EuroNPUD

Peer-led

Consultation Mechanism

A survey involving people who use drugs in harm reduction services in Antwerp, Brno, Helsinki and Rome.

BoOst

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Executive Summary

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This report presents an analysis showing that, while people who use drugs (PWUD) are accessing harm reduction services, significant challenges remain in relation to employment opportunities, access to comprehensive healthcare, and persistent stigma. The findings offer valuable, community-led insights that will inform the annual overview of harm reduction services across Europe, complementing the *Correlation Civil Society Monitoring of Harm Reduction in Europe* conducted by the European Harm Reduction Network (C-EHRN).

The questionnaire provides essential perspectives on the views and lived experiences of PWUD in four key "Lighthouse" countries participating in the EU4Health BOOST Project: Czechia, Finland, Belgium, and Italy — with a particular focus on the cities of Brno, Helsinki, Antwerp, and Rome. It explores how people experience harm reduction services within existing programmes, practices, and policy frameworks.

The European Network of People Who Use Drugs (EuroNPUD) collaborated with community focal points in each country to ensure that the voices and realities of those accessing harm reduction services were central to the data collection process. This initiative represents a vital step toward improving harm reduction responses and promoting more inclusive and participatory local and European drug services and policies.

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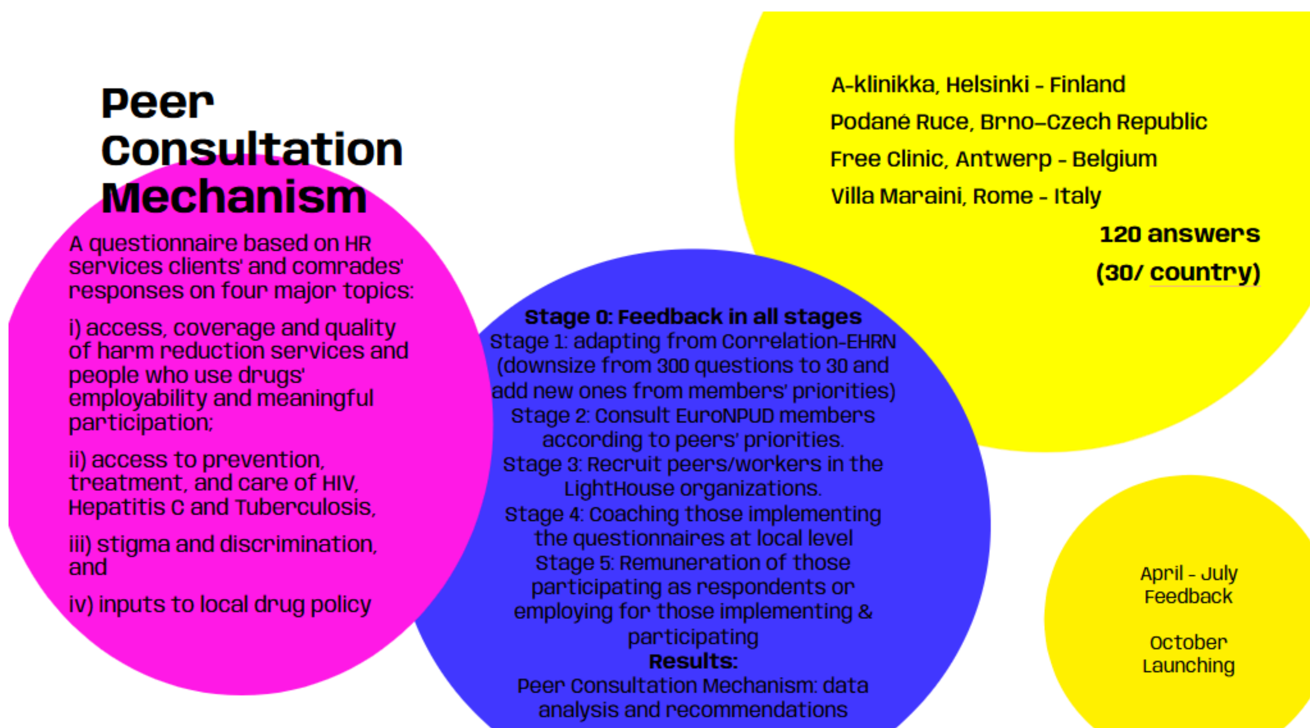
1. Methodology and Scope: Peer-Led Monitoring Mechanism

The findings presented in this section are based on data collected through the Peer Consultation Mechanism, as part of the Work Package 5, of BOOST EU4Health Project, coordinated by Correlation Network (C-EHRN). Aiming at contributing to the monitoring and evaluation of harm reduction services & related issues, a participatory monitoring method was implemented across multiple European cities in 2024 (October - December). This methodology centers the experiences and insights of people who use drugs (PWUD), aiming to assess not just the availability of services, but their accessibility, quality, and impact from a community-led perspective.

Fig 1. Peer Consultation Mechanism: stages of development



1.1. Community-Led Data Collection

- ☐ Local focal points carried out the monitoring — often harm reduction NGOs peer employees — working in close partnership with other peers and community members. Peer researchers and community activists contributed to the design, distribution, and analysis of the monitoring tools (during a first stage from August to October 2024), including structured questionnaires based on C-EHRN's Harm Reduction Monitoring framework and following the preferences of EuroNPUD members;

- ☐ Personalized supervision by the main peer researcher during the questionnaire implementation by focal points
- ☐ Feedback of data collection with focal points, C-EHRN, EuroNPUD Executive and EU4Health BOOST “Lighthouse” countries.

This peer-led model ensures that the living and lived realities of service users - our comrades, are central to the monitoring process, providing nuanced insights often missed by institutional reporting. Each indicator was scored using a standardized scale (e.g., not available, partially available, available to a great extent), with space for qualitative input and examples from local realities.

1.2. Advantages of the Peer-Led Approach

This approach brings multiple strengths:

First of all, it holds credibility: Peer researchers are more likely to access “hidden populations” and generate trust among our community.

Secondly, this consultation mechanism tries to be based on accuracy: Peers are able to detect barriers and dynamics that external evaluators may overlook.

Thirdly, empowerment: Involving peers meaningfully supports capacity building and increases community ownership of policy advocacy.

We therefore hope that the data generated is directly relevant for use in local, national and European advocacy.

Note: Peer-led monitoring offers valuable qualitative insights but often faces challenges such as limited funding or institutional support for meaningful peer involvement. For this first experience, EuroNPUD congratulates all peers and PWUD involved and hopes that the results of the survey could further contribute to improve service delivery and related matters.

1.3. Acknowledgments, Sampling Limitations and Representation Bias

While the peer-led monitoring methodology provides rich, grounded insights from people who use drugs, it also entails certain limitations regarding sample size and representativeness. In each city, approximately 30 respondents contributed to data collection — a number that may not fully capture the diversity of experiences and conditions of service access across the broader urban context.

This limitation introduces a potential representation bias, particularly in larger or highly segregated cities, where access to harm reduction services and institutional dynamics can vary considerably between neighborhoods and sub-populations. Consequently, the findings should be interpreted as indicative rather than comprehensive, reflecting the lived realities of those reached through local harm reduction networks and outreach activities.

It is also important to note that participation in this assessment was entirely voluntary and confidential. This ethical approach may have limited the volume of responses in some areas but likely enhanced the honesty and authenticity of participants' contributions, fostering a sense of trust and openness throughout the process. Some sections contained incomplete data due to this voluntary nature, which may affect the consistency of certain trends; however, most open-ended responses were rich in detail and context, providing valuable qualitative insights.

Finally, as the data are based on personal experiences, they may include subjective interpretations or individual biases. At the same time, this report recognizes and deeply values the contributions of all respondents and stakeholders who participated in the consultation. This initiative represents the first peer-led assessment of harm reduction service accessibility conducted simultaneously across the four "Lighthouse" countries, offering a unique perspective on community-based monitoring and local realities.

A final note: data analysis process faced additional challenges due to language barriers. While efforts were made to translate all responses into English for consistency, some were originally written in national or local languages. In several cases, automated translation tools (such as Google Translate) did not fully capture the nuance or accuracy of participants' expressions, occasionally resulting in duplicated or unclear responses. This was particularly evident in the Czech Republic, where many participants answered in their native language, making interpretation and thematic coding more complex. Despite these difficulties, every effort was made to preserve the meaning and authenticity of respondents' contributions, ensuring that linguistic diversity did not overshadow the depth of community insights.

Missing Data:

- Some columns have missing values. However, open-ended response sections were helpful to complete the recommendations presented here.
- Certain fields, such as "Where do you access this service?" have less answers and "If other, please specify," appear to have no responses at all.

1.4. From Harm Reduction Essentials in European Cities to the Peer-led Consultation Mechanism

Based on Civil Society Monitoring of Harm Reduction in Europe , 2020 & 2024

This section summarizes the current landscape of harm reduction services across five European cities — Prague & Brno, Antwerp, Helsinki and Rome — highlighting service availability, institutional cooperation, peer involvement, and the presence (or absence) of drug consumption rooms (DCRs).

