed for the unique challenges and needs of chemsex users.

PRISONS

Within the boundaries of the prison system, a stark contrast emerges in the availability of harm reduction services compared to the outside world. While people in prison settings have easy access to OAT and are provided testing and treatment options for HIV and hepatitis, there is a significant gap in the provision of other critical harm reduction measures. Notably, services such as needle and syringe programmes and the distribution of condoms, which are integral components of comprehensive harm reduction strategies in the community, are absent within prisons.

INFECTIOUS DISEASES SERVICES: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY, AND AFFORDABILITY

In the context of infectious diseases, people who use drugs face a complex scenario when it comes to accessing prevention services. Formally, there are no substantial barriers—undocumented migrants may even obtain a temporary stay card granting them service access. However, the practicality of this access is more complicated, particularly concerning vaccinations for HBV and HAV. While vaccinations are available, they are not administered through harm reduction service providers. Individuals must navigate the public health care system to access them, often facing stigma and cultural or language obstacles.

PrEP is officially available and reimbursed as of June 2023. However, the guidelines for eligibility do not explicitly include all people who use drugs, focusing instead on chemsex participants with specific risk profiles. Although community checkpoints could facilitate broader access, knowledge, and awareness about PrEP among people who use drugs, and information provision by service providers is insufficient. This has resulted in little to no demand from people who use drugs, exacerbated by the disconnection between harm reduction and PrEP services.

On a more positive note, substance abstinence is not required for enrolment or continuity in treatment for HIV, TB, HCV, HBV, or STIs. Community-based services are committed to client care by actively coordinating with infectious disease hospitals to ensure that people who use drugs and test reactive receive the necessary care. This coordinated effort highlights the dedication to facilitating linkage to care.

CHALLENGES AND POSSIBLE SOLUTIONS

In the context of advancing public health, particularly concerning individuals who use drugs, the Italian situation presents distinct challenges and priorities. The pressing issue remains to enhance access to treatment, care, and prevention services for HIV and

associated co-infections. Paramount among these challenges is the need to establish drug-checking programmes and drug consumption rooms, alongside the integration of needle and syringe programmes within the prison system. These initiatives are critical in mitigating the risks associated with drug use and in fostering a safer, more supportive environment for affected communities.

Concerning the legal framework, the barriers hindering progress are not inscribed in law but are instead rooted in ideological perspectives and a lack of political will to elicit change. Such obstacles are arguably more formidable than statutory constraints, as they require a shift in mindset and policy orientation.

In practical terms, a range of measures can improve the situation. Enhancing psycho-socio-educational support within hospitals, emergency rooms, and treatment services is vital to bridging the gap between the medical and psychosocial aspects of individuals' well-being. Furthermore, establishing, or refining protocols that facilitate cooperation between public and private entities and between harm reduction services and hospitals is crucial for ensuring a continuum of care.

The overarching principle dictates that drug policies ought to be grounded in pragmatism, disregarding ideological stances that fail to recognise the complex reality of drug use and its intersections.

TO THIS END, IT IS RECOMMENDED TO:

- Implement drug-checking programmes and DCRs.
- Introduce NSP within the prison system.
- Adopt pragmatic rather than ideological drug policies.
- Enhance psycho-socio-educational support in medical and treatment facilities.
- Establish cooperative protocols between various service providers for integrated care.

LITHUANIA

INFECTIOUS DISEASES: EPIDEMIOLOGICAL OVERVIEW

The incidence of infectious diseases among people who use drugs and people who inject drugs in Lithuania reveals significant health challenges in this vulnerable population. According to the data provided by the National Public Health Centre, there were 32 new cases of HIV attributed to injecting drug use in 2022 and 29 in 2021. This data indicates a slight increase in the incidence rate within this group.

Although the data on Hepatitis C incidence is not explicitly collected for people who use/inject drugs, the Annual Report by the National Drug, Tobacco, and Alcohol Control Department provides alarming statistics for Hepatitis C prevalence in this population. The data shows that in 2019, a staggering 85.9% of people who inject drugs in five surveyed towns were found to have HVC, a sharp increase from 77% in 2015. For Hepatitis B, the same source reported a decrease in prevalence from 10.5% in 2015 to 4.9% in 2019 among people who inject drugs. This data, albeit limited, points to a pervasive issue with bloodborne infections among this group, especially in the context of HCV.

Looking at the broader epidemiological trends, the HIV incidence in Lithuania showed an increase in 2022, with 8.9 cases per 100 000 of the population. Although a large portion of this rise can be attributed to the recent influx of Ukrainian refugees, the rate of HIV incidence among Lithuanian citizens rose from 3.95 to 4.7 per 100 000 inhabitants.

Regarding the routes of transmission, among all 3 835 HIV cases diagnosed in 1988-2022, the majority was attributed to injecting drug use (54.8%) and approximately a quarter to heterosexual intercourse (24.6%). Recently, there has been a notable shift in the prevalent transmission route. In 2022, the most significant proportion of new HIV cases was due to heterosexual transmission (60.3%), followed by injecting drug use (12.7%) and sex between men (11.5%). There has also been a significant reduction in late-stage HIV diagnoses

from 2019 to 2021 (13.6% and 46.2%, respectively), indicating some progress in earlier detection and intervention.

Despite a decrease in new cases overall, and specifically among people who inject drugs in the last years, this group still accounts for a significant portion of new HIV cases. It is, next to people in prison settings and GBMSM a population where HIV is concentrated.

DRUG USE PATTERNS & TRENDS

Lithuania is a country struggling with the complexities of drug use among its population, with the proportion of people who inject drugs higher than the EU average.

The most recent estimates from 2017 show that there were approximately 9 000 individuals using drugs intravenously, with high-risk opioid users numbering around 7 500 and individuals using amphetamine close to 6 000—a notable figure given Lithuania's population of 2.77 million. These high-risk groups were predominantly found in urban centres, with Vilnius, Klaipėda, and Kaunas having the highest concentrations.

Fast forward to 2021, a population survey illuminated the broader landscape of drug use, revealing that 14.1% of the adult population (aged 15–64) had used any illicit drug at least once in their lifetime, with 4.5% reporting use in the past year (recent use) and 1.6% in the last 30 days (current use). The prevalence of drug use was higher among males and young people (15-34 years old).

General population survey shows that cannabis (like trends seen in other EU member states), followed by cocaine and MDMA and amphetamine-type stimulants topped the list of illicit drugs most widely used in Lithuania. The results are slightly different for an internet-based survey conducted by the EMCDDA, with MDMA on the 2nd position after cannabis, followed by LSD, cocaine, and ATS. Contrasting the general population data, opioids were the most used substance among individuals seeking drug-related treatment in 2021 (78%).

The COVID-19 pandemic influenced drug use patterns, causing an increase in cannabis use, while MDMA/ecstasy saw a decline.

Moreover, 2021 sewage analyses in three major cities showed a surge in cocaine use since 2020, along with increased amphetamine and methamphetamine traces. MDMA use continued its downward trajectory. Syringe residue tests conducted the same year found diphenhydramine in a staggering 96% of samples, with carfentanyl present in 49%, indicating a common mixture of these substances – a trend that has already been seen before the COVID-19, but not during the pandemic.

DRUG USE AND LAW

The Lithuanian legal framework, informed by various codes and ongoing political debate, sketches how drug use is perceived and addressed in the country.

Drug use is penalised under the administrative law. Detection of drugs in a person's blood or urine results in financial penalties, which escalate from a nominal fine for first-time offenders to higher fines or mandated drug prevention courses for repeat offences. Despite their intent, it is argued that these drug prevention courses are often regarded as mere formalities by those subjected to them.

The legal landscape experienced a significant shift on January 1, 2017. Before this date, possession of small amounts of illegal substances fell under both the Administrative and Criminal Codes, creating a legal collision. However, introducing the new Administrative Code removed such sanctions from its jurisdiction, leaving drug-related matters exclusively to the Criminal Code. Possession of small amounts for personal use is treated as a misdemeanour with a range of penalties from (extremely high) fines to community service to up to two years of imprisonment. Fines accompanied by a criminal record have emerged as the most applied penalty.

The adjudication of drug possession relies heavily on the recommendations of the Minister of Health, which offers guidelines on what constitutes small, large, or extensive quantities of drugs. Courts often use this recommendation as their primary reference, and they give verdicts considering the amount of active substance possessed and not the total quantity of the confiscated drug.

Politically, Lithuania has recently seen lively debates centred on drug regulation. The national drug agenda envisages substantial legal revisions, including the decriminalisation of possession of small quantities of drugs for personal use, steering towards more health-oriented solutions. However, the political pathway to such reforms is filled with contention. Proposals have oscillated in Parliament, facing opposition and calls for revision. The latest developments in this story focused on decriminalising cannabis possession only, viewed as the only compromise that might be politically feasible. Nevertheless, the ruling coalition struggles with its identity, caught between liberal aspirations and less liberal leanings of the public opinion, casting doubt on whether even modest decriminalisation efforts will materialise.

HARM REDUCTION FRAMEWORK

In Lithuania, harm reduction is an officially recognised component within the country's health strategy, firmly embedded in several legislative and policy documents. These include directives from the Minister of Health, the comprehensive National Agenda for Drug, Tobacco, Alcohol Control, Prevention, and Drug Harm Reduction, and targeted plans addressing the enhancement of treatment and harm reduction service accessibility and quality.

Funding for harm reduction has been a long-standing issue, characterised by insufficient, unstable, and fragmented financial resources. Historically reliant on extremely limited national grants, sporadic municipal support, and foreign donations, the situation saw some improvement with the allocation of substantial EU Structural Funds for 2020-2022. In 2022 and 2023, delayed calls for grant proposals for national funds led to underutilised budgets due to the limited capacity of service providers. While some municipalities continue to offer meaningful support, the sustainability of harm reduction financing remains a concern, with the upcoming year's budget still being determined.

This story of harm reduction in Lithuania paints a picture of a country that recognises the importance of such services but struggles with consistent implementation and integration within the broader healthcare and social service frameworks.

HARM REDUCTION SERVICES

The country's harm reduction services are mandated to provide needle and syringe programmes, distribution of other safe drug use supplies and harm reduction materials (e.g., condoms, lubricants, disinfectants, self-tests for infectious diseases), and a range of information, counselling, and educational interventions. There is also a range of non-mandatory services stipulated in the national policy documents, including, but not limited to, rapid testing for infectious diseases, distribution of naloxone, wound care and necessary supplies, and treatment adherence support.

The availability of both types (mandatory and optional) interventions varies significantly across service providers. Some services, such as needle exchanges, are omnipresent, while others, like distribution of lubricants or specialised counselling, are less uniformly available. Naloxone distribution, crucial for opioid overdose prevention, is in place, but its provision is subject to specific medical settings and licensing requirements. Certain services, such as rapid testing for infectious diseases and wound care, are constrained to quasi-medical settings or medical centres, reflecting a gap between harm reduction potential and practice.

Harm reduction services stand relatively isolated, with no effective system for referring individuals to broader social services such as educational or vocational training, psychological or family support, or housing services.

NALOXONE

Naloxone is legally available and relatively widely accessible, though not without limitations. It is available at emergency units and can be purchased in pharmacies. Moreover, it is possible to obtain naloxone at community low-threshold service providers collaborating with a licensed health care clinic, albeit with certain conditions. Namely, individuals must consult a doctor on site and sign a distribution sheet.

