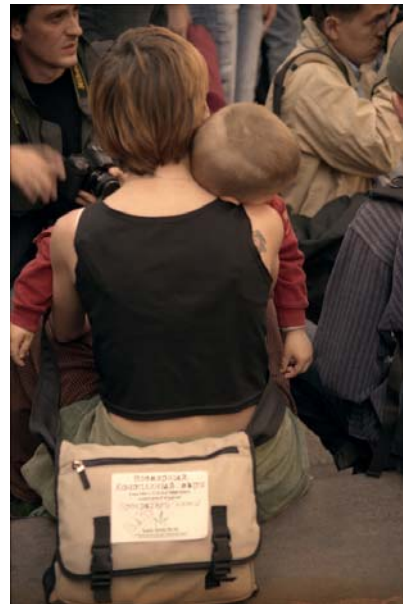


# Drug Use and Mobility in Central Europe





Neither the European Commission nor any person acting on its behalf is liable for any use made of this information.



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# INTRODUCTION

Definition of ‘the Central Europe’ as a region is changing. Originally being a geographical characteristic of several European countries, today it acquires more and more political shapes of meaning.

Tension between ‘Eastern Europe’ and ‘Western Europe’ existed for decades in the 20<sup>th</sup> century; now they give place to harmonization of politics and policies that defines development of Europe of the 21<sup>st</sup> century.

Attitude of a society to marginalized communities is a good indicator to estimate the readiness of people to build a civil society. National and religious intolerance often come together with totalitarian regimes; stigma against national minorities, drug users and people living with HIV/AIDS, refugees, and prisoners is a bad solution of social problems.

Current policies related to drug use and illegal migration put affected communities into social isolation in many countries of the world. We believe that in the countries of the Central Europe a balance between law enforcement, public health and human rights approaches would be found in the field of migration and drug policies.

Historically, in the area of Central and Eastern Europe migration was always high. Even in 1950 – 1988 when international traveling in this region was politically suppressed, people managed to travel within the region, mostly for business and tourist purposes. During Stalin’s period there also was ‘forced’ migration, when ethnic groups were moved, for example from some Polish cities (at that time Western Ukraine) to Kazakhstan, and native people of Kazakhstan to Siberia. At this period of time political immigration also took place, but it was more typical of the Soviet Union.

After 1989 migration in Central Europe changed greatly, and the region saw a number of previously not observed trends: mobility of false tourists, illegal or semi-legal transit migration, inflow of refugees, asylum seekers and temporary protected persons, multi-form short-term flows of labor within the region and from or to other regions, seasonal movements of migrant workers, immigration for settlement (including re-emigration), not to mention huge movements of the members of many

ethnic groups following the collapse of the former Soviet Union, either between its former republics or to beyond its boundaries [Marek Okolskij, New Migration Trends in Central and Eastern in the 1990s, 1997].

On the other hand, 1989 can be also called a starting point of huge spread of drug use in the region. Number of drug users increased in times during the last decade of the 20<sup>th</sup> century, as well as the migration. Several reasons can be identified to explain why these two processes happened in Central Europe at the same time.

In the beginning of 90s there were great *changes of border policies* in the region. More open borders, simplified visa regimes, and development of tourist business influenced both motivation and ability of people of the Central Europe to travel to the West. New border policies led to the increase of import and export of goods, but at the same time it led to the increase of smuggling, and of drug smuggling as well.

Another important factor both for migration and drug use was the *instability of economy after the collapse of the socialist regime*. Many Central European citizens faced the problem of unemployment, which was new to them after a period of planned economics. Poverty and unemployment always create the strongest motivation for international migration. At the same time, poverty, unemployment, and low access to education are factors that make youth more vulnerable to drugs.

Probably the most important changes that characterize the last decade of the 20<sup>th</sup> century in Central Europe can be called *'feeling of freedom'*. Political freedoms, free access to information, and freedom of choice open new horizons. Young people like to experiment. Many of them tried to get new experience in other countries. Many of young people started to experiment drugs using.

Being obviously related, drug use and mobility were not regarded as complex social phenomenon in the countries of Central Europe. There are no monitoring and no scientific studies of mobile drug users in the CE. It's impossible today to find numbers (even estimated ones) of mobile drug users and where they come from, neither on regional, nor country or city levels. There is no data about patterns of drug use and injection practices of mobile users and of their influence on general population of drug users, though it's an interesting scientific question because culture of drug use and drug production differs in different countries. There is even no information about HIV and HCV prevalence among mobile drug users, which

can become a critical issue of national public health system, especially if we keep in mind that HIV prevalence among IDUs differs greatly in Eastern, Western and Central Europe. Medical and social needs of mobile drug users in CE have never been assessed and there is no exact information what kind of services (for example antiretroviral treatment or methadone substitution treatment) they can get if they don't have health insurance and citizenship.

Being departed from their cultures, their families and friends, mobile drug users in Central Europe find themselves in a double social exclusion – both as foreigners and as drug users. In the 90s when harm reduction and drug treatment services started to expand in the countries of Central Europe, social and medical workers and peer educators did not reach mobile drug users. Many of them lack information and skills to live and stay healthy while using drugs. Their behavior (injecting practices) influences not only their own health status, but may have a negative impact of HIV and HCV prevalence among IDUs in Central Europe. Epidemics in Russia and Ukraine, for example, show that prevalence of HIV among IDUs may reach 50% and more in a few years.

The problem of mobile drug users in CE exists for more than a decade. It seems that only now it starts to be addressed. In 2003-2004 AC COMPANY, European network for the target group of mobile drug users, implanted a study devoted to migration and drug use in 5 countries of CE – **Lithuania, Poland, Czech Republic, Slovakia, and Romania**. Also, the problem of mobile drug users involved in sex-business was studied in **Estonia**. In the report you will also find a summary of the study of rave-scene and mobility done by AC COMPANY partners from **Hungary**. This report gives a brief analysis of information gathered by members of AC COMPANY during the study.

The study is based on WHO/UNAIDS principles of Rapid Assessment and Response (RAR). Available national and international statistics, interviews with drug users, opinions of doctors, social workers and police, and examples of case management made it possible to come to a generalized description of the problem, probable consequences and recommendations for policy-makers on how to start medical and social interventions to avoid these consequences.



