beyond the numbers

Harm Reduction across South-Eastern Europe

Title

Beyond the Numbers: Harm Reduction across South-Eastern Europe

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content

#foreword

The trajectory of harm reduction in South-Eastern Europe illustrates a persistent paradox in which global scientific evidence confirms that interventions such as opioid agonist treatment, needle and syringe programmes, HIV and hepatitis prevention, overdose management, and community outreach are indispensable elements of public health, yet across the region these services remain fragmented, inconsistently funded, and inaccessible to many of those who need them most. The gap between what is known to be effective and what is delivered in practice has endured for decades, with grave consequences for health systems, human dignity, and the lives of people who use drugs.

This report was developed in recognition that statistical data alone cannot capture lived realities or reflect the structural barriers shaping access to essential services. The research, therefore, combines epidemiological indicators with qualitative inquiry, drawing on the perspectives of civil society organisations, peer networks, health practitioners, and people with lived experience. What emerges is a regional assessment that situates quantitative evidence within everyday contexts, exposing discrepancies between reported availability and actual access.

To enable comparability, the study introduces a Scorecard framework that evaluates national harm reduction systems across four domains. Far from simplifying complexity, the Scorecard provides a transparent structure for identifying both deficits and promising practices. It establishes a regional baseline that compels policymakers and donors to confront the consequences of fragmented systems and underinvestment. Findings are sobering. In much of the Western Balkans, needle and syringe programmes have collapsed following the withdrawal of external donors. Opioid agonist treatment is formally available but undermined by restrictive conditions, waiting lists, and geographic disparities. Even in EU member states such as Bulgaria and Romania, continuity of services remains precarious due to political neglect and reliance on state funding that has gaps, with only major cities service coverage while the rest of the country lacks basic services.

Yet the report also highlights resilience. Civil society organisations and peer-led groups continue to sustain outreach, rebuild services, and pioneer new interventions. Slovenia has emerged as a regional leader by embedding harm reduction within health and social systems, including the establishment of the first officially sanctioned drug consumption room. Greece demonstrates that sustained public financing and integrated governance can expand access and ensure stability, while Croatia reflects both the potential and the limitations of embedding harm reduction into universal health coverage.

The evidence presented here indicates that harm reduction in South-Eastern Europe stands at a decisive crossroads. Without sustained political commitment and secure financing, gaps in services will deepen, fuelling HIV and HCV transmission, preventable overdose deaths, and social marginalisation. With strategic investment, legal reform, and meaningful community participation, countries in the region can build resilient systems that protect health, strengthen rights, and advance social justice.

#summary (part one)

Harm reduction across Southeast Europe (SEE) presents a highly uneven landscape, shaped by political will, financing models, and entrenched structural barriers. While some countries have integrated harm reduction into public health and social welfare systems, most remain dependent on short-term donor funding or fragmented national arrangements, creating chronic instability. The contrast between frontrunners such as Slovenia and Greece and countries like Bosnia and Herzegovina, North Macedonia, Kosovo, and Serbia illustrates a persistent regional divide, with service coverage, policy alignment, and sustainability determined more by governance and financing than by epidemiological need.

Prisons represent the clearest point of divergence. Slovenia and Greece are the only countries where opioid agonist treatment (OAT) can be initiated during incarceration and continued seamlessly after release. In most Western Balkan states, including Serbia, Montenegro, Bosnia and Herzegovina, and North Macedonia, OAT is limited to continuation only, excluding new entrants and leaving opioid dependence untreated throughout imprisonment. Antiretroviral therapy (ART) for people living with HIV is generally available, but access is obstructed by bureaucratic delays, fragmented infrastructure, and stigma from prison staff. No country in the region provides needle and syringe programmes in prison settings, despite clear WHO and UNODC recommendations. The absence of sterile injecting equipment perpetuates high HIV and HCV transmission risks behind bars, with drug use acknowledged informally but addressed only through restrictive policies. Fentanyl-specific measures are almost entirely absent; only Slovenia has regular detection via its drug-checking system, while elsewhere occasional donor-funded initiatives distribute test strips on a pilot basis.

These deficits mirror broader harm reduction challenges outside prisons. OAT is available in all SEE countries but often geographically restricted and conditional on health insurance, abstinence requirements, or lengthy waiting lists. NSP networks have collapsed in Bosnia and Herzegovina and shrunk drastically in North Macedonia and Serbia, leaving rural populations and hidden groups without consistent access to sterile injecting equipment. Where programmes exist, such as in Bulgaria, Greece or Romania, they are concentrated in a handful of cities while the rest of the countries lack basic services. In contrast, Slovenia and Croatia demonstrate that public financing and integration into national health systems can ensure stable access and allow the expansion of innovative services, including drug consumption rooms and drug checking , but even their geographical coverage is not complete.

Epidemiological data confirm that HIV prevalence among people who inject drugs (PWID) ranges from below 2 percent in Albania and Bosnia and Herzegovina to 20 percent in Romania, while HCV prevalence remains high throughout the region, exceeding 40 percent in most countries. Yet these statistics are compromised by outdated surveys, urban bias, and a lack of transparent, disaggregated reporting. Women, migrants, homeless populations, and rural PWID are consistently absent from official data, making service gaps appear smaller than they are. Community-led monitoring is sporadic and underused, despite its potential to reveal hidden need and guide responsive programming.

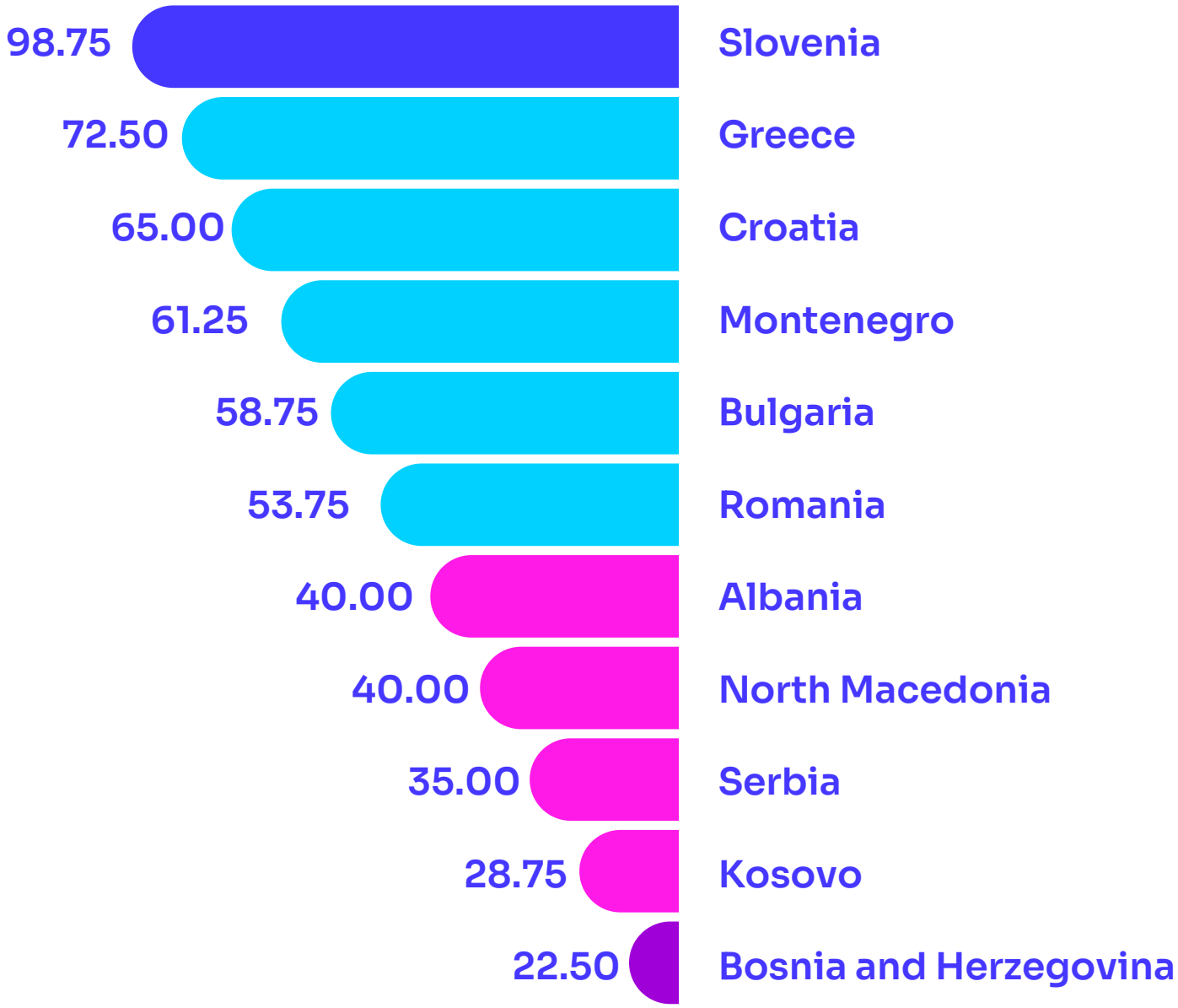
#summary (part two)

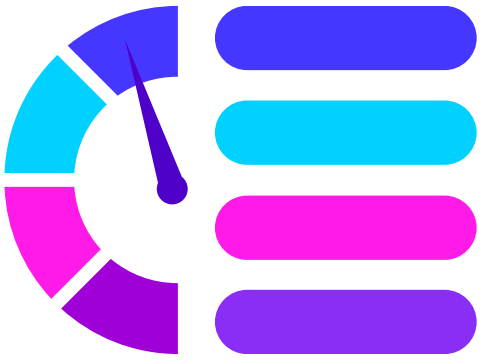
The funding landscape further reinforces fragmentation. In countries where the Global Fund has withdrawn, such as Bosnia and Herzegovina and North Macedonia, harm reduction services have contracted or collapsed, with no domestic mechanisms replacing donor support. Elsewhere, reliance on short-term project grants leaves NGOs in survival mode, unable to plan beyond annual funding cycles. Slovenia, Croatia, and Greece provide rare examples of stable state financing, but even in these contexts, political fatigue and stigma threaten expansion of services geographically, as well as introducing services like take-home naloxone and prison-based interventions.

Policy and advocacy priorities are clear where sustainable financing must be embedded through multi-year domestic mechanisms, including social contracting, to replace donor dependency. Legal frameworks must be reformed to decriminalise possession for personal use and remove abstinence and insurance requirements that exclude the most marginalised from treatment. Integration of harm reduction into national drug, HIV, and HCV strategies, backed by dedicated budgets, is essential to strengthen system resilience. Community-led monitoring must be institutionalised to ensure that policies reflect lived realities. Finally, innovation, such as drug checking, drug consumption rooms, and national take-home naloxone programmes, should be scaled up regionally, using frontrunners like Slovenia and Greece as models.

Unless these reforms are enacted, SEE will remain defined by fragmented, inequitable harm reduction coverage, with preventable HIV and HCV infections, overdose deaths, and systemic exclusion of people who use drugs. Countries that embed harm reduction within public health and social protection systems, however, can achieve measurable improvements in health outcomes, rights protection, and social inclusion.

#ranking





Strong - 76–100%

Moderate - 51-75%

Weak - 26-50%

Critical - 0-25%

5

methodology

#methodology (part one)

research design

The study adopted a mixed-methods design that systematically combined desk-based research with qualitative inquiry to construct comprehensive country profiles of harm reduction systems across eleven South-Eastern European (SEE) countries. This approach was driven by the recognition that epidemiological statistics, while indispensable, are insufficient on their own to capture the multidimensional character of harm reduction landscapes. Statistical evidence was therefore contextualized and interrogated through qualitative insights from civil society organisations (CSOs), peer-led networks, and individuals with lived and living experience of drug use.