Naloxone distribution also extends to specialised centres, such as the five branches of the Republican Centre for Addictive Disorders, and prisons, which offer naloxone to individuals before their release. It has been noted, however, that released individuals often do not take the naloxone provided to them, with the reasons for this disinterest remaining unclear as the practice is relatively new in the prison system.

DRUG CHECKING

Drug checking is not available in Lithuania. This is primarily due to the criminalisation of drug possession, which places drug checking in a precarious legal position, bordering on criminal activity. In recent years, small-scale initiatives to provide drug testing kits have been implemented at summer music festivals. Still, state funds do not support these efforts and are not part of a broader, systematic harm-reduction strategy.

NEEDLE AND SYRINGE PROGRAMMES (NSPS)

Needle and syringe programmes for people who inject drugs have been in place since the mid-1990s. Ever since, they have suffered from low coverage, limited range of interventions, and chronic underfunding, jeopardizing their sustainability. The coverage of NSPs has been low, with only 28.5% of people using drugs high-risk regularly accessing NSPs in 2021, each of them receiving only 30 clean syringes per year on average (in contrast to 110 needles-syringes in case of other, non-high-risk clients). Financially, only a few municipalities allocate funds for NSPs. Despite a recent influx of EU Structural Funds providing significant support for several sites, utilising available national funds has been inefficient due to late allocations and application complexities.

Policy and practical barriers also hamper access to NSPs. These include the reluctance of municipalities to offer services, a scarcity of competent providers, a history of insufficient funding, and prevalent stigma. Legally, NSPs encounter hurdles when providing certain harm reduction services, like rapid testing for infectious diseases

and dispensing take-home injectable naloxone, due to regulations requiring affiliation with licensed healthcare institutions and the presence of licensed medical personnel.

OPIOID AGONIST THERAPY (OAT) AND HEROIN-ASSISTED TREATMENT (HAT)

Opioid agonist therapy in Lithuania utilises both methadone and buprenorphine, with basic state health insurance covering costs only recently for both—buprenorphine coverage starting towards the end of 2022. Previously, methadone was the only state-funded option, leading to an implicit preference as individuals would need to self-fund buprenorphine. OAT can be accessed at one of the five existing branches of the Republican Centre for Addictive Disorders as well as in local primary mental health clinics. However, contrary to the official policy, not all offer OAT.

OAT is provided through state health insurance and national budget allocations. Coverage of OAT is low, at 12% in 2021 (including buprenorphine which was not compensated by state in 2021), and is not geographically accessible, requiring patients in many areas to travel substantial distances for treatment. Stigma also presents a significant barrier to the provision of OAT in many municipalities.

Initiating OAT requires mandatory state health insurance and having a history of unsuccessful alternative treatments for dependence.

Regarding the treatment regimen, take-home dosages of methadone are allowed for up to one week, depending on the individual's stability and risk of misuse or relapse. Continuation of OAT may be ceased under certain conditions, such as regular illicit substance use, though this decision weighs multiple factors like overall health and societal impact. In prisons, violent behaviour towards staff or non-compliance with treatment plans can result in the discontinuation of OAT.

Client records, including OAT, are documented and accessible to medical personnel and state institutions under specific conditions, ensuring confidentiality and reducing the risk of the information being used against individuals in treatment.

Heroin-assisted treatment (HAT) is not available.

DRUG CONSUMPTION ROOMS (DCRS)

There are no drug consumption rooms available, primarily due to the criminalisation of possession of even small amounts of illicit substances under the Criminal Code. This legal barrier, alongside the high level and prevalence of stigma attached to drug use, presents formidable challenges to establishing DCRs. Policymakers resist the idea; attempts to include DCRs in health policy documents have been politically

suppressed. Additionally, the current climate of heavy criminalisation and political opposition discourages existing low-threshold service providers from attempting to set up DCRs. Overcoming these barriers seems unlikely without a shift in the legal stance on criminalisation and a substantial change in the political and social perception of DCRs and drug use.

CHEMSEX SERVICES

Harm reduction services tailored specifically for people engaging in chemsex are essentially non-existent, except for one facility in Vilnius that provides an HIV rapid testing checkpoint predominantly for the LGBTQI+ community, among whom people practising chemsex are likely to be found. The current services do not explicitly cater to the needs unique to people engaging in chemsex, and data on the number of such individuals utilising harm reduction services is not available.

To enhance services for people practising chemsex, there is a clear need for more information about chemsex itself and the specific needs of those who participate in it. Lithuania is only beginning to recognise and address these needs within its low-threshold services, which have traditionally focused on people who inject drugs. Thus, a tailored approach that is inclusive and responsive to the chemsex community is imperative for improvement.

PRISONS

In the Lithuanian prison system, there are virtually no harm reduction services. No needle and syringe programmes exist within these settings, and interventions such as condom distribution are restricted solely to the context of intimate visits. This problem persists despite numerous HIV outbreaks over two decades and intense advocacy from NGOs and international bodies for the implementation of NSPs in prisons.

OAT in prisons is a relatively recent development, introduced less than ten years ago following a landmark legal victory where an NGO supported an OAT client's fight against the unlawful termination of OAT upon incarceration. Initially, only a handful of individuals were enrolled in OAT in prisons. Still, recent policy changes—triggered by adopting a new prison system order regarding the implementation of OAT—have seen participant numbers rise within the past one to one and a half years. Progress continues to be made with the introduction of a 2022 order on release preparation, which includes provisions for distributing naloxone to individuals nearing their release date. This initiative marks a step forward in addressing the risks associated with drug use post-incarceration.

HARM REDUCTION SERVICES: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND AFFORDABILITY

In the landscape of harm reduction and access to healthcare services in Lithuania, the story is one of commitment to inclusive support juxtaposed with systemic and practical challenges that affect service delivery.

Low-threshold services stand out for their universal and anonymous access, requiring no formal pre-conditions such as proof of insurance or residency, serving even undocumented individuals. However, these services operate within a framework that is only partially responsive to the diverse schedules of those they aim to support, with evening and weekend hours largely uncovered by services nationwide.

Insurance is a requisite for more structured treatment programmes, with state health insurance mandatory for citizens and Ukrainian refugees. The anonymity of low-threshold services is safeguarded by using a coding system for client statistics, which does not extend to OAT or antiretroviral therapy, where stringent pre-conditions apply.

There is uneven availability regarding geographical coverage, with only three out of five major cities hosting low-threshold sites and a minimal presence in smaller municipalities. This reflects a service distribution that heavily favours urban centres over rural areas.

Inadequately served populations such as women, the LGBTQI+ community, Roma, non-Ukrainian migrants, people who use drugs in a non-injecting way, and sex workers encounter a multitude of barriers. These include the limited operational capacity of services, insufficient funding, societal stigma, and a lack of specialised services or tailored approaches that meet their unique needs. For instance, specific demographic groups might require separate facilities or resources, such as baby formula for HIV-positive mothers, which is not funded.

The COVID-19 pandemic has further strained this fragile ecosystem, with one site ceasing operations over staff safety concerns, others reducing opening hours, and many limiting services to non-contact distribution of supplies. The pandemic also disrupted the provision of rapid testing services and slightly decreased the number of clients engaging with these services.

INFECTIOUS DISEASES SERVICES: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY, AND AFFORDABILITY

Like in the case of essential harm reduction, access to prevention and treatment of infectious diseases for persons who use drugs is characterised by both policy and practical barriers. While there is no explicit legal requirement for individuals to keep abstinence from drugs to access

treatments for infections like HIV, TB, or Hepatitis, there exist underlying barriers that make the access more complicated.

For prevention services, such as testing and vaccination for HIV, HCV, HBV, STIs, and TB, practical barriers are especially concerning. Vaccines for HBV and HVA are not freely accessible to all, as they are not fully reimbursed, even for those with mandatory health insurance. This stands as a significant access obstacle, particularly for marginalised groups such as people who use drugs.

When it comes to PrEP, although available, it is not reimbursed, placing it out of reach for many, especially for individuals who face social and financial challenges and may not be well informed about this possibility. Service providers tend to focus on immediate survival needs, with the high cost of PrEP and the absence of reimbursement mechanisms discouraging them from offering information on PrEP to people who use drugs. The need for PrEP among people who use drugs remains an area yet to be thoroughly researched, but those who are not socially disadvantaged may procure it out-of-pocket.

The accessibility of antiretroviral therapy is obstructed by insurance and logistical barriers; only specialists in major cities offer treatment, and initial tests require either insurance coverage or self-payment, which is a significant obstacle for some individuals, particularly those without personal identification. Furthermore, for Hepatitis C, treatment compensation is reserved for those in the later stages of the disease. In turn, for Hepatitis B and STIs, mandatory state health insurance or self-payment is again a prerequisite.

Tuberculosis treatment reveals a paradox: although individuals with TB automatically qualify for state health insurance upon diagnosis, accessing healthcare services for diagnosis remains a challenge.

Community-based services strive to bridge the gap to treatment with a variety of strategies. Several low-threshold centres have developed unique ‘green corridors’ for rapid linkage to HIV care, facilitated through agreements with healthcare institutions or individual practitioners and supported by foreign donors or municipal funds. These centres assist clients with obtaining mandatory health insurance and arranging medical appointments. However, for Hepatitis B/C, TB, and STIs, where free diagnosis and treatment are contingent on having health insurance, the challenge intensifies. If acquiring insurance is not an option, the last resort is self-funded treatment, an often-impossible solution for people who use drugs.

The current system is fragmented and incoherent, lacking a unified approach. This gap in the treatment system highlights the need for enhanced

efforts to connect individuals to care, particularly among socially disadvantaged individuals who use drugs. The story of harm reduction in Lithuania is thus one of effort amidst adversity, with a system striving to overcome structural barriers to meet the urgent health needs of its most vulnerable citizens.

CHALLENGES AND POSSIBLE SOLUTIONS

In addressing the national challenges related to the provision of treatment, care, and prevention services for HIV and co-infections among people who use drugs, it has been recognised that current HIV testing policies in Lithuania do not sufficiently target key populations. The responsibility for funding rapid HIV testing, a critical method for detecting most new HIV cases, has fallen mainly on non-governmental organisations, yet the provision remains inadequate. This shortfall has led to a concerning trend where many individuals are diagnosed in the later stages of HIV.

Legal constraints also hinder the potential for rapid testing by low-threshold service providers in non-medical settings, which could serve as an essential strategy for reaching key at-risk populations. Furthermore, the country's efforts to meet the UNAIDS 90-90-90 target are stalled, with only 43% of diagnosed individuals on antiretroviral therapy and no structured support system to assist key populations in accessing ART. The process for people who use drugs to access ART is notably burdensome and complicated, often overwhelming for those who are socially disadvantaged. Finally, no dedicated services support these individuals in adhering to ART regimens.

Coverage for OAT and NSP remains alarmingly limited. A history of inadequate funding hinders service providers who cannot expand their services meaningfully. This issue is exacerbated by persistent, substantial stigma within the society.

Criminal penalties for drug possession, even in small quantities for personal use, act as a significant deterrent to service expansion and engagement of people with living experience, further complicating the situation for individuals seeking assistance.