Prague & Brno

Both Prague (city reported at the C-EHRN civil society-led monitoring) and Brno illustrate the Czech Republic's long-standing commitment to harm reduction, yet they differ in maturity, scope, and the institutionalisation of peer engagement.

Harm reduction services in both cities include needle and syringe programmes (NSP) and opioid agonist treatment (OAT), which are available and generally accessible. A key national advancement has been the expansion of drug checking services — first introduced in Prague in 2023 and already operational in Brno — reflecting a growing emphasis on evidence-based risk reduction. In Brno, a mobile DCR has been working since 2023 operated by Podané Ruce.

Peer involvement presents a mixed picture. In Brno, peer engagement is more visible and valued, often facilitated by NGOs that include people with lived experience in outreach and community support activities. In contrast, in Prague, participation remains largely informal, with few structured or institutionalised roles for peers in service design or evaluation.

The Czech Republic continues to uphold one of the most progressive drug policy frameworks in Central and Eastern Europe, with personal possession of small quantities for use decriminalized since 2010. This pragmatic approach supports the expansion of harm reduction services and contributes to relatively low levels of drug-related criminalization. However, recent debates on the regulation of cannabis and new psychoactive substances have reignited tensions between public health and law enforcement approaches, underscoring the need for sustained advocacy and evidence-based policymaking.

Overall, both cities demonstrate solid harm reduction infrastructures anchored in long-standing public health principles, while facing common gaps in formal peer

participation and the integration of harm reduction within broader social inclusion frameworks (C-EHRN, 2024).

Antwerp

Antwerp continues to provide the core harm reduction package; however, drug checking services remain unavailable. Sexual-risk prevention services have seen a marked increase in availability, reaching a “great extent” in 2024. Providers report improved practices regarding data confidentiality and client-centered responsiveness. Nonetheless, cooperation with employment reintegration programmes and prisons is largely rated as ‘not possible’ or ‘challenging.’ Antwerp lacks operational DCRs, and peer involvement is predominantly informal and underfunded, limiting the inclusion of lived experience in policy and service planning (C-EHRN 2020), despite studies that preview the operationality of a DCR.

Helsinki

In Helsinki, NSP services remain available but have experienced a reduction in coverage. Crucially, both naloxone distribution and drug checking services were absent in 2024, indicating significant service gaps. While confidentiality protections have improved, the lack of drug checking and naloxone limits risk mitigation efforts. There are no DCRs in operation, and peer engagement in formal services is nearly non-existent and lacks institutional pathways. Cooperation with employment and training sectors is considered not possible, further isolating service users from broader social supports (C-EHRN 2020, 2024).

Rome

Rome shows the most limited harm reduction infrastructure among the cities studied. Although drug checking services were introduced in 2023, many other harm reduction interventions remain fragmented or inconsistently delivered. Cooperation with prisons, employment offices is reported as largely difficult, restricting holistic support for vulnerable groups. No DCRs are present, and peer participation is minimal, with civil society organizations facing political and funding challenges (C-EHRN 2020, 2024).

1.5. Towards Bridging Monitoring Gaps

Further comparisons with C-EHRN monitoring reports highlight an important discrepancy between the assessments made by NGO focal points and the lived experiences of people who use drugs. While focal point evaluations offer valuable insights

into policy implementation and service availability, they may not fully capture barriers related to accessibility, trust, stigma, and cultural relevance experienced on the ground. This reinforces the need for more inclusive monitoring frameworks that directly involve peers not only as informants but also as co-evaluators and co-designers of services. Strengthening the participation of people who use drugs in data collection, analysis, and reporting will be essential to identify blind spots, improve service responsiveness, and ensure accountability in harm reduction systems across Europe.

2. EuroNPUD Peer Consultation Mechanism: areas of evaluation, key findings and process-tracking

The consultation feedback was done accordingly to EuronPUD members priorities reflected in the questions covered here, that were also inspired by C-EHRN Civil Society Monitoring on European Harm Reduction, and is analyzed based on four major themes:

i) Access, Coverage, and Quality of Harm Reduction Services: Assessing availability, usability, and perceptions of effectiveness.

Questions regarding access to harm reduction services, opioid agonist treatment (OAT), needle exchange programs, drug consumption rooms, and safer smoking kits.

ii) Access to Prevention, Treatment, and Care of HIV, Hepatitis C, and Tuberculosis: Exploring barriers and facilitators to healthcare services.

Questions related to health services regarding HIV services, including PrEP, PEP, HCV and Tuberculosis and their experiences with the services.

iii) Stigma and Discrimination: Analyzing experiences of stigma related to drug use and its impact on social inclusion.

Experiences of stigma and discrimination based on drug use, living with HIV, HCV, or TB, and whether the respondent encountered discrimination while accessing services.

iv) Inputs to Local Drug Policy: Gathering insights on policy preferences, barriers, and suggested improvements. Each section provides a breakdown of trends, key takeaways, and potential areas for advocacy or policy enhancement.

Opinions on ideal drug policies, government priorities, and the impact of drug prohibition on personal wellbeing.

i) Access, Coverage, and Quality of Harm Reduction Services:

Key Findings:

- Access to Opioid Agonist Treatment (OAT) and Needle and Syringe Programs (NSP) varies across cities, with some countries like Brno (Czechia) and Rome (Italy) reporting wider availability of treatment options (such as buprenorphine and methadone), while others like in Helsinki (Finland) face limitations. Regarding satisfaction with services, some respondents reported long waiting times, stigma, and legal barriers. Significant barriers include distance, operating hours, and stigma/discrimination (experienced by some).
- Mobile units for NSP are widely used in some cities, which helps reach a broader population.
- Employability of peers in harm reduction services is still limited, as the majority reported no employment opportunities in peer roles, highlighting a need for more meaningful involvement of people who use drugs in harm reduction work.

ii) Access to Prevention, Treatment, and Care of HIV, Hepatitis C, and Tuberculosis:

Key Findings:

- High levels of engagement with testing for HIV and Hepatitis C were reported, particularly in cities like Antwerp and Brno. Coincidentally or not, these are the cities that include peers in outreach and service delivery.
- There are gaps in access to Post-exposure prophylaxis (PEP) services, indicating the need for improved awareness and availability of this preventative treatment. Most respondents were not aware of PEP in their countries and none of them has ever used PREP (Pré-exposure prophylaxis).

iii) Stigma and Discrimination:

Key Findings:

- Nearly 50% of respondents reported experiencing stigma and discrimination, particularly in healthcare settings (such as hospitals). This reflects the significant barrier stigma poses to accessing health services, leading people to search for harm reduction - low-threshold services to overcome these barriers.
- Stigma was also linked to respondents' interactions with law enforcement, namely with police.
- Respondents also experienced stigma in the workplace, which highlights the societal and systemic issues that need to be addressed for better economic and social rights outcomes.

iv) Inputs to Local Drug Policy:

Key Findings:

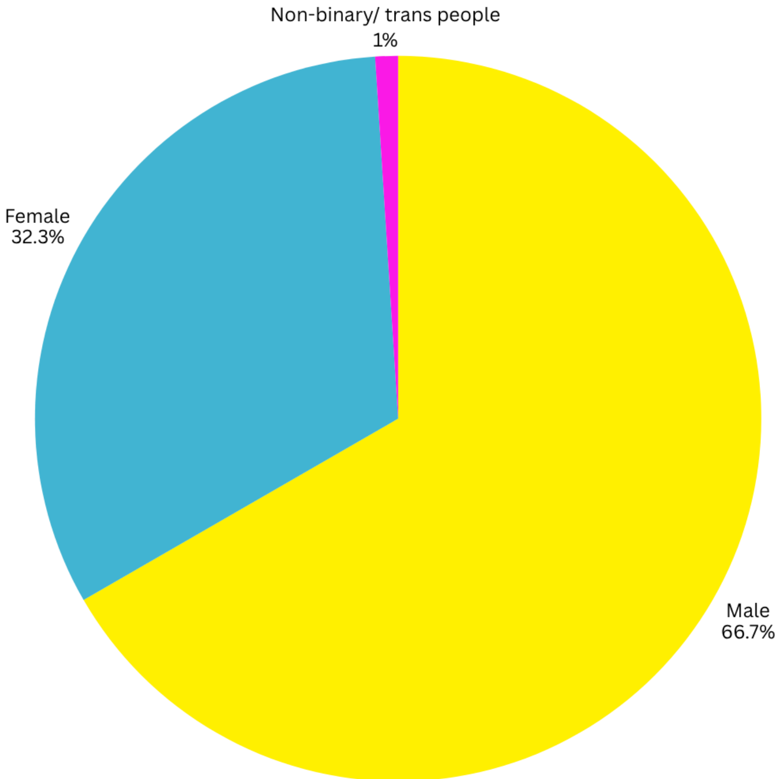
- Respondents across the Lighthouse cities expressed a strong preference for drug regulation and the adoption of harm reduction-focused policies. Most respondents highlighted the importance of shifting focus from punitive measures to public health strategies.
- Support for drug law reform was clear, with people advocating for more inclusive and supportive drug policies fighting back persistent stigma and penalties.