# MOBILE COMMUNITIES OF DRUG USERS IN CENTRAL EUROPE

## What do we mean by 'mobile drug users'

Mobile drug users are not a homogeneous group; we have identified a number of sub groups, which they can be classified into.

***Drug tourists*** are drug users who come to foreign countries for leisure, and they often take drugs for recreational purposes. For example, on rave-festivals or other culture events one can meet relatively big numbers of drug tourists. Most popular drugs among this group are club drugs, stimulants and hallucinogens, but opiates are sometimes also used. Drug tourists often stay for short period of time – days or weeks. They usually have financial means, place to stay, and less social problems than other groups of mobile drug user, though some support may come from harm reduction and medical be requires.

***Drug users - refugees*** are drug users who escape form their native countries for social, private (psychological) or legal grounds. Usually they are illegal refugees, and have no documents, no or minimum financial means, and social bonds. They stay for a long period of time – months and years. Medical, social and psychological help may be vital for this group of mobile drug users.

***Drug users with integration perspective*** are mobile drug users looking for work in other countries, that usually have a partner in the host country, have medical / humanitarian grounds and are stateless. This subgroup of mobile drug users usually lack initial help and may have severe diseases like AIDS.

In some European countries ***Roma*** communities form another big subgroup of migrants. Historically moving from city to city and from country to country, even if they stay in a particular place for decades, they are often regarded by society as aliens, and may have very much in common with 'real' mobile populations. For a

number of social reasons Roma are seen as a population vulnerable to drug use. These reasons will be discussed later.

## Mobile drug users in the Central Europe – how to estimate

Prevalence of drug use among foreigners in Central Europe differs for countries and cities, and correlates with the general mobility trends in the region. In 6 countries where the study took place, numbers of immigrants can be compared in the following table:

At the same time official migration statistics doesn't reflect precisely the situation with socially vulnerable mobile populations – practice shows that these groups of people are usually illegal, and try to avoid any contacts with governmental structures. We can even say that being a hidden population, mobile drug users do the best they can and we can not measure the total number of them in Central Europe. We can only use direct and indirect indicators to estimate proportion of them among drug users.

Governmental or international institutions do not study drug use prevalence among foreigners. Some data can only be taken from the public health statistic departments if the system of official registration of drug users for treatment is established. As treatment expenses are covered by governmental sources, foreign drug users may be registered as persons without health insurance and citizenship.

The only country that we have data on is the Czech Republic where, according to the information coming from *Station Regional Hygiene*, there were 220 mobile drug users (average age is 31, 76% - male).

It is obvious that the real number is much bigger. To some extent, ***the number of registered drug users / foreigners do not reflects the prevalence of drug use among foreigners, but how public health services are prepared to provide treatment to them.***

The other public health criterion to estimate the proportion of mobile drug users could be a ***number of drug overdoses***. The Czech Republic public health system was again the only one to provide our interviewers with this data.

For example in the city of Prague in 2003 1,3% of the registered overdoses were among foreigners (5 of 380 total).

The problems here are that 1) in general overdoses happen to injecting opiate users, and stimulant users, smokers cannot be measured with this criterion, 2) drug users do not often call ambulance when one overdoses, and foreign drug users may call it even rarely, 3) there is no European monitoring drug overdose system, and every country may have its own monitoring system (or even have no at all).

HIV/AIDS is being better monitored in Europe. *AIDS and MOBILITY* is a European network to address the issues of HIV and mobile populations. Unfortunately, they don't have their national focal points in the countries of Central Europe. For rapid situation assessment of mobile drug use in CE, our team tried to collect data of ***HIV prevalence among migrants***.

We managed to get number only for Slovakia, where according to the information of *International Organization for Migration*: the incidence of HIV positive migrants in the total new cases of HIV on the country in the last years is remarkable: for example in 2002 the total number of new cases was 22, migrants – 9 (40,9%).

The other possible source of information is police data. The ***proportion of foreigners among people sentenced for drug-related crimes*** may show us, to some extent the proportion of mobile drug users.

For example, in Poland in 1999 13 people from Ukraine committed crimes related to drugs, 4 Germans, and no Vietnamese.

Another option is to get information from outreach, needle-exchange programs and drop-in, if they collect data about nationality or citizenship of their clients.

A survey of 23 drop-in centers answers in Poland showed that in total 25 clients were defined as mobile drug users.

Low numbers of contact with mobile drug users show that foreigners are one of the most hidden subgroups of drug users and require specific interventions.

## Mobile drug users as a hidden population

There is a number of reasons why foreigners are one of the most hidden subgroups of drug users.

The most obvious reason is that these people face ‘double stigma’ from society, services, and law enforcement – as illegal drug users and as illegal immigrants. Though in the countries of Central Europe we didn’t find any specific law regulations against foreign drug users, in several cities where the study took place there were police actions targeted at street users that drove mobile users away from the streets.

Mobile drug users hide. They hide from police, from citizens, and even from their compatriots. On the first stage contacts with them are possible only through outreach services, which target people in streets, flats and squats. But ‘double stigma’ adds to the mistrust of mobile drug users towards health providers and social workers.

Most of the respondents of the harm reduction services report that the most serious problem of addressing mobile drug users is their mistrust and their unwillingness to contact anyone from ‘official institutions’.

Here we come to another reason why mobile drug users are so hard to work with. As our study shows, mobile drug users in Central Europe are in majority people from the former Soviet Union and from Asia. In these regions harm reduction approach and low-threshold services are relatively new. Many drug users who live now in these countries are not informed that such services exist, and do not understand the real goals and methods of harm reduction. We should not expect mobile drug users to understand this as well.

One of the good examples of these information gaps is the situation in the streets of Prague. Subutex (buprenorphine) is on the black market there, and mobile drug users from Soviet Union are convinced that the substance is an illegal injecting drug. They know nothing about substitution treatment, and try to get it with Subutex.

Informing mobile drug users about risk reduction and services available is a challenge also because of the language barrier. To establish the first contact with them one has to understand and to be understood. There are some examples when Russian speakers are recruited by harm reduction services, and this makes it easier to drug users to 'stop to hide' and get involved.

## **Who are mobile drugs users in Central Europe**

Mobile drug users come to Central Europe from many countries, and the leading ones are Commonwealth of Independent States. In the streets of Prague, Bucharest, Krakow, Budapest, etc. one can meet many users from Russia, Ukraine, Moldova, Belarus, Caucasus, and Central Asia. Usually they are referred to as Russian, just because most of them speak Russian. People coming from Middle East – Afghanistan, Iraq, Iran and others, form another group. Vietnam, China and other countries of Asia also are drug users from Central Europe. For drug users of Western Europe, Central European countries are not so much attractive, and this correlates with global routes of migration which go from East to West and South to North. Harm reduction programs in the region do not report of contacts with American drug users

Mobile drug users usually gather in the capitals and border regions, but for example in Poland there is evidence that there are many of them in Lodz, which is neither a capital, nor a border city.

Together with 'ordinary' street mobile drug users we can talk about several additional groups of foreigners who use drugs: mobile sex-workers, inmates, rave scene/club drug users, people from border regions, and also drug users from Roma communities. Situation with these subgroups is described further on, because in practically every country the researchers focused on one of the specific subgroups.

# THE CZECH REPUBLIC

## The Czech Republic: Brief Description

In the Czech Republic, a country of 10 200 000 population, in 2003 there were 8522 drug users registered by public health institutions, but according to estimations the number of problem drug users reaches 32 600 people (*Station Regional Hygiene*). In the last few years, the number of IDUs has not been increasing and there has been increase in their average age.

After the revolution of 1989, borders opened and more drugs, besides the home production, appeared on the drug scene of the Czech Republic: heroin, party drugs, cocaine, and others. The Czech Republic has become, due to its central European location, an important transition country and a crossroads of drug paths. Therefore the majority of drugs in the Czech territory are not sold at the home market.

The most popular drugs are pervitine (metamphetamine), heroin and buprenorphine (*Subutex*). Two years ago *Subutex* was introduced as a drug for substitution treatment, besides the already established methadone. Contrary to methadone prescription is far less controlled, and *Subutex* entered black market in such a big amount that it almost replaced heroin. Cocaine is a drug of higher society in the CR, so it can be seen rarely on the street market. Often the drugs used are the so called party drugs - ecstasy, LSD, etc.

Drug use and possession for private use is legal, production and distribution is illegal with certain penalty from one to five years. In 2002 there were 4330 drug-related criminal offenses conducted in the Czech Republic (*Czech National Focal Point for Drugs & Drug Addiction*).

In total 662 HIV cases were registered in the country by 2003, 35 of them being related to drug injecting. 1 to 4 new cases among injecting drug users are annually registered (*National Health Institute*). Around 30% of injecting drug users are HCV positive.

Harm reduction programs have been established quite soon after the coming of democracy and operate almost in all big cities. Probably thanks to this fact, there is a relatively low prevalence of HIV and hepatitis C among injecting drug users.

Harm reduction approach in the country is based on needle-exchange and outreach programs, drop-in centers, and methadone / buprenorphine substitution treatment. Drug treatment system offers a variety of services – detox, rehabilitation, therapeutic community, and after-care centers.

## Methodology, data source

The study was conducted by SANANIM drop-in center in Prague. Main focus of the study was:

- Street drug users from countries of the NIS,
- Their problems and needs,
- Medical and social services, including harm reduction programs that can accept mobile drug users.

The following sources were used in the rapid assessment: official reports of *Station Regional Hygiene, National Health Institute, Ministry of Interior of the Czech Republic, Ministry of Justice, EMCDDA, International Organization for Migration*. A lot of support to get qualitative data was provided by organizations *Bliss without Risk* and *Podané ruce, Brno*. Qualitative data used in the study was also taken from interviews with drug users, mobile drug users, and staff of harm reduction programs.

Drug users were recruited in drop-center and, mainly, through street outreach services in Prague. Some mobile users were contacted with the help of drug users-volunteers.

Streams of mobility of drug users in and out the country were not studied in Poland because no reports of official services on this topic were available.

## Mobility in the Czech Republic

In recent years the Czech Republic has become an important crossroads of immigrants of different nationalities. For many of them it is only a transition country, from where they try to find a way further to the West. Nevertheless, recently there are more and more foreigners who stay long-term.

A lot of Russian-speaking foreigners, mostly Ukrainians, come to the Czech Republic as seasonal workers, without working permits, often being employed by

criminal structures. Many workers come to the Czech Republic also from Slovakia, which has strong historical links, and similar language to Czech. Today integration of Slovaks in the Czech Republic is, compared to other nations, less problematic.

One of the traditional immigrant communities are Vietnamese who has been working in the Czech Republic already during the communist era and many of them stayed. As the Russian-speaking foreigners do, the Vietnamese also form a very closed group, sometimes with strong links to international mafia and organized crime of all kinds.

The Czech Republic remains legally inaccessible for many foreigners due to its strict immigration policy, which starts to be more thoroughly asserted with the on-coming access to the EU. Although there have been no important changes in legislation, there is a remarkable trend of increased repression claimed by public authorities which can be seen more often in controls of personal documents of drug users and frequent swoops. Considering the fact that many immigrants live and work illegally, their mistrust of any institution, including non-governmental organizations, is increasing.

According to the *Ministry of Interior of the Czech Republic*, in 2002 1674 of foreigners entered the country. In the same year 1674 of foreigners were in prisons (*Ministry of Justice*).

There are several routes of migration to the Czech Republic:

- **Western Europe:** After the Velvet Revolution a big number of Germans started to come to the CR for holidays. They come for several days or weeks as tourists, and they may be involved in drug use and small-scale drug trafficking, but there is no data upon this issue. There are also a lot of tourists from the other EU countries and Britain.
- **Russia – Belarus – Poland – Czech Republic:** It's a route of legal migration from FSU. Most of the people who come this way have legal documents and permission for work, or a tourist visa. The majority of immigrants from FSU came to the CR in the end of 90s. They are not regarded as a vulnerable population by social services because most of them have passports, health insurance, and they know the language. The vulnerable group is the population of their children who for some (unknown) reasons have a greater risk to become drug users.
- **Russia – Ukraine – Slovakia – Czech Republic:** It's a route of illegal migration from FSU. Border control is not very strict between Ukraine and



Slovakia, and that's why individuals who are not able to get visa or permission to work often use this way. The biggest wave of migration was also in late 90s.

The places most attractive for mobile populations are the capital (Prague) and the border regions, for example the city Brno at the border with Slovakia.

## Mobile drug users in the Czech Republic

Drug use is not punishable in the Czech Republic. Also there is a very good access to harm reduction services, including needle exchange. Nevertheless, police very often monitors the open drug scene, and due to the fact that the immigration policy has been considerably tighten up the majority of mobile drug users are illegal in the country. Therefore, the movement on the street drug scene is not safe; risk of police control, arrestment and subsequent deportation home is very high. As a consequence of their illegal status, the mobile drug users have very problematic access to medical care (including substitution treatment) and social services.

According to the information coming from *Station Regional Hygiene*, there are 220 mobile drug users in the country. The mean age is 31, 76% - male. The actual number is definitely bigger, but hard to estimate.

Based on data coming from social workers involved in the study, several main groups of mobile drug users can be identified:

- Russian-speaking workers who work often illegally and seasonally in the Czech Republic form the first group. Many of them work for extremely low salaries and in absolutely inconvenient conditions. Some of them turn to using pervitine (metamphetamine) to be able to bear their hard work. This group of users is potentially very important for harm reduction projects because, with regard to their social situation, they could use a range of harm reduction services. They use mainly pervitine and heroin.
- Russian-speaking users also form the second group. They are often involved in criminal activities, drug dealing, organized crime, eventual contacts with the Russian 'mafia'. They appear mostly in game bars, casinos and clubs. It is very difficult to contact this group of users because they are socially secured and have therefore no need to use the services NGOs and public health can offer.. Probably the biggest problem NGOs have faced is the reservation of these groups of Russian-speaking users, caused by their legal statute in the Czech Republic, language barrier and ethnical specifics. Their drugs of choice are heroin and cocaine.

- A very unclear group form the users of Vietnamese nationality. It's known they exist; yet SANANIM has no information about them except that they deal with white heroin. However, they don't appeared on open drug scene.
- Slovaks form the fourth group of mobile drug users. SANANIM services contacted mainly occasional users who had come to the Czech Republic as season workers. They use to have quite a good background in their country, and they form a non-problematic group. The exception is if they have escaped from Slovakia because of legal problems. They are able to use services for drug users in the same extent as the native users do. They use mainly pervitine.

It's hard to say whether there is a big group of homeless mobile drug users in the Czech Republic. Harm reduction programs in Prague never had contacts with them in open drug scene sites.

*Bliss without risk* – organization working for sex-workers, reports that there are around 10 000 sex-workers in the country, 45% of them being foreigners, and 10% - mobile drug users. HIV prevalence among sex-workers is 0,7% in general, and around 1% among mobile users. In Prague the total number of sex-workers reaches 4 000, 20% of whom are mobile drug users. Mobile sex-workers come from Slovakia, Russia, Ukraine, Bulgaria. Most popular drugs are heroin and pervitine, which are used intravenously or snorted.

According to information of *Podané ruce, Brno* there are around 20 000 club drug users in the Czech Republic and approximately 2 000 of them are foreigners. For Prague the numbers are 6 000 and 1 000. Average age is around 20 years, 35% - female. The most usual countries of origin are Great Britain, Germany and Austria. Cannabis, ecstasy, and pervitine (amphetamine) are popular drugs among mobile club drug users.

## Prague

Prague is the capital of the Czech Republic with a population of 1 200 000 people. Over 2 000 000 of foreigners enter the city every year. There are 1549 registered drug users (*Station Regional Hygiene*), but according to the estimate of SANAMIM, the actual number is around 10 000. By 2003 354 cases of HIV were registered in the city, only 9 of them being related to injecting (*National Health*

*Institute*). *Station Regional Hygiene* reports of 380 drug overdoses in 2003, 5 of them among foreign drug users.

The outreach program of SANANIM realized most of the contacts with Russian-speaking users during 2001 - 2002. During 2003 they started to disappear slowly from the open drug scene. In autumn 2003 they vanished completely and today contacts with them are rather scarce. The reasons for the changes can be:

- The open drug scene started to be better monitored by the police, which was more of a danger for illegal immigrants, especially when the police directly targeted them. With regard to the character of criminal acts they commit they have become a very welcomed object for the police.
- The fact that *Subutex* appeared on the black market may be associated with decrease in interest in heroin. There also may be some connections with the events in Afghanistan when for some period of time there was a decrease of heroin in Europe, and in some places *Subutex* has replaced heroin very quickly.

All this influenced the situation with the open drug scene, and many clients who were in contact with outreach workers were arrested or deported. The others have left the open scene, and they stay hidden, acting in isolated, closed communities. Although considerable efforts to convince these clients of guaranteed anonymity and confidentiality were done, they often are afraid that harm reduction services cooperate with state institutions and are connected to law enforcement. Hence it is very difficult to contact them and above all gain from them the information needed.

Because of the low number of foreigners who come to the Contact Center, most of the research activities were carried out during outreach work with mobile drug users in open drug scene sites, above all places with the most numerous attendances of drug users.

A Russian native speaker has been employed as a part-time worker. Her mission was to reach Russian-speaking users among the already contacted clients of outreach program, and work with them. To contact Russian-speaking clients there were also invited external outreach workers, who were active drug users who cooperate with health and social professionals and who cover hidden drug scene with needle exchange and other basic services. They work mainly in drug users' flats and squats.

Another activity represents production of leaflets and comics with information about harm reduction in Russian language. Outreach workers and Contact Center staff have distributed these materials. Later, contacts with other organizations

providing similar services in Prague and other places in the Czech Republic were established.

From 1.10.2003 to 15.4.2004 SANANIM services (outreach and Contact Center) contacted 28 foreigners: 12 Russian-speaking, 2 Yugoslavians, one Bulgarian, one Moroccan, one Italian and 11 Slovaks. Mostly these were casual, unique contacts, except the contacts with Slovaks who used the services regularly. The total number of contacts was 174. The mostly used service was needle exchange program (559 changed needles).

## **Services for mobile drug users in Prague**

There are 5 outreach needle-exchange programs operating in Prague (SANANIM, Drop-in, HOST) and 2 drop-in centers (SANANIM, ESET). All these services can accept mobile drug users, and in SANANIM outreach program there is a Russian-speaking social worker.

There are 2 methadone and over 3 buprenorphine maintenance programs, and in theory they are available also for mobile users. Detox (3 programs) and after-care centers (2) can accept foreign drug users, but detox can be paid.

There also are several programs for sex-workers, run by *Host, La Strada, Rozkoš bez rizika (Bliss without Risk)* that have outreach, contact centers, medical help, testing, and mobile (bus) services; 2 programs for prisoners, and 1 program for club drug users.

## **CASE DESCRIPTIONS**

***Male drug user, 26 year old,  
born in Tbilisi (Georgia) in 1978***

He comes from Tbilisi. His mother died of cancer; his father is an alcoholic, with whom he has no contact. He came to the Czech Republic a year ago to find a job. He found it but lost it soon after. Then he met some drug users on the Main Railway Station and joined them.

Before coming to Prague he had been injecting heroin for three years. During this period he was infected with hepatitis C. Currently he uses buprenorphine (*Subutex*) which he tried for the first time in Prague. Since September 2003 he reduced the doses of Subutex from 8mg per day to 2mg per two days.

He stays illegally there in the Czech Republic and currently he is pending for a long-term visa with labor permit (for 1 year). He does not want to have problems with law and police, therefore his aim is to obtain all documents needed, find a job and a good living. Now he lives in the dormitory. He does not want to go back to Georgia but he would like to send there the money he earns for his 10-year-old sister. According to the latter information he obtained the documents and has a legal job.

***Ljuba, 19 years old, born in Moscow in 1985***

She lives in Prague since 2000. She moved to Prague with her parents when she was 15. Her parents are having some business there and they live all together in a rented flat.

When contacted she faced a very difficult family situation. Her partner was in prison for physical aggression and drug dealing. In June 2003 Ljuba gave birth to a girl, who was taken from her and placed in a children asylum. Ljuba demonstrated interest in treatment but she did not come to the individual contact arranged with her. Her main motivation for treatment is the effort to gain back her child; she has no other motivation concerning only herself. The contact with us was interrupted.

When she was 16 she met a 21-year-old Russian who was a drug user. She started to use heroin with him, intravenously. She had had no experience with drugs before. Since her partner was set free, they have been both using *Subutex*. The doses and

frequency are not known.

Since the contact with us was interrupted, Ljuba has used five times the needle exchange program and refused our effort for a dialogue. She did not want to talk neither about her parents nor the child. Ljuba spends most of her time in the community of older Russian-speaking men.

***Ludek, 47 year old,  
born in Leningrad (St. Petersburg) in 1957***

His mother is Russian, his father Czech, they met during university studies in Leningrad. When Ludek was 14, he moved with his parents to Prague. He has never been to Russia again and he lives in Prague.

Being 15 he started to smoke Cannabis, after a year he changed for pervitine (metamphetamine). Since 17 he has tried all kinds of drugs, including heroin and homemade opiates, cocaine and diluents. Since the age of 20 he spends most of his time among drug users, and after Revolution (1989) he has been in contact mostly with Russian-speaking drug users. For 10 years he occasionally makes pervitine at home, it is not known where he obtains the necessary substances. He produces it mainly for his own needs but partly sells it, too. He has been few times on treatment in centers all over the country but he always left it untimely. During the last 4 years he has been repeatedly on detoxification in a psychiatric hospital Bohnice in Prague. He is trying to stay on low doses.

He lives with his partner in a rented flat, already for 2 years. Often he uses the needle exchange program in the Contact Center SANANIM. He has no critical point of view on his own drug using and health condition, he lives with minimal social background and lives with the partner who is also a drug user. He receives social benefits and obtains further financial means from drug dealing. He has no contact with his family, he has been divorced for 10 years already and has a 20-year-old son with whom he has no contact, too.

He is infected with hepatitis type C, has ill-conditioned liver and heart arrhythmia. He uses no medicine and is not in care of any doctor.

***Igor, 33 years old, born in Ukraine in 1971***

Igor came to Prague 7 years ago. He left Ukraine because of a pending liability for service and a drug use. He used 'Khanka' - home-made opiate. After having come to Prague he had found a job and had stopped drug use for 8 months. Then he started to use drugs again, with a friend from Ukraine. He married an Ukrainian woman 5 years ago, who has never used any drugs. He met her in Prague; both of them have a long-term residence permit. In the recent 5 years, they have been 3 times in Ukraine, always only for a short visit to their families.

During his stay in the Czech Republic he has tried to quit drugs several times, yet without a long-term success. Igor has been using drugs already for 14 years. He has used 'Khanka' for 7 years in Ukraine, after coming to Prague he started to use heroin, sometimes buprenorphine. His maximal dose was 3,5g of heroin per day but he has been trying to reduce it slowly up to today's 1,5 g per day.

Currently, Igor lives on illegal activities which he did not want to specify. He lives with his wife in a rented flat. He is HIV negative.

Igor uses mainly the needle exchange programme. Few days ago he got into the substitution programme with *Subutex*.

# POLAND

## Poland: Brief Description

In Poland, a country with 38 654 000 population, in 2003 estimated number drug users is 30 000 – 71 000 (around 130 for 100 000), according to the *National bureau of drug prevention*. The same source says that in 2002 there were registered 9096 people who started drug treatment in hospital or therapeutic communities, and 5617 (61,8%) cases were new ones.

8491 HIV cases have been registered from the beginning of the epidemic in 1985 up to 31 December 2003. In 2003 661 new HIV cases were registered, 213 of them was being related to injecting drug use (*Polish Hygiene Institute*). According to the UNAIDS estimates of 2001, 15% to 50% of injecting drug users living in Warsaw are HIV-positive.

There are numerous services for drug users in Poland, if we compare it with the border countries. The most developed system of community drug-services is run by MONAR that first started to offer drug users community-based rehabilitation. Now MONAR has a wide range of services, including needle-exchange, outreach, drop-in centers, Subutex substitution, detox and after-care center in many cities. Methadone substitution treatment is also available in Poland. According to EMCDDA, 700 opiate users were on methadone substitution in Poland, which is 4% of problem drug users.

## Methodology, data source

The study implemented in Krakow, Poland was focused on three specific questions:

- Problems of mobile drug users,
- Medical and social services, including harm reduction programs, that can accept mobile drug users,
- National laws and policy related to refugees, drug use and mobile drug users.



The following sources were used in the rapid assessment: official reports of *National sanitation institute, Department of repatriation and foreigners, National Bureau for Drug Prevention, International Organization for Migration*, research data from *Institute of Psychiatry and Neurology, Jagiellonian University*.

Qualitative data used in the study was taken from numerous interviews with the staff of prisons, medical centers, drop-in centers in Poland, needle-exchange programs, and outreach projects for drug users and sex workers. Also, interviews of drug users, both native and foreigners, and drug dealers were conducted. Drug users were recruited for the interviews in open sites of needle-exchange, hospital yard for people living with HIV/AIDS, temporary prison in Krakow.

Streams of mobility of drug users in and out of the country were not studied in Poland because no reports of official services on this topic were available. Also, no statistical data related to HIV/AIDS, hepatitis and STIs were found.

## **Mobility in Poland**

Poland appears to be an attractive country to foreigners from all over the world. During 5 years (1998-2002) over 80 thousand visas were issued, and 97 thousand foreigners applied for the residence permit. The number of foreigners to whom decisions on expulsion were issued during the same period of time was about 45 thousand. 5 leading countries are Ukraine, Viet Nam, Russian Federation, Armenia, and Belarus – people coming from them to settle in Poland form more then 50% of all foreigners.

There is also a big wave of migration to Poland from Kazakhstan, because many ethnical Polish people were sent there during the repressive migration policy of the Soviet Union in the middle of the 20<sup>th</sup> century. Now Polish families are repatriated from Kazakhstan back to Poland. There are several programs of repatriation, and one of them is focused on young people so that they can enter universities of different cities in Poland. Though they know the language and many national traditions, and also get social and psychological support, they are the population at risk of drug use. Specific features of this group will be discussed later.

Illegal border crossing is widespread in Poland, though there is a decline in the number of foreigners apprehended by the Border Guard (5312 in 1997 vs. 3086 in 2002). The biggest groups are from Ukraine (3129 people from 1997 to 2002), Czech Republic (3044), Afghanistan (2605), Romania (2179) and Russia (1250) - *IOM*.

Official statistics says that there were 1173 foreigners among inmates on 31.12.2003. The largest group is Ukrainian - 434, the second group is Belarus - 146, Armenians - 84, Russians - 79. *International Organization for Migration* reports that in 1999, for example, of 1661 crimes committed by Ukrainians only 13 were related to drug dealing or drug possession.

Refugees and immigrants are entitled to medical care free of charge and social benefits if they stay in Poland legally and if they are legally employed (or run a registered business activity and pay contributions to the *Social Security Office*). The refugees are also entitled to free medical care during the process of job seeking performed through *Local Labor Offices*. The actual access of refugees to medical care is in fact hard to estimate. Some limitations can obviously derive from weak language skills and difficulties in communicating with the doctor, as well as from the necessity to become familiar with the structure and functioning of the Polish health care system.

Of course, the situation of people who entered Poland legally, like the majority of the migrants from the former USSR, and who have not prolonged their stay over the allowed limit, is far better than that of individuals who were trafficked in or overstayed their visas. They usually avoid using public medical care, fearing the discovery of their presence and the subsequent deportation to the country of origin; and they cannot often afford private medical service. Their situation is problematical, since, apart from the possible health and life danger of migrants themselves caused by developing diseases, they can also be carriers of very dangerous pathogens, e.g. tuberculosis, HIV and hepatitis.

## **Mobile drug users in Poland**

Though it was not possible to get official statistics or evaluation on how many drug users are among these thousands of foreigners in Poland, there is strong evidence that some Polish cities are popular among European drug users, in particular Warsaw and Lodz. In Krakow where the study has taken place foreign drug users do not form a big community.

During the study 50 drop-in centers all over Poland have been contacted to get information about the situation with mobile drug users, and 23 answers were

received. 21 of these drop-in centers answered that there should be foreign drug users in their cities, but they are hard or impossible to access.

Here is the number of mobile drug users who has contacted drop-in centers in 2003:

Leszno - 4 people

Zgorzelec - 2

Kamienna Góra - 2

Elbląg - 2

Gdańsk - 4

Białystok - 3

Wrocław - 3

Skoczów - 2

Zielona Góra – 3

These mobile got following services: street outreach, counseling, relegation to detox or other treatment (but that doesn't mean that treatment is provided, because there may have been no possibility of reception).

Social workers and health care providers name the following reasons for low access of mobile drug users to their services:

- No or low motivation
- Fear of deportation
- Fear that health care provider or social worker can warn the police
- Lack of knowledge about services and facilities for drug users and that they have access to it
- No medical insurance
- Language barrier
- Formal difficulties
- Distrust
- Lack of knowledge about the Polish health system
- Short period of stay in Poland
- Financial barrier
- Traverse of illness

## Lodz

Information about the situation with mobile drug users in Lodz comes from the clients of MONAR project in Krakow. There are no low-threshold services in Lodz, so it is not possible to find out details about situation there.

According to the observations of drug users, foreign users can be divided into several groups.

- Most of the young foreigners come to Lodz from the countries of the former Soviet Union to get work, and in the beginning they are often employed by small business. Later some of them begin to be involved in small-scale drug dealing, drug production, and other casual crime. A lot of people from this particular group of mobile drug users in Lodz start from amphetamine use, and later they begin to use street heroin. One of the reasons for this drug users see in a strong connection of amphetamine and heroin markets in Poland, which is not so strong in some other Eastern European countries. This kind of the development of drug career is among the main reasons why people lose their work, and become a part of drug-dealing system.
- In Lodz you can also meet some people who have come there as 'drug refugees'. They say that in their countries of origin drugs are of lower quality and more expensive, and drug policies are so repressive that big numbers of drug users get in prison just for their drug use or possession of small (for less than 0.05 grams of heroin in Russia) amount of drugs. These factors form their motivation to leave their cities and move to Lodz, as one of the cities not far from these Eastern European countries. Lodz is also attractive for this group of mobile drug users because of better quality of amphetamines and heroin, and lower prices. These mobile drug users usually are illegal immigrants, and they have double problems of illegal immigrant status and illegal drug use.
- A similar group of mobile drug users in Lodz are those drug users who came to Poland because they have 'problems with mafia' in their countries. It's hard to say for sure what problems they got and what they mean by 'mafia', but probably they have either borrowed money from criminal structures, or have been involved in drug dealing, which they decided to quit. Interviews with drug users in Russia support this idea.

- Foreigners who have been in rehab centers in Poland form the fourth group. Polish rehab centers of MONAR were widely discussed in mass media in Central and Eastern Europe, being described as effective and as a last hope for heavy drug user. This is why a lot of foreign drug users came to Poland with decision about to start rehabilitation. Many of them failed, and became street drug users in Poland. The others finished rehabilitation successfully, but soon started to use drugs again. Not many drug users from this group return to their countries of origin: many drug users lose their documents, or don't have money to travel, or have strong relationship or partners in Poland. In comparison to the other groups of mobile drug users in Lodz described above, they are more educated in terms of health risks of drug use, such as HIV, hepatitis and overdose, and at least know that social and medical services exist in Poland. Probably it would be easier to establish contact with this subgroup of foreign users if any harm reduction service start in Lodz and care about drug use and mobility.

Being illegal in Lodz, mobile drug users they do not have any access to HIV and HCV treatment. They are not accepted by detox programs, or any other medical facilities, which always require official registration and medical insurance. Because there are no needle-exchange or other harm reduction programs in Lodz, there are not social workers, which can help mobile drug users to get support and counseling and medical help if required. Absence of substitution treatment in Lodz adds to the risk of involvement in criminal activities such as drug trafficking and robbery, and there may be a big number of foreign drug users in prisons there, though the official data is missing.

As in the other countries and cities, female foreign drug users are often involved in sex work faced problem of STI, and double risk of HIV infection.

## **Krakow**

The population of Krakow is 890 000. In total in 2003 there were around 20 000 drug users (if pot smokers are included), among which there were 1500 – 3000 of problem drug users. 23 HIV cases have been registered in Krakow according to the data of *Polish Hygiene Institute*.

In 3 prisons in Krakow area now there are 28 foreigners, and police and prison authorities gave no data about their drug use status.

Most of mobile drug users in Krakow are in their late 20s or 30s. Typically, they are injecting opiate (heroin and/or home-made opium) users. Reasons to come to Poland usually are treatment, work and ethnical repatriation. They usually stay in Krakow for several years, mainly because of imprisonments. Foreign drug users prefer to keep together often rent a flat in the city, but sometimes they stay in a shelter or in squats.

As many of these drug users come from Ukraine where HIV prevalence among IDUs is extremely high, they may have HIV-positive status, and may require medical assistance, education and antiretroviral treatment. Though there are no statistics about number of HIV or HBV/HCV tests among foreigners, or positive cases, it's obvious that this problem should be addressed by health care system, and solutions should be found regarding HIV/hepatitis and related drug treatment of positive drug users.

## **Services for mobile drug users**

There is one street outreach project in Krakow, and it's run by MONAR/KPTU. It provides needle-exchange and counseling to drug users, and mobile drug users are accepted, though they are not typical clients of the project. MONAR/KPTU is the AC COMPANY partner for the research and work targeted to mobile drug users.

There are 5 drop-in centers in Krakow provided by 4 organizations, both non-governmental and governmental. The most popular among foreigners is housed by MONAR/KPTU. MONAR shelter for injecting drug users is available near Krakow, it's open in the evening and nights, and mobile drug users can stay for long period of time (months or even years).

There are 2 methadone substitution programs, one of them being in temporary prison and available for foreign inmates. Buprenorphine (Subutex) is also possible for foreigners, and can be prescribed by MONAR/KPTU psychiatrist.

There are also 2 detox, 3 rehab and 1 after-care center, which now do not accept mobile drug users.

## CASE DESCRIPTIONS

1. He's a 27-years-old man from Lvov, Ukraine. He's dependent from opiates since 1997. He says that he started to use drugs after an accident in which he had broken his backbone.

For the first time, he came to Poland in 1997, and after few months of stay he was deported back to Ukraine. In this time he used different name than now (in the fact he has changed his name 3 times, because of fear of deportation and passport problems on the board).

His second deportation was in 2002 from Spain, when he was in a therapeutic center for 2 months.

The purpose of his last visit in Poland was to start drug treatment. Also he had some health problems, and also problems with lung. The police caught him and gave him 3 days to leave Poland. He went back to Ukraine and after a few days returned again to Poland.

Now he had a high motivation to start therapy. After 3 days of telephone calls I found a place for him. They agree to accept him, a foreigner, with no health insurance and money to pay for treatment.

2. One drug user from Paris visited us [*Drop-in center of MONAR in Krakow*] and asked about possibility of getting methadone substitution treatment.

His father, a Polish citizen, died, and our client came for his funeral and to look after the heritage case. In Paris he is on substitution treatment. He took his medicine with himself but after few days it was obvious that there was a need to stay a few days longer than he supposed to. He came to our drop-in center. We sent him to hospital where he received subscription for methadone for 3 weeks. He had to pay for methadone.

3. Sasha is from Lvov, Ukraine where he lives with his wife and child. His mother and sister live here, in Krakow. He came to us because he is interested in starting substitution treatment, which is impossible in his country.

Sasha named many obstacles why he can't start treatment in Ukraine [*Recently methadone and other substitution treatment was illegal in Ukraine. Now a pilot program starts, but it's hard to say what the access will be to it and when it becomes large-scale*] He is an injecting drug user since 1997, and he never tried to go to treatment before. He doesn't have medical insurance but he claimed to be able to pay for methadone.

We prepared a visit to specialized hospital for him. After a contact with a psychiatrist he got a prescription for buprenorphine. At the last visit he said that he was going to Lvov for 3 weeks.

After he returned to Poland we saw him at an open drug scene site where he used the outreach needle-exchange program. Probably he still uses street heroin. The psychiatrist thinks that he is probably dealing with the buprenorphine he has got as substitution.

4. Sergey is a 26-years-old man from Belarus. He lives in Poland since 1996, where he came to study. His grandfather is Polish.

For the last 2 years he was in prison. After being released he came here [*Krakow*]. He doesn't have any plans for the future, but he is content that he has a possibility to contact someone in case of problems. He doesn't have any place to stay, and the only option for him is a MONAR shelter for injecting drug users near Krakow.

Recently the director of the shelter closed entry for foreigners, because of several incidents with the "Russian mafia". But after few conversations and a little pressure [*from social workers*] the shelter doors were opened for everyone. So Sergey lives there now. But the last days our clients said that he was caught by the police for robbery and was sent back to his country.



# LITHUANIA

## Lithuania: Brief Description

In Lithuania, a country with a population of 3.7 million, in 2001 medical services knew of around 4000 people who were registered by the mental health institutions as dependant drug users. There are no estimates based on surveys, but it seems that the actual number of injecting drug users is much bigger. The most popular drugs are cannabis, opiates (including home-made heroin), and there is evidence that stimulants use also spreads in big cities.

According to EMCDDA, HIV the prevalence increased to more than 1% among IDUs in 1997 but remained consistently below 5% until 2001. In 2001 the users of intravenous drugs among the newly diagnosed HIV cases accounted for 77.8 percent (72.3% in 2000). Among known persons infected with HBV in 2001, 42.4 percent were infected through injections of drugs and this transmission route accounted for 59.1% of all known infections with HCV

Drug treatment in Lithuania is provided in primary health care institutions and in 61 mental health centers (EMCDDA, 2002). In the big cities, Vilnius, Kaunas, Klaipeda, Šiauliai and Panevėžys, there are specialized centers or departments for the treatment of addiction-related diseases. These institutions provide drug addicts and their family the opportunity to consult doctors, social workers and in some cases psychologists, to give them information about dependency diseases and possibilities for treatment, either outpatient or in-patient detoxification.

In the treatment centers for addiction-related diseases in Vilnius, Kaunas, and Klaipeda, in the specialized department in Druskininkai and in Panevėžys, opiate users are able to get methadone, but access to this service is very limited.

## Methodology, data source

The study of mobile drug users was implemented in Vilnius, the capital of Lithuania on the basis of the *Vilnius Center of Addictions*. Brief situation analysis showed that there were no significant problems with 'classical' mobile drug users in Lithuania (illegal immigrants and drug tourists). At the same time, there is a big

Roma community that has moved to Lithuania 2 decades ago, and that has severe social and also drug-related problems. This is why the main focus of the study is:

- Roma community as a mobile population with drug-related problems
- Harm reduction programs to cover needs of this population

The statistical data used in the study is taken from reports of *Vilnius Center for Addictions, EMCDDA, IOM, CEEHRN*. All the qualitative data was collected through interviews with outreach workers, Lithuanian drug users union, drug users, staff of the needle-exchange program, police, and medical professionals of Vilnius. Interviews and focus groups with Roma drug users were done in a Roma settlement near Vilnius.

Streams of mobility of drug users in and out the country were not studied in Poland because no reports of official services on this topic were available. No statistical data related to HIV/AIDS, hepatitis and STIs among foreigners were found.

## Mobility in Lithuania

From July 1997 until 1 April 2002 Lithuania received just over 1,000 asylum applications. Since 2000, there has been a sharp increase in the number of these applications. At present, the majority of the persons applying for asylum in Lithuania come from the Chechen Republic of the Russian Federation (around 70%) and Afghanistan (around 22%), although there are also persons coming from India (2%) and Sri Lanka (2%) as well as other States (4%). - *ECRI*

The number of illegal migrants detained in the country dropped from approximately 1,600 in 1996 to 114 in 2002. In 2001 approximately one half of 107 illegal immigrants detained apprehended at Lithuanian borders were from Afghanistan (*Ministry of Foreign Affairs of the Republic of Lithuania, Information and Culture Department*).

Lithuania seems not to attract big numbers of foreigners, mostly because of economical reasons. According to the statistical data, **the problem of emigration from Lithuania is much more serious than immigration into the country**. For example, in 2002 114 illegal immigrants were arrested in 2002, while 4 724 Lithuanians were repatriated from other countries (mostly Britain, Germany, Sweden). Lots of women are trafficked annually to the Western countries from

Lithuania since it is also a transit country for women from Russia. There is no data on how many Lithuanians are involved into the sex trade abroad. In 1999 1928 people came back to Lithuania, in 2000 - almost twice as much - 3498 persons. Trafficking is organized by criminal international groups that are professionals in this field, promptly acting to any market changes (Y. Kalikov - ???).

Between Baltic States there is no visa regime, but migration is rather low. Most of migrants are businessmen. Estonia is less popular than Latvia. The social level there is a little bit higher than in Lithuania.

Local drug users used to go to Slovakia for rehabilitation. Some time ago they also used drug treatment services in Latvia (Riga).

Most of the immigrants came to the country during the Soviet period. At that time, high mobility was typical of all Soviet republics. Besides, Lithuania was situated at the Western borders of the USSR, so a lot of Russians were sent there with their families as militaries, and also as fleet staff. Today most of ethnic minorities living in Lithuania are families of those people who moved to the republic before 90s.

In general, we can talk about **Russian-speaking population** in Lithuania rather than about mobile populations. These are people with or without citizenship who know very little of the Lithuanian language, or don't speak it at all. Compared to the Russian-speaking minorities in the other Baltic States (Estonia and Latvia), they don't face severe discrimination and social exclusion, though in their daily life they can sometimes meet negative reactions from the ethnic Lithuanians.

Different communities of Roma form another big group of minority. For example in Vilnius there are 3 Roma communities: 2 of them have come to Lithuania during and even before Soviet period, and the third has moved from Belarus and Moldova in 90s. Specifics of the third Roma community will be described further.

There is also an evidence of relatively high migration from Belarus, and some 'organized' immigration from Chechnya. The biggest port in the country – Klaipėda – is potentially a place where a big number of foreign drug users could be seen, but Klaipėda harm reduction services do not report about foreign clients (even among

sex workers). There also may be some migration in the border regions (with Belarus) but no official data or research is available.

### **Mobile drug users in Lithuania**

Mobile drug users do not form a big population in Lithuania. Labor market, social and economic situation, together with drug policy and drug market of Lithuania doesn't make the country attractive to drug tourists and illegal immigrants who are usually the most obvious mobile drug users. At the same time there is a number of ethnical groups that are not usually regarded as 'classical' mobile drug users, but in Lithuania