Correlation
European Network
Social Inclusion & Health

POLICY PAPER

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Who is paying the price for austerity ?

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Introduction

The economical crisis has a huge impact on the public health situation in most of the European countries. Severe budget cuts and austerity measures aimed at NGO's and low threshold services strongly affect the social and health situation of marginalised and vulnerable groups.

This newsletter is devoted to this urgent issue and presents examples and reports from Correlation partner's in the Southern and South Eastern European region. Greece, for example, is in the middle of a public health disaster. To meet budget-deficit reduction targets set by the European Central Bank, European Commission, and International Monetary Fund (the so-called troika), Greece's public health budget has been cut by more than 40%. As Greece's health minister observed, "these aren't cuts with a scalpel, but with a butchers knife. The spending was reduced to 6% of GDP, a figure lower than the UK, at 8%, and Germany, at 9%.
As a result, HIV infections have jumped by more than 200% since 2010, mainly affecting intravenous drug users, as needle-exchange programme budgets were cut in half.

David Stuckler, UK political economist and epidemiologist, and Sanjay Basu, a US physician and epidemiologist have analysed the consequences of the austerity policy on public health. The results of their in-depth research have recently been published under the title "The Body Economic: Why austerity kills."

One of their main findings is that austerity, designed to shrink debts, is not a solution, but a part of the problem, having a devastating impact on public health and huge human costs. They say that if austerity had been a clinical trial it would have been stopped directly. They also argue that the world has not learned from its lessons in the past and that this is proving fatal. Their research found that each Euro invested in public health could yield up to three Euros return, if wisely invested.

One might argue, that this is the unavoidable short-term consequence of a painful but necessary policy, which will prevent the situation from worsening in the long run. However, this argument does not apply. Countries that have opted for stimulating policies, instead of austerity measures have charted faster economic recoveries.

The last contribution of this paper presents the evaluation of the current state of harm reduction in Europe, commisioned by the European Council just recently. The report concludes that harm reduction interventions have been effective in the last decade and it suggests to increase the coverage and availability in Europe.

All in all, there are enough reasons to plead for a more evidence-informed and stimulus-driven policy, which keeps the health and the well-being of people at the centre of attention.

The Correlation Team

Support the campaign

Support.
don't
punish.

SUPPORT. DON'T PUNISH. is a global advocacy campaign to raise awareness of the harms caused by the criminalisation of people who use drugs.
http://supportdontpunish.org

The impact of the economic crisis on prevention, harm reduction and drug addiction services in South East Europe

By Thanasis Apostolou, director of the Diogenis Association, Drug Policy Dialogue in SEE

Developments and trends in drug policy in the vast majority of the countries of South Eastern Europe (SEE) have to be seen in the context of political transitions in the beginning of the 1990s, the war in ex-Yugoslavia and the outbreak of the HIV/AIDS epidemic. The recent economic crisis, however, affects all countries of SEE more or less in the same way. The budget cuts in the health sector directly affect the services for problematic drug users, such as prevention programmes, harm reduction, treatment and social integration services.

Harm reduction services are particularly vulnerable, because they are missing solid ground in the national legislation. There is still much to do in order to enshrine harm reduction in the national drug laws. In the past years, most governments have relied on the financial resources they have obtained through the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria. They have involved and supported several NGO initiatives in setting up and running services for harm reduction with very little or no financial support from national budgets. In countries without Global Fund money, the NGOs are confronted with severe budget cuts, which result in the shutdown of services. If the Global Fund withdraws from more countries in the forthcoming period, the number of harm reduction services will dramatically decrease.

NGOs in South Eastern Europe are discussing ways to find alternative financial resources. Pressure on governments is needed, to stress the importance of harm reduction services and secure their future existence. European cooperation can support and strengthen NGOs to formulate strategic choices and find alternatives. Target group representatives, such as drug users, but also parents and family members, HIV/AIDS organisations and other associations need to combine their forces to stress their needs and demands.

An important aspect, which contributes to the continuity and sustainability of harm reduction services, is the dialogue between harm reduction services and politicians, professionals and the general public. Several surveys and opinion polls show that a large percentage of the general public is not informed or convinced about the importance of harm reduction. There is resistance and there are many misunderstandings and misconceptions. Although harm reduction services reach the most vulnerable groups, have a real impact on the health and social wellbeing of these groups and reduce public nuisance, the general public sees harm reduction still as something negative and threatening. This is a point of concern for all parties involved.

One of the most critical factors in the implementation of drug policies is the need to develop and implement services according to the needs of drug users and other vulnerable populations. Most services do what they can, but long waiting lists for substitution treatment and the inability to provide basic services to people who need support constitute a big challenge.