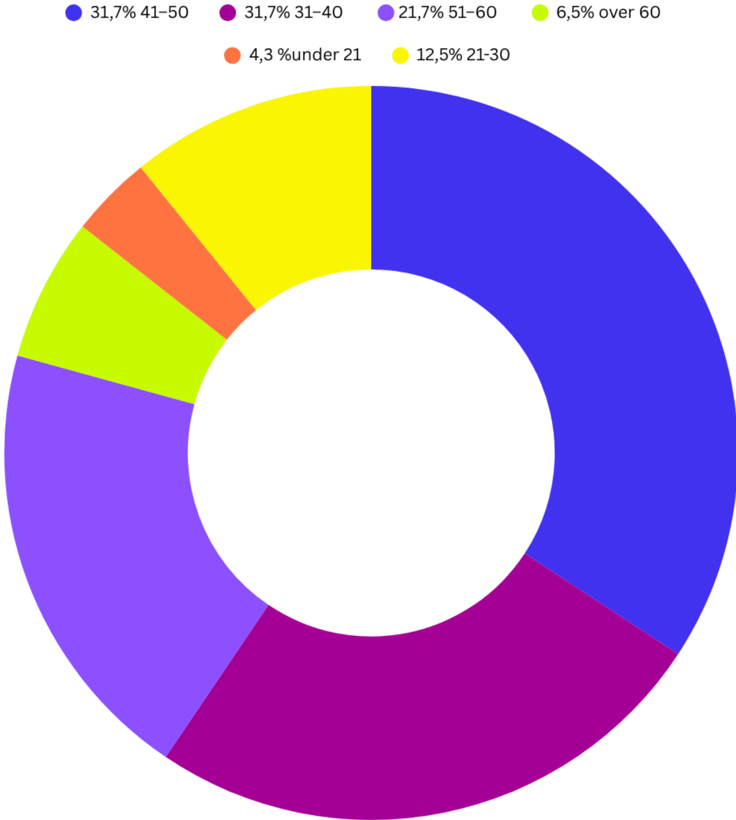
3. Key demographic data and substance use & others

Sociodemographic Trends:

This section will summarize key trends based on gender, age, and the country of response (city). The dataset captures diverse demographic backgrounds, allowing for an analysis of representation across different regions. Understanding these trends helps contextualize the feedback provided in the consultation and ensures that insights are interpreted with a clear view of the respondents' backgrounds.

Gender:





Age:

3.1. Thematic Analysis

Demographic Profile

Most respondents fall within the 41–50 age group (31.7%), followed by those aged 31–40 (23.3%) and 51–60 (21.7%). People under 21 and over 60 also responded to the questionnaire but were the least represented groups.

Participation in Peer or Civil Society Groups

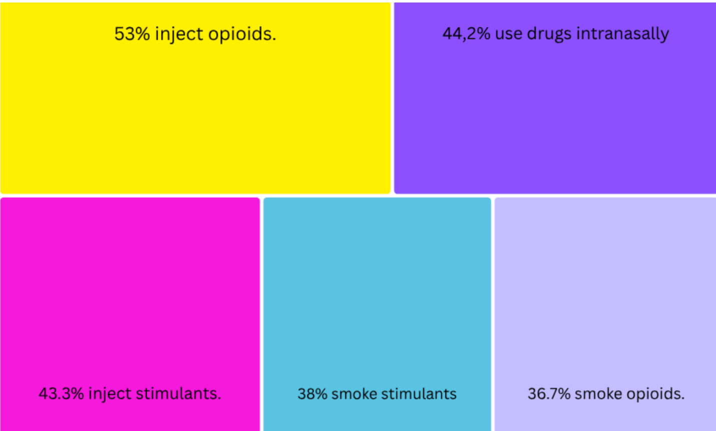
A striking **93.3% of respondents are not involved in any peer group**, **drug users' union, or NGO.** This reveals a concerning lack of community engagement or representation and suggests barriers to social participation or lack of access to peer-led structures.

Legal Status and Representation of Migrants

Aknowledging that 25% of respondents are migrants, 92.2% reported having a permanent visa or official residency status, indicating that migrants — particularly those with precarious or undocumented status — are likely underrepresented in the sample. This underrepresentation may stem from multiple factors, including barriers to access, fear of exposure, language limitations, or the limited reach of harm reduction services among migrant populations. In some contexts, such as Brno, it may also reflect a smaller migrant community.

Diverse Backgrounds and limited access to specific data:
The respondents come from various backgrounds, including migrants. Approximately 13% of respondents did not specify their age, and detailed migration status was available for only a subset, which may affect the representativeness of these demographic insights.

Type of Substance intake:



Note: Stimulant users include cathinones and methamphetamine.

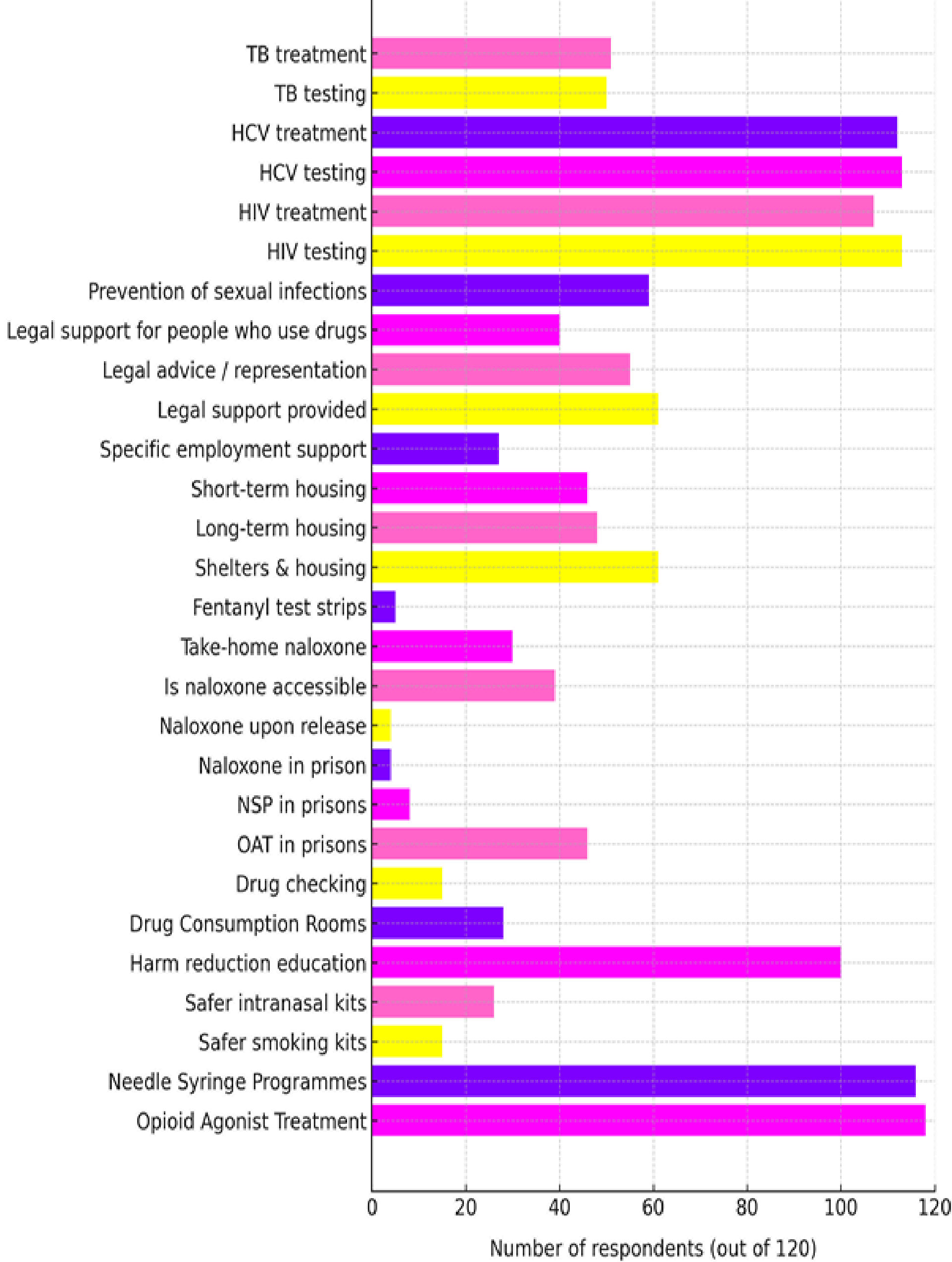
How the correspondents identify themselves (multiple choices)

- 53% People who inject opioids
- 43,3% People who inject stimulants
- 49% Experiencing homeleness
- 36,7% People who smoke opioids
- 38% People who smoke stimulants
- 44,2% Poeple who also use drugs via intranasal
- 13% Sex Workers
- 36,7% Parent who use drugs
- 5% Chem Sex Practicioners
- 17% Party Goers

It should be noted that 75,8% of respondents have experienced homelessness by the time they answered the questionnaire. That said, by the end of 2024 nearly 50% of respondents are people who use drugs experiencing homelessness. Access to housing is therefore the most difficult barrier identified by comrades, in the context of their use.