The central rationale was to avoid a reductionist, purely quantitative account and instead create an integrated evaluative framework where epidemiological indicators, policy environments, and experiential knowledge converge. This was operationalized through the construction of a comparative scorecard system, specifically designed to provide a transparent, standardized, and replicable instrument for assessing harm reduction provision, governance, and monitoring across national settings.

desk-based analysis

The first stage of the research consisted of a comprehensive desk review of existing epidemiological and policy data. This included an assessment of HIV and HCV prevalence among people who inject drugs, opioid substitution therapy (OST) coverage, needle and syringe programme (NSP) availability for various populations, access to hepatitis and HIV testing and treatment, overdose prevention measures, and harm reduction provision in closed settings such as prisons. In addition, the review examined national legal frameworks, drug policy strategies, funding mechanisms, and institutional arrangements.

Sources were included if they provided data directly related to harm reduction, drug use, or health outcomes for people who use drugs in South Eastern Europe. Priority was given to:

- official national reports and epidemiological bulletins,
- publications by international organisations (WHO, UNODC, EUDA, ECDC),
- regional and European harm reduction monitoring reports (C-EHRN, EHRA, DPNSEE), and
- peer-reviewed academic studies.

#methodology (part two)

Sources were excluded if they were outdated (prior to 2015 unless still considered the most recent official figure), lacked methodological transparency, or reported data not specific to PWUD or harm reduction. Media reports and non-documented opinion pieces were also excluded unless they contained verified information on service closures or funding decisions.

The desk review combined structured database and website searches with targeted consultation of organisational repositories. For international and regional data, keyword searches were conducted in English using terms such as “harm reduction,” “opioid substitution therapy,” “needle and syringe programme,” “HIV among PWID,” “HCV among PWID,” “overdose prevention,” and “drug policy South Eastern Europe.” For national-level searches, keywords were adapted into local languages where possible. Where Google searches were insufficient (e.g., grey literature or unpublished national reports), data was obtained directly through organisational websites (ministries of health, public health institutes, CSO portals) or by contacting focal points within national and regional networks.

The desk review not only collated available evidence but also systematically documented missing or inconsistent information. These gaps were treated as findings in their own right, signalling weaknesses in national monitoring systems and framing the agenda for validation through stakeholder consultation.

qualitative inquiry

The second stage of the research consisted of qualitative data collection, designed to contextualise and critically examine the desk-based findings. Seven online focus groups and two semi-structured interviews were conducted with stakeholders across 11 countries in the region. Participants included representatives of community-based organisations, harm reduction service providers, peer-led groups, and, wherever feasible, people who use drugs and/or people with lived experience of drug use. Discussions were guided by a semi-structured protocol that addressed service availability, accessibility barriers, funding dynamics, and the lived consequences of policy frameworks.

Focus groups were scheduled at different times and dates in order to maximise opportunities for participation across the region. In some cases, participants from the same country joined more than one group, for example, in Serbia, Montenegro, and Croatia, different service providers contributed across two separate sessions. In North Macedonia, a single national focus group was held, with three participants representing different types of service providers, allowing for a more comprehensive national picture. In Bosnia and Herzegovina, where service closures limited participation, alternative tools were employed: a structured questionnaire administered by a peer worker ensured that local realities were still documented.

#methodology (part three)

Where logistical or political constraints prevented the convening of focus groups, tailored instruments were employed. In Bosnia and Herzegovina, for instance, service closures rendered the group format impracticable. A structured questionnaire was therefore designed and administered through a peer worker to ensure that local realities were adequately documented.

Coverage was not complete across all countries. No participants from Kosovo or Albania joined the focus groups directly; however, an interview with a regional representative was conducted to provide insight and approximate the situation in those contexts. This ensured that, while uneven, all countries were represented in some form within the data collection process.

Participants were identified through purposive sampling, drawing primarily on existing harm reduction and civil society networks (C-EHRN, EHRA, DPNSEE) to ensure representation of key perspectives. Invitations were sent via email and personal outreach through trusted network contacts. Inclusion criteria were that participants had direct experience with harm reduction service delivery or advocacy in their country. A clear limitation of this stage was that the community of practitioners within SEE harm reduction CSOs is very small. In practice, this meant that anyone available and willing to contribute was included. By contrast, service providers from government institutions and policy-makers were completely absent, as they either ignored or declined invitations, a dynamic that reflects the chronic disengagement of official actors from civil society-led harm reduction debates.

Focus groups were held online via Zoom between February and May 2024. Each session lasted between 90 minutes and two hours. Interviews and discussions were conducted in English, Bosnian-Croatian-Serbian (BHS), and Macedonian, depending on participant preference. Where necessary, ad hoc translation was provided by bilingual CSO staff. With participant consent, all sessions were audio-recorded for transcription. Transcripts were anonymised to protect identities.

All qualitative materials, focus group transcripts, interview notes, and questionnaire responses, were transcribed and analysed thematically. The coding was conducted against predefined themes derived from the research plan (availability, accessibility, funding, governance, and community involvement), rather than through in vivo or purely data-driven coding. While the analysis remained open to emergent issues, these core themes provided the primary structure for interpretation. Automatic software-assisted coding was not used, as the transcripts were produced in three different languages (English, Macedonian, and Bosnian-Croatian-Serbian), with BHS discussions further complicated by 3–4 dialectal variations. Instead, coding was performed manually to ensure accuracy and consistency across languages. In line with the advocacy purpose of the report, the emphasis remained on amplifying the voices of community members and service providers, ensuring that their perspectives were not overshadowed by institutional data.

#methodology (part four)

integration and triangulation (see Annex 1)

The final stage of the methodology entailed the systematic integration of desk-based and qualitative findings. Statistical indicators were cross-referenced with stakeholder narratives, enabling the identification of areas where official data aligned with, or diverged from, lived realities. For example, where national statistics reported service availability but focus groups described structural inaccessibility, the interpretation was adjusted to foreground these discrepancies. Missing data and inconsistencies were explicitly treated as findings in their own right, highlighting weaknesses in national monitoring frameworks and gaps in institutional accountability.

Thematic integration followed the predefined categories set out in the research plan (availability, accessibility, funding and governance, community involvement, and stigma/discrimination). This ensured comparability across countries while still allowing space for unique, country-specific dynamics to emerge. The process was manual rather than software-assisted, given the multilingual nature of the material (English, Macedonian, and Bosnian-Croatian-Serbian with multiple dialects).

By triangulating quantitative indicators with community perspectives, the country profiles were shaped to be not only descriptive but interpretative. This approach produced evidence that is empirically grounded yet also socially meaningful, ensuring that the voices of service providers and people who use drugs remain central to both analysis and advocacy.

the scorecard framework

To transform heterogeneous evidence into a comparative instrument, a scorecard system was developed. Each country was assessed across four equally weighted domains, each scored on a 0–10 scale, yielding a maximum composite score of 40.

- Services (0–10): Evaluates the presence, coverage, and accessibility of core harm reduction interventions, including OAT, NSP, HIV/HCV testing, overdose prevention, and prison-based provision.
- Policy (0–10): Examines the legal and policy environment, integration within public health systems, financing arrangements, and the extent of community participation in governance.
- Epidemiology (0–10): Assesses the availability, recency, and scope of epidemiological indicators, including prevalence estimates, treatment coverage, and mortality data.
- Data & Monitoring (0–10): Evaluates the systematisation of national monitoring, the existence of registries, annual reporting, overdose surveillance, and public transparency of data.

#methodology (part five)

scoring formula

Each domain is composed of sub-indicators, each with an assigned maximum. The domain score is calculated as:

Domain score = 10 × (sum of observed sub-indicator values ÷ sum of maximum sub-indicator values).

The total score T is the sum of all four domain scores (range 0–40). For ease of interpretation, this is normalised into a percentage index:

Percentage Index = 100 × (T ÷ 40).

Scores are further categorised into a four-tier traffic-light model to facilitate comparability and advocacy use:

- Purple - 0–25% (Critical) – Minimal system presence; services largely absent and data extremely limited.
- Pink - 26–50% (Weak) – Fragmentary services with poor accessibility and fragile funding; monitoring is partial.
- Light blue - 51–75% (Moderate) – Services and policies present but uneven, unstable, or constrained; data incomplete.
- Dark blue - 76–100% (Strong) – Services integrated, accessible, and sustainably financed; policies aligned with international standards; monitoring is functional.

methodological limitations

The scoring system developed for this assessment was designed by the author and piloted with several service providers across the SEE region. The intention was to create a structured, comparable tool that allows countries to be assessed against the same set of criteria and thereby highlight common gaps and shared advocacy priorities. This approach has the advantage of offering a synthetic overview, providing decision-makers with clear indicators that can be aggregated at the regional level and mobilised in policy dialogue.

However, several limitations must be acknowledged. First, the translation of complex service environments into numerical scores inevitably oversimplifies reality. Harm reduction service provision is highly context-dependent: in some countries, availability may be formally guaranteed but in practice limited by geography, stigma, or administrative barriers. Conversely, small but highly adaptive NGO-led programmes may achieve impact that is not adequately reflected in their score.

#methodology (part six)

Second, the scoring system, while tested with practitioners, remains subject to interpretative bias. Scores depend on available data and on the perspectives of those consulted, which may vary by city, service type, or organisational role. Similar monitoring exercises, such as the C-EHRN civil society monitoring of essential services or the BOOST multi-modular survey, also note the challenge of reconciling self-reported data with uneven official statistics and service realities. [82][83]

To mitigate these issues, the scoring results are not presented in isolation. They are complemented by qualitative findings from focus groups, interviews, and country profiles. These narratives highlight the “thin lines” and grey areas between formal provision and lived experience, like whether OST is accessible only in capital cities, or not accessible in the islands, whether HCV treatment requires abstinence, or whether outreach coverage exists in practice. In this way, the report recognises that no scoring system can fully capture the structural barriers, human impact, and resilience strategies of harm reduction actors in SEE. The scores therefore serve as an entry point for comparison, while the discussion sections provide the necessary depth and nuance to ensure findings remain grounded in real-world experiences. [6][75]

advocacy rationale of the scorecard and validation

The Scorecard was developed after the completion of data collection to ensure that the framework reflected real service conditions and could serve as an advocacy tool. Rather than functioning as a technical index, it was conceived as a way to translate complex findings into a clear and comparable format that supports policy dialogue. The decision to construct it after gathering evidence allowed the research to capture how systems operate in practice, aligning the indicators with the lived experiences of those delivering and using harm reduction services across South Eastern Europe.

The methodological foundation of the framework draws on three complementary streams of evidence. Desk based analysis provided a structured overview of national systems and policies, while focus groups and interviews brought forward the voices of practitioners and communities. Together, these inputs revealed how harm reduction is shaped by legal, financial, and social realities. Developing the Scorecard in this sequence made it possible to integrate these perspectives into the assessment criteria, ensuring that numerical results would remain connected to the real world rather than abstract data points. The conceptual model followed international guidance, particularly from the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

#methodology (part seven)

These references provided recognised standards for harm reduction coverage and quality. Incorporating their principles gave the framework scientific coherence while allowing flexibility for national variation and regional interpretation.

After the initial scoring exercise, each national assessment was validated through structured consultations with harm reduction service providers, national focal points, and civil society networks. These consultations were essential to verify the accuracy of the scores, confirm contextual relevance, and ensure representativeness across different subregions and service models. The iterative dialogue between data and practitioner insight strengthened both methodological consistency and practical utility.

From an epistemological perspective, the Scorecard represents a hybrid model that links empirical research and advocacy practice. Its primary function is to enhance the interpretability and visibility of evidence within policy dialogue rather than to establish definitive numerical rankings. Quantification in this context operates as a communicative tool that reveals structural gaps, enables cross country comparison, and supports the formulation of actionable policy recommendations. This approach follows the tradition of civil society monitoring and participatory evaluation, where the aim is to make empirical evidence accessible and policy relevant.