KEY RECOMMENDATIONS:

- Revise the HIV testing policy to include key populations.
- Remove legal obstacles to allow rapid HIV testing in non-medical settings by trained lay providers.
- Develop and implement a system to facilitate key populations' access to ART.
- Simplify the process for accessing ART, tailoring it to meet the needs of socially disadvantaged PWUDs.
- Establish support services to enhance ART adherence among PWUDs.
- Increase funding and resources for OAT and NSP to expand coverage.
- Decriminalise the possession of small amounts of drugs to remove barriers to service access and reduce stigma.

PORTUGAL

INFECTIOUS DISEASES: EPIDEMIOLOGICAL OVERVIEW

The epidemiological landscape of infectious diseases among people who use drugs in Portugal has been marked by significant challenges and changes over the years.

In the years 2020 and 2021, Portugal witnessed 41 new HIV cases among people who inject drugs, with a demographic distribution of 34 men and 7 women, and an average age of 44. These cases among PWID represented 2.3% of the total HIV cases in the country for that period.

The prevalence of Hepatitis C among people who inject drugs in Portugal is alarmingly high, with data indicating levels above 80%. This is corroborated by the most up-to-date data from EMCDDA 2023, which reported an 82.5% HCV prevalence among people who use drugs in 2021 and HCV prevalence study conducted in 2018-2020 among people who inject drugs in contact with harm reduction services, which reported HCV prevalence at 70.5% level. Specific data on HCV incidence is not available, but the consistency in high prevalence rates across sources highlights the seriousness of the situation.

The situation of Hepatitis B among people who inject drugs in Portugal is not very well documented either, with no incidence data available. The National Programme for Viral Hepatitis 2022 Report notes a very low prevalence of Hepatitis B in the general population, while the EMCDDA reported a 6.7% prevalence of HBsAg among PWID in 2021. The discrepancy in data availability makes it challenging to draw definitive conclusions, but it suggests a less severe impact compared to Hepatitis C.

In 2021, Portugal reported a total of 1513 cases of Tuberculosis, 5.2% of which were among people who use drugs.

A dive into the epidemiological trends reveals that sexual transmission predominates new HIV infections in Portugal, accounting for 92.0% of cases diagnosed between 2020 and 2021. Heterosexual transmission is

more prevalent, but a considerable 56.0% of new diagnoses among men are attributed to sex between men. Injecting drug use, once a major driver of the HIV epidemic in Portugal in the 1990s, now represents a smaller fraction of the annual total of new cases. There has been an 88% reduction in cases associated with injecting drug use over the last decade (2012-2021). Still, 59% of new HIV cases among people who inject drugs are diagnosed late, highlighting an area in need of improvement.

DRUG USE PATTERNS & TRENDS

Examining drug use patterns and trends in Portugal brings to light a variety of substances used across different demographics. In 2018, an estimated 28 287 individuals were reported as using opioid in the last 12 months ('recent use'), which equals to a rate of 4.5% per thousand adult inhabitants (15-64 years). The years 2016 and 2017 saw a significant number of high-risk cannabis users, estimated at 60 215, and translating to a rate of 9% per thousand of adults The year 2015 witnessed 62 570 individuals using cocaine and 13 162 people who inject drugs, with rates per thousand adult inhabitants at 9.8% and 2.1%, respectively.

When looking into the most used drugs and their administration methods assessed based on general population surveys, cannabis tops the list in terms of lifetime prevalence at 12.2%, followed by cocaine (1.1%), and ecstasy (0.9%). Within conventional harm reduction services, the predominant patterns of use involve crack cocaine and heroin, primarily through inhalation, followed by injecting.

DRUG USE AND LAW

Portugal's drug policy has undergone a remarkable transformation since the turn of the century, setting a progressive precedent for how drug use and possession are handled. The adoption of Law 30/2000 in November 2001 marked a pivotal shift, decriminalising the use and possession of drugs for personal use, while drawing a clear line between people using drugs occasionally and traffickers (for more information, see the chapter Good Practices).

Recent political discourse in Portugal has been marked by debates around the legalisation of cannabis for adult use. Currently, there are multiple legislative proposals in play, with expectations for a new law to be potentially implemented by May 2024. This discussion represents a continuation of Portugal's forward-thinking approach to drug policy, reflecting a commitment to public health and harm reduction. Portugal's progressive stance on drug use distinguishes it on the global stage, emphasizing support and rehabilitation for people who use drugs while maintaining stringent measures against trafficking.

HARM REDUCTION FRAMEWORK

Portugal's approach to harm reduction is deeply rooted in principles of humanism and pragmatism, which has been acknowledged and adopted within the country's Drug Strategy since 1999. The legal framework in Portugal does not impose any limits or prohibitions on the provision of harm reduction services, reflecting a progressive approach to tackling drug use.

The connection between harm reduction services and other social services is strong, with educational, employment, vocational training, treatment, recovery, family support, and housing services being integrated through referral systems. This interconnectedness ensures a comprehensive support network for individuals in need of help.

Funding for harm reduction services primarily comes from the National Drugs Agency (SICAD) and is distributed predominantly to NGOs. However, this funding model presents challenges, as organisations are required to reapply for funding every two years, and only 80% of their expenses are covered. The rigidity in the types of harm reduction responses funded makes it very difficult to introduce innovations in services. Outdated community assessments and minimal community participation in creating necessary responses hinder the development of adequate services tailored well to the needs of people who use drugs. Furthermore, underfunding is one of the severe problems in the field, indicating a need for a more stable and sustainable financial model to support and expand harm reduction services in Portugal.

HARM REDUCTION SERVICES

A variety of harm reduction services are available across the country, however regional inequalities exist.
A significant portion of services is being offered on-site, mostly in major urban areas. These services range from the distribution of safer drug consumption materials, and access to opioid agonist treatment (OAT) with methadone and buprenorphine, to overdose prevention activities, including – to a limited extent – the use of nasal naloxone. Additionally, there are official drug consumption rooms operating in Lisbon and Porto, alongside services for HIV and viral hepatitis testing, drug checking, and decentralised HCV treatment. Holistic support is also provided in the form of housing initiatives, peer support, basic healthcare, mental health consultations, and case management.

However, certain medical services such as vaccinations for HBV, TB screening, and treatment are exclusively provided in clinical settings or certified vaccination centres. Notably, there is an absence of harm reduction services within prison settings, marking a gap in the nationwide approach.

NALOXONE

Naloxone is accessible but its distribution faces several challenges. Injectable naloxone is limited to healthcare settings and emergency situations, with an extension to drug consumption rooms in 2019. Nasal naloxone was introduced to harm reduction teams in early 2020; however, its supply has been inconsistent and its distribution uneven across regions. There is a noticeable lack of a national strategy or programme to oversee the distribution and training for naloxone use, leaving it to individual teams or organisations to decide on community distribution. Unfortunately, most teams are unable to distribute to people who use drugs due to insufficient stock. This has resulted in limited intervention for overdose prevention, especially in prisons where harm reduction interventions, including naloxone provision, are completely absent.

Nasal naloxone is available at pharmacies, but a medical prescription is required, and its cost of around 40€ poses a significant barrier.

DRUG CHECKING

Drug checking services are limited to specific locations and situations. Lisbon, the capital city, hosts the sole permanent drug checking facility, established in 2019 as a walk-in service. Additionally, a mobile unit targeting vulnerable people who use drugs operated as a one-year pilot intervention in 2022 within Lisbon, though its funding ceased subsequently. Beyond these, drug checking services are sporadically available at some large-scale music festivals.

The services, however, face notable barriers hindering broader accessibility. First and foremost, the permanent service in Lisbon exclusively caters to people who use drugs within nightlife settings, leaving those in other contexts without access. Furthermore, logistical constraints dictate that samples for analysis must be provided on-site, prohibiting mail-in submissions or collections via other services, such as conventional harm reduction facilities. These challenges underscore the need for an expanded and more inclusive approach to drug checking services in the country.

NEEDLE AND SYRINGE PROGRAMMES

The current situation of needles and syringes programmes can be described as uneven and concentrated, with a need for more comprehensive support and distribution channels. NSPs are implemented in a variety of ways including harm reduction teams primarily within non-governmental organizations (majority of distribution), pharmacies, and some primary healthcare centres. NSPs are predominantly focused in urban areas, leading to geographical disparities in access. People who inject drugs in rural areas face considerable barriers including stigma and a lack of

privacy. Furthermore, the availability of other drug equipment, such as crack smoking kits or sniff kits, is notably absent under the national and publicly funded NSP, indicating a gap in the resources provided. This absence, along with the lack of alternative distribution methods such as vending machines or postal services, highlights the limitations of the current system. These factors collectively contribute to an environment that may discourage people who use drugs from using the services.

OPIOID AGONIST TREATMENT AND HEROIN ASSISTED TREATMENT

Within the framework of OAT, methadone and buprenorphine are available. Data from 2021 indicates a client base of around 18 000 individuals participating in OAT programmes, with a larger proportion (63%) opting for methadone in comparison to buprenorphine (37%). This distribution is influenced by the ease of access to these medications; methadone is readily available at no cost through harm reduction services, whereas buprenorphine is free exclusively at the National Drug Agency's Treatment Centres (in other settings but it requires a co-payment).

The commencement of OAT aligns with globally recognised and nationally endorsed guidelines. For instance, the procedures for starting methadone in harm reduction settings are the responsibility of the respective institutions providing OAT, with a mandatory requirement to be transparent and share procedures with government entities responsible for technical supervision.

Importantly, in low-threshold harm reduction settings, methadone administration requires the presence of medical professionals, thereby excluding the possibility of take-home doses. On the other hand, OAT programs facilitated by the National Drug Agency do offer take-home options. However, in these more restrictive, high threshold service settings, continuation in OAT programs is contingent on negative drug tests and consistent attendance at medical and psychological consultations. Failure to meet these requirements could result in termination from the program.

Crucially, there is no official registry for individuals undergoing OAT, ensuring that participation does not become a barrier to seeking treatment and safeguarding against the potential misuse of such personal information.

Heroin-assisted treatment (HAT) is absent. Regarding the dispensation of OAT medications, methadone is offered at no cost in public drug treatment centres and harm reduction teams.

DRUG CONSUMPTION ROOMS

The country hosts three official drug consumption rooms: two in Lisbon (a fixed location and a mobile unit) and one in Porto, all regulated under the

2001 harm reduction law. Despite their legal standing, DCRs face significant challenges due to political, financial, and operational barriers, including the need for local government approval and initial funding, as well as achieving local consensus and maintaining trained staff.

The primary barriers for people who use drugs in accessing DCRs stem from their locations, opening hours, and internal rules, rather than confidentiality concerns, as registration does not involve a national database and visitor confidentiality is maintained.

CHEMSEX SERVICES

Chemsex services are limited, with the first significant campaign emerging in 2020 through Kosmicare, aiming to address the intersection of drug use, sexual health, gender, and recreational settings. Presently, a few organisations are initiating chemsex projects, encompassing harm reduction, peer counselling, and mental health, though services that are LGBTQI+ friendly and meet the unique needs of people engaging in chemsex users are scarce.

To improve the situation, there is a pressing need to broaden community-based health services, establish specialised and inclusive services within the National Health Service, and secure necessary funding to ensure the sustainability and expansion of these initiatives. This approach promises to enhance access, inclusivity, and efficacy in support for those engaged in chemsex, leading to better health outcomes in this community.

PRISONS

Harm reduction services do not exist in prison settings.

HARM REDUCTION SERVICES: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND AFFORDABILITY

The availability and accessibility of harm reduction services in Portugal present notable disparities, with services being predominantly concentrated in major urban areas such as Lisbon and Porto. The insufficient funding and support for harm reduction services, particularly outside these big cities, contribute to a lack of comprehensive coverage, leaving specific populations and those in rural areas inadequately served.

From an accessibility standpoint, the working hours and operational days of harm reduction services do not adequately meet the needs of service users, necessitating a re-evaluation and potential expansion of these aspects. While individuals without insurance and undocumented migrants can access harm reduction services (access is ensured in both law and practice), geographical accessibility remains a significant challenge. Specific services tailored to the needs of specific populations are scarce. Some initiatives are in place, such as women-only hours, but these are not sufficient to address the diverse needs of all inadequately served populations.

The COVID-19 pandemic required adaptions in service delivery, with screening measures, protective equipment usage, and alterations in operational procedures being implemented. In Lisbon, harm reduction services demonstrated resilience, even expanding in some aspects to integrate emergency responses for people experiencing homelessness. However, in other parts of the country, a reduction in service provision was reported, highlighting the uneven impact of the pandemic on harm reduction services.

INFECTIOUS DISEASES SERVICES: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY, AND AFFORDABILITY

Examining the specific components of harm reduction services reveals clear discrepancies between the theoretical access and the actual utilisation of various prevention and treatment services by people who use drugs.

Legally, people who use drugs are entitled to access a range of prevention services, from testing and informational support to vaccination for infectious diseases. Nevertheless, the real-world provision of these services is hindered by stigmatising attitudes among health care professionals and the uneven distribution of resources across different regions of the country.

Pre-exposure prophylaxis is available and fully reimbursed, but its distribution is confined to hospital settings, excluding community-based options, and creating barriers for certain demographics, such as sex workers and transgender individuals who often struggle with navigating and adhering to the standardised procedures of the National Health Service.

Regarding treatment, the situation is more encouraging. People who use drugs are not required abstinence to access treatment for HIV, TB, HCV, HBV, or STI. Services like antiretroviral therapy (ARV) and hepatitis treatments are available, but only in hospitals and specific health centres, limiting their accessibility. Community-based services bridge a critical gap by detecting infections and ensuring linkage to care, but the current system's structural barriers hinder the seamless transition from detection to treatment.

CHALLENGES AND POSSIBLE SOLUTIONS

Addressing the national challenges and setting priorities for enhancing access to HIV and co-infection treatment, care, and prevention services for people who use drugs is essential. A holistic approach to proximity services stands out as a crucial strategy, where the implementation of a 'one-stop-shop' methodology is key. This approach encompasses the integration of peer support, social aid, and healthcare delivered by friendly professionals. There is also a pressing need to extend harm reduction and sexually transmitted infections services throughout the country, which necessitates increased funding.

Regarding legislation, progress can be achieved through the approval of additional options for OAT, including medicalised heroin. This would be complemented by the development and scaling up of integrated services that facilitate safe consumption.

From a practical standpoint, the focus should be on capacity building, ensuring better working conditions for health professionals, technicians, and peers involved in harm reduction services. This would not only enhance the efficiency and effectiveness of the services provided but also contribute to a more supportive and understanding environment for people who use drugs.

- Implement “one-stop-shop” proximity services integrating health, social support, and peer assistance.
- Extend harm reduction and STI services nationwide, backed by sufficient funding.
- Legalize a wider array of options for OAT, including medicalized heroin.
- Increase the number of integrated services facilitating safe consumption.
- Focus on capacity building and improve working conditions for all professionals involved.

ROMANIA

INFECTIOUS DISEASES: EPIDEMIOLOGICAL OVERVIEW

Romania lacks comprehensive incidence data on the incidence of infectious diseases specifically among people who inject drugs. However, estimations and case reports do provide some insights. In Bucharest, the estimated population of people who inject drugs stood at 7 007 in 2021 and decreased to 5 120 in 2022 according to the Agenţia Naţională Antidrog (ANA; National Antidrug Agency) National Reports. The total number of new HIV cases was 388 in 2021 and 403 in 2022. Of these, 28 and 23 new cases were identified among people who use drugs in 2021 and 2022 respectively. Romania also faces the challenge of AIDS. As reported by CNLAS - Department for Monitoring and Evaluation of HIV/AIDS in Romania, the number of newly registered AIDS cases was 268 in 2021 and 304 in 2022 (including 27 cases among people who inject drugs in each year).

Romania has seen a cumulative total of 27 077 new HIV / AIDS cases in the period from 1985 to December 2022, including 9 287 recorded in the early 1990s among children. The adult prevalence of HIV / AIDS in Romania hovers around 0.2%, with much higher rates among specific populations: 18% for GBMSM, 11.2-28.9% for people who inject drugs, and 1% for each female sex workers and people in prison setting .

The period from 2007 to 2021 was characterised by several challenges that caused the deterioration of HIV prevention interventions and treatment in terms of their coverage and quality. These challenges included the lack of strategic frameworks, reduced multisectoral collaboration, the withdrawal of international donors, and the COVID-19 pandemic's impact on the accessibility of healthcare in general. This period also saw a shift in the main HIV transmission routes, with heterosexual transmission being the most prevalent, followed by sexual transmission among GBMSM, drug injection, and mother-to-child transmission.

From 2007 to 2022, there was an increase in newly diagnosed HIV/AIDS

cases across all population groups, with key populations experiencing substantial increases. As reported by the Department for Monitoring and Evaluation of HIV/AIDS in Romania, National Infectious Diseases Institute's prof. Dr. Matei Balș, heterosexual transmission accounted 61% of all new cases during this period, while transmission among GBMSM was 18% and through drug injection – 15%.

People who inject drugs are of particular concern in the context of Romania's landscape of infectious diseases. ARAS reports that they account for over 15% of all new HIV cases nationally, with approximately 37% co-infected with tuberculosis (TB), and a striking 82% co-infected with Hepatitis C Virus (HCV). The year 2013 marked a peak in HIV incidence among people who inject drugs with 324 new cases, attributed partly to the emergence of new psychoactive substances. Since then, a decrease was observed until a slight increase in 2021. Among individuals registered at needle and syringe programmes, prevalence of HIV is 6% of HBV – 5.2%, and of HCV – 46.3%.

DRUG USE PATTERNS & TRENDS

In 2021, Bucharest reported a total of 5 120 people who inject drugs. Anecdotal information from the Minister of Family, Youth and Chance Equality shows that the number of people who use drugs in the country is estimated at 1 200 000. The most used drugs in 2021 were new psychoactive substances, primarily injected, and cannabis, predominantly smoked. There is no official data available on recent trends in drug use patterns in Romania. Observations from ARAS indicate a rise in poly-drug use and an increase in the use of new psychoactive substances.

People who inject drugs typically lack employment, stable housing, identity documentation, and health insurance, practice risky behaviours and have a high prevalence of infections such as HIV, hepatitis, and TB, alongside (unmanaged) mental health issues. Their social skills and autonomy are often compromised due to street living and violence, leading also to poor hygiene and nutrition.

The 2022 National Drug Report highlights that most people who inject drugs admitted to treatment in 2021 were male, middle-aged, initiated drug use in their late teens, and exhibit daily injectable drug use. Most are treated as outpatients, live with their families, are based in Bucharest and have at least a secondary school education. A significant portion shared injection equipment at least once in their lives.

Needle exchange programmes in 2021 were mainly used by males over 35 and accessed roughly equally through drop-in centres and outreach services.

DRUG USE AND LAW

In Romania, drug use-related issues are governed by Law 143/2000, which addresses the prevention and combatting of illicit drug traffic and use. Drug consumption itself is not penalised, but drug possession faces stringent legal consequences, with 'risk drugs' (including cannabis and ketamine) possession punishable by 3-10 years of imprisonment and possession of high-risk drugs (such as heroin, cocaine, amphetamine, LSD) punishable by 5-15 years of prison. An important feature of this legislation is its lack of specification regarding threshold quantities, resulting in a subjective law enforcement that can depend on the police officer's or judge's discretion and the context of the situation.

Due to growing concerns, the Romanian political landscape has seen proposals aimed at reforming drug laws in yet more punitive direction. Following incidents of drug possession and fatalities linked to drug use at festivals, proposals emerged; one seeking to increase penalties was adopted in February 2023. According to this change, possession of risk drugs, (that is, drugs other than cannabis, used to be punished by 2-7 years in prison, while the amendment stipulates 3-10 years of incarceration; cultivating, offering, selling, transporting, buying, and possessing high-risk drugs (e.g., cocaine, heroin, ecstasy) were punishable by 5-12 years in prison, while the amendment increased the penalties to 5-15 years.

In May 2023, a progressive step was taken with the introduction of a proposal to the Parliament, advocating for a change in Law 143 / 2000. This proposed amendment suggests that possession of up to 3 grams of cannabis for personal use be reclassified as an administrative offence, punishable by a fine ranging from 200 to 600 Euros. Notwithstanding this small movement towards change, the road to more liberal reform has been slow and challenging, as exemplified by the 2017 proposition for the regulation of drug consumption rooms. Despite extensive debates and media attention, the law has not been considered by the legislative bodies.

HARM REDUCTION FRAMEWORK: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND AFFORDABILITY

In Romania, harm reduction strategies are incorporated into national drug legislation and policies under the term 'reducing the risks associated with drug use'. This term encompasses mobile services and drop-in centres tailored for individuals who use drugs, as acknowledged in national social assistance and drug legislation, as well as in strategic documents such as the National Antidrug Strategy 2022-2026 and the National HIV Strategy 2022-2030. While opioid substitution

treatment (OAT) is recognised as a specialised form of drug treatment, certain harm reduction measures face legal and practical challenges.

The legal framework in Romania not only prohibits the establishment of specific harm reduction services but also imposes limitations on the provision of existing ones. A legal provision from the social services sector mandates the collection of personal information (including identity card details) from all individuals accessing harm reduction services. This requirement restricts the allocation of public funding for social services to only those individuals who can provide valid identification, thereby excluding certain demographics from accessing vital harm reduction support.

The insufficiency of available services, stemming from a lack of funding, results in low coverage and a restricted schedule that does not align with the needs of services clients. This is particularly evident in the uneven geographical distribution of services, which are predominantly concentrated in the capital city, leaving people who use drugs outside Bucharest with limited access to necessary care.

Moreover, public medical services other than emergency services require health insurance and identification documents (for Romanian citizens), or ID, residence, and insurance for non-EU citizens. This creates a potential barrier to access, especially for individuals without valid documents. Private medical services also require identification, irrespective of nationality. In contrast, social services are more universally accessible as they do not impose preconditions.

Accessibility varies depending on the service provider and the demographic of the service user. While needle exchange programmes, rapid testing for HIV, HBV, and HCV, and other related services are low-threshold and available free of charge from NGOs, regardless of insurance or identification documents, accessing OAT programmes requires at least a valid identity document or passport.

Specific groups, including women, LGBTQI+ individuals, Roma communities, and youth, are identified as inadequately served populations, receiving insufficient harm reduction services due to the severe lack of funding.

The COVID-19 pandemic has exacerbated the problems, restricting movement and access to health and social services, while also diverting significant public resources to respond to the pandemic. This has resulted in the complete closure of needle exchange programmes for 2.5 months during the lockdown and limited access to treatment and diagnostic services for infectious diseases. However, on the more positive side, the pandemic also accelerated the digitalisation of services and allowed for longer prescriptions for OAT in publicly and privately operated health centres.

Drug consumption rooms (DCRs) are notably absent in Romania, stemming from the fact that any form of drug possession is deemed illegal, regardless of quantity, rendering DCRs non-compliant with existing laws. Additionally, the use of naloxone for overdose prevention is hindered by its status, as it is available only in emergency rooms. This limits its accessibility to the public and confines it to medical settings.

In sum, the availability, accessibility, acceptability, and affordability of harm reduction services are severely hindered by funding shortages, geographical disparities, and the impacts of the COVID-19 pandemic. The lack of comprehensive and targeted support in national health strategies further exacerbates these issues, resulting in a scenario where the needs of people who use drugs and other vulnerable populations remain inadequately met.

HARM REDUCTION SERVICES

In Romania, harm reduction services cover a range of support, including needle exchange, other limited injection paraphernalia distribution, HIV and hepatitis testing and counselling, condom distribution, information, education and communication, social services, referrals, and adherence counselling for HIV and tuberculosis treatment. Opioid agonist treatment is also available, but its provision is restricted exclusively to authorised medical providers. There is a notable lack of connection between harm reduction and other social services.

Funding for harm reduction in Romania is precarious and has seen a substantial decrease, particularly after international support from the United Nations, Open Society Institute and the Global Fund ended in 2010, resulting in the closure of many of needle exchange programmes in the country due to the lack of plan for transition towards the state-funded provision. Today, of the ten initial service providers, only two remain operational, both in the capital city. There are no formal or informal groups of people who inject drugs.

In the decade following 2010, funding for harm reduction services in Romania became sporadic and fragmented. It primarily covered harm reduction materials, with only a modest allocation for human resources. Funding amounts were inconsistent year on year, falling short of the comprehensive financial support required for needle exchange programmes. From 2015 to 2023, various national and international agencies provided intermittent funding and material support for infectious disease screenings, harm reduction materials, and other expenses, aiming to maintain the continuity of services.

Notwithstanding these initiatives, a funding shortfall persisted. Post-2010, needle exchange programmes in Bucharest, both stationary and mobile,

have relied significantly on self-funding and locally generated funds. As a result, they exhibited highly insufficient coverage ranging from 15% to 30% annually.

Resources remain scarce also in case of OAT. The National Health Insurance House annually finances 1 200 – 1 300 OAT slots, covering merely under 10% of the estimated population of people using opioids high-risk. The funding is restricted to methadone and urine tests, and there are no maintenance services available beyond the capital city.

In a promising development in May 2023, the National Anti-Drug Agency initiated a funding opportunity aiming to enhance prevention and harm reduction efforts, earmarking a budget equivalent to 400 000 Euros to potentially assist approximately 1 000 individuals over a five-month span. Despite this advancement, the path toward a comprehensive and adequately financed harm reduction framework in Romania requires more lasting dedication and financial commitment.

NALOXONE

Naloxone is highly restricted, with availability limited only to emergency departments in hospitals and the national emergency medical system. It can only be administered by medical professionals, adhering strictly to established medical protocols. This restriction extends to the point that neither harm reduction services clients nor other community actors are permitted to access or distribute naloxone. Furthermore, ambulances are not equipped with it.

DRUG CHECKING

Drug checking is completely absent due to legal constraints tied to the criminalisation of drug possession. The situation is worsened by the lack of any feasibility studies conducted to explore potential solutions or workarounds.

NEEDLE AND SYRINGE PROGRAMMES (NSPS)

Needle and syringe programmes exist only in Bucharest. The provision of service is highly insufficient to meet the needs of people who inject drugs, with less than 50% coverage achieved by two NGOs and one public service combined. In 2022, the annual distribution amounted to an average of 250 syringes per person, indicating a limited resource pool for these essential harm reduction services.

There are notable gaps in accessibility, with no vending machines available for syringe sale or distribution and only a few pharmacies in the capital participating in syringe sales to people who inject drugs. While online pharmacies/shops offer syringes without restriction, this option is not popular among the community. An alternative source for syringes comes directly from drug dealers, highlighting a parallel, informal channel of access.

Despite the existence of NSP in the country and policy frameworks that mention and/or recommend these interventions, practical barriers persist. Geographical challenges require individuals to travel significant distances to access services, and motivational barriers exist due to a lack of incentives for returning used syringes. Furthermore, the fear of police abuse discourages people who inject drugs from carrying or bringing used syringes to exchange services, exacerbating access issues.

OPIOID AGONIST TREATMENT AND HEROIN ASSISTED TREATMENT (OAT AND HAT)

OAT is dominated by methadone in pill form (there is no liquid), while other medications like Suboxone remain virtually absent from the market. The preference for methadone is not a matter of regulated policy or clients' needs but is driven by profit considerations. Namely, the low reimbursement rates from the National Mental Health Programme funding OAT do not cover the costs of Suboxone, deterring service providers from making it available.

To start operating an OAT programme, institutions must adhere to minimum organisational and functioning standards. Clients, on the other hand, must meet specific criteria including being over 18 years of age (or over 16 with guardian consent if the benefits outweigh the risks), having a diagnosis of opiate dependence, and testing positive for opiates. Additional criteria for inclusion include multiple past attempts to cease consumption, risky consumption behaviour, HIV/AIDS, pregnancy, and having somatic or psychiatric comorbidities or polydrug dependence.

The protocols for take-home OAT and travel involve a phased approach, starting with mandatory daily attendance and gradually allowing for more home-based treatment days, contingent on program adherence and negative drug tests (with a week take-home dose after 12 months, and 2-weeks dose after 18 months possible). Challenges arise when beneficiaries need to travel or relocate. For in-country travel, a physician's recommendation can facilitate continuity of care. However, in practice it can be very difficult to receive it outside Bucharest. For international travel, clients need to coordinate with OAT centres in their destination country or carry a maximum 30-day supply of their medication, as per Romanian law.

Non-compliance with medical recommendations, violating internal rules, refusal to undergo drug testing, displaying aggressive behaviour, forging medical documents, and drug use or trafficking within treatment facilities are grounds for discontinuation of OAT, as stipulated in the Mental Health Programme of the National Health Insurance House.

Heroin-assisted treatment is not available as heroin is considered a highly restricted substance and not registered as a medicine.

DRUG CONSUMPTION ROOMS (DCRS)

Drug consumption rooms are not present due to restrictive laws and policies. The primary hindrance is Law no.143 / 2000, which criminalises drug possession entirely, regardless of the quantity involved. Moreover, the law expressly prohibits providing or tolerating any premises for the illicit consumption of drugs, with penalties ranging from 2 to 7 years of imprisonment. Overcoming these obstacles necessitates a revision of the drug possession laws and a shift towards decriminalisation, accompanied by increased public awareness regarding decriminalisation.

CHEMSEX SERVICES

Harm reduction services for people involved in chemsex have been recently initiated by ARAS (autumn 2023) within a project funded by the National Antidrug Agency. Kits including a variety of supplies such as condoms, straws, leaflets etc., are available free of charge in the ARAS' checkpoint service for GBMSM where HIV and viral hepatitis testing and HBV vaccination are provided. In addition, informational materials and short videos are at public disposal on the first harm reduction website in Romania www.reducereariscurilor.ro. Besides ARAS, no other service provider offers such services to people engaging in chemsex. This model will be piloted in Bucharest and subsequently replicated in other big cities where ARAS operates checkpoint services for GBMSM. Nonetheless, there is a need for more data collection and a comprehensive understanding of the scope and needs of people practicing chemsex in Romania.

PRISONS

While harm reduction interventions theoretically should be as accessible in prisons as in community settings, in practice, there are notable differences. Condom distribution is available at minimal level, and OAT with methadone is offered in just 15 of the 44 prisons. Needle exchange programmes have ceased operation several years ago as a result of the prison authorities declaring no requests for needles and syringes. To access needle exchange in prisons, individuals would have to openly declare their drug use. At the same time, as ARAS reports, it seems that some internal orders are in place preventing people who use drugs from working during serving their sentence, resulting in reluctance to disclose one's drug use. Importantly, individuals in prison settings tend to not disclose their drug use also to avoid being placed in more restrictive institutions or being prohibited to work. Moreover, there is a

clear contrast in OAT access between preventive arrests and prisons. Namely, individuals in preventive arrest often do not receive their treatment until they are formally imprisoned, highlighting a significant barrier to continuous care for drug users within the judicial system.

INFECTIOUS DISEASES SERVICES: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY, AND AFFORDABILITY

Like harm reduction, the situation with other infectious diseases services in Romania is also complex and faces multifaceted challenges.

While prevention services for PWUD are available in Bucharest, mainly through two NGOs and a city hall-managed outreach unit, their effectiveness is hampered by several barriers.

The services, albeit present, are not sufficiently widespread to meet the needs of people who use drugs. This significantly hampers the ability of people who use drugs to maintain consistent and regular access to necessary preventive measures. A lack of interest and engagement in personal health care among people who use drugs results in low participation in HIV, hepatitis, and TB screening programmes. Furthermore, structural barriers, including a lack of health insurance and insufficient state funding for diagnostic examinations, create substantial barriers for those who do get tested.

Stigma and discrimination play a significant role in limiting access to public prevention and health services for people who use drugs. The prevailing public health messages emphasise abstinence and cessation of risky behaviours, alienating people who use drugs and reducing the likelihood of their participation in available programmes. Furthermore, there is a reluctance within medical facilities to integrate this community into national health programmes, motivated by a perception of this group as a 'waste' of resources due to their frequent chronic conditions and low adherence to treatment.

The financial barrier is particularly evident in the limited access to HBV / HVA vaccines, which are freely available only to minors under 18, and must be paid by adults, irrespective of the health insurance status. This leaves adult people who use drugs in a vulnerable position, often unable to afford vaccinations.

Regarding PrEP, it is primarily accessible through unofficial online channels or abroad, with no reimbursement options available. The national guidelines do not currently accommodate people who use drugs for PrEP eligibility, and awareness about PrEP within this group is low. Provision of information about PrEP in harm reduction services is focused on people who use drugs in the context of sexual activities, such as chemsex, but not really on people who inject drugs.

In a similar way, there is a range of challenges regarding treatment of infectious diseases.

There is no explicit policy requiring drug abstinence for enrolment or continuation in HIV, TB, HCV, HBV, and STI treatment programmes, and theoretically, treatment for all these conditions is available to people who use drugs. However, this community still faces informal pressures and barriers that can result in treatment denial or discontinuation.

Common barriers to access treatment include the necessity for identification document, health insurance, and having a family doctor. In case of HCV and HBV additional clinical criteria apply. From a practical perspective, challenges range from delayed launch of treatment because of other priorities of individuals (especially those with co-existing mental health problems), to discontinuity in treatment when transitioning from prison to the community, to low treatment adherence (especially prevalent among people experiencing homelessness). A lack of integrated care and social support further exacerbates these issues, leading to therapeutic failure.

Community NGOs serve as crucial intermediaries, linking people who use drugs to necessary treatment services on a limited basis (due to resource constraints) and within restricted geographic boundaries. These entities educate people who use drugs about the importance of treatment for HIV, hepatitis, or TB, providing comprehensive information and sometimes direct assistance in accessing medical facilities, especially when challenges arise. They also facilitate the acquisition of necessary identification documents and help in scheduling free medical consultations and tests for comorbidities. Despite these efforts, the impact is modest, with less than 100 individuals annually receiving connections to treatment through the support of workers from the two NGOs offering needle exchange services.

CHALLENGES AND POSSIBLE SOLUTIONS

In 2023, Romania struggles with providing adequate access to services for people who use drugs, specifically in relation to HIV and other infectious diseases. National strategies have outlined necessary interventions, yet there is a glaring lack of government funding for prevention initiatives targeting at-risk groups. Civil society organisations like ARAS and Carusel have stepped in to offer prevention services, but they are severely underfunded, resulting in needle exchange programmes operating on minimal resources. Moreover, opioid agonist treatment centres, both public and private, are stretched thin, serving just about 10% of the estimated population of people who use high-risk opioids. This lack of resources also leads to long waiting times for treatment.

Viral hepatitis B and C services further highlight the access disparities; the National Insurance House funds services exclusively for insured individuals, leaving non-insured people who use drugs without access to vital services. The minimum service package does not cover HIV, HBV, and HCV for non-insured individuals, though some services can be accessed through emergency rooms funded by the Ministry of Health.

The legal framework in place exacerbates these problems, as stringent access criteria apply to both Ministry of Health and National Insurance House funding, requiring valid identification and proof of insurance or lack of income. These requirements create significant barriers for many people who use drugs to access necessary health services.

Legally, there is an immediate need to remove healthcare access barriers for uninsured individuals or those without identity documents, benefiting not just people who use drugs but also providing clarity and financial certainty for healthcare providers. Additionally, establishing a collaborative agreement between the Ministry of Health and the National Anti-drug Agency is crucial for supporting the operation of much needed drug consumption rooms.

Practically, urgent, and comprehensive cooperation among all actors in health and social assistance services is required, spanning both the private and public sectors, to clarify funding and implementation responsibilities for services dedicated to people who use drugs. The Ministry of Health should be at the forefront of such an initiative, taking responsibility for coordinating and funding all related services, therefore ensuring an integrated approach.

KEY RECOMMENDATIONS:

- Eliminate legal restrictions on service access for uninsured individuals and / or those without identity documents.
- Establish a collaborative agreement between the Ministry of Health and the National Anti-drug Agency to support the establishment of drug consumption rooms.
- Foster immediate and close cooperation among all stakeholders in health and social services to clarify funding and implementation responsibilities.
- Ensure the Ministry of Health assumes responsibility for coordinating and funding all services for people who use drugs.

SLOVAKIA

INFECTIOUS DISEASES: EPIDEMIOLOGICAL OVERVIEW

Infectious diseases remain a critical public health challenge in Slovakia, with varying impacts across different communities. Slovakia has consistently reported low yearly incidences of new HIV cases; however, the last decade has seen an upward trajectory, peaking in 2021 with 110 new cases. In 2022, there was a slight reduction to 103 new cases. In Slovakia new HIV infections affect mostly GBMSM: most cases are among males (85-90%), while sex between men was identified as the way of transmission in 70% cases. Injecting drugs was determined as the route of HIV transmission in only 1.2% cases. Hepatitis C poses a significant threat to communities of people who use drugs, with a 79.5% reactivity rate observed in 2023 among 39 PWUD in Bratislava, as OZ Odyseus reports.

DRUG USE PATTERNS & TRENDS

Understanding the patterns of drug use and the demographic characteristics of people who use drugs is an essential component in developing effective interventions and policies.

Slovakia witnessed 2 919 individuals receiving treatment for drug dependency in 2021, with a significant majority being men (81%). A closer look at the age distribution reveals a concentration in the 30-39 age bracket, indicating a (young) adult demographic. Data specific to the socio-demographic characteristics of all people who use drugs in Slovakia remains scarce, highlighting a gap in the comprehensive understanding of this population. Still, anecdotal evidence from OZ Odyseus reveals that the group of people who inject drugs is ageing. The service's clients use mostly methamphetamine or heroin, or a mix of both substances through injection.

However, there is a new generation of people who use drugs whose preference is for stimulants and other, less invasive ways of use than injections.

Regarding drug use patterns and trends, official data on the number of people who use drugs is not readily available. Nevertheless, collaborative estimates from 2019 between the Ministry of Health of the Slovak Republic and three existing harm reduction organisations offer a range of 2 336 – 5 939 for individuals using heroin and 4 207 – 11 246 of people using amphetamine, with midpoints at 3 222 and 5 596 respectively. The European Drug Report 2022 further elaborates on the prevalence, identifying 10 380 high-risk amphetamine users in Slovakia.

In the broader spectrum of the general population, cannabis, and its products, alongside methamphetamines, stand out as the dominant substances of choice. However, a divergence is observed when focusing on treated PWUD, where stimulants (44.4%) take precedence, followed by opiates (22.0%), and cannabis (17.6%). Administration routes predominantly include smoking (35.5%), injecting (27.3%), and intranasal use (24%).

Recent years have seen Slovakia maintain its position as one of the European countries with a high prevalence of methamphetamine use, with an upward trend in cocaine use from 2013 to 2020 and a simultaneous decrease in demand for heroin, attributed to its low street quality. Despite these shifts, the outreach work and drop-in centre data pf OZ Odyseus indicate a sustained pattern of heroin and/or methamphetamine injection among their clients.

DRUG USE AND LAW

In Slovakia, the drug-related policies are marked by stringent laws and an emerging dialogue for change. Drug use itself is not criminalised; however, drug possession faces severe penalties under the country's Criminal Code. The severity of punishment is contingent on the quantity of drugs in possession, calibrated by the potential number of doses that can be produced from the amount seized.

In the specific case of cannabis, which has been under considerable scrutiny and debate, the legislation stipulates the punishment based on the quantity. Possession of 1-3 doses could result in a one-year imprisonment, and this escalates to two years for up to 10 doses. For drugs other than cannabis, the penalties are even more severe, with a range of three years for 1-3 doses and five years for up to 10 doses. Notably, for quantities larger than this, indicating potential involvement in drug dealing, the imprisonment ranges from 3 to 7 years for cannabis and 3 to 10 years for other drugs, with the possibility of even longer

sentences under specific circumstances, such as selling drugs to individuals under treatment or minors under 15.

Despite this stringent legal framework, there is a growing dialogue and movement towards change, led by various campaigns highlighting the disproportionate punishments for cannabis possession, particularly when it pertains to personal use or health purposes.

Reflecting this momentum for change, a new draft of the Criminal Code is currently in the parliament, having successfully passed the first reading. The draft amendment aims to recalibrate the legal regulations surrounding cannabis, specifically addressing the quantities, and associated statutory penalties.

HARM REDUCTION FRAMEWORK: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND AFFORDABILITY

In Slovakia, the concept of harm reduction is included in the national policies and legal frameworks, with specific emphasis on its role in combating the HIV/AIDS epidemic and addressing drug-related issues. The National prevention programme of HIV / and the National Drug Strategy both mention harm reduction services as vital measures. However, these documents do not offer a robust support mechanism or clear directives for implementing these services. Moreover, the concept does not appear in other relevant regulations, such as laws concerning social services, etc. Interestingly, the City of Bratislava stands out in its proactive approach, having incorporated harm reduction services in its Community Plan of Social Services (2023-2030) with a dedicated budget, showcasing a local government's commitment to this cause.

The situation of harm reduction in Slovakia is not without challenges. As reported by OZ Odyseus, legal regulations constitute a serious barrier to develop harm reduction services in the country. This is due to a provision in the Criminal Code that stipulates up to five years of imprisonment for 'propagating drug dependency', meaning persuading someone to use an illicit substance. Depending on legal interpretation, many harm reduction services can be seen as 'facilitating' drug use. For example, needle and syringe distribution is a grey zone where services are operating despite the possibility of being interpreted as 'facilitating drug use' and getting charges pressed against them. The law is also the reason why drug consumption rooms and proper drug checking do not exist in Slovakia.

The funding situation for harm reduction in Slovakia is precarious, characterised by instability and insufficiency. With the absence of stable funding, organisations are left to struggle with yearly grant

applications, which do not guarantee comprehensive coverage of expenses. The withdrawal of the 'antidrug' dotation by the Ministry of Health in 2021 further exacerbated the situation, stripping away a crucial funding source for material expenses. Currently, harm reduction services are heavily reliant on municipal, regional, and European structural funds.

Regarding accessibility, low-threshold services offered by NGOs present a more accessible option, as they do not require any form of pre-conditions, ensuring a broader reach within communities. However, in case of the services provided by specialised centres for drug treatment, the accessibility becomes conditional. Individuals are required to present an ID card and possess health insurance, which creates a barrier for people who use drugs, as many of them lack these necessities. Despite this, there exists a special cooperation of OZ Odyseus for clients without an ID in need of opioid agonist treatment, although this is not a widespread practice (see more in the good practices section).

The working hours of OAT programmes, constrained to the early hours of the day, pose a significant challenge for individuals who are employed, highlighting a gap in service provision. On the other hand, outreach services demonstrate flexibility, extending their availability into the evening hours, albeit without providing OAT.

Geographically, the distribution of harm reduction services is skewed, with a noticeable concentration in four cities in western Slovakia. This leaves vast regions without adequate access to low-threshold services, a situation further exacerbated when considering OAT programmes, which are only present in the three biggest cities of Slovakia. This geographic disparity highlights a striking contrast in service availability, especially outside of Bratislava and western Slovakia.

The system also fails to adequately serve specific population groups, including women with children, (undocumented) migrants, and minors. Women with children face the challenge of accessing drug dependency treatment due to the absence of inpatient treatment options accommodating children. (Undocumented) migrants and refugees find themselves disconnected, largely due to a lack of communication and cooperation of harm reduction services with asylum centres. The youth demographic is left completely out of the harm reduction reach, with no services available for those under the age of 18.

The onset of the COVID-19 pandemic introduced new dimensions to the harm reduction landscape. Excluded communities of people who use drugs

and sex workers found themselves disproportionately affected, with job losses and ineligibility for state aid further marginalising these groups. OZ Odyseus stepped in, adjusting their services to meet the basic needs of these communities, providing food aid, protective equipment, and facilitating access to COVID-19 testing and vaccination. However, these escalated efforts and increased costs did not find financial backing from state institutions, highlighting a disconnect between the needs of the marginalised and the support structures in place.

In essence, while low-threshold services provide an impression of availability and reach, the harm reduction landscape in Slovakia is marked by geographical disparities, systemic barriers for specific demographic groups, and a lack of support for extended services. The current situation implies the need for a more inclusive, geographically dispersed, and supportive harm reduction framework, capable of adapting to the evolving needs of all communities, particularly in the face of unprecedented challenges such as the COVID-19 pandemic.

HARM REDUCTION SERVICES

When it comes to the available harm reduction services in Slovakia, there is a mix of low-threshold programmes operated by non-governmental organisations and services delivered within the health and care system. Needle/syringe exchange, material distribution, rapid testing for various diseases, counselling, and housing assistance are available in the former; in contrast, confirmatory testing, and opioid agonist treatment (OAT) are exclusively provided in medical centres, some of which also distributing needles / syringes.

Despite the existence of the services mentioned above, there is a noticeable gap in the connectivity between harm reduction and other social services. The prevalent stigma around drug use often results in clients either not accessing social services or withholding information about their drug use. Harm reduction organisations usually serve as the first point of contact, trying to bridge this gap and facilitate referrals to other necessary programmes.

NALOXONE

Naloxone is inaccessible to the public and is strictly regulated, with only injecting form officially registered. The medication is only available within hospital settings and ambulance/mobile emergency units and can exclusively be administered by medical professionals.

DRUG CHECKING

Drug checking services are non-existent due to stringent drug legislation that

criminalises the possession of drugs. This legal barrier has successfully halted the establishment and implementation of such interventions. Notwithstanding, OZ Odyseus has taken initiatives to distribute rapid colorimetric drug tests, although this is a limited measure compared to what is offered by a proper laboratory testing.

NEEDLE AND SYRINGE PROGRAMMES (NSPS)

Needles and syringes are distributed through low-threshold on-site and outreach services in four western cities in Slovakia and at a specialised centre for drug treatment in Bratislava. Pharmacies do stock needles and syringes, but stigma and discrimination often act as deterrents for people who use drugs to access sterile equipment this way. Online purchases are possible, but not very prevalent among people who inject drugs due to limited access to necessary devices and internet connection, and often lack of postal address.

There are noticeable regional disparities and practical barriers that limit access to NSPs. The absence of services providing needles and syringes outside of western Slovakia is a significant concern. Additionally, the lack of vending machines for needles and syringes further restricts access, particularly during out-of-office hours.

OPIOID AGONIST TREATMENT AND HEROIN ASSISTED TREATMENT (OAT AND HAT)

Opioid agonist treatment is provided only in Slovakia's three largest cities: Bratislava (western Slovakia), Banská Bystrica (central Slovakia), and Košice (eastern Slovakia) by specialised drug dependency treatment centres. In Bratislava, mostly methadone is prescribed, as a result of doctors' preferences. Suboxone (not fully covered by health insurance) can be also prescribed by psychiatrists. This means that in smaller cities, theoretically, individuals can access suboxone treatment given that a psychiatry clinic works in the area. However, in practice doctors do not want to accept people who need OAT as clients, making this option to access treatment virtually impossible. It is very difficult (but not impossible) to obtain OAT outside of the three major cities. There is no official document regulating the preference of these medications.

To initiate OAT, individuals must possess an ID card, have health insurance (even if with existing debts), and undergo mandatory medical and psychological evaluations. Methadone requires daily collection, with potential for more flexible pick-up options contingent on drug abstinence verified through urine tests. Suboxone, on the other hand, is

prescribed weekly, with a chance for a bi-weekly prescription after three months, subject to clean urine tests. Violation of methadone-based OAT rules, such as the detection of other substances or missing methadone collections for more than three days, results in a return to stricter treatment protocols or cessation of treatment, necessitating a restart of the setup process. This applies to all situations, including when an individual needs to travel (as anyone can receive only maximum 3-days dose at an occasion). For individuals using Suboxone, continuous use of other substances results in shift to methadone or offering inpatient treatment.

Regarding patient confidentiality, the registration of individuals on OAT is official and visible to health providers through health insurance company records. This visibility could potentially deter individuals from initiating OAT due to privacy concerns or fear of stigmatisation.

Heroin-assisted treatment is not available in Slovakia.

DRUG CONSUMPTION ROOMS (DCRS)

Drug Consumption Rooms in Slovakia are currently non-existent, facing substantial legal and practical challenges. The lack of a facilitating legal framework and the need for compliance with drug consumption laws leaves such initiatives in a precarious position. Sections of the Criminal Code penalising drug possession for personal use and criminalising the 'encouragement' of drug use pose significant legal barriers to the establishment and operation of DCRs. Additionally, the 'Not in My Back Yard' (NIMBY) phenomenon presents a practical challenge, as finding an appropriate location for a DCR in Bratislava or other areas could meet with public resistance.

Access to DCRs for people who use drugs could be further complicated by potential registration requirements, with concerns about confidentiality and the potential use of personal information against individuals serving as deterrents. To overcome these barriers, a combination of awareness-raising campaigns to highlight the benefits of harm reduction services, and advocacy efforts at various levels of government would be is necessary.

CHEMSEX SERVICES

Harm reduction services seem to have limited engagement with the chemsex community. While OZ Odyseus has served people engaging in chemsex in the past, none are currently using their services. Most clients of OZ Odyseus (57%) are experiencing homelessness. The chemsex community appears to require more specialised, higher threshold services, or a specific venue tailored to their needs. Although the LGBTQI+ community does use OZ

Odyseus' services, it mainly includes marginalised groups such as those experiencing homelessness or Roma individuals.

To enhance support for the chemsex community, OZ Odyseus highlights the need for additional financial and human resources. However, due to current limitations, they propose alternative solutions such as conducting online research on dating apps and considering the employment of someone from the chemsex community to develop and implement a new, more targeted service.

PRISONS

Access to harm reduction services inside prisons significantly differs from the outside. Substances like drugs and alcohol are prohibited, and essential services such as OAT and NSP are unavailable. While drug dependency treatment is accessible and can be either court-ordered or voluntary, it is limited to specific psychiatric departments or special drug-free zones in only two out of the 17 prisons in Slovakia. Additionally, people in prison settings who use drugs and sex workers are subject to mandatory testing for HIV, HCV, HBV, and syphilis. Despite the availability of HCV and HIV treatment in theory, reports from clients of OZ Odyseus indicate that in practice, it is rarely administered.

INFECTIOUS DISEASES SERVICES: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY, AND AFFORDABILITY

Accessibility of prevention and treatment services for infectious diseases for people who use drugs in Slovakia paints a picture of gradual improvement, though certainly serious challenges remain.

Until 2023, people who use drugs faced significant barriers in accessing services related to the prevention of HIV, HCV, HBV, STI, and TB, with only low-threshold rapid testing readily available. Access to confirmation testing, vaccination, and treatment was contingent upon having health insurance with no outstanding debts, and for hepatitis C treatment, a year of abstinence was also required. These stringent conditions effectively barred virtually all people who use drugs from accessing these essential healthcare services.

However, legislative changes in 2023 have begun to dismantle these barriers. In 2023, individuals with health insurance debts gained access to vaccinations and confirmatory testing. While these changes are promising, they are still in their infancy, and concerns about potential future discrimination against people who use drugs in medical centres persist.

The situation regarding access to HBV/HVA vaccines is less optimistic. The Twinrix vaccine is not provided free of charge, with one of three required doses costing around 40-45 Euros. Some health insurance companies offer a 50% discount, but the financial burden, coupled with widespread debts on health insurance among people who use drugs, makes access challenging. The specialised centre for drug treatment in Bratislava does offer free hepatitis B vaccination for its registered patients, though this service comes with its own set of preconditions.

Regarding PrEP availability, it is accessible and reimbursed for those fitting national guidelines, though not by every health insurance company. NGO Dom Svetla Slovensko offers an alternative means of obtaining PrEP at a reduced cost. However, most people who use drugs remain ineligible due to health insurance debts and are generally unaware of PrEP due to its inaccessibility and a low prevalence of HIV within their communities.

As for treatment accessibility, the recent removal of the health insurance without debt and the drug abstinence requirements marks significant progress, though practical barriers remain. These include the necessity of a referral from a general practitioner for specialist visits—a significant hurdle for people who use drugs who are often disconnected from the healthcare system—and a general lack of specialists, affecting the broader population as well.

Since the change of the law in June 2023, some of its effects and related challenges could already be observed by professionals in the field. As reported by OZ Odyseus, the HCV treatment, although accessible, is characterised by rather high threshold, hindering the effective implementation of the policy. More specifically, clients are required to possess an ID and insurance card for confirmatory tests, and the test is followed by a bureaucratic process (involving approval from the Ministry of Health) that prolongs the waiting time for treatment, often reaching up to 30 days. This extended timeframe, approximately 60 days from the first visit to treatment approval, constitutes a major obstacle for marginalised communities, posing difficulties in maintaining motivation and engagement. Additionally, healthcare providers lack awareness of the law changes allowing people who use drugs to benefit from the treatment programmes. Stigmatisation and discrimination by medical providers add an additional layer of complexity to the issue, leading to inappropriate comments or questions unrelated to HCV treatment. OZ Odyseus reports cases when people who use drugs were required, without

evidence-based justification, more frequent visits and blood tests compared to the general population. Such practises raise the threshold for treatment adherence, particularly for individuals with vein-related issues, adding to the pool of challenges in providing effective and accessible HCV treatment.

CHALLENGES AND POSSIBLE SOLUTIONS

Addressing the main challenges and setting priorities for improving access to treatment, care, and prevention services for people who use drugs in relation to HIV and other communicable diseases is critical. Experience has shown that when establishing new services, harm reduction organisations often face significant opposition, predominantly from residents, a manifestation of the 'Not in My Backyard' phenomenon. Typically, only prevention services are accessible via low-threshold provision, with necessary procedures such as vaccination, confirmation testing, and treatment confined to medical centres. Until recently, treatment for sexually transmitted infections was unavailable to people who use drugs due to discriminatory practices concerning abstinence and outstanding health insurance debts.

The healthcare system presents a significant challenge, as its high-threshold nature may prove too daunting for vulnerable communities, raising concerns about treatment adherence and the ability to attend necessary appointments. The stigmatisation and discrimination of people who use drugs by health personnel also pose serious issues, further compounded by the disproportionate availability of services across the country, coupled with funding shortfalls and personnel shortages.

To address these challenges on a legal level, it is imperative to integrate harm reduction services into national legislation, such as the law on social services, ensuring stable and secure funding. Introducing anti-discrimination laws and removing restrictive indicators for STI treatment, which currently necessitate attendance at specialised clinics, are also crucial steps.

On a practical level, the establishment of a low-threshold daily centre in Bratislava catering to both people who use drugs and sex workers, offering a comprehensive range of services, is recommended. Expanding the network of (low threshold) harm reduction services across Slovakia, with particular attention to central and eastern regions and enhancing existing services in the west is also vital. The Ministry of Health should actively support harm reduction services, fostering a direct connection between these services and the healthcare system.

KEY RECOMMENDATIONS:

Integrate harm reduction services into national legislation with guaranteed funding.

Implement anti-discrimination laws to protect people who use drugs.

Remove restrictions on STI treatment, allowing access outside of specialised clinics.

Establish a low-threshold daily centre for PWUD and sex workers in Bratislava.

Expand harm reduction services across Slovakia, especially in central and eastern regions.

Ensure active support from the Ministry of Health, directly linking harm reduction services and healthcare.

GOOD PRACTICES

GOOD PRACTICES

COMPREHENSIVE, PERSON-CENTRED CARE

Most of the examples of good practices reported by the expert in their countries are related to ensuring a person-centred, holistic care, adjusted to the specific needs of people who use drugs.

In Helsinki, Finland, the Aurora Day Centre provides comprehensive services for people who inject drugs and live with HIV. Established to support clients in reducing substance use and promoting their health and well-being, the centre offers a range of services including medication (such as ART and OAT), doctor and nurse appointments, laboratory services, health guidance, and social work.

The centre aims to provide all needed services under one roof, including syringe and needle exchange, and it is responsible for provision of OAT. HIV medication is provided by the Infectious Disease Unit at Aurora Hospital District of Helsinki and Uusimaa in collaboration with the Helsinki Deaconess Institute. The centre also offers short-term accommodation and special social and nursing services to support people's adherence to ART.

The centre's services are part of a low-threshold health service centre for people who inject drugs, which has been recognised as an example of best practices in preventing the spread of HIV. The centre's work is also supported by the Handbook for HIV Care, which was published by the Finnish Association for Nurses in AIDS Care, the Finnish AIDS Council, and Helsinki University Hospital Aurora Infectious Diseases Unit

France's approach to facilitating access to HIV and co-infection treatment, care, and prevention services for individuals who use drugs also includes some exemplary practices. Central to this approach are the CAARUD facilities—medico-social establishments committed to protecting the rights of people who use drugs. They operate without any preconditions for entry, ensuring that services are free and accessible to all. These centres welcome people with lived and living experience of drug use, providing interventions aiming for risk reduction, as well as HIV and/or hepatitis testing. Their role extends beyond low-threshold health care, as they serve as a bridge to broader social support, including housing and employment opportunities.

In Greece, the approach to HIV and co-infection treatment, care, and prevention services for people who use drugs has seen essential initiatives, such as projects Aristoteles and Alexandros. These programmes, specifically targeting people injecting drugs and living with HIV and/or hepatitis C, have been instrumental in addressing the health crisis within this community. Originating in response to the significant HIV outbreak between 2011 and 2013 in central Athens, Aristoteles was widely recognised for its effectiveness, leading to its expansion under the name Aristoteles 2 in Athens and a subsequent launch in Thessaloniki in 2018.

The projects have revealed concerning data about the prevalence of HIV/HCV among people who inject drugs and have highlighted a surge in mortality rates. The Aristoteles HCV & HIV programme focuses on reducing hepatitis C and HIV transmission, improving diagnosis, and ensuring that people who inject drugs in Athens are linked to care and treatment. A central facility has been established in Athens, offering comprehensive testing and individual counselling. A collaborative network with the public health care system doctors ensures that clients are referred promptly.

The programmes echoe the proactive measures taken during the initial outbreak, employing peer navigators to reach out to people who use drugs via street work, guiding them to testing and screening facilities, and supporting their referral to HIV clinics. Positive Voice, a key organisation in the field in both Athens and Thessaloniki, has significantly contributed to peer empowerment and the facilitation of access to healthcare services, including harm reduction and rehabilitation.

In Italy, a noteworthy example of a strategic approach to facilitating access to treatment, care, and prevention services for HIV and co-infections among people who use drugs is embodied in the operations of the drop-in centre situated in Monza. This model, which has subsequently been adopted by various other drop-in centres and mobile units, is characterised by a series of integrated actions and collaborations. The service begins with developing partnerships with STI clinics, which provide a steady supply of rapid test kits, enabling the drop-in centre to carry out immediate screening for HIV and hepatitis as part of its harm reduction initiatives. Following the initial screening, the service ensures a smooth transition for those requiring further investigation, connecting individuals to hospital facilities for confirmatory testing. Completing the circle of care, the model ensures individuals are then linked to the nearest hospital for ongoing care and treatment. This holistic approach shows the potential of well-designed cooperation between different health

service providers to create a continuum of care that meets the immediate and long-term needs of people who use drugs.

Portuguese experts highlighted the European Monitoring Centre for Drugs and Drug Addiction setting an example through its specific guidelines, ensuring that people who use drugs have free and specialised access to treatment, care, and prevention services for HIV and co-infections. Highlighting the holistic approach, the exemplary practices involve providing integrated support that addresses both the health and social needs of people who use drugs.

From a health perspective, this includes comprehensive interventions for HIV, viral hepatitis (HCV and HBV), other sexually transmitted infections, and tuberculosis. On the social front, it involves implementing decentralised hospital consultations for HCV treatment at low threshold/harm reduction centres. This 'one-stop-shop' model acknowledges and caters to the multiple vulnerabilities of people who use drugs, effectively combining health and social responses to provide tailored and accessible care.

In Romania, it is noteworthy to highlight a distinctive collaborative initiative between a community-based OAT Centre, managed by a non-governmental organisation, and an infectious diseases hospital. This partnership has proven instrumental, particularly for HIV-positive patients integrated into the programme. It ensures consistent health monitoring by the medical team at the OAT centre, encompassing regular uptake of ARV medications and tracking of viral loads. The synergy between the NGO and hospital professionals facilitates smooth linkage to care for newly diagnosed HIV clients, enhancing their access to crucial services. Furthermore, HIV clients engaged in OAT receive tailored information about their condition, coupled with psycho-social support, substantially improving their life quality.

Finally, in Slovakia, at the level of service provision, OZ Odyseus has successfully established meaningful collaborations with medical professionals to enhance the support provided to its clients. They have formed a partnership with an OAT provider, enabling clients who lack official identification to access treatment, with their identity verified through confirmation by OZ Odyseus staff members. Additionally, the organisation has fostered an informal partnership with an infectious disease specialist, who accepts OZ Odyseus' clients without necessitating a referral from a general practitioner—a typically mandatory prerequisite. This exemplifies OZ Odyseus's dedication to ensuring their clients receive essential medical services, demonstrating their willingness to navigate and adapt to standard protocols for the benefit of those they serve.

LEGISLATION AND POLICY

Portugal decriminalised drug use and possession for personal use in 2001. Under this law, individuals caught with drugs below a designated threshold for personal consumption face administrative, not criminal, penalties, overseen by the Commissions for the Dissuasion of Drug Addiction (CDT). This innovative approach treats drug use as a public health issue rather than a criminal activity, aiming to provide support and rehabilitation to people in need of dependency treatment.

However, it is crucial to note that while decriminalisation has occurred, depenalisation has not; drug use remains an offense punishable by law. The CDTs play a central role in this system, assessing each case to determine the appropriate response, whether that be referral to support services, community service, or fines.

On the other side of the spectrum, activities like drug trafficking and cultivation for personal use remain criminal offenses, subject to judicial proceedings and potential prison sentences. The CDTs work collaboratively with local community services to offer comprehensive support and reduce drug consumption.

Another example is the Romanian comprehensive financial support and range of benefits available to all people living with HIV in Romania, which have significantly benefited people who use drugs diagnosed with HIV. These individuals are eligible for free medical insurance through the National HIV/AIDS programme, allowing them access to all health services. They also receive a stable monthly food allowance and can potentially access an indemnity for handicap annually or for a lifetime, given that HIV infection is categorised as an incapacitating disease. Moreover, they enjoy the privilege of free transportation, exemption from income taxes, and numerous other benefits, all of which collectively play a pivotal role in enhancing their overall well-being and integration into society.

In Slovakia, regarding national legal modifications and practical advancements related to the provision of treatment, care, and preventive services for HIV and co-infections among people who use drugs, has recently witnessed significant progress. Commencing from the year 2023, important legal reforms have been instituted, including the abolishment of the previous mandate that required individuals to be abstinent from drugs for a duration of twelve months as a prerequisite for accessing Hepatitis C treatment. The reforms have facilitated improved access to crucial health services, such as confirmatory testing, vaccinations, and treatments for HIV, Hepatitis C, and sexually transmitted infections, even for those struggling with outstanding health insurance debts.

While these changes mark a big leap towards enhancing healthcare accessibility for people who use drugs, it is crucial to note that as these amendments are relatively recent, the practical exemplifications of their successful implementation and the tangible benefits they bring to the affected population are yet to be fully observed and documented.

INNOVATIVE TYPES OF SERVICES

One of the examples of good practices in this area is France, which has established two drug consumption rooms in Strasbourg and Paris, recently rebranded as Haltes Soins Addictions (HSA). These are part of an experimental initiative by the French Ministry of Health and adhere to stringent criteria, including consistent seven-day operation and a permanent medical presence. The legal framework of this trial permits the inclusion of inhalation rooms, although they currently restrict the provision of other harm reduction tools, including drug checking.

A wide network of DCRs is also operating in Germany, with services catering to individuals aged 18 and above. While these facilities generally welcome individuals of legal age, a notable barrier exists in specific (but very few) DCRs, where restrictions mandate that only residents of the city hosting the service may use its services. This restriction aims to prevent individuals from neighbouring cities lacking such assistance from travelling to the cities that do offer the facilities.

The level of anonymity afforded to DCR users varies significantly across cities. In progressive locales like Berlin, DCRs operate on a principle of anonymity, allowing individuals to use the services without disclosing personal information, which makes the facilities accessible to people without legal documents. Conversely, a more stringent approach is adopted in other cities, requiring individuals to present personal identification, such as a national identity card.

Among the 28 DCRs and three mobile units nationwide, only a minority, two or three DCRs, implement stricter regulations. Most of these facilities remain open to all individuals above the age of 18, reflecting the inclusive approaches and policies adopted by different cities in addressing drug consumption within the context of harm reduction.

The German Heroin-assisted Treatment (HAT) programme, unique on the European scale, has been successfully implemented for more than 10 years, serving as a complementary approach to opioid agonist treatment for individuals who did not experience significant benefits from conventional oral treatment methods. The 14 existing HAT centres extend their services to individuals residing in other cities.

Initially tailored for people injecting opioids due to the availability of only liquid heroin for intravenous use, the HAT programmes

are going to undergo positive changes in the upcoming year. New developments, including the introduction of heroin pills, will expand accessibility to people using opioids through routes other than injecting and a younger demographic, thereby removing existing barriers and broadening the programmes' impact.

The efficacy of HAT is highlighted by its successes, with approximately 20% of participants securing employment while on the programme. Contrary to initial misconceptions, HAT has proven instrumental in reintegrating individuals into the workforce while concurrently reducing off-site heroin use and the use of other substances.

Overcoming its challenging initiation phase marked by a high eligibility threshold and social controversy, HAT is now recognised for its multifaceted benefits, including improved social situations, enhanced health, and offering a pathway to employment. Although acceptance has grown, specific barriers persist, limiting HAT to a relatively small population of people using heroin.

One enduring barrier is the prerequisite for individuals to undergo OAT and experience two failures before accessing HAT. Currently, a new law is under construction aiming to reduce the existing barriers to accessing HAT.

HAT centres offer a range of support services, allowing participants to stay for extended periods, partake in psychosocial activities, and address various needs. The centres resemble a balance between a medical facility and a drop-in centre, accommodating diverse schedules for participants, whether requiring multiple daily visits or opting for a more streamlined approach, thereby enhancing the flexibility and effectiveness of the programme.

COMMUNITY INVOLVEMENT AND OUTREACH TO THE MOST MARGINALISED

In Athens, Greece, Positive Voice, and other civil society organisations have implemented best practice strategies, including creating non-judgmental testing environments, offering peer support and empowerment, assisting with healthcare navigation, conducting community educational seminars, and leading peer-driven harm reduction interventions. Such strategies extend to support for people engaging in chemsex, standing in contrast to traditional medicalised harm reduction models.

Additionally, some organisations periodically assist seropositive people who use drugs released from prison, providing temporary hotel accommodations, and facilitating linkage

to specialised care structures. These comprehensive efforts highlight a commitment to addressing the complex needs of people who use drugs in Greece, setting good practices in the field of public health and drug use services.

Moreover, there's an innovative pilot programme catering to HIV+ people who inject drugs in Athens, offering ART medication that does not require strict adherence, thus suiting those with less organised lifestyles and dynamically changing drug use patterns.

In Hungary's challenging landscape of harm reduction, where funding and political backing have disappeared in the last decade, the HepaGo project emerges as a singular example of good practice. Established amid the COVID-19 epidemic, HepaGo is an outreach initiative designed to connect with the most marginalised individuals. This programme and its documented impact highlight both the potential and precarious nature of harm reduction services in the face of financial and political challenges in Hungary. The HepaGo project is a light of hope and a responsive care model in an environment where such initiatives are increasingly scarce.

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