Chapter 1: Access, Coverage, and Quality of Harm Reduction Services

General Overview of availability of Harm Reduction Services in respondents cities:

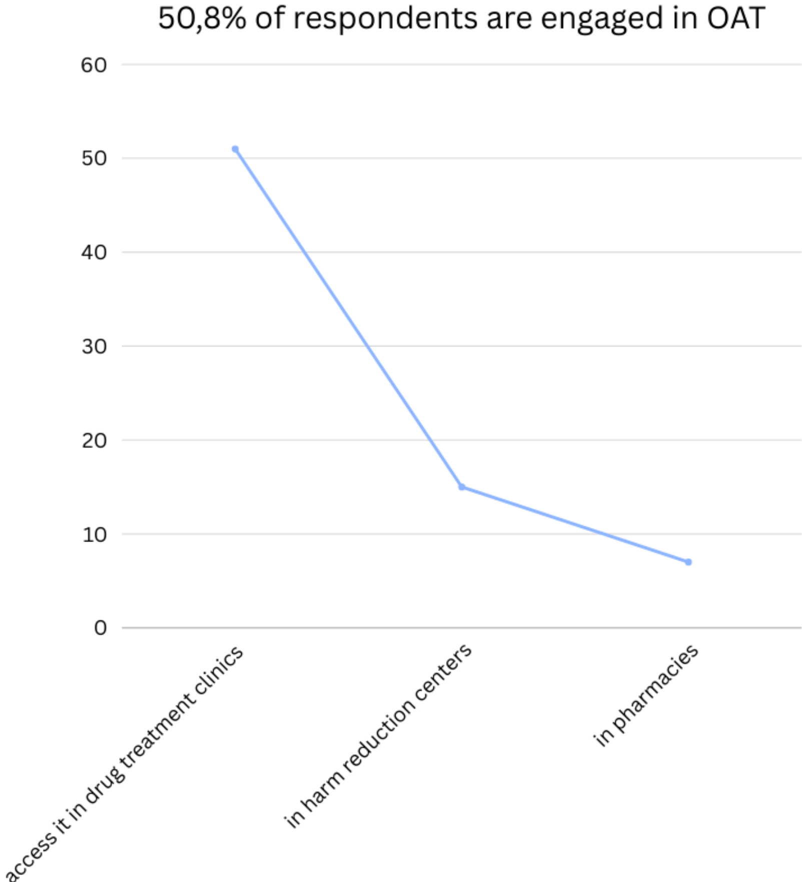


The data shows that core harm reduction interventions such as opioid agonist treatment (OAT), needle and syringe programmes (NSP), and HIV and HCV testing and treatment are among the most widely available services. This suggests that many cities have at least some of the fundamental components of a harm reduction infrastructure in place. However, even within these categories, availability is not universal, indicating gaps in consistent service provision and accessibility.

In contrast, more specialized harm reduction services — such as take-home doses, drug checking, safer smoking and intranasal kits, and drug consumption rooms (DCR) — appear to be much less available. Similarly, support services addressing broader social and structural needs (such as employment support, housing, and legal assistance) are unevenly provided. Also, there is a limited presence of naloxone in prisons.

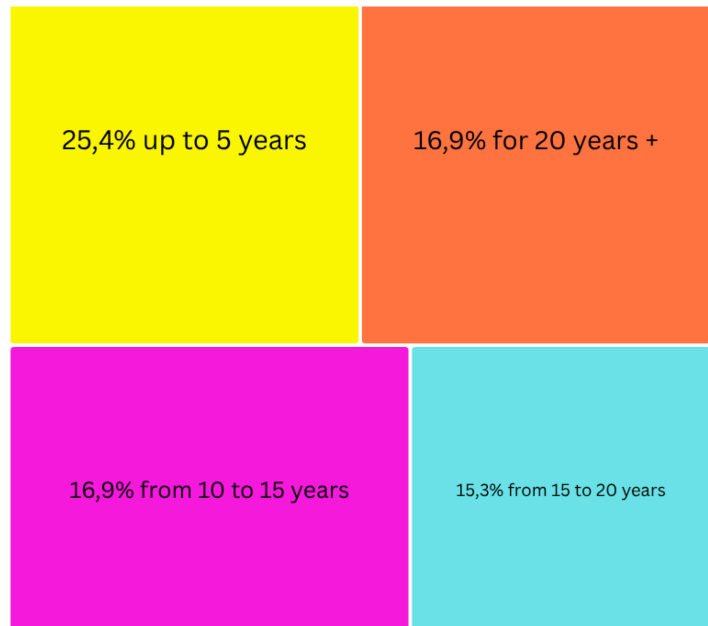
<u>Opioid Agonist Maintenance Treatment (OAMT):</u>
50,8% of participants are engaged in OAMT.

Only a minority of respondents indicated that they accessed OAMT services with immediate access (6 responses). The time waiting for the treatment is very variable but can sometimes exceed one year.



There is a broad diversity in the duration of participants' engagement in opioid substitution treatment. The majority (around one in four) have been in treatment between one and five years, suggesting a relatively recent but established engagement with OAMT.

Nearly half of the respondents (around 48%) report being in treatment for over 10 years, showing strong long-term retention within opioid agonist programmes. Only a smaller share (15.3%) have been in treatment for less than one year, suggesting limited recent entries into treatment. That suggests significant retention in treatment and low recent intake of new users, possibly associated with barriers to access or a stabilisation of the clientele served.



Regarding the treatment options, nearly 50% of respondents who are in on OAT programs said they could choose other options besides methadone, namely buprenorphine, meaning 35 participants stated that alternatives are available, However, for the other half the option presented in OAMT is exclusively methadone. **None of the respondents has access to Prescribed Heroin (Diamorphine).**

This illustrates that people in opioid agonist maintenance treatment often have limited autonomy in choosing their treatment options, which goes against the principles of *"My Treatment, My Choice."*

Needle and Syringe Programs (NSP):

A large portion of respondents (73 out of 104) stated they accessed NSP services. For 95,8% of people this service is available.

NSP services were accessed mostly through mobile units or drop-in centers.

Drug Consumption Rooms (DCR):

Only 34 out of 112 respondents confirmed they have been in a DCR in their city.

Of those who access DCRs, the majority reported using the injection model room.

Respondents envision DCRs as:

- Non-judgmental and respectful spaces
- Run or co-run by peers, where people feel understood
- Easily accessible — without ID, excessive bureaucracy, or police presence
- Linked to healthcare and harm reduction services

As only 30,36% of respondents confirmed the existence of Drug Consumption Rooms (DCRs) in their city, among those who do have access to DCRs, most reported using them for injection purposes, with only a very limited number mentioning access to inhalation or smoking rooms. Several respondents stressed the need for safer inhalation spaces, often noting that current facilities were insufficient or not adapted to different modes of use:

“There’s nowhere safe to smoke — we are forced to use in the street.”
“DCRs only allow for injecting, but I smoke. We need both options.”

“It’s better when it’s run by peers. We understand each other.”

Additionally, concerns were raised regarding over-policing and surveillance in or around DCRs. Some respondents reported avoiding these spaces entirely due to fear of being targeted by law enforcement:

“Police wait outside the consumption rooms, so it’s too risky.”
“They say it’s safe, but I was stopped right after leaving.”

“A drug consumption room should be a safe space, not a disguised police station.”

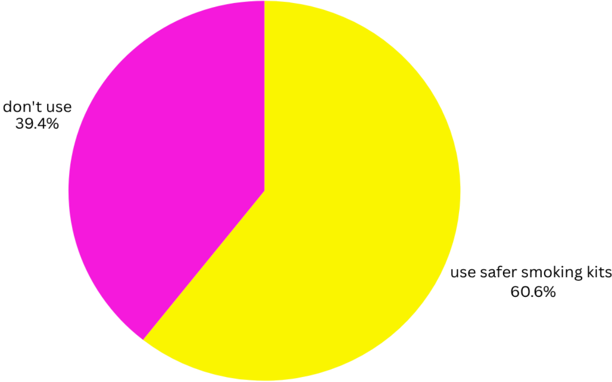
Other recommendations done by clients:

“There shouldn’t be a need for papers or ID to enter — it should be a right.”

These responses indicate that even when DCRs exist, their accessibility and effectiveness are undermined by repressive environments, narrow design, and a lack of user-led input.

<u>Safer Smoking Kits:</u>

57 out of 94 respondents use safer smoking kits, with services mainly accessed through specialized harm reduction programs:



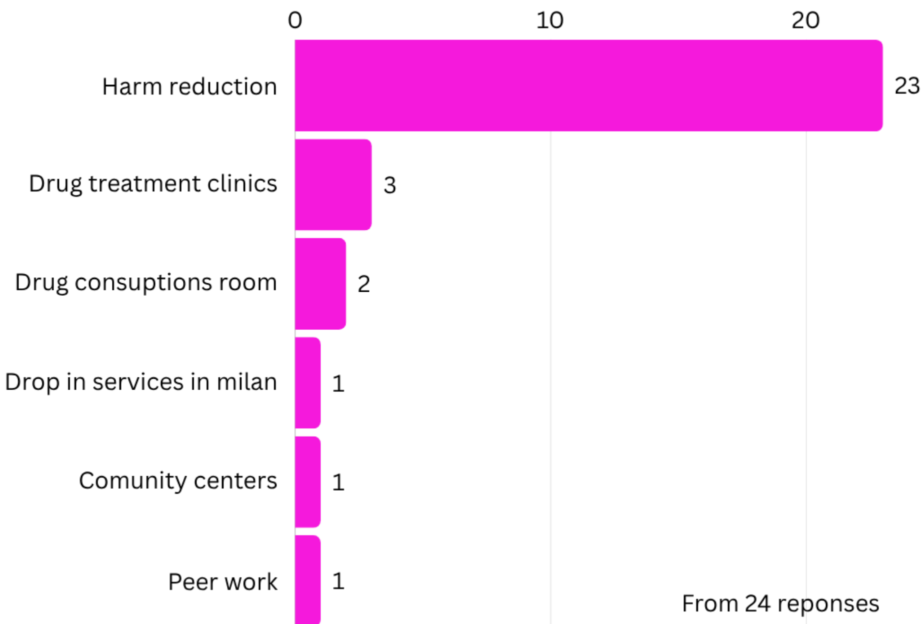
<u>Legal Support:</u>

A significant number (74 out of 121) indicated the need for legal support, and 65 respondents accessed such services that are however accordingly to participants not so accessible.

<u>Take-home Naloxone</u>

Meanwhile, naloxone access, services in prison settings, and safer use kits were reportedly less available.

When asked about take-home naloxone A particularly concerning finding relates to take-home naloxone: In total, 63.2% of respondents either do not access or are unaware of this life-saving intervention. The first question posed on take-home naloxone programs shows responses to wether take-home naloxone exists in their city (n=120). 35,8% responded "Yes", indicating that the service is available, against 52,5% that said "No", meaning the service does not exist in their locality. 11,7% were unsure or did not know. This suggests take that take-home naloxone is still not widely available across some of the "Lighthouses" cities, with more than half of respondents reporting no access at all. Naloxone is said to be available across all cities, yet in Finland it can still only be accessed through a limited pilot project, The fact that only a minority of people access the service is **a reminder that availability does not**



necessarily mean accessibility.

The second question refers to people living in the cities where the service exists (n=57) and explores whether they personally access it. 36,8% of respondents said “Yes”, they access the service. 63,2% said “No” they d not. This reveals an additional gap between availability and utilization: even in places where take-home naloxone is available, most people who use drugs do not access it - possibly due to limited awareness, restrictive distribution models, or barriers in eligibility and outreach. Those who access it is mainly through harm reduction centers.

Barriers to Accessing Services

Several participants reported experiencing barriers when trying to access services, particularly:
- Discrimination in hospitals and clinics;
- Lack of respect, empathy, or being listened to;
- Stigma due to drug use, gender identity, or sexual orientation;
- Judgmental or humiliating treatment by health professionals;
- Inappropriate denial of care (e.g. being denied painkillers).

Examples from testimonials withdraw from the open questions:
"Nurses are never polite. {Felt] Discrimination as a drug user."
"Once they didn’t give me any painkillers even though my ankle was broken... I bought drugs to kill the pain."
"I was not taken seriously because I use drugs. On a social level, I felt labeled."

Chapter 2: Health and Social Responses

HIV testing and treatment seems to be universally available. Most of participants have already been tested for HIV, and the same goes for HCV.

Access to HIV, Hepatitis C and Tuberculosis Services

Across the four “Lighthouse” cities, participants reported high levels of engagement with HIV and HCV testing and related services, while tuberculosis (TB) screening remains considerably lower. These findings highlight encouraging progress in harm reduction–linked healthcare but also persistent gaps in comprehensive infectious disease coverage among people who use drugs.

HIV

HIV testing coverage was notably strong, with 94.2% of respondents having been tested at least once and 91.2% reporting access to HIV-related services. However, HIV self-testing remains uncommon (96.3% have never done one), suggesting limited community-level availability or awareness. These findings are consistent with efforts to reach the *first UNAIDS 95 target* — ensuring that 95% of people living with HIV know their status. Expanding self-testing options and community-based testing models could strengthen early diagnosis and help reduce inequalities in access.

Hepatitis C (HCV).

HCV responses were similarly positive: 95% of participants reported having been tested, and 100% of those confirmed access to testing services. Testing occurs most often in harm reduction services (71.9%), hospitals (61.4%), and drug treatment clinics (57.9%). Access to HCV treatment services was also high, at 93.2% among those aware of or needing them, typically provided through hospitals (72.2%) and treatment clinics (55.6%). These results indicate a strong integration of HCV testing and treatment into national systems, aligning with WHO's hepatitis elimination goals. However, over-reliance on institutional settings may still limit access for more marginalised populations, highlighting the importance of peer-led and low-threshold HCV interventions.

Tuberculosis (TB).

In contrast, TB testing showed significant gaps: only 27.7% of respondents had ever been tested, while 54.6% had not and 17.6% were unsure. Among those familiar with the service, 89.3% reported having access, suggesting that TB screening exists but remains poorly integrated into harm reduction and community health networks. This low testing uptake underscores a lack of awareness, proactive screening, and linkage between TB and harm reduction services—particularly concerning the vulnerability of communities of pees who have/ are experiencing homelessness, incarceration, or co-morbidities.

The results of this survey reflect encouraging progress toward HIV and HCV testing targets and partially align with the *UNAIDS 95–95–95 framework*, particularly the goal of expanding diagnosis and linkage to care in the "Lighthouses" services an cities. However, significant disparities persist—especially in access to TB testing and community-based HIV self-testing. Strengthening cross-disease integration, ensuring multilingual and peer-led approaches, and embedding screening within harm reduction settings are essential next steps for achieving more inclusive, equitable, and effective public health responses in Europe.

Detailed data allow us to see, that:

HIV Testing:
A significant number of respondents (114 out of 120) indicated that they had undergone HIV testing.

The most common place for accessing testing services is Harm Reduction Services or Low-threshold Services.

Hepatitis C:
Many respondents accessed these services primarily through harm reduction centers and hospitals. In these case, the follow-up happens mostly in hospitals.

Tuberculosis:

Most of respondents were not tested for Tb, reinforcing here that peer-led harm reduction can be a leading solution in reducing these gaps, by building trust and connecting the community who use drugs and/ or living with HIV to get tested. The data shows that all respondents (100%) reported accessing the service at hospitals, indicating that hospitals are the primary — and possibly the only — consistent point of access. A smaller proportion also mentioned drug treatment clinics (23.5%) and general practitioners (17.6%), suggesting that some users obtain support through more specialized or community-based medical settings. Only one respondent (5.9%) reported accessing the service in prisons, while no one identified harm reduction services or other community services accessible for screening for TB.

Pre-exposure Prophylaxis (PrEP):

The results show that PrEP use among respondents is extremely low. Out of 118 participants, 98.3% reported never having used PrEP. Only two respondents currently access it — one through a hospital and another at an HIV point — indicating that PrEP is mainly available in formal health settings. One person stated not knowing what PrEP is. Overall, these findings suggest that PrEP remains largely inaccessible, particularly in low-threshold services such as harm reduction centers, where it could potentially reach populations at higher risk.

Post-exposure Prophylaxis (PEP):

100% of respondents indicated they had not used PEP services.

Regarding HIV and HEP C access to testing, respondents report 100% access to testing for HIV and Hep C, but less availability of treatment for HCV and TB. Around 90% of respondents have not experienced discrimination in related services, and for TB around 80% reports the absence of discrimination.

Discrimination Based on Drug Use or Health Status:

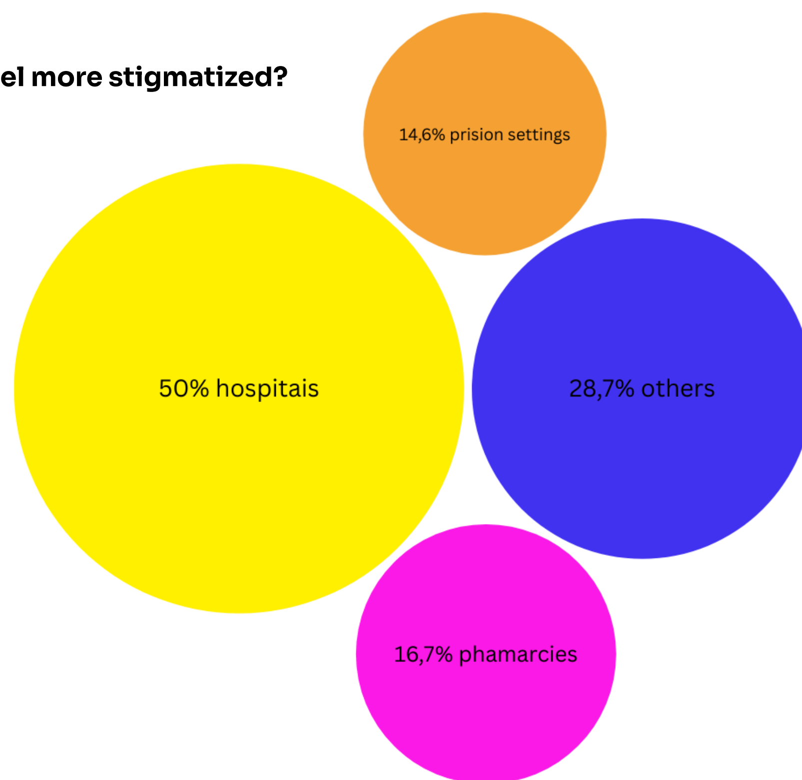
62 respondents (out of 120) indicated they did not feel discriminated against or stigmatized due to drug use, HIV, HCV, or TB when accessing these services.

For those who experienced discrimination, hospitals were the most frequently cited location (24 respondents).

Feedback on Discriminatory Services:

Respondents shared various discriminatory experiences, with feedback such as being ignored or not having feedback valued by services.

Where do people feel more stigmatized?



Examples of discrimination were spread across different services, including police and workplaces.

<u>Non-discriminatory Centers:</u>

Only 50% of respondents believe that there are spaces free from stigma and discrimination in their cities. This indicates that half of the sample continues to experience stigma, often in healthcare settings, workplaces, and even in family environments. However, services related to HIV and HCV are those where around 90% of respondents never felt discriminated against.

What are these "stigma-free spaces"?

While the survey does not specify which spaces are perceived as free of stigma, the answers suggest that some harm reduction services, namely some of the Ligh Houses, peer-led organizations, and community-based interventions may be viewed more positively and as safer spaces for this community.

These environments are likely:
- Staffed by professionals trained in non-judgmental care, some including peers as part of the staff;
- Peer-inclusive, where people feel respected and understood;
-Based on principles of harm reduction and human rights, rather than abstinence or punitive models.

This is a promising sign that alternative, inclusive service models can foster dignity and encourage engagement.

Intersectionality and Compounded Exclusion

Some participants reported discrimination based on multiple identities (e.g. drug use, HIV status, gender, sexual orientation). For instance:

"Being a lesbian with a drug addiction is just a mixture that seems to be too much to any doctor or nurse... They make fun of me and don't believe anything I say."

Conclusion

The data may reflect that the community of people who use drugs is systemically marginalized, and exposed to long-term institutional dependency. Despite the existence of some supportive environments, many continue to face barriers rooted in stigma, social

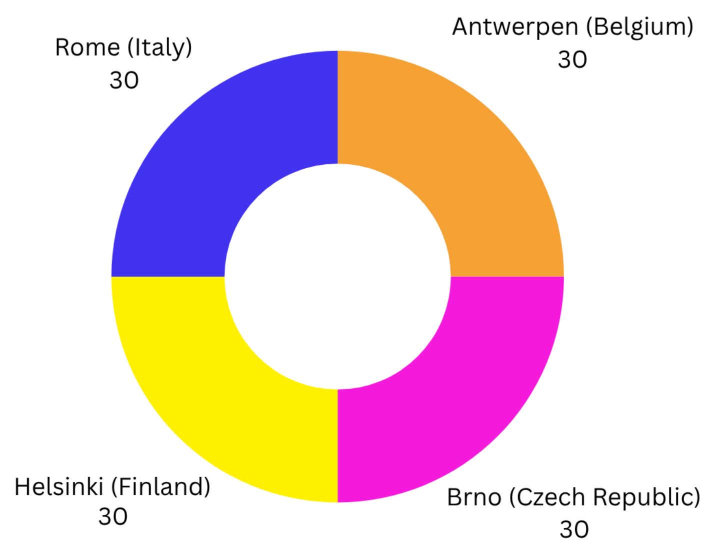
judgment, and systemic discrimination.

There is a clear need to:
- Expand access to low-threshold, peer-led services;
- Address institutional stigma through training and accountability;
- Support social reintegration for long-term OAT clients;
- Include migrant populations and young people who use drugs more effectively in service delivery and data collection.

Key findings by country

The dataset has 30 responses from each of the following cities in 2025.

The analysis for each city (Antwerp, Brno, Helsinki, and Rome) shows detailed statistics across the various questionnaire responses. However, due to the large number of columns, the output is truncated. To provide meaningful insights for each city, I'll focus on summarizing key trends from the data in the four chapters (Access, Health, Stigma, Policy) for each country.



1. Antwerp, Belgium

i) Access, Coverage, and Quality of Harm Reduction Services:

Most respondents indicated that OAT (Opioid Agonist Treatment) services were available, but limited options beyond methadone were noted.

NSP (Needle and Syringe Programs) services were easily accessible, especially through mobile units.

ii) Health and Social Responses:

High uptake of HIV and Hepatitis C testing among respondents, but lower access to services such as PEP.

iii) Stigma and Discrimination:

Some reported experiencing discrimination in healthcare settings, particularly in hospitals.

iv) Drug Policy:

Preference for decriminalization and harm reduction policies was noted, with government focus still largely on law enforcement.

2. Brno, Czech Republic

i) Access, Coverage, and Quality of Harm Reduction Services:

OAT services were widely used with availability of buprenorphine in addition to methadone.

Good access to NSP and smoking kits, especially through drop-in centers, presence of a drug consumption room..

ii) Health and Social Responses:

High access to testing services, with many using HIV and Hepatitis C tests.

iii) Stigma and Discrimination:

Fewer instances of discrimination reported compared to other cities, with non-discriminatory services available.

iv) Drug Policy:

Regulation of drug use was favored over outright prohibition, with respondents advocating for more harm reduction approaches.

3. Helsinki, Finland

i) Access, Coverage, and Quality of Harm Reduction Services:

Limited availability of alternatives to methadone in OAT services. NSP services were mostly accessed through mobile clinics.

ii) Health and Social Responses:

Strong engagement in health testing programs (HIV, HCV) but very low use of PEP services.

iii) Stigma and Discrimination:

Reports of stigmatization were focused on interactions with law enforcement and healthcare professionals.

iv) Drug Policy:

Strong support for drug decriminalization, with respondents highlighting the need for reform in existing drug laws.

4. Rome, Italy

i) Access, Coverage, and Quality of Harm Reduction Services:

Most respondents were satisfied with OAT services, with alternatives like buprenorphine available.

NSP services were more readily accessed in drop-in centers.

ii) Health and Social Responses:

Consistent use of HIV and HCV testing services, but limited awareness and use of PEP.

iii) Stigma and Discrimination:

Many respondents reported feeling discriminated against, especially in hospitals and by law enforcement.

iv) Drug Policy:

Respondents voiced strong opinions in favor of a public health approach, with less focus on punitive measures.

Recommendations to improve local harm reduction services:

- Focus groups can complete this monitoring tool and provide valuable insights to tailor interventions, improve service delivery, and foster more inclusive environments that effectively reduce stigma and enhance access.
- It was highlighted by the participants the need of increase outreach activities led by peers.

Chapter 3: Discrimination and stigma

Stigma and discrimination continue to act as major obstacles to care and wellbeing.

Respondents repeatedly called for respectful, anonymous, and peer-led services, free from criminalization and social control measures such as mandatory ID checks or police surveillance.

In terms of community participation, the data points to significant underrepresentation of people who use drugs in decision-making processes.

Services People Trust — And Those They Avoid

When asked which services they value and trust, respondents overwhelmingly recommended community-based, harm reduction, and peer-led services. These are often the only places where they feel respected, understood, and safe. In contrast, formal institutions such as hospitals and pharmacies were described as judgmental and punitive environments.

“I trust my community association more than the hospital or general practitioner.”
“We need to be treated better. We need warmth and human connection. I prefer going to the drug consumption room because we’re treated with respect.”

This highlights the importance of low-threshold, peer-run models that prioritize dignity and care over control and compliance.

Quantitative Indicators of Discrimination

The consultation revealed alarming rates of discrimination in key public services:

50% of respondents experienced discrimination at hospitals
16.7% reported discrimination at pharmacies
14.6% experienced discrimination in prisons
74.6% identified social control mechanisms (e.g. mandatory ID, surveillance, police presence) as a major barrier when accessing services
These might confirm that stigma is not limited to isolated incidents but is embedded in the very systems meant to support public health and social protection.

How Discrimination Happens — Direct Testimonies

Respondents described repeated experiences of being treated with suspicion, hostility, or outright refusal of care solely based on their drug use or association with harm reduction.

In Hospitals:

“One time at the hospital I said I was on methadone and they completely changed their behavior.”
“They treated me like I was lying when I talked about my pain. Because I use drugs, they assumed I just wanted medication.”

In Pharmacies:

“At the pharmacy, they refused to give me syringes even though I had a prescription.”
“They refused to sell me a syringe. They said they don’t sell to drug addicts.”

In Prisons:

“There was no harm reduction material at all. They don’t care if we get infected.”

With Police:

“I got arrested right after leaving a consumption room. They wait outside.”

These testimonies reflect a clear pattern: simply identifying as a person who uses drugs is enough to trigger suspicion, medical neglect, and legal risk — even in environments meant to be protective or therapeutic.

Respondents also emphasized how bureaucratic requirements and surveillance tools — such as mandatory identification, registration processes, or law enforcement presence — serve as deterrents to accessing help. Far from feeling supported, people often feel watched, judged, and criminalized when they seek services.

“Everywhere we go, we’re watched. It’s exhausting.”
“If you say you use drugs, they isolate you straight away.”

In effect, this turns public health systems into spaces of social control rather than care, disproportionately punishing people for their drug use rather than supporting them to achieve wellbeing on their own terms.

Costs of Prohibition and How It Affects People’s Lives

The personal testimonies and data collected through the BOOST Peer Consultation clearly demonstrate that the impacts of drug prohibition extend far beyond legal risk or fear of arrest. For many respondents, prohibition is not an abstract policy framework but a daily, lived experience of criminalization, exclusion, and harm. It systematically undermines their access to healthcare, housing, employment, social support, and their ability to stay alive and well.

Qualitative data gathered on the costs of prohibition varied widely, but the most frequent comment reflected negative impacts on personal wellbeing and social trajectory, including descriptions like "bad trajectory", “death” and lack of success in life.

Prohibition, as experienced by people who use drugs, is deeply intertwined with state surveillance, institutional violence, and structural inequality. Rather than reducing harm, punitive drug laws intensify it — creating conditions where people are more exposed to overdose, infectious diseases, homelessness, stigma, and isolation.

Respondents described how fear of police harassment leads them to avoid essential harm reduction tools, such as sterile injecting equipment or naloxone. Even where these services are available, simply attempting to access them can result in criminal suspicion or actual arrest:

> **“I don’t go get syringes anymore because the police stop me every time.”**
> **“Because of the laws, we’re afraid to call an ambulance.”**

This criminalization of survival strategies makes basic health interventions risky — pushing people further into unsafe and often invisible practices. The fear of being policed or punished for carrying harm reduction supplies means that lives are being lost not from drug use itself, but from the systems that punish people for trying to stay alive.

For others, the consequences of prohibition extend into every area of life. Respondents spoke of losing jobs, homes, and even custody of their children — not because of drug use alone, but because of the way society and institutions punish and marginalize people who use drugs.

> **“Prohibition took everything from me — my job, my house, my kids.”**

These are not isolated tragedies. They reflect a broader structural pattern in which drug laws reinforce cycles of poverty, homelessness, and social exclusion. Criminal records create barriers to employment and housing; police surveillance undermines trust in health and social services; fear of being reported prevents people from accessing emergency care.

In many cases, respondents expressed a profound sense of hopelessness and exhaustion, having been criminalized not just for drug use, but for seeking help, for protecting their health, or simply for existing.

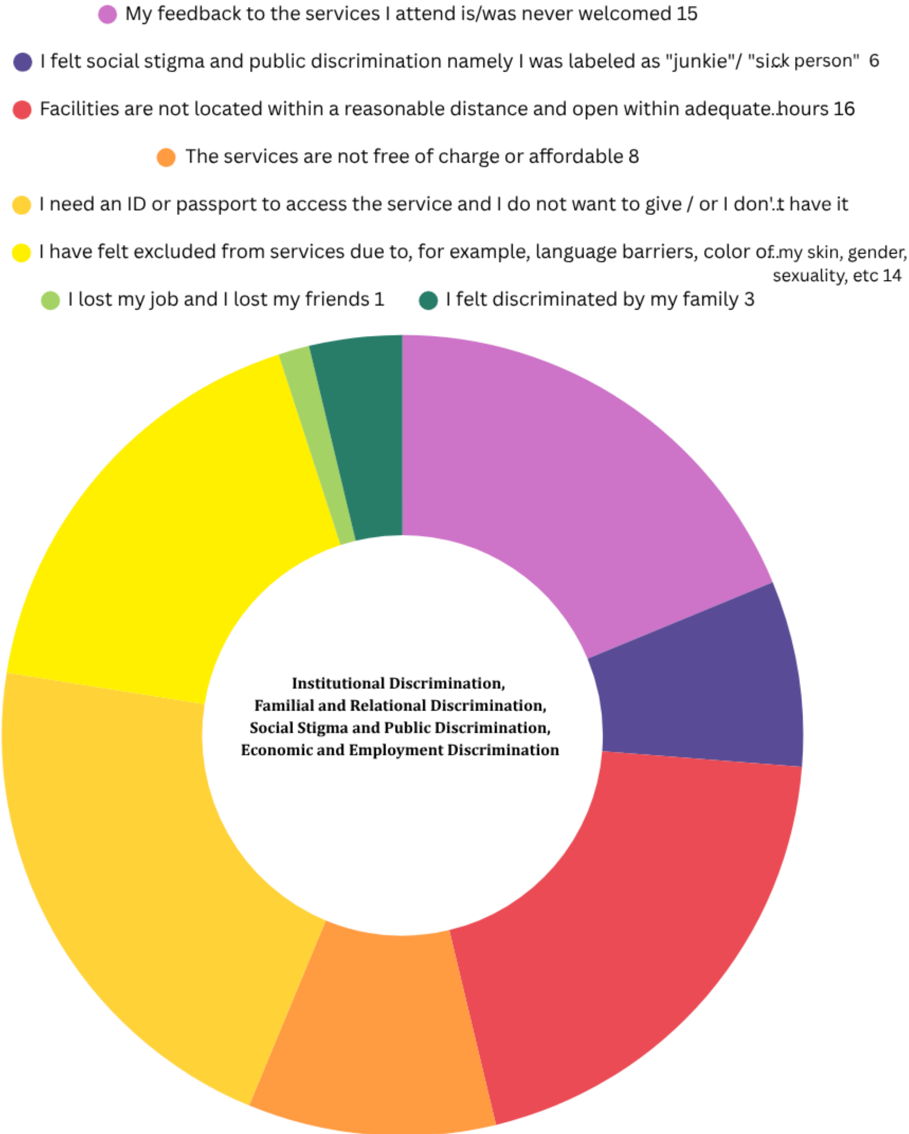
> **“The system makes us choose between dying in silence or being punished for asking for help.”**

The cumulative effect of these harms is not only personal but systemic: prohibition creates a landscape in which health inequalities are deepened, human rights are routinely violated, and the lives of people who use drugs are devalued.

These testimonies demand urgent attention. The costs of prohibition are not theoretical — they are visible in the daily trauma, social exclusion, and preventable deaths experienced by people who use drugs across Europe. Ending criminalization is not only a matter of public health but a matter of justice, dignity, and human rights.

Discrimination in health and social services is not just about isolated “bad experiences.” It is the result of deeply institutionalized stigma, criminalization, and lack of peer involvement. Until people who use drugs are treated as rights-bearing individuals rather than deviants or criminals, these barriers will persist — with deadly consequences.

Dimensions of Discrimination and Access Barriers Faced by PWUD



Social Control and Structural Discrimination:

In line with EuroNPUD's HCV report, and in light of these findings, we recommend organizing participatory focus groups and consultations with people who use drugs to deepen understanding of their priorities, needs, and lived experiences — particularly regarding naloxone access, hepatitis services, DCR accessibility, and peer participation in governance and service design.

Discrimination remains a persistent and systemic barrier for people who use drugs when accessing essential health and social services. The findings from the BOOST Peer Consultation highlight how stigma, moral judgment, and criminalizing attitudes

embedded in institutional practices continue to impact service quality, access, and safety. Respondents shared both statistical data and personal testimonies that illustrate how prejudice manifests in hospitals, pharmacies, prisons, and through social control mechanisms — reinforcing mistrust, exclusion, and harm. These dynamics also extend sometimes to low-threshold harm reduction services, where fear of judgment, and bureaucratic requirements — such as identification or registration — continue to discourage access and undermine the principle of accessibility that should define such settings.

Chapter 4: Drug Policy and Governance

Preferred Drug Policy:
50 respondents (out of 121) favored regulation of illicit drugs as their ideal drug policy.

Other preferences included decriminalization and public health approaches. More specifically a strong preference for progressive approaches appears in the data. The majority (41.7%) selected the regulation of illicit drugs as their ideal policy model, followed by legalization (25%), showing broad support for frameworks that prioritize control, safety, and public health over punishment. Meanwhile, decriminalization was chosen by 18.3% and depenalization by 10.8%, reflecting moderate endorsement of less punitive reforms. Only 10.8% of participants supported the criminalization of illicit drugs.

Government Priorities:
Respondents identified the main government priorities as Prevention and Dissuasion (Law Enforcement Agencies).

Peer Work & employability

This section is specifically dedicated to employment and experiences as peers. I will analyze any relevant data that reflects the respondents' employment status, peer work in harm reduction, or related experiences.

Insights regarding employment and peer work from the responses:

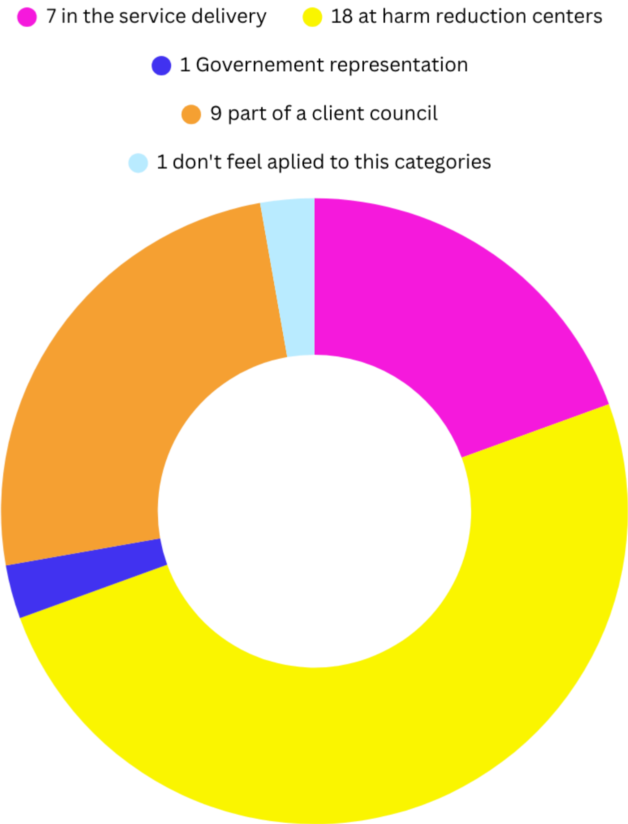
Employment Opportunities as Peers/Activists:

Have you had specific employment opportunities/income as a peer/drug user activist/educator/harm reductionist?

Out of 120 respondents, only 15 comrades and service clients answered regarding involvement in service delivery: 3 peers as full time job, 7 in parti-me and 5 volunteers, which represents a minority of the people participating in this survey: 87,5% of PWUD has never worked in harm reduction or related services. This suggests that formal employment in peer-related roles is limited for most respondents.

Engagement of Peers in Harm Reduction Services:

In which level are peers (people who use drugs) engaged in harm reduction services in your city?



These findings indicate that while peer involvement in harm reduction services exists, formal employment opportunities in these roles are not widespread. The data highlights the need for more structured opportunities for people who use drugs to be employed in harm reduction and advocacy roles. The findings from our peer-led consultation mechanism reaffirm the structural challenges people who use drugs continue to face across Europe. Most respondents identified as non-migrants and described ongoing difficulties in accessing harm reduction services free from stigma, surveillance, and legal barriers.

These experiences mirror the results of the EuroNPUD HCV Peer Study, underlining that discrimination and lack of autonomy within service provision are common concerns across countries and contexts.While harm reduction services such as Opioid Agonist Treatment (OAT), Needle and Syringe Programs (NSP), and community outreach are reported as available in many cities, their accessibility is often limited by bureaucratic demands, inconsistent opening hours, long distances, or fear of police intervention. Mobile units and drop-in centers were highlighted as particularly vital for reaching

marginalized populations and those living in unstable conditions.However, key harm reduction interventions remain underutilized or inaccessible.

What EuroNPUD considers important?

Following a Global Peer Work Consultation led by Doctors of the World (Fr) where several EuroNPUD members were present, four pilar are considered to be important:

Relationships and empowerment

Peer workers should not be limited to service delivery but encouraged to self-organise, represent their communities, and act autonomously. Organisations must respect and support this independence rather than perceive it as competition.

Career development and fair employment

Lived experience should be recognised as a professional skill in job frameworks. Peer workers need proper training, fair remuneration, and access to career progression opportunities, including benefits such as health insurance and social security.

Safety and working conditions

Organisations must adopt risk management and support protocols to protect peer workers from harm, including injury or arrest. There is also a need to sensitise other stakeholders — such as police, health professionals, and religious leaders — to ensure safer and more collaborative environments.

Policy participation and advocacy

Peer workers should have equal access to policy and advocacy spaces at local, national, and international levels. Meaningful participation requires capacity building and tailored training that matches each peer worker's knowledge and engagement goals.

Limited Information on Service Quality and Barriers

While the survey captured access points and some qualitative feedback, detailed quantitative data on service satisfaction, perceived quality, and specific barriers (e.g., transportation, legal issues, stigma) are limited. These aspects require further exploration to inform targeted improvements.

Potential Response Bias:

As with all survey-based studies, responses may be influenced by self-reporting bias, social desirability, or recall limitations, which could impact data accuracy.

The findings provide a foundational understanding of the current landscape of harm reduction services and user experiences. Nonetheless, future research should aim for more comprehensive data collection focusing on country-level and different services, explore more service quality, barriers, and demographic variables to develop more targeted and effective interventions.

Recommendations for Drug Policy Reform: Voices from the Community

The open responses collected through the BOOST Peer Consultation Mechanism offer powerful and urgent insights into the realities faced by people who use drugs under punitive legal frameworks. Participants did not simply recount the harms they experienced — they also articulated concrete demands and ideas for change. These lived experiences should be understood as a call to action and a blueprint for more humane, effective, and equitable drug policy.

Ending Criminalization and Repression

Across the responses, there is a consistent and deeply felt demand to end the criminalization of drug use and possession. Many participants highlighted how prohibitionist laws perpetuate fear, stigma, and violence — not only from police, but also within health services and everyday life. The presence of police around harm reduction

facilities, such as drug consumption rooms, was repeatedly cited as a barrier that undermines safety and access.

> **“Stop criminalizing us for using — we need help, not jail.”**
> **“Police shouldn’t wait outside consumption rooms — it makes them unsafe.”**

Participants emphasized that punitive approaches only deepen marginalization, making it harder to access care, protect their health, or seek support in moments of crisis.

Dismantling Systems of Social Control

In addition to direct criminalization, respondents expressed strong concerns about surveillance and control mechanisms embedded within health and social services. Requirements such as compulsory identification, registration systems, or excessive data collection were perceived as intrusive, stigmatizing, and counterproductive.

> **“Everywhere we go, we’re watched. It’s exhausting.”**
> **“We need services, not control.”**

For many, these practices mirror the logic of law enforcement rather than public health, creating a chilling effect that drives people away from potentially life-saving services.

Centering Peer Leadership and Lived Experience

A powerful theme that emerged is the need to recognize and support the leadership of people who use drugs within harm reduction, health services, and policymaking. Participants clearly stated that peer involvement is not only about representation, but about effectiveness, trust, and safety.

> **“Hire more peers — we understand what’s really going on.”**
> **“Let us lead our own services. No one knows better than us.”**

This means ensuring that peer-led organizations are adequately funded, involved in decision-making, and protected from the same stigmas and controls that affect their communities.

Removing Barriers to Harm Reduction and Health Services

Participants called for a significant expansion of low-threshold, accessible harm reduction services, including naloxone distribution, sterile syringe access, and drug consumption rooms. These services must be free, anonymous, and respectful — not conditioned on documentation, surveillance, or judgment.

> **"No more ID to get syringes."**
> **"Naloxone should be everywhere, no questions asked."**
> **"Consumption rooms need to be in more cities — not just in secret."**

There was also a demand for integrated care models, where various health services (HIV, HCV, TB, wound care,- substitution treatment) are co-located and delivered by staff trained in harm reduction.

Building Systems, Programs and Practices Based on Dignity and Trust

Finally, many respondents reflected on the need for dignity, respect, and safety in all services and institutions. Discrimination by healthcare workers, social workers, and pharmacists was described as a daily reality — one that is both harmful and preventable.

> **"Treat us like humans."**
> **"I only go to community services where I'm respected — never to hospitals."**

This highlights the urgent need for anti-discrimination training, peer-led monitoring, and mechanisms for accountability across all service settings.

Summary of Recommendations

1. **Regulate illicit drugs and promote the decriminalization of drug use, possession** to reduce stigma and legal risk.
2. **End police presence** near harm reduction services and guarantee legal protections for clients.
3. **Eliminate surveillance tools** like mandatory ID or registration for service access.
4. **Fund and scale up peer-led services**, namely outreach work led by peers
5. **Ensure meaningful involvement** of peers in policy design.

6. **Expand free, low-threshold access** to naloxone, DCRs, and integrated healthcare.
7. **Train service providers** in non-discriminatory, person-centered and intersectional community care and create feedback channels for users to report mistreatment and continuously provide feedback to the services.
8. **Increase participation of PWUD** in the design, implementation, monitoring and evaluation of policies and services.

Concluding Remarks

The peer-led mechanism was not only cost-effective but also rich in insight, grounded in the living and lived experiences of people who use drugs. All peers were fairly paid for their contributions and acted as focal points, connecting directly with respondents and ensuring that the process remained accessible and trustworthy. This approach reflects our commitment to fair, community-led, and ethically sound methodologies.

We hope that this experience will inspire and strengthen future participatory models, where people who use drugs are not just consulted but lead and shape the processes that affect their lives. By centering peer leadership and fair compensation, we move closer to a research culture built on equity, respect, and solidarity.