It would be logical that the first priority is to meet the users' needs, starting with common basic standards for the vast majority, rather than high quality standards for the few and no services for the many. In the last informal drug policy dialogue organised in Greece last June, representatives of organisations of people you use drugs pointed out that their opinion must be taken into serious consideration. They argued that in the current structure of service providers there are too many time consuming activities for persons in treatment without a real impact. Their consented opinion was that psychosocial support is of principal importance. However, it should not be perceived in the sense of staffing relevant agencies with 2-3 social workers and psychologists, but rather as prioritizing the actual users' needs, i.e. employment, professional training and support in general, to improve their daily life. The call for a more practical approach must be heard. It is understandable that people who are asking for treatment and end up on a waiting list for years, question the way that available resources are spent. In a situation where increasing budgets of governments are unlikely, a more just system of sharing resources has to be discussed and decided on. Harm reduction services do not only deserve recognition, but also actual financial support through the sharing of available resources.

** The Diogenis Association is active in SEE organising Drug Policy dialogues on national, regional and international level, supports -as secretariat- the Drug Policy Network in SEE where 14 NGOs from the 10 Countries in the region are participating and runs the project "Drug Law reform in SEE" in co-operation with Universities and research institutes in South East Europe. The volume "Drug Policy and Drug Legislation in South East Europe" published in June 2013 is the first publication of the project.*

November 2013.

DIOGENIS
Drug Policy Dialogue in South East Europe

Drugs and HCV: a look at Romania

Ionut Alexandrescu, Carusel Foundation (Romania)

According to the World Health Organization's data, Romania has the highest rate of Hepatitis C Virus (HCV) prevalence in Europe. Moreover, it is ranked 4th in Europe as the main cause of death due to liver disease, with an average of 44.5 deaths per 100,000. In comparison Europe's average is 15 deaths per 100,0000 persons. Romania holds 10% out of Europe's estimated 12 million people who are Hepatitis C positive.

A study conducted by The Fundeni Clinic Institute in collaboration with the National Institute for Public Safety, between 2006 and 2008, shows that there is 3.23% HCV prevalence among the general population in Romania. Many of the new HCV cases were caused by improper sterilization of the medical equipment, such as surgery instruments and dental equipment.

Currently, Romania is facing an HCV epidemic among injecting drug users. According to the National Antidrug Agency Report of 2013, 82.4% of the approximated 19,400 injecting drug users from Bucharest are HCV positive, and the numbers are constantly rising. Another major concern for IDUs is the rapidly rising numbers of new HIV infections. Out of the 131 new HIV positive IDU confirmed cases between January and June 2013, 64.88% are also HCV positive.

Moreover, the problems of drug users do not end here. When diagnosed with HCV, Drug users face lack of treatment. The access to proper medical treatment is often hindered by the lack of medical insurance, drug detoxification/drug abstinence and the high costs of the various medical tests, which are not covered by medical insurance. Drug users are frequently discriminated against and stigmatised, concerning access to proper treatment. Even if it is not a written rule, another criterion for receiving Hepatitis treatment concerns how the patients got infected. Often, drug users are refused treatment in favour of other people, because of prevailing mentalities such as: "they didn't get infected accidentally, it is their own fault".

Although certain specialists are trying to convince other doctors that drug users should receive treatment for their HCV infection even if they are on substitution treatment, not many drug users have access to such treatments. According to the National Antidrug Agency, there are approximately 19,400 injecting drug users in Bucharest and the number of patients in substitution treatment is between 800 and 1000. If drug users want access to substitution treatment they either have to pay for treatment in a private clinic or they are placed on the waiting list of the free substitution treatment facilities provided by the National Antidrug Agency or the Ministry of Health. The duration of the waiting list for free substitution treatment lies somewhere between 2-3 months up to 1 year.

Thus, the biggest obstacles in receiving treatment as a drug are: the medical insurance, the reduced possibilities of accessing a substitution treatment, the new rising HIV epidemic among injecting drug users and in some cases the lack of ID papers. Not many drug users are, or have had, medical insurance throughout their drug consumption period. Many of them come from poor families and support themselves by illegal activities such as: parking tips, scrap iron collecting and recycling. Also, more than 45% of the injecting drug users are coming from Roma families with low incomes.

The main criteria for receiving treatment for Hepatitis C are: holding medical insurance, liver wound tests resulting in liver puncture or Fibromax, and the number of virus copies needs to be bigger than 5000 units per millilitre. Most of these laboratory tests are not covered by the medical insurance. Those who need further investigation need to pay these tests out of their own pocket. Before 2013, there were also other criteria for refusing HCV tratment to drug users, such as: being HIV positive or being an active drug user or receiving substitution treatment. As the number of new Hepatitis C cases is rising, the number of persons that receive treatment has surprisingly decreased from 3.500 patients of Hepatitis C and B, to an approximated 2.600 patients. In Romania the number of people who have access to treatment has been drastically reduced, due to major budget cuts instilled by the Ministry of Health. Thus, treatment availability has decreased. Most drug users can get the free Hepatitis C rapid test provided by NGOs, but they do not continue the investigation and treatment for their disease. Many drug users are infected with HCV for more than 5 years without getting additional diagnosis or treatment, due to the lack of financial means to pay for additional tests.

Greece... the country of harm induction

Efi Kokkini, Greek Drug & Substitute Users Union, Greece

Greek Drug & Substitute Users Union

Greece is known as the country where people still remain warm and human, the country where one will always find a meal, a glass of wine and a friendly word, the country of altruism, of hospitality and of noble values. But then again, if Greece is indeed a human-centered society, how can someone explain the unbelievable violation of people's rights and the gigantic reproduction of stereotypical and stigmatizing attitudes towards certain populations such as drug users?

Being a drug user in Greece in the era of bankruptcy, of political and social maelstrom, of fear, instability and injustice sometimes feels like balancing on a tightrope without a safety net, at least that is the feeling drug users describe in their private discussions. Financial austerity has profoundly attacked the most crucial domain of people's existence: human rights. As for our community, the problem is largely magnified. The right to health treatment, to equal opportunities, to privacy, to confidentiality, to safety and to dignity are notions with no particular value in the Greek reality. A new system has been inaugurated with absolutely no consideration of drug users' realistic needs. The limited measures supposedly responding to the significance of these needs look like a bad farce. It could be argued that public health has been abolished completely and human rights are systematically circumvented to an extent that even the most distorted minds could have never predicted. In comparison to other European Harm Reduction countries, Greece wins the prize for the policy novelty of ***'harm induction'.***

It was April & May 2012, when, according to a despicable governmental heath ordinance, 27 women labelled as sex-workers, were arrested from the streets of Athens by the Greek police and were tested on HIV by force, exposed to an unprecedented abusing violation of their rights. Those who were found HIV positive were put into prison with the accusation of spreading the virus and their names and personal data were publicized into newspapers and TV news! The Ministry of Health and a great majority of journalists were talking about a 'major threat to the public health' writing articles about 'remorseless prostitutes that were spreading death to the Greek society' legitimizing, thus, one of the worst, absolutely inhuman and condemnable practices of rights violation. Many NGOs and movements of solidarity towards the arrested women, with a range of concerted actions of resistance and a legal challenge to the State Council, forced the Ministry of Health to abolish this pathetic law, release all women (who were mainly drug users) and apologize for the moral and practical damage they were subjected to. With the legal and ethical support of all these organizations, the women are now demanding compensation from the State for what they have been through and they are struggling to stand on their feet again. I know they will ultimately find a way to get on with their lives, but the public rage, the cruel stigmatization, the unjust imprisonment and the brutal abuse of their personality will be engraved in their hearts forever.

One year later, on April 2013, in a massive sweep operation called ***'Thetis'***, the Greek police collected drug users walking into the centre of Athens, leading them handcuffed and in crates to the infamous immigrant concentration camp (another open wound for Greek humanism) of Amygdaleza (a distant area outside the Athens city border), forcing them into mandatory HIV testing and to all night cleaning 'shifts'. The people transferred there, stayed up all night, hungry & exhausted, and were only released at dawn, left alone to return to Athens by foot covering a three-hour walking distance. Many of them were recollected again right after they had finally returned into the city centre. The same camp has become the prison for hundreds of illegal immigrants who live there for months with no health service provision, no proper food and no measures taken concerning their deportation. Some of them eventually die as a result of receiving no treatment for their chronic diseases. Amygdaleza is a human hellhole functioning with the blessings of the Greek government converting human beings into garbage in a brutal plunder of human rights.

Drug treatment in Greece has turned into a battlefield with two rivals: abstinence against substitution programmes. The national OST programme called OKANA serves 90% of the Greek drug user population, the majority of which has attended at least once in their lives, one of the cold-turkey detoxification and abstinence programmes (ΚΕΘΕΑ), usually under court order. The fact that OKANA scores first in drug users' treatment choice, raises a merciless propaganda against substitution programmes, which are characterized dangerous, harmful and criminal for the Greek society. For most Greeks, harm reduction is not an option, as simple as that; it's abstinence or nothing. Substitution is accused to create a new generation of 'public junkies'. On the other hand, drug users, who are perfectly capable to decide what is best for them, request a place in methadone or buprenorphine treatment, but the 4 year waiting list completely sabotages their dreams of a better life. Until 2011, drug users had to wait 7-8 years (!) to enter a substitution programme and according to OKANA statistics, 1 out of 4 was either in prison or dead by the time they could enter the programme. But even now, the only way to get treatment immediately is either to be HIV positive, pregnant, married to an OST member or parent of a minor child. Moreover, the quality of services provided in OST programmes is at least questionable: no common framework in units, therapists with no expertise on the field, unable to approach users' mentality, unit directors applying their personal perceptions, which are often opposed to the harm reduction concept, punitive measures, penalties and expulsions for 'relapsing' (even cannabis use), and many more. OST units are divided into good and bad ones and it's a matter of luck where you'll accidentally be placed. Furthermore, the cut downs in financial resources are so high that basic material like take home bottles, urine collection bags, labelling tags and all kinds of supplies are often in absence. In May of 2013, units ran out of methadone stock for 3 weeks and everyone's dosage was significantly reduced sending people to the black market. OKANA's legal services and accommodation shelters are closed and welfare benefits are denied unless drug users are HIV positive. But even in that scenery, and being absolutely aware of the gaps of these services, drug users who live in the streets, who have no access to ethical or technical support and are condemned to this absurd environment of persecution, desperately ask for a place in treatment. And it hurts and makes us feel guilty that this remains to be a 'privilege', while it should actually be a fundamental right of all equal citizens in every civilized and humane society. We will never stop fighting against those who insist to forget that people are living bodies and speaking souls and not fading numbers in the piles of their forgotten lists. We will continue to fight for those who lack the belief that there are still people who care for them. Even in Greece, their homeland, the country of harm induction.

Greece

Harm Reduction services in Slovakia at the stake

Miroslava Zilinska, Iveta Chovancova,
C.A. Odyseus, Slovakia

In Slovakia, people who use drugs and sex workers are just a marginal part of social and political interests. With each passing year, the situation is getting more serious and worse. Last year, one syringe exchange program was cancelled and another one became based on voluntary work, leaving most of the country without harm reduction services. The only existing harm reduction services are run in Western Slovakia and in one city in Eastern Slovakia, based on voluntary work.

C.A. Odyseus, one of the four existing harm reduction organizations, is facing financial difficulties every year. State funding related to drug prevention declined by more than 50% between 2010 and 2011. Financial crisis and austerity measures are not the only warning signs. The main state representative on drug-related issues was demoted from the General Secretariat of the Committee of Ministers for Drug Dependencies and Drug Control to the Section of Health under the Ministry of Health of the Slovak Republic. This is another example of the fact that drug policy and drug-related issues are being reduced to the margins of political and state interests.

Harm reduction in Slovakia is mostly represented via the non-governmental sector. However, this year, the Council of the Slovak Republic for Drug Policy did not engage civil society (e.g. representatives from NGOs) in the council, arguing that the Plenipotentiary of the Slovak Government for the Development of Civil Society is already one of the council members. He can invite one representative from an NGO, and that should suffice. In autumn 2013, the Plenipotentiary of the Slovak Government for the Development of Civil Society announced his resignation and it seems that this post will remain vacant. It leaves the Council of the Slovak Republic for Drug Policy without any participation from the representatives of civil society. This status quo ignores the fact that the EU Drug Strategy (2013–2020)and National Anti-Drug* Strategy for the Slovak Republic (2013-2020) stress the need of involvement of civil society and people from the community and that syringe exchange programmes are an effective strategy, which is mostly undertaken by the non-governmental sector in Slovakia.

C.A. Odyseus is facing financial difficulties every year.

Moreover, the National Programme of HIV/AIDS Prevention expired in 2012. Slovakia does not yet have a new national programme, and there is no budget for HIV/AIDS prevention. The proposed, but not yet accepted budget to the National Programme of HIV/AIDS Prevention is inadequate and undervalued.

Apart from the declining financial resources coming from the main State representative on drug-related issues, drug use and sex work are also becoming a marginal part of social interest. This year, the Ministry of Labour, Family and Social Affairs of the Slovak Republic only gave financial support to 1 of 4 harm reduction programmes in Slovakia, even though the open grant focused on tackling drug addiction through outreach programmes. In the case of our organization, Odyseus, the reason for the unsuccessful application was a formal error, which was due to misleading advice given directly by an employee of the Ministry. Another organization was offered financial support under such terms that the organization could not adhere to them.

The financial crisis and the marginalisation of drug use topics, have large consequences on the organization, but in the end, those really affected are the marginalised groups – and the society as a whole, since public health is at the stake.

Without adequate financial resources, outreach work cannot be expanded (even though it is required), distribution of harm reduction material is inadequate, and social accompaniments are reduced to 1 per week. How can we effectively address the need for HIV and Hepatitis C prevention and social inclusion of marginalised groups and public health when organizations are struggling to survive due to financial difficulties, and have to tackle the lack of interest of the authorities?

The situation of drug users and the consequences of austerity measures in daily life

Luís Mendão, Rosa Freitas, Daniel Simões

Portugal is one of the most HIV affected countries in the European Union; it has the second highest epidemic. It has a concentrated epidemic (i.e. >5% of HIV-infected in certain populations) among injecting drug users, people in prison, sex workers, men who have sex with men and some African origin groups.

In Western Europe (WHO definition), Portugal has the highest HIV prevalence, highest TB incidence (nowadays there is only one TB diagnosis center in Lisbon) among drug users on treatment (1%-2%) and no reliable data available for Hepatitis, although a study conducted in 2008 estimated that during the first year of drug injection the risk of acquisition of HCV was higher than 50%.

At the end of December 2012, the proportion of reports (in the last 3 years) of newly diagnosed cases with HIV infection and AIDS attributed to the use of injected drugs was 12% and 21% respectively, which is very high compared to other Western Europe countries.
Currently the main transmission route of HIV is sexual contact. The previously high epidemic among drug injectors has been reduced substantially through the expansion of harm reduction measures; this contributes to less new HIV cases. The Portuguese framework, which started in 2001, also included legal innovative interventions such as needle exchange in prisons, drug consumption rooms and pilot medical treatments with heroin. The latter two have never been implemented, and needle exchange in prisons was attempted but has not become a current practice.

Also, the Portuguese Needle and Syringe Exchange Programme (NSP) was launched in 1993 involving community pharmacies, and was later extended to different governmental and nongovernmental organizations. In 2012 the number of NGOs performing NSP was reduced. In 2012, 1.340.000 needles/syringes were distributed through the programme and merely 350 000 in the first five months of 2013.

As Portugal faces a financial and social crisis, being one of the four EU countries on bail out, the government has made severe cuts on health and social security. We already have examples of some European countries where decreased investment in areas such as prevention and harm reduction, combined with the usual increase in drug use in times of crisis, had as a consequence an increase in the number of HIV and HCV cases among PWID, whose costs will be reflected in the upcoming years.

The latest news regarding the Portuguese situation came to public in October 2013, and stated that in 2012, there was an increase of nearly 2000 people applying for public treatment structures, due to drug related relapses, accounting for a total of 3.897 requests. Heroin was the first drug related to these cases, with 2.418 people reporting heroin relapses .

In addition, in 2012, 8.844 drug users requested assistance of the public services for the first time. This number represents the highest number of new cases in the last 10 years .

Another concern recently reported by SICAD's Director, João Goulão, is the increase in new cases related to crack consumption .

In the "Joint EMCDDA and ECDC rapid risk assessment" (2012), Portugal is not explicitly mentioned but fits in the criteria identified, and the current decline in needle exchange coverage (due to the end of the NSP in Pharmacies and the end of some HR projects around the country) and the increasing waiting list for drug treatment could increase the risk of outbreaks.

Despite the fact that severe cuts have been made in several public structures, the drug area has not been one of the most affected, and has maintained most of its funding. Even so, the restructuring of the former Institute for Drugs and Drug

GAT
Grupo Português de Activistas sobre Tratamentos de VIH/SIDA
Pedro Santos

Addiction and the inclusion of the treatment structure on the Regional Health Administrations generated a new management dynamic, and its challenges and practical effects are not yet known.

As for the support for Civil Society, several NGOs seem to have lost some response capacity, and are having difficulties accessing materials to maintain their NSP working. Additionally, the implementation of the new public NSP has also faced difficulties, as it was shifted from pharmacies to primary health care centres. Not only has the process not been concluded yet, there are also reports of very low adhesion. The combination of these factors will no doubt have as a consequence that some PWID will face increased difficulties in accessing safe injection material.

Also, several civil society projects that work with PWUD have undergone several months of financial gaps, since new funding calls started late, and thus created a time interval where several HR projects were not funded.

We think that mobilizing the community of PWUD, Civil Society and Harm Reduction organizations and increasing their involvement both in a political (planning) level and in terms of evaluation of needs and responses is crucial for sustaining and increasing the quality of rights based and evidence based responses in Portugal.

Portugal

http://www.noticiasaominuto.com/pais/118432/aparecimento-de-crack-preocupa-autoridades-de-saude
http://www.publico.pt/sociedade/noticia/quase-nove-mil-novos-toxicodependentes-nos-centros-de-tratamento-em-2012-1608901
http://sicnoticias.sapo.pt/pais/2013/10/17/aparecimento-de-crack-e-recaidas-de-heroina-preocupam-autoridades-de-saude-1

SAVE PEOPLE, NOT BANKS - Impact of the economic crises on drug users' care in Catalonia and Spain

Xavier Majó i Roca, Subdirecció General de Drogodependències /
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Everybody knows who to blame for the economic crises and who is paying for it. As in a never-ending story of humankind, the powerful who are usually responsible for the disasters remain unpunished, while the poor pay the most to fix the problems.

The greed of the banks, the lax regulation and control of them by governments, the vast expenditures on unnecessary but politically beneficial things (mostly infrastructure), connivance between politicians and bankers, and so on; all this has lead to the biggest economic crisis in the last 50 years in Catalonia and Spain.

This has caused the government to pay for its own accumulated deficits and the deficits of private banks in order to avoid the economic failure of the country. This means that money from the country's citizens, which is supposed to go to education, health and social welfare is now redirected to pay the huge debts of our governments and banks.

These major debts along with the lack of credit for companies have almost paralyzed the economy of the country with an unemployment rate of 26%, which reaches 50% among 20 to 24 year olds. The money that Spanish banks got from the EU (40.000 million euros) has hardly provided credit to the companies in order to foster the country's economic activity. Meanwhile, people's salaries have dropped in an internal devaluation to make the country more competitive.

Accordingly the biggest budgets of the governments, which are education, health, social care and welfare, have been hit most heavily, and this has caused some negative changes. For instance universal access to healthcare has almost reverted to the 1970s system when the access to healthcare was dependent on a person's payment of social security contributions linked to his work salary. This is an example of one of many great achievements in social welfare and labour legislation slowly obtained over the years that has been suppressed.

So far, the overall health expenditure has dropped 15% in Catalonia. On drug care this implies 2 main things:

- Activities that provide direct care to individuals have been prioritized over other activities that have been reduced, such as training of professionals, research, production of education materials, etc.
- No drug care centre has been closed so far, although some opening times have been reduced as well as some reduction of staff and activities in some centres. Opening of new services is out of question, unless there is a crystal clear need for them.

Improvement of the efficiency of centres and a high commitment of service workers and managers has balanced out some of the economic impact.

Our drug information system (admission and care in drug treatment centres and harm reduction centres, drug consumption surveys, drug related morbidity and mortality, emergency admission to hospitals) have not been able to detect any major changes since the beginning of the crisis in 2008, but this might be because the system is not able to monitor minor and slow developing changes.

Catalonia and Spain

New Report on Harm Reduction in Europe 2003 to 2010

Martin Busch, Gesundheit Österreich Forschung- und Planung GmbH, Austria

Gesundheit Österreich
Forschungs- und Planungs GmbH

The report on the current state of play of the Council Recommendation (CR) of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence has been finalised. The CR mentions the following main objectives:

> *Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.*
>
> *Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-induced deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse.*
>
> *Member States should consider measures, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks.*

The report is the result of the collaboration of experts from different organizations and departments, such as SOGETI, EAHC, EMCDDA, DG SANCO, and DG JUST. It presents the updated overview of the implementation of the Council Recommendation in the EU countries and several candidate countries, including country profiles, as well as analyses of epidemiological trends. The study also assesses the availability of, access to, and coverage of harm reduction measures based on the answers to a policy survey and a survey among field organisations. The available scientific evidence regarding interventions to prevent and reduce health-harms associated with drug dependence was analysed and in addition four systematic Literature Reviews were produced (peer naloxone programs, prison release management, needle exchange in prison, measures to change the route of administration). Finally, the report provides country overviews on harm reduction policies, services and facilities. The main output is a set of 13 conclusions regarding the follow-up of the Council Recommendation, based on the application and combination of the scientific effectiveness of interventions and their availability and coverage. Based on these conclusions the authors have identified 3 priority areas of action:

Epidemiological situation: Concerning drug-related harm it can be stated that a significant reduction of **HIV infections** among IDUs in most countries was achieved, but infection rates of **Hepatitis C** are still high in many countries. Recent HIV-outbreaks in Greece and Romania show that HIV infection rates can increase rapidly under specific conditions, including low coverage of harm reduction measures. High rates of HCV infection can be seen as an indicator for the risk of a HIV-outbreak. It was not possible to reduce **drug-induced deaths** (deaths due to overdoses) since 2003 in most countries, although the coverage of OST increased. On one hand, measures to improve retention rates in OST and to avoid interruptions (e. g. prison, attempts to become drug free with no adequate indication) are necessary. On the other hand interventions focusing on overdose risk like drug consumption rooms and peer naloxone programmes should be considered. Prison release is a risk factor for drug-induced deaths and therefore adequate through-care including prison release management and continuation of OST in prison and over the period of release is crucial.

Effectiveness of harm reduction measures: Strong scientific evidence exists for the effectiveness of **opioid substitution treatment (OST)** to reduce the infection risk in connection with drug-related infectious diseases (DRID) as well as mortality. Interruptions of OST are a risk factor for drug-induced deaths. Challenges for the future are to clarify how coverage can be increased further (e. g. avoid waiting lists), how interruptions can be avoided and how OST concerning substances and regimes can be diversified to meet the needs of different subgroups of opioid addicts. For **syringe provision through specialised programmes (NSP)** there is strong scientific evidence concerning the reduction of infection risk (e. g. HIV, HCV, HBV) too. Challenges are the improvement of coverage and dealing with other routes of administration than injecting. There is strong evidence concerning the effectiveness of **harm reduction (e. g. OST and NSP)** in prison. Information,

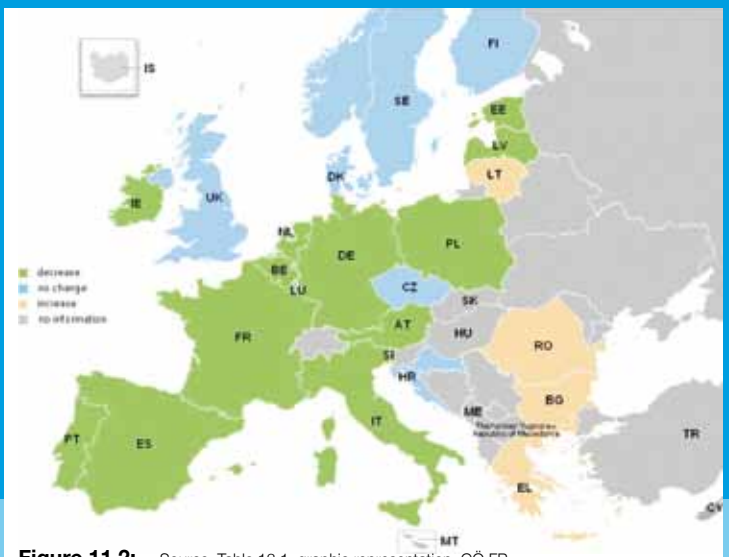

Figure 11.2: Source: Table 13.1; graphic representation: GÖ FP

Figure 11.5: Source: Table 13.1; graphic representation: GÖ FP

education and communication are effective when the setting is appropriate and messages are provided in an adequate form by trustable persons. One possibility to assure the right setting is **outreach work**. Since peers are the most trustable persons in many aspects **peer involvement,** which has proven to be effective, is a good strategy. In the last decade evidence on **heroin-assisted treatment** as a second line intervention, **drug consumption rooms** and **peer naloxone programmes** have increased significantly. Based on this evidence, it can be assumed that these interventions are effective, but that they should be further monitored and evaluated. **Vaccination for hepatitis B, treatment of HIV, HBV and HCV** in IDUs are effective measures. The treatment for HCV is a particularly effective instrument of infection prevention for others too. **Drug Checking** is considered an integrated service that always combines chemical analysis with advice or counselling. Although there is no new evidence on the effectiveness of Drug Checking programmes, it might be worth conducting new studies; on the one hand, because Drug Checking/counselling might be a reaction to the emergence of new psychoactive substances on the markets, on the other hand, because professionalization took place concerning testing and counselling methods during the last few years. The possible benefit of measures to avoid shifting from other routes of administration to injecting drug use (IDU) and to foster shifting from IDU to other **routes of administration** is pointed out in scientific literature. However, there is hardly any evidence on concrete projects

Implementation of harm reduction measures and impact of the CR: the situation concerning harm reduction measures improved a lot in most countries. The Coverage of **OST and NSP** has increased considerably but especially NSP is still far away from full coverage in all countries. While OST is now available in many prisons, NSP is not. Therefore, **prisons are still a high risk environment for infections** with HIV or HCV and a driving factor for infectious diseases among injecting drug users (IDUs). Therefore, improvements in the prison setting are very urgent. Heroin assisted treatment as a second line intervention, **Drug Checking, peer naloxone programmes** and **drug consumption rooms** are implemented in a few countries only. In times of economic crises, the financing of the status quo and the expansion of harm reduction is an important issue in all countries. In some EU 12 states (e. g. Bulgaria and Romania) harm reduction projects were initially funded by the "Global Fund to Fight AIDS, Tuberculosis, and Malaria". There are now problems to ensure national funding.

The **impact of the CR** can be judged as substantial especially in the countries joining the EU in 2004 or later. Further support from EU level is requested from organisations involved in harm reduction. A clear new statement on harm reduction can help to foster the expansion of harm reduction measures. These EU-recommendations should also include, in particular, new measures like drug consumption rooms and peer naloxone programmes related to the reduction of drug-induced death and give a special focus to prisons (OST, NSP and adequate throughcare). In addition, the new recommendations should cover new areas like housing, social re-integration and occupation because these are the main factors for stabilisation (or de-stabilisation if lacking). However, existing harm reduction measures, such as OSP and NSP as the backbone of any harm reduction strategy, need to be strengthened.

The main output of the report is a set of 13 conclusions regarding the follow-up of the Council Recommendation, based on the application and combination of the scientific effectiveness of interventions and the availability and coverage. Based on these the authors have identified **3 priority areas of action:**

- the reduction of drug-induced deaths,
- the improvement of harm reduction in prison
- the reduction of harm caused by drug-related infections.

The report can be downloaded from http://ec.europa.eu/eahc/news/news280.html

or http://www.goeg.at/de/Bereich/EAHC-17.html

http://ec.europa.eu/eahc/documents/health/report-drug-dependence_en.pdf
http://ec.europa.eu/eahc/documents/health/drug-dependence-systematic-review_en.pdf
http://ec.europa.eu/eahc/documents/health/drug-dependence-country-profiles_en.pdf

Figure 11.2:
Significant changes of HIV infections via IDU 2003-2010 in the EU

Figure 11.5:
Significant changes of mortality rated due to direct drug-induced deaths 2003/2004-2009/2010 in the EU

Figure 5.1:
Coverage of harm reduction measures, estimated by stakeholders and policy makers
HBV=hepatitis B virus, HCV=hepatitis C virus, HIV=human immunodeficiency virus, OST=opioid substitution treatment, STD=sexually transmitted diseases, TBC=tuberculosis
Remark: data refer to Austria, Belgium, Bulgaria, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Malta, Netherlands, Portugal, Romania, Slovakia, Slovenia, Spain, United Kingdom; The full wording of all CRs can be found in section 15.
Coverage: 1=not available, 2=rare, 3=limited, 4=extensive, 5=full coverage

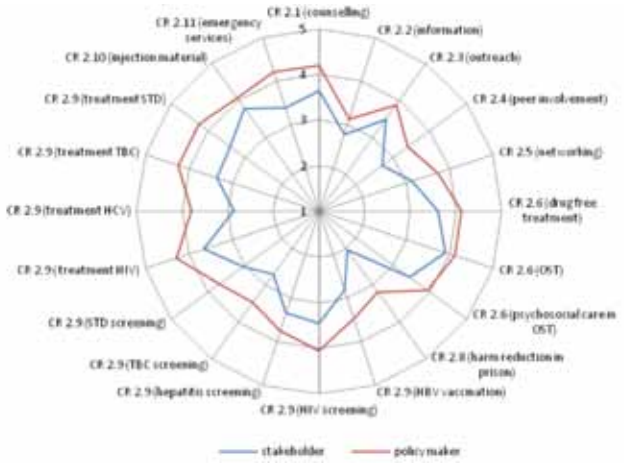

Figure 5.1:
Source: GÖ FP, stakeholder survey, policy maker survey; graphic representation: GÖ FP

13 evidence based recommendations related to harm reduction

1. **Political strengthening of harm reduction**
2. **Improvement of coverage of syringe provision through specialised programmes**
3. **Improvement of coverage and organisation of opioid substitution treatment**
4. **Harm reduction in prison**
5. **Naloxone “take-home” programmes**
6. **Use of emergency services (no police in case of drug related overdoses)**
7. **Drug consumption rooms**
8. **Counselling, outreach and peer involvement**
9. **Access to HCV treatment**
10. **HBV vaccination**
11. **Housing**
12. **Integration of services**
13. **Research**

Are you

- **an individual or part of an organisation engaged in the field of social inclusion and health?**
- **working on grass root level, as a service provider, in a research or policy institution?**
- **interested in knowledge exchange and collaboration on european level?**
- **advocating for fair and inclusive services and participation of affected communities?**

Then you should join the network at

www.correlation-net.org

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Social Inclusion & Health

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