As this framework has been applied for the first time, it should be regarded as an evolving methodology rather than a fixed model. The process of translating diverse evidence into a comparative structure inevitably reveals both its potential and its limitations. Future iterations will benefit from broader data coverage, closer alignment with national monitoring systems, and deeper participation of community actors. The intention is for the Scorecard to remain adaptable, capable of incorporating new indicators and analytical tools as regional capacities grow.

country ranking

Albania [1] [2] [3] [4] [5] [6]

#7

Total population 2.715 million **PWID** 8.700 **HIV prevalence** 1% **HCV prevalence** 56%

services

6.0/10

OST coverage = 2
NSP coverage = 2
HIV&HCV = 1.5
Overdose prevention = 0
Prison services = 0.5

policy

3.5/10

Status of possession = 1
Overdose legal enablers = 0.5
Strategy&Sustainable financing = 1
Community participation = 0.5
Prison policy alignment = 0.5

epidemiology

2.0/10

HIV&HCV prevalence data = 0
Incidence/new diagnoses reporting = 0
Overdose mortality statistics = 1
Treatment coverage = 1
Recent population size estimation = 0

data & monitoring

4.5/10

Registries and reporting = 2
Overdose surveillance = 1
Data transparency & public access = 1
Early Warning System = 0
Prison health data reporting = 0.5

total index

40.00

Albania's harm reduction response is implemented through several cities operating across country cities, providing needle and syringe programmes (NSP) and opioid substitution treatment (OST). Based on the 2019 estimate of people who inject drugs, NSP coverage was 35.7 syringes per person per year. OST is available at six sites in the country, including limited provision in prisons, but overall coverage remains low at around 16% of estimated need. National strategies reference harm reduction, but NSPs lack formal legal and financial support, and most services rely on the Global Fund for sustainability.

Key gaps

- OAT coverage critically below international benchmarks.
- Take-home naloxone and overdose surveillance absent nationally.
- Data outdated, with last IBBS survey in 2019.

Enabling factors

- Free, anonymous HIV testing and treatment, including a dedicated clinic.
- Prison OAT services available in all facilities.
- Harm reduction mentioned in health and HIV/AIDS strategies.
- ARVs fully government-financed, aligned with UNAIDS targets.

[2] [7] [8] [9] [10] [11]
[12] [13] [14] [15]

Bosnia and Herzegovina

#11

Total population 3.2 million **PWID** 12.500 **HIV prevalence** 1.1% **HCV prevalence** 30.8%

services

2.5/10

OST coverage = 1
NSP coverage = 0
HIV&HCV = 1
Overdose prevention = 0
Prison services = 0.5

policy

1.5/10

Status of possession = 0
Overdose legal enablers = 0
Strategy&Sustainable financing = 1
Community participation = 0
Prison policy alignment = 0.5

epidemiology

2.0/10

HIV&HCV prevalence data = 0
Incidence/new diagnoses reporting = 1
Overdose mortality statistics = 0
Treatment coverage = 1
Recent population size estimation = 0

data & monitoring

3.0/10

Registries and reporting = 1
Overdose surveillance = 1
Data transparency & public access = 0
Early Warning System = 0.5
Prison health data reporting = 0.5

total index

22.50

Harm reduction in Bosnia and Herzegovina is critically weak. OST is available but with unclear coverage, while NSP has fully collapsed, with zero syringes distributed since 2020. Testing for HIV and HCV exists, yet monitoring and national data systems are absent. The state drug strategy expired in 2023, funding is unsustainable, and governance is fragmented across entities and cantons, leaving the system without coherence or accountability.

Key gaps

- No national NSP since 2020; out-of-treatment PWID left unserved.
- Absence of a national drug observatory, real-time overdose monitoring, or reliable epidemiological surveys.
- Fragmented governance: state strategy lapsed, entity/cantonal approaches diverge.
- Funding remains unsustainable, with no domestic budget line for harm reduction.

Enabling factors

- OST services exist and are partially funded by health insurance at entity/cantonal level.
- VCT and HBV/HCV testing available in multiple health facilities.
- ART reported accessible in prisons, with some continuation of OST.
- EU alignment pressure: calls for national observatory, early warning system, and harmonisation with EUDA standards.

Bulgaria [2] [17] [18] [20] [21] [22] [23]

#5

Total population 6.444 million **PWID** 18.600 **HIV prevalence** N/A **HCV prevalence** N/A

services

7.0/10

OST coverage = 2
NSP coverage = 2.5
HIV&HCV = 2
Overdose prevention = 0
Prison services = 0.5

policy

4.5/10

Status of possession = 0
Overdose legal enablers = 0.5
Strategy&Sustainable financing = 3
Community participation = 0.5
Prison policy alignment = 0.5

epidemiology

5.5/10

HIV&HCV prevalence data = 2
Incidence/new diagnoses reporting = 1
Overdose mortality statistics = 1
Treatment coverage = 1
Recent population size estimation = 0.5

data & monitoring

6.5/10

Registries and reporting = 3
Overdose surveillance = 1
Data transparency & public access = 1
Early Warning System = 1
Prison health data reporting = 0.5

total index

58.75

After years of harm-reduction collapse, when NSPs survived only through crowdfunding and volunteers, Bulgaria has rebuilt a publicly financed, nationally coordinated system. A multi-site OAT network operates across regions, while NSPs function in two cities, and HIV/HCV testing and treatment are available through low-threshold services. All programmes are supported by domestic funding and social contracting with CSOs. Despite strong data systems, national prevalence studies, and an Early Warning System, overdose prevention remains weak, no community naloxone, no response protocols, and limited prison harm reduction.

Key gaps

- No take-home or community naloxone access.
- No overdose-response protocols beyond clinical settings.
- Limited harm-reduction coverage in prisons.
- Criminalisation of personal possession persists.

Enabling factors

- Presence of OAT programmes with methadone and morphine.
- Municipal support for 2 HR programs in Plovdiv and Sofia, yet NSPs are out of reach for people outside those.
- Free HCV treatment available upon referral.
- Harm reduction included in strategic documents, though underfunded.

Croatia [1] [17] [18] [24] [25] [26] [29] [31] [32] [33]

#3

Total population 3.866 million **PWID** 6.344 **HIV prevalence** 0.3% **HCV prevalence** 30.7%

services

8.5/10

OST coverage = 2.5
NSP coverage = 3
HIV&HCV = 1.5
Overdose prevention = 0.5
Prison services = 1

policy

6.5/10

Status of possession = 1
Overdose legal enablers = 1.5
Strategy&Sustainable financing = 3
Community participation = 0.5
Prison policy alignment = 0.5

epidemiology

5.5/10

HIV&HCV prevalence data = 2
Incidence/new diagnoses reporting = 1
Overdose mortality statistics = 1
Treatment coverage = 1
Recent population size estimation = 0.5

data & monitoring

5.5/10

Registries and reporting = 2
Overdose surveillance = 1
Data transparency & public access = 1
Early Warning System = 1
Prison health data reporting = 0.5

total index

65.00

Croatia has integrated OST and NSP into universal health coverage, yet access is uneven due to strict administrative requirements and unstable short-term funding. Marginalised groups such as homeless PWUD, migrants and island residents remain excluded. Overdose prevention is only piloted, prison-based NSP are absent, and HCV treatment is restricted by abstinence rules. Although a National Addiction Strategy to 2030 with an Action Plan (2024–2026) was adopted, the absence of secured budgets and reliance on short contracts undermine sustainability.

Key gaps

- OST access tied to ID, residence, and insurance, excluding many vulnerable PWUD.
- HCV treatment requires six months of abstinence, creating barriers to care.
- No prison-based NSP and only limited take-home naloxone pilots.
- Funding cycles are fragmented, with 4–7 month gaps undermining NGO stability.

Enabling factors

- OST and NSP integrated into universal health coverage.
- National Addiction Strategy to 2030 and first Action Plan 2024–2026 adopted.
- Widespread NSP network (8 sites and 129 outreach points).
- PrEP and HIV testing available free through public clinics and NGOs.

Greece [2] [17] [26] [35] [36] [37] [38] [39] [40] [41] [42] [43]

#2

Total population 10.400 million **PWID** 2.287 **HIV prevalence** 7.3% **HCV prevalence** 53.7- 69.6%

services

8.0/10

OST coverage = 2.5
NSP coverage = 2
HIV&HCV = 2
Overdose prevention = 1
Prison services = 0.5

policy

6.5/10

Status of possession = 0
Overdose legal enablers = 1
Strategy&Sustainable financing = 4
Community participation = 1
Prison policy alignment = 0.5

epidemiology

8.0/10

HIV&HCV prevalence data = 4
Incidence/new diagnoses reporting = 1.5
Overdose mortality statistics = 1
Treatment coverage = 1
Recent population size estimation = 0.5

data & monitoring

6.5/10

Registries and reporting = 3
Overdose surveillance = 1
Data transparency & public access = 1
Early Warning System = 1
Prison health data reporting = 0.5

total index

72.50

Greece is a regional leader in harm reduction, with a nationwide state-financed OAT network, a drug consumption room in Athens, and a mobile DCR in Thessaloniki. All All state-recognized addiction treatment and harm reduction services now operate under EOPAE (National Organism for Prevention and Treatment of Addiction), which succeeded OKANA. HIV prevention has progressed through a national plan and free PrEP rollout in 2025, while HCV care is widely available. Yet overdose deaths and ongoing HIV transmission expose service gaps. Access remains concentrated in Athens and Thessaloniki, leaving rural areas underserved.

Key gaps

- Access concentrated in two hubs; limited reach to islands and rural north.
- Alarming overdose mortality and ongoing HIV transmission.
- No community take-home naloxone.
- Fragmented and inconsistent overdose data.
- Weak harm-reduction coverage in prisons.

Enabling factors

- Nationwide OAT network integrated under EOPAE, ensuring continuity of care.
- Operational fixed DCR in Athens and mobile DCR in Thessaloniki.
- National HIV plan and free PrEP rollout in 2025.
- Public financing and municipal partnerships sustaining core services.

Kosovo [2] [6] [17] [45] [46]

#10

Total population 1.6 million **PWID** 4.600 **HIV prevalence** 0% **HCV prevalence** 23.8%

services

3.5/10

OST coverage = 0.5
NSP coverage = 1.5
HIV&HCV = 1
Overdose prevention = 0
Prison services = 0.5

policy

2.5/10

Status of possession = 0
Overdose legal enablers = 0
Strategy&Sustainable financing = 2
Community participation = 0.5
Prison policy alignment = 0

epidemiology

3.5/10

HIV&HCV prevalence data = 2
Incidence/new diagnoses reporting = 0
Overdose mortality statistics = 0
Treatment coverage = 1
Recent population size estimation = 0.5

data & monitoring

2.0/10

Registries and reporting = 1
Overdose surveillance = 0
Data transparency & public access = 0.5
Early Warning System = 0.5
Prison health data reporting = 0

total index

28.75

Harm reduction in Kosovo is minimal and donor-dependent. Among an estimated 4,600 PWID, OST covers under 0.3%, and NSP is run by the NGO Labyrint, which operates in Pristina and a few other cities. The north remains outside national systems and receives no support from Serbia, resulting in no services. Testing is fragmented, PrEP unavailable, and HCV treatment restricted, with no naloxone, overdose prevention, or prison programmes. Criminalisation, weak surveillance, and reliance on outdated data further hinder response, while the phase-out of Global Fund support threatens the few existing services.

Key gaps

- OST/NSP reach negligible (<0.3 % of PWID).
- No prison services or naloxone access.
- Weak surveillance, outdated surveys, poor toxicology.
- Services donor-dependent, domestic funding absent.

Enabling factors

- National Drug Observatory launched in 2024.
- Harm reduction included in national strategies.
- NGO Labyrinth maintains sites and outreach.
- GFATM transition plan pushes co-financing.

Montenegro [2] [17] [48] [49] [51] [52]

#4

Total population 1.792 million **PWID** 2.300 **HIV prevalence** 0.5% **HCV prevalence** 62.8%

services

8.0/10

OST coverage = 2.5
NSP coverage = 3
HIV&HCV = 2
Overdose prevention = 0
Prison services = 0.5

policy

5.0/10

Status of possession = 0
Overdose legal enablers = 0
Strategy&Sustainable financing = 3
Community participation = 1
Prison policy alignment = 1

epidemiology

6.5/10

HIV&HCV prevalence data = 3
Incidence/new diagnoses reporting = 1
Overdose mortality statistics = 1
Treatment coverage = 1
Recent population size estimation = 0.5

data & monitoring

5.0/10

Registries and reporting = 3
Overdose surveillance = 0
Data transparency & public access = 1
Early Warning System = 0.5
Prison health data reporting = 0.5

total index

61.25

Montenegro has OAT and NSP services, but access is uneven and mostly limited to larger towns. Testing exists, yet surveillance and data remain weak, while overdose prevention is almost absent. Services collapsed during funding gaps but were recently restored with Global Fund support. The new 2024–2027 Drugs Strategy introduces a public health approach aligned with EU standards, though structural barriers, punitive laws, and fragile financing continue to undermine continuity.

Key gaps

- Services concentrated in Podgorica; rural PWID excluded.
- No naloxone distribution or systematic overdose data.
- Women and sex workers under-served and stigmatized.
- Monitoring systems unreliable and incomplete.

Enabling factors

- OAT/NSP infrastructure functional with NGO outreach.
- 2024–2027 national strategy includes harm reduction.
- Global Fund support reactivated, reopening drop-ins.
- Public health framing aligned with EU standards.

North Macedonia [2] [17] [54] [55] [56]

#8

Total population 1.792 million **PWID** 6.756 **HIV prevalence** N/A **HCV prevalence** 65.4%

services

5.5/10

OST coverage = 2.5
NSP coverage = 1
HIV&HCV = 1.5
Overdose prevention = 0
Prison services = 0.5

policy

4.5/10

Status of possession = 1
Overdose legal enablers = 0.5
Strategy&Sustainable financing = 2
Community participation = 0.5
Prison policy alignment = 0.5

epidemiology

2.0/10

HIV&HCV prevalence data = 0
Incidence/new diagnoses reporting = 1
Overdose mortality statistics = 1
Treatment coverage = 0
Recent population size estimation = 0

data & monitoring

4.0/10

Registries and reporting = 1
Overdose surveillance = 1
Data transparency & public access = 1
Early Warning System = 0.5
Prison health data reporting = 0.5

total index

40.00

North Macedonia maintains methadone treatment centres and CSO-led NSP outreach, but service access outside Skopje has sharply declined since Global Fund withdrawal and budget cuts. HIV testing expanded through free public and CSO channels, with self-testing introduced in 2025, while HCV treatment is available yet inconsistently accessed. Overdose prevention and prison-based harm reduction remain absent. Although harm reduction is embedded in national policy and action plans, funding is modest, CSO provision is precarious, and epidemiological monitoring remains irregular, leaving rural and hidden PWID underserved.

Key gaps

- Underfunded HR programmes post-Global Fund.
- Services concentrated in Skopje; rural PWID excluded.
- No naloxone or overdose registry.
- Outdated surveillance (last PWID survey 2017).

Enabling factors

- Harm reduction is mentioned in National Drug Strategy 2021–25, but Strategy is poorly implemented.
- CSOs sustain NSP and HIV testing.
- HIV self-testing launched 2025.
- DAAs on formulary with scale-up potential.

Romania [2] [6] [17] [26] [58] [59] [60] [61] [62] [63] [84]

#6

Total population 19.07 million **PWID** 7657 **HIV prevalence** 20.8% **HCV prevalence** 62.3%

services

6.5/10

OST coverage = 1.5
NSP coverage = 2.5
HIV&HCV = 1.5
Overdose prevention = 0.5
Prison services = 0.5

policy

4.0/10

Status of possession = 0
Overdose legal enablers = 0.5
Strategy&Sustainable financing = 2
Community participation = 1
Prison policy alignment = 0.5

epidemiology

6.0/10

HIV&HCV prevalence data = 4
Incidence/new diagnoses reporting = 1
Overdose mortality statistics = 0
Treatment coverage = 1
Recent population size estimation = 0

data & monitoring

5.0/10

Registries and reporting = 3
Overdose surveillance = 0
Data transparency & public access = 1
Early Warning System = 0.5
Prison health data reporting = 0.5

total index

53.75

Romania's drug policy reveals a gap between strategy and implementation. Though the 2022–2026 National Drug Strategy includes harm reduction, services are limited: OST is mostly in Bucharest, NSPs are sparse, and there's no overdose prevention. Possession of small amounts is criminalized, deterring access to care. The dismantling of the National Anti-Drug Agency and transfer of duties to the Health Ministry has led to coordination issues. Data systems are weak, with misclassified overdoses and delayed reporting. Funding is unstable, OST gets limited state support, while NSPs rely on short-term donor aid, making services fragile.

Key gaps

- OST and NSP concentrated in Bucharest; poor national coverage.
- Possession laws deter PWUD from services.
- No national overdose registry; deaths misclassified.
- Marginalised groups under-represented and unserved.

Enabling factors

- National Drug Strategy embeds harm reduction.
- Ministry of Health funds OST.
- CSOs maintain outreach and advocacy.
- Policy discussions on PrEP and HIV/HCV care create entry points.

Serbia [2] [17] [65] [66] [67] [6]

#9

Total population 6.568 million **PWID** 15.000 **HIV prevalence** 2.3% **HCV prevalence** 25.9%

services

4.5/10

OST coverage = 1.5
NSP coverage = 1
HIV&HCV = 1.5
Overdose prevention = 0
Prison services = 0.5

policy

2.5/10

Status of possession = 0
Overdose legal enablers = 0
Strategy&Sustainable financing = 1
Community participation = 1
Prison policy alignment = 0.5

epidemiology

2.0/10

HIV&HCV prevalence data = 0
Incidence/new diagnoses reporting = 0
Overdose mortality statistics = 2
Treatment coverage = 0
Recent population size estimation = 0

data & monitoring

5.0/10

Registries and reporting = 2
Overdose surveillance = 1
Data transparency & public access = 1
Early Warning System = 0.5
Prison health data reporting = 0.5

total index

35.00

Harm reduction in Serbia is constrained. OST exists in 23 sites but access is limited by insurance, gaps, and waiting lists. NSPs are almost absent (1 site + 1 outreach), leaving most PWID unserved. HIV testing is free but NGO-driven, while PrEP restricted to MSM. Hepatitis C treatment requires OST enrollment and insurance; naloxone unavailable. In prisons, OST continuation-only, NSP absent, ART partially accessible. Possession remains criminalized, with no thresholds or differentiation. Data outdated (last PWID survey 2014), overdoses misclassified, and key groups excluded. Funding donor-dependent, with no stable public financing or strategy.

Key gaps

- Minimal NSP and overdose-prevention coverage.
- Punitive possession laws deter service access.
- Outdated data and no overdose registry.
- Lack of sustainable domestic funding.

Enabling factors

- OST integrated into the public health system.
- Free HIV testing with NGO outreach.
- ART available in community and prisons.
- Harm reduction formally recognised in policy.

Slovenia [2] [17] [68] [69] [71] [72] [73]

#1

Total population 2.130 million **PWID** 4.900 **HIV prevalence** 0% **HCV prevalence** 25%

services

10.0/10

OST coverage = 3
NSP coverage = 3
HIV&HCV = 2
Overdose prevention = 1
Prison services = 1

policy

9.5/10

Status of possession = 2
Overdose legal enablers = 1.5
Strategy&Sustainable financing = 4
Community participation = 1
Prison policy alignment = 1

epidemiology

10.0/10

HIV&HCV prevalence data = 4
Incidence/new diagnoses reporting = 1.5
Overdose mortality statistics = 2
Treatment coverage = 2
Recent population size estimation = 0.5

data & monitoring

10.0/10

Registries and reporting = 4
Overdose surveillance = 2
Data transparency & public access = 2
Early Warning System = 1
Prison health data reporting = 1

total index

98.75

Slovenia has the region's most advanced harm reduction system. The 2023–2030 National Programme secures nationwide OAT, NSP, HIV/HCV testing, PrEP, and take-home naloxone. In 2024, it opened the first sanctioned Drug Consumption Room in SEE (Nova Gorica). Services are state-funded and professionally managed, yet access is uneven, with weaker OAT/NSP coverage outside major cities. Prisons lack NSP and have only partial HCV testing. Naloxone is mainly distributed through OAT providers or doctors. Monitoring depends on service data rather than updated IBBS surveys. Despite strong progress, gaps remain in coverage, prison care, and data.

Key gaps

- No prison NSP, limited HCV testing inside.
- Uneven naloxone access via OAT/doctors.
- No recent IBBS survey; weak monitoring.
- Migrants/homeless users underserved.

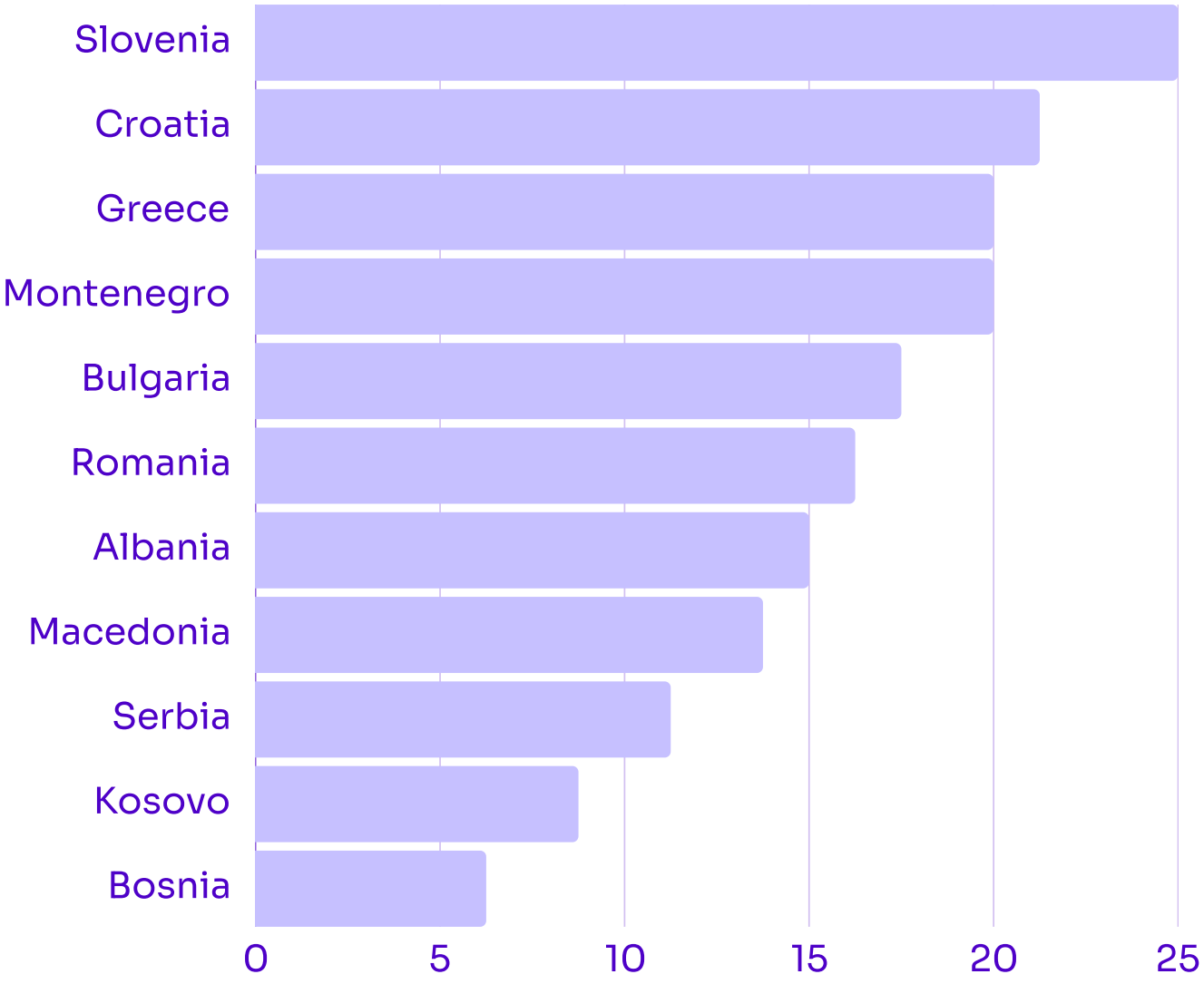
Enabling factors

- Strong state financing and insurance coverage.
- National Drug Strategy 2023–2030 with action plans.
- Fully mainstreamed PrEP and naloxone programme.
- First DCR in SEE (Nova Gorica).

domain ranking

#domain1 – services

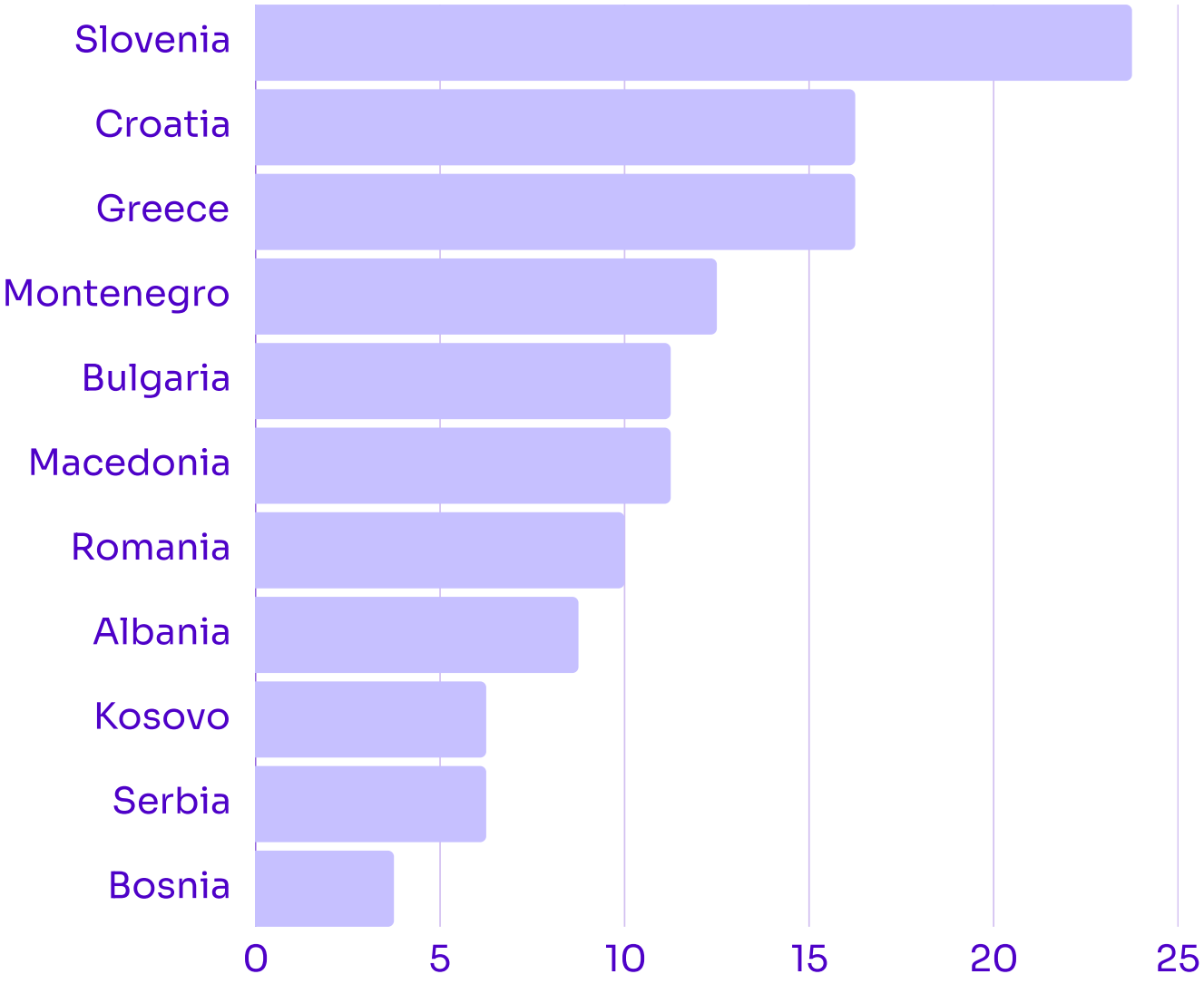
This domain evaluates the presence and scope of essential harm reduction interventions across South-Eastern Europe. It captures both the formal availability and the real coverage of services such as opioid agonist therapy (OAT), needle and syringe programmes (NSP), HIV and HCV testing and treatment, overdose prevention, drug consumption rooms (DCR), and prison-based interventions. The scoring system distinguishes between nominal availability and sustainable, geographically distributed service networks, recognising that fragmented or donor-dependent provision cannot guarantee equitable access.



Slovenia (25.00), Croatia (21.25), Greece (20.00), Montenegro (20.00), Bulgaria (17.50), Romania (16.25), Albania (15.00), North Macedonia (13.75), Serbia (11.25), Kosovo (8.75), Bosnia and Herzegovina (6.25).

#domain2 – policy

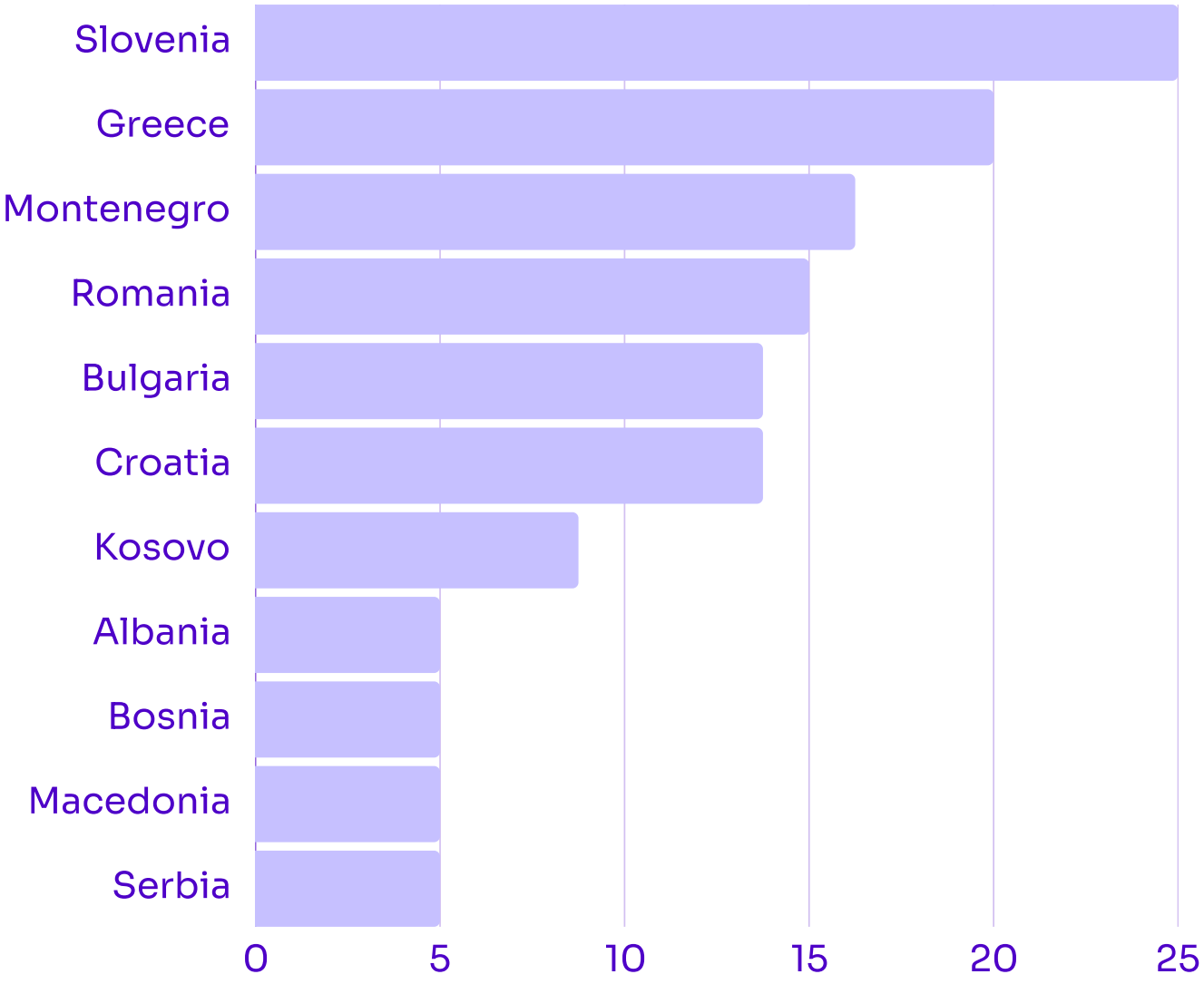
The policy domain assesses the legal and institutional frameworks that enable or constrain harm reduction. It considers the criminalisation of possession for personal use, the existence of overdose-enabling laws, the inclusion of harm reduction in national strategies, sustainable financing mechanisms, community participation in decision-making, and alignment of prison policies with international standards. Scores reflect the degree to which harm reduction is embedded in public health and human rights approaches, rather than treated as temporary or marginal.



Slovenia (23.75), Croatia (16.25), Greece (16.25), Montenegro (12.50), Bulgaria (11.25), North Macedonia (11.25), Romania (10.00), Albania (8.75), Kosovo (6.25), Serbia (6.25), Bosnia and Herzegovina (3.75).

#domain3 – epidemiology

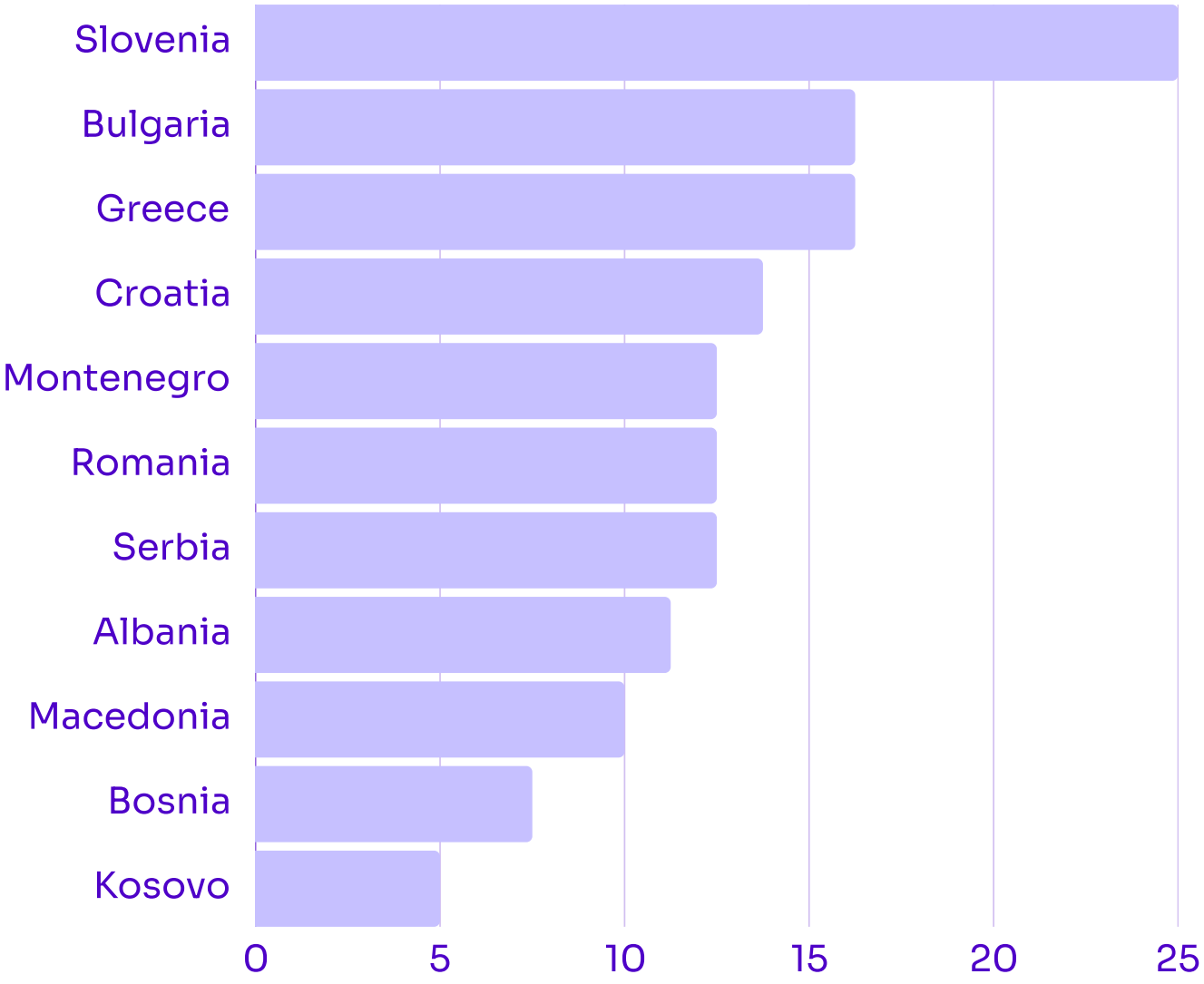
This domain evaluates the availability, recency, and reliability of epidemiological data on people who use drugs. Indicators include HIV and HCV prevalence, incidence and new diagnoses, overdose mortality statistics, treatment coverage, and population size estimations. The purpose of this domain is not only to measure health outcomes but also to examine whether governments maintain transparent, evidence-based monitoring systems that can inform effective responses. Outdated or partial data are treated as systemic weaknesses, since they mask the true scale of need.



Slovenia (25.00), Greece (20.00), Montenegro (16.25), Romania (15.00), Bulgaria (13.75), Croatia (13.75), Kosovo (8.75), Albania (5.00), Bosnia and Herzegovina (5.00), North Macedonia (5.00), Serbia (5.00).

#domain4 – data & monitoring

The data and monitoring domain captures the strength of national systems for surveillance, reporting, and transparency. It includes registries, annual reports, overdose surveillance, early warning systems, and prison health data. Scoring emphasises whether monitoring is systematic, accessible to the public, and aligned with European standards. Weaknesses in this domain undermine accountability, obscure service gaps, and leave governments and donors without the tools to evaluate impact or allocate resources effectively.



Slovenia (25.00), Bulgaria (16.25), Greece (16.25), Croatia (13.75), Montenegro (12.50), Romania (12.50), Serbia (12.50), Albania (11.25), North Macedonia (10.00), Bosnia and Herzegovina (7.50), Kosovo (5.00).

30

qualitative report

#regional context and structural determinants

The development of harm reduction systems in South Eastern Europe cannot be separated from the broader political, economic and social environment that defines the region. Instead of a uniform landscape, what emerges is a picture of divergence, where some countries have institutionalised services and integrated them into health systems, while others continue to depend on donors or operate in an atmosphere of legal uncertainty and fragile funding. The contrast between European Union member states and Western Balkan countries is evident, yet EU membership alone has not guaranteed stability, as the cases of Romania and Bulgaria demonstrate.

Patterns of fragility are most visible when donor support is withdrawn without adequate transition planning. Entire infrastructures collapse, programmes close and services are forced to rebuild from scratch under conditions of financial scarcity. Bosnia and Herzegovina, North Macedonia and Serbia have all experienced such cycles, where once functional networks of needle and syringe programmes disappeared after the Global Fund's exit, leaving outreach as the only mechanism to maintain contact with people who use drugs. Although outreach has value, it cannot replace fixed centres that provide continuity of care, counselling and testing.

Legal frameworks further complicate access. In many states, possession for personal use is still treated as a criminal offence, resulting in fines or custodial sentences that push individuals away from health and social services. Even in jurisdictions where decriminalisation exists on paper, gaps in implementation and aggressive policing continue to undermine the protective intent of the law. Interviews revealed frequent examples of harassment, confiscation of prescribed medications and fear of arrest, which together create an environment of mistrust that isolates the very people these systems should serve.

Equally important are the socio economic conditions that shape access to care. High levels of unemployment, poverty and stigma intersect to reinforce exclusion. Rural and urban divides are particularly striking, as services are concentrated in capital cities while smaller municipalities remain underserved. The testimonies from Montenegro, North Macedonia and Bosnia and Herzegovina illustrated how clients must spend significant time and money on travel to reach opioid agonist treatment or harm reduction programmes. This reality means that services which are technically "available" are functionally inaccessible to many.

Taken together, these dynamics reveal a region where fragmentation has become the defining feature of harm reduction. Services exist but are unevenly distributed, policies are drafted but rarely translated into practice, and data are produced yet consistently exclude the most vulnerable groups and often are overlooked by the ones who are drafting the policies and creating the service coverage. Even those countries that appear comparatively advanced still face gaps in coverage and equity, while others continue to operate in a state of dependency and political volatility. Across South Eastern Europe, access to essential interventions is determined less by public health planning and more by geography, funding cycles and the legal environment.

#availability of services

In South Eastern Europe, the availability of harm reduction services is consistently undermined by the gap between what governments report and what people on the ground experience. Official data and national strategies often indicate that services such as opioid agonist treatment (OAT) and needle and syringe programs (NSP) are present, yet this availability is uneven and conditional. For example, OAT programs may be concentrated in capital cities or regional centres, leaving people in smaller towns and rural areas without access unless they are able to travel long distances at their own expense. Similarly, NSPs are often limited to a few NGO-led drop-in centres, with no provision in prisons despite high levels of injecting drug use in these settings. Even in higher scoring countries, in both Greece and Croatia, opioid agonist treatment (OAT) and needle and syringe programs (NSP) remain largely confined to the mainland and a handful of larger urban centres. On the islands, such services are absent, forcing people who use drugs to travel long distances, often at high personal cost, or go without essential harm reduction support.

At the same time, there are important innovations that distinguish frontrunners. Greece and Slovenia have introduced drug consumption rooms (DCRs) and drug checking services, making them the only countries in SEE where these interventions are available in practice. These measures not only expand the range of services but also signal alignment with European good practice models. Croatia is in the process of developing its first drug checking service, but implementation is not yet fully confirmed, leaving Greece and Slovenia as the only two consolidated examples in the region.

Geographic centralisation is compounded by administrative requirements that act as hidden barriers to availability. In several countries, access to OAT or HCV treatment requires proof of health insurance, documentation, or prior enrollment in another program, effectively excluding undocumented persons, homeless people, and those with unstable life conditions. Even where regulations appear to allow universal access, frontline testimonies reveal that implementation often depends on the discretion of individual doctors or clinics. This explains the discrepancy between national-level assurances and the lived experience of clients, which the scoring system used in this report captures only in part.

Unstable and project-based funding further undermines service continuity. Many countries in the region transitioned from Global Fund support to partial or no domestic funding, resulting in closures of drop-in centres and interruptions in NSP provision. The Macedonian case, where the drop-in centre in Kisela Voda was forced to shut down after the withdrawal of international funds, illustrates how fragile service provision can be when dependent on short-term projects. Additionally, this is demonstrated also through the case of Serbia where the Ministry of Health do not fund NSP though national (GF supported) program anymore, so country is left with one mobile site that runs occasionally. In Romania, the survival of harm reduction relies almost entirely on donor-funded NGOs, only three NSPs providers still active in Bucharest (and only one fix NSP), despite national reports claiming broader coverage.

The availability of gender-sensitive harm reduction services remains extremely limited across SEE. While women are not explicitly refused access to OAT, NSP, or testing, very few services are tailored to their specific needs. Aside from Greece, Montenegro, and Slovenia, where services exist for sex workers in the capitals, little has been done to design programs that address women who use drugs outside of this most vulnerable group. In Serbia, for example, harm reduction providers often lack awareness of gender-specific needs, and safe houses are inaccessible to women who use drugs who are also victims of violence. This structural neglect perpetuates invisibility and leaves women without adequate support.

The result across SEE is a fragmented system that fails to guarantee equitable coverage for those most in need. Availability is highly uneven not only between countries but also within them: while Slovenia maintains relatively consistent OAT coverage and mobile NSPs, countries such as Greece or Romania show extreme disparities between capital cities and peripheral areas. The overall picture is therefore one of nominal availability without reliable, universal access. These contradictions highlight the need to treat “availability” not simply as the existence of a service on paper, but as a measure of whether services are consistently and equitably present in the daily lives of people who use drugs.

#accessibility and coverage of services

Geographic disparities are among the most visible barriers to care. Capital cities concentrate the majority of clinics and drop-in sites, while rural areas and smaller towns often remain without any provision. In Bosnia and Herzegovina and Montenegro, people must travel long distances to reach the nearest opioid treatment centre, frequently at their own expense. Outreach workers in North Macedonia explained that clients from villages eventually abandoned therapy because repeated trips became unaffordable and exhausting. One participant described a young client who travelled several hours each week for methadone, only to give up entirely when the cost of transport began to exceed his income. These stories illustrate how formal availability does not necessarily translate into real access, and why geographical centralisation continues to undermine service retention.

Administrative and financial obstacles exacerbate these geographic inequalities. In Serbia, Croatia, Montenegro, and Romania, health insurance is a prerequisite for diagnostics, continuation of care, and sometimes even enrolment into OAT. Those without stable housing, migrants, and undocumented individuals are excluded outright. Waiting lists in Serbia delay treatment for weeks or months, leaving people at risk of relapse or overdose during the waiting period. In Montenegro, participants reported that rules around take-home doses vary depending on the individual staff member on duty, creating a sense of arbitrariness.

Clients expressed frustration at having their dose schedules suddenly changed without explanation, which eroded their trust in the system. These accounts demonstrate how inconsistent or bureaucratic practices create insecurity for patients and discourage them from staying engaged with treatment.

Service orientation itself is often a barrier. In several SEE countries, harm reduction is framed not as a public health intervention or harm reduction service, but as a step toward abstinence. This results in high-threshold, clinicalised models of care, where access is conditional rather than universal. Needle and syringe programmes (NSPs) exemplify this fragility. In Serbia, the closure of the fixed site left only minimal outreach capacity, with one client explaining they "no longer have a place to rest, talk, or get information - just receive syringes in the street, or through a contact to a service." Bosnia and Herzegovina has reported zero syringes distributed since 2020 after the withdrawal of Global Fund support, leaving clients without any formal source of sterile equipment. Romania relies almost entirely on three sites in Bucharest, while the rest of the country remains uncovered. In North Macedonia, the closure of the Kisela Voda drop-in centre in 2024 forced services to shift entirely to outreach. While outreach workers emphasised its value, they also admitted that it cannot replace the safe spaces, counselling, and continuity provided by drop-in centres.

Some barriers directly target people who use drugs by imposing requirements that contradict international guidance. In North Macedonia, service providers reported that hepatitis C treatment required proof of six months of abstinence before initiation, a rule that excluded nearly all clients actively injecting. In Serbia, health professionals were reluctant to provide therapy to clients who continued to use other substances, leaving many untreated despite urgent need. In one transcript, a client explained: "They told me to come back when I was clean, but I needed treatment to stay alive, not after I stopped." These practices disproportionately exclude those at highest risk of infection and overdose, undermining both individual health and public health outcomes.

Taken together, these layers of barriers show how accessibility is systematically undermined in South Eastern Europe. Services may appear available on paper, but geographic distance, financial and administrative obstacles, restrictive service orientation, and discriminatory rules mean that many people cannot use them in practice. The result is a fragmented and exclusionary system where clients are forced into unsafe alternatives, such as buying methadone on the illicit market in Romania, abandoning therapy in North Macedonia, or disengaging entirely from care in Serbia and Montenegro. Ensuring accessibility therefore requires more than expanding the number of services, it demands removing bureaucratic barriers, decentralizing provision, and redesigning harm reduction as truly low-threshold, community-centred support.

#integration with healthcare and social system

IIntegration between harm reduction and wider healthcare and social systems in South Eastern Europe represents one of the most decisive factors shaping the effectiveness of national responses, and countries such as Slovenia and Croatia demonstrate that when harm reduction is embedded within public health institutions, referral pathways are smoother, testing and treatment for HIV and HCV are more immediate, and overdose prevention measures are accessible. In much of the Western Balkans, by contrast, services function in separate silos, creating obstacles at every stage of the continuum of care, as community organisations, infectious disease clinics, and primary healthcare providers rarely operate in coordination, resulting in friction that undermines both continuity and outcomes.

Testing and treatment patterns highlight the consequences of these structural divides, since HIV testing is generally accessible through public facilities, voluntary counselling centres, and mobile NGO teams, but HCV testing and treatment remain far less integrated with harm reduction across most of the region. In Slovenia, rapid tests conducted in low threshold centres are directly linked to specialist clinics, with diagnostics and direct acting antivirals fully covered by compulsory insurance, while Greece operates through the state financed OKANA system, connecting harm reduction units, hospital care, and preventive tools into a single network. In Montenegro, NGOs cooperate with public health authorities, yet consistent linkage is uneven outside the capital, and in North Macedonia outreach teams bring rapid HIV testing directly into neighbourhoods because clients are unwilling or unable to visit formal health centres. In Romania, provision is concentrated almost entirely in Bucharest, while in Serbia HCV testing is available through public health centres but not embedded in harm reduction services, reducing uptake.

Barriers at the interface of systems appear across multiple contexts, as abstinence requirements for HCV therapy remain in force in Montenegro, North Macedonia, and parts of Bosnia and Herzegovina, excluding many PWID in contradiction to international recommendations. Administrative hurdles such as proof of residence, identity documents, or health insurance block access in Serbia, Montenegro, and Romania, producing a cycle in which uninsured clients cannot undergo required tests and therefore cannot start treatment, while regional variation in enrolment procedures, waiting lists for opioid agonist treatment, and bureaucratic delays erode trust and discourage retention.

PrEP is available throughout the region of SEE but almost exclusively for men who have sex with men (MSM). but almost exclusively targeted toward men who have sex with men (MSM). Within MSM communities, it is actively promoted and accessible, while harm reduction services for PWUD rarely have formal referral pathways. CSOs reported that referrals sometimes happen through cooperation with MSM or HIV-focused organisations, but this depends on goodwill and informal agreements rather than systematic inclusion.

As a result, PWUD remain largely excluded from PrEP access, reflecting fragmented HIV prevention that reinforces stigma and gaps in continuity of care. In Serbia, service providers explained that while NGOs working with MSM populations can refer clients directly to PrEP services, organisations focused on people who inject drugs are not recognised as referral partners. One provider described being told by a clinic that “our clients don’t qualify” when they attempted to make a referral for a PWUD who also engaged in sex work.

Linkages with social protection systems are the least developed dimension of integration, since NGOs frequently act as informal brokers, assisting clients with documents, health insurance, housing, benefits, or legal aid, but formal pathways and financed case management are rare. Shelters across several Western Balkan countries refuse entry to people actively using drugs, excluding some of the most vulnerable, while Bulgaria’s Pink House illustrates how municipal level funding can stabilise access, and Slovenia shows that when social and health financing are coordinated, one stop services become achievable. Without such integration, harm reduction remains fragile, and treatment cascades fail for those at highest risk.

#closed settings and high-risk environments

Closed settings and high risk environments remain among the weakest elements of harm reduction systems in South Eastern Europe, and prisons expose the structural shortcomings of national responses in particularly stark ways. Opioid agonist treatment is formally available in several countries, yet in practice initiation behind bars is almost never possible, and continuation is frequently conditional on enrolment before detention. As a result, many people with opioid dependence go untreated during incarceration, a period widely recognised as one of the highest risk contexts for relapse and disease transmission. In Serbia, Montenegro, and Bosnia and Herzegovina, entry into methadone or buprenorphine programmes inside prison is almost impossible, while Romania and North Macedonia offer continuation only in limited facilities. Slovenia, Montenegro and Greece remain the exceptions, where both initiation and continuity of OAT are possible, showing that when treatment is properly integrated into public health systems, post release outcomes improve significantly.

The total absence of needle and syringe programmes in prisons across the region compounds these risks. Injecting is known to occur inside, yet governments prohibit or ignore sterile syringe provision, forcing individuals to share or reuse equipment under unsafe conditions. This accelerates HIV and HCV transmission, especially in overcrowded facilities where stigma from staff and poor infection control are common.

Even antiretroviral therapy for people living with HIV is not reliably accessible, as delays in initiation and interruptions in medication supply occur often in smaller facilities. Reports from North Macedonia describe prisoners waiting weeks for ART deliveries from Skopje, while in Serbia bureaucratic undermine continuity of care.

Emerging substances such as synthetic opiates represent another unaddressed risk. With the exception of Slovenia, which integrates drug checking that occasionally identifies fentanyl in samples linked to prisons, there is no systematic monitoring elsewhere. Donor funded pilot projects in Montenegro and North Macedonia have distributed small quantities of fentanyl test strips, but legal restrictions and lack of institutional support prevent sustained use, and no country maintains an early warning mechanism in prisons.

Outside custodial institutions, similar exclusion is experienced by other high risk groups. Women who use drugs fear losing custody of their children or facing violence, which discourages them from seeking services. Migrants and undocumented individuals encounter legal and bureaucratic requirements, such as health insurance or identification, that block access to treatment.

Homeless people are often refused entry to shelters if they use drugs, leaving them in unstable environments that exacerbate health risks. These populations remain absent from national data yet are at elevated risk, and qualitative evidence makes clear that unless structural reforms are pursued, both prison populations and marginalized groups will continue to face systemic neglect.

#governance, funding, and community involvement

Governance, funding, and community involvement together determine whether harm reduction systems in South Eastern Europe can function as stable and equitable public health responses or remain fragile and inconsistent. Financial instability is the most persistent theme emerging from qualitative evidence. In almost every country outside Slovenia and Greece, harm reduction relies on mixed sources of funding - limited government allocations supplemented by international donors and short-term projects. While national budgets do provide some support, these resources are rarely sufficient or delivered on time. State tenders are frequently announced late and lack timely implementation, leaving long gaps during which programmes struggle to operate. In practice, other donor or project-based funds are used to fill these gaps, but this creates a patchwork system that is reactive rather than sustainable. One service provider explained how delayed tenders forced funds to be spent within just a few months, often on supplies rather than meaningful activities, highlighting the wasteful “start–stop” nature of current financing.

The weakness of intersectoral cooperation further undermines system stability. Ministries of health, social affairs, and justice often operate in silos, leaving service providers to navigate conflicting priorities. In Montenegro and Serbia, for instance, health authorities require abstinence for HCV treatment, while social welfare agencies simultaneously exclude active drug users from shelters, producing contradictory policies that marginalise the same populations they claim to support. Where national drug strategies exist, they are often not implemented or are left without secured budgets, as seen in Romania and Bosnia and Herzegovina. In other cases, such as Serbia, strategies have expired without replacement, leaving a vacuum in which CSOs struggle to maintain minimum harm reduction coverage without an official framework.

The exclusion of people who use drugs and their organisations from policymaking is another structural barrier. Consultation processes are often described as tokenistic, where CSOs are invited to meetings only after decisions are made, with no role in setting priorities or allocating resources. A participant from North Macedonia noted that while NGOs send regular service data to ministries, there is no feedback or evidence that the information shapes policy. Such dynamics discourage meaningful participation and reinforce mistrust between communities and institutions.

A further challenge is that people who use drugs in the Western Balkans remain largely disconnected from the broader European PWUD community. Because most SEE countries are not part of the European Union, their activists and informal networks are often excluded from participation in INPUD and EuroNPUD structures, leaving them without access to solidarity, training, or advocacy platforms available to peers elsewhere. This isolation reinforces fragmentation and weakens their ability to articulate rights-based claims.

#stigma and discrimination

Stigma is not just an individual attitude but a structural feature of harm reduction systems in South Eastern Europe. It influences how services are designed, who feels entitled to use them, and whether institutions consider people who use drugs as part of the population they are mandated to serve. In interviews, providers frequently noted that services are tolerated but not embraced by authorities, described as “unpopular” or “politically unattractive.” This lack of political legitimacy translates into marginalization at every level, from budget negotiations to interactions at clinic counters.

Discrimination also emerges in subtle forms of bureaucratic gatekeeping. Requirements for documentation, permanent addresses, or insurance status are not only administrative hurdles; they are ways of signalling that people who use drugs do not fully belong in public systems.

A respondent from Montenegro explained that even when services are technically free, staff may "decide who deserves help," reinforcing a hierarchy of worthiness. Such dynamics mean that stigma is built into the very procedures of care, not only expressed through overt hostility.

Gender adds another layer of invisibility. While a handful of services in Greece, Montenegro, and Slovenia reach sex workers, most women who use drugs remain outside any tailored support. They often avoid services out of fear of losing custody of children, exposure to partners, or public shaming. The absence of gender-sensitive models signals a deeper bias: women are rarely recognised as independent service users, but only as mothers, sex workers, or "exceptions." In countries like Serbia, there is evidence from previous research that service providers have a little understanding of how women's needs differ, which leaves entire groups unacknowledged in system planning.

At the community level, stigma operates through silence and exclusion. In many places, people who use drugs are invisible in policy discussions not only because governments exclude them but also because there are no strong, recognised user-led organisations. Without a collective voice, discriminatory practices remain unchallenged and are normalised as part of "how the system works." This absence is particularly acute in the Western Balkans, where regional PWUD communities remain disconnected from larger European networks.

The result is that stigma becomes self-perpetuating: people avoid services because they anticipate negative treatment, institutions interpret this absence as lack of need, and policymakers justify underfunding by claiming harm reduction has "low demand." Breaking this cycle requires creating spaces where people who use drugs are visible, legitimate stakeholders, not as "exceptions" but as full members of society entitled to health, dignity, and rights.

#new drug trends and changing contexts of use

Across the Western Balkans and parts of SEE, harm reduction providers increasingly report shifts in the types of substances being used and the contexts in which they are consumed. In Serbia, Montenegro, and North Macedonia, the rise of use of stimulants, often associated with rapid cycles of dependence and high-risk patterns. Romania continues to grapple with "ethnobotanicals" and synthetic cathinones, which remain widely available in urban areas and drive complex health and social problems. These changing patterns challenge traditional harm reduction models that were largely designed around opioid injection. Providers highlighted that their services are struggling to adapt — outreach and OAT coverage alone cannot address stimulant use, poly-drug consumption, or the overlapping realities of nightlife, homelessness, and mental health needs. Without adaptation, harm reduction risks falling behind the realities of drug use, leaving both staff and clients exposed to new harms.

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recommendations

#recommendations

1. Governments must establish multi-year domestic budget lines for harm reduction services, including opioid agonist treatment, needle and syringe programmes, HIV/HCV testing, and overdose prevention. Reliance on short-term donor or project-based funding is unsustainable and drives service interruptions. Social contracting mechanisms should be institutionalised to ensure stable support for civil society organisations.

2. Decriminalise possession of small amounts of drugs for personal use, introduce Good Samaritan laws, and remove restrictive provisions that criminalise harm reduction clients. Legal reform must align drug policy with public health objectives and eliminate abstinence or insurance requirements that block access to HIV/HCV treatment and OAT.

3. Assist in pushing national drug observatories or focal points to ensure systematic collection, analysis, and publication of data on service coverage, overdose mortality, and epidemiological indicators. Open data platforms should be developed to enable independent verification and accountability, ideally in collaboration with the EUDA. At present, civil society organisations are the main providers of high-quality data but remain excluded from official reporting and policy evaluation.

4. Position harm reduction as an integral part of national HIV, HCV, and addiction strategies. Link OAT, NSP, and HIV/HCV treatment with social services, housing, and prison health systems to guarantee continuity of care across all settings.

5. Scale up geographic availability of OAT and NSP beyond capital cities, ensure low-threshold access points, and integrate overdose prevention (take-home naloxone) into national systems. In prisons, expand OAT initiation, ensure uninterrupted ART, and introduce pilot NSP in line with WHO and UNODC recommendations. In Greece and Croatia, for example, OAT and NSP remain limited to the mainland and a few large urban centres, leaving most islands without access except Crete, highlighting the urgent need for geographic expansion.

6. Embed community-led monitoring (CLM) in national systems and guarantee representation of people who use drugs in policy fora, advisory bodies, and decision-making structures. Ensure that their data and perspectives are formally recognised in planning, evaluation, and funding allocation. In the Western Balkans and SEE, where formal PWUD organisations are still largely absent, larger European networks (e.g., EuroNPUD, C-EHRN, EHRA, DPNSEE) should take on an “incubation role” by seeding new user-led groups, mentoring emerging leaders, and providing the flexible resources and protection needed for communities to organise and stand up for themselves. National CSOs can facilitate this process by hosting advisory boards of PWUD, offering safe organising spaces, and gradually transferring leadership to community members.

7. A key recommendation is to actively support the creation of a Western Balkans PWUD chapter within EuroNPUD or INPUD, which would provide an organised channel for engagement, capacity-building, and representation. Such a step could help local PWUD communities navigate EU and international policy arenas, advocate for their rights, and ensure their perspectives are integrated into regional harm reduction and health strategies.

8. Introduce evidence-based interventions such as drug checking, drug consumption rooms, and fentanyl monitoring. Learning from best practices in Slovenia and Greece, countries should adapt models of integrated harm reduction and scale them up regionally.

   While systemic change ultimately requires governments to secure sustainable funding, enact legal reforms, and integrate harm reduction into national strategies, the political reality in South Eastern Europe makes these shifts slow and uncertain. Policy cycles are fragile, and progress is often undermined by instability, competing priorities, or lack of political will.

   For this reason, it is equally important to highlight what civil society organisations and networks can do now. The following set of recommendations focuses on actionable steps for CSOs and networks, initiatives that can be implemented even without immediate government buy-in. These actions are designed to prototype solutions, document gaps, and build political capital, ensuring that communities are not left waiting for change but actively shaping it.

#immediate recommendations (next 12 months)

1. Establish PWUD advisory councils within existing NGOs to give people who use drugs formal spaces for input until independent organisations can emerge. In case of Bosnia and Herzegovina where there is no active NGO - ask a partner NGO or former activist to act as a bridge.

2. Convene regional PWUD assemblies alongside SEE harm reduction or HIV events, even if informal, to create visibility and solidarity. With language as a barrier, ask existing CSO members to facilitate and help in communication.

3. Launch shadow monitoring reports and “availability gap trackers” to document discrepancies between government reporting and lived realities.

4. EPilot overdose alert systems (SMS, Telegram, or social media) to share rapid warnings on contaminated batches, in close collaboration with organizations who are working on Drugchecking and are relevant to the region (Slovenia, Austria, Italy).

5. Expand mobile and pop-up harm reduction units (vans, tents, nightlife teams) that combine NSP, naloxone distribution, and testing.

6. Provide stigma-reduction training to frontline professionals in collaboration with medical and social work associations, using PWUD and peers as co-trainers.

#mid-term recommendations (12–36 months)

1. Create leadership pipelines for peers (outreach workers, volunteers) with stipends, mentorship, and exchange visits to transition them into advocacy and representation roles.

2. Develop crowdsourced service mapping apps where users and staff update availability of OAT, NSP, or testing in real time.

3. Advocate for earmarking mechanisms (e.g., alcohol, tobacco, gambling taxes) to create sustainable domestic funding streams for harm reduction.

4. Build regional emergency funds managed by networks like DPNSEE, EHRA, C-EHRN to cover sudden funding gaps that threaten continuity of services.

5. Target EU accession leverage: For WB countries, tie harm reduction commitments to EU negotiation chapters (health, justice, human rights). CSOs can feed shadow reports into Brussels processes.

6. Develop women-focused harm reduction models, piloting services that address needs outside sex work (e.g., childcare, safe housing, domestic violence support). Launch pilot drug checking services in nightlife or street settings under NGO umbrellas, using European best practice as models.

#long-term recommendations (36 months and beyond)

1. Support the emergence of independent PWUD organisations in SEE through incubation, mentorship, and initial resourcing from larger European networks (EuroNPUD, C-EHRN, EHRA).

2. Use strategic litigation to set legal precedents (e.g., denial of OAT in prison, barriers to HCV treatment), leveraging European and constitutional courts.

3. Anchor harm reduction in EU accession processes by producing shadow reports tied to negotiation chapters on health, justice, and human rights.

4. Transform drop-in centres into integrated peer hubs offering harm reduction, housing support, legal aid, and digital access, to serve as community anchors.

5. Position PWUD and CSO networks as recognized policy interlocutors in national and regional fora, ensuring community-led monitoring and advocacy become institutionalised.

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annexes

annex 1 (part one)
sub-indicators and scoring structure

To ensure transparency and replicability, each domain in the scorecard is decomposed into sub-indicators with explicitly assigned maxima. This system avoids arbitrary scoring, anchors the evaluation in concrete criteria and enables comparability across countries. Each domain is capped at 10 points, producing a balanced framework where all four domains contribute equally to the composite score (maximum 40).

Justification for equal weighting of domains

Each of the four domains Services, Policy, Epidemiology and Data & Monitoring was assigned an equal weight of 10 points. This methodological decision was made to preserve balance between service delivery (frontline availability), structural enablers (policy and financing), epidemiological evidence (burden and coverage), and accountability mechanisms (data and monitoring). Over-weighting any single domain risked overshadowing the multidimensional nature of harm reduction systems.

By keeping the domains equal, the framework ensures that no country appears to perform well solely by excelling in one area while neglecting others. For example, strong epidemiological monitoring without service availability, or comprehensive legal frameworks without sustainable financing, cannot by themselves constitute a functional harm reduction system. Equal weighting thus reflects a normative commitment: effective harm reduction requires simultaneous progress across service, policy, epidemiological, and monitoring dimensions.

The table below illustrates how scoring is coupled within domains, highlighted by white and grey cells.

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annex 1 (part two)
sub-indicators and scoring structure

No	Services (0–10)	Max	Values
S1	OAT service network	1	0 = none; 0.5 = ≥1 site but ≤2 cities; 1.0 = multi-site with sub-national coverage (incl. at least 1 non-capital area)
S2	OAT coverage vs need	2	2.0 = ≥40% of estimated opioid-dependent pop.; 1.5 = 20–39%; 1.0 = 5–19%; 0.5 = >0–4%; 0 = 0%
S3	NSP geographical presence	1	0 = none; 0.5 = pilot/1 city; 1.0 = routine provision in ≥2 cities or national programme
S4	NSP distribution intensity	2	2.0 = ≥3 active programmes/services (multi-city or multi-operator coverage); 1.5 = 2 active programmes/services; 1.0 = 1 active programme/service; 0.5 = mobile outreach services; 0 = no service available
S5	HIV testing availability	1	1.0 = HIV testing routinely available via VCCT or low-threshold services in multiple locations; 0.5 = HIV testing available, but limited to one location or irregular campaigns; 0 = no access
S6	HCV testing & treatment availability	1	1.0 = HCV testing and treatment are available and accessible through VCCT/low-threshold or multiple locations; 0.5 = HCV testing and/or treatment available but only in one city or with significant barriers (insurance, abstinence); 0 = no practical access
S7	Overdose prevention	0.5	0.5 = naloxone availability in community/peers/NGOs with training and EMS protocols; 0 = none
S8	DCR service available	0.5	0.5 = one fix site available; 0 = none
S9	Prison harm reduction	1	1.0 = OAT continuation & initiation + HIV/HCV testing & ART; 0.5 = OAT continuation only and/or ART only; 0 = none

annex 1 (part three)
sub-indicators and scoring structure

No	Policy (0–10)		Values
P1	Legal status of possession for personal use	2	2.0 = decriminalised/diversion in law & practice; 1.0 = administrative offence or inconsistent diversion; 0 = criminalised
P2	Overdose legal enablers	1.5	1.5 = Over the Counter/community ake-Home Naloxone lawful + Good-Samaritan protections; 1.0 = ake-Home Naloxone lawful but no GS; 0.5 = clinical-only; 0 = neither
P3	Strategy & funded action plan	2	2.0 = national strategy with costed action plan and active implementation; 1.0 = strategy without secured budget; 0 = no current strategy
P4	Sustainable financing & social contracting	2	2.0 = multi-year domestic lines (health/social) incl. CSO contracting; 1.0 = mixed/short-term public grants; 0 = donor-dependent/no line
P5	Community participation in governance	1.5	1.5 = formal seats, voting rights, and remuneration for PWUD/CSOs; 1.0 = advisory only; 0.5 = ad-hoc consultation; 0 = none
P6	Prison policy alignment	1	1.0 = policy permits OAT initiation and envisages prison HR (testing/ART); 0.5 = partial (continuation only); 0 = restrictive

annex 1 (part four)
sub-indicators and scoring structure

No	Epidemiology (0–10)		Values
E1	HIV prevalence data among PWID	2	2.0 = national IBBS or equivalent ≤3 years, RDS/TS methods; 1.0 = ≥4–6 years or city-only; 0 = older/none
E2	HCV prevalence data among PWID	2	2.0 = national IBBS or equivalent ≤3 years, RDS/TS methods; 1.0 = ≥4–6 years or city-only; 0 = older/none
E3	Incidence/new diagnoses trend reporting	1.5	1.5 = annual trends for PWID disaggregated (≥3 consecutive years); 1.0 = partial; 0 = none
E4	Overdose mortality statistics	2	2.0 = national ICD-10/11 with toxicology, annual release; 1.0 = partial/estimates; 0 = none
E5	Treatment coverage indicators (OAT, ART, HCV DAA)	2	2.0 = routine national coverage rates for all three with ≤2-year lag; 1.0 = one/two indicators; 0 = none
E6	PWID population size estimation	0.5	0.5 = formal PSE ≤5 years (multiplier/capture-recapture/RDS-SS); 0 = none/older

annex 1 (part five)
sub-indicators and scoring structure

No	Data & Monitoring (0–10)		Values
D1	National drug observatory/focal point functionality	2	2.0 = designated NFP producing annual reports to EUDA/WHO; 1.0 = partial; 0 = none
D2	Routine HR service monitoring	2	2.0 = standardised national reporting for NSP items, OAT registry, testing, THN; 1.0 = partial; 0 = none
D3	Overdose surveillance (fatal & non-fatal)	2	2.0 = fatal + non-fatal (EMS/ED) with case definitions; 1.0 = fatal only; 0 = none
D4	Data transparency & public access	2	2.0 = open datasets/dashboards with disaggregation and documentation; 1.0 = PDFs only/limited; 0 = not public
D5	Early Warning System	1	1.0 = EWS with public alerts incl. fentanyl; 0.5 = internal EWS only; 0 = none
D6	Prison health data reporting	1	1.0 = routine national prison indicators (OAT, HIV/HCV testing/ART); 0.5 = ad-hoc; 0 = none

beyond the numbers

Harm Reduction across South-Eastern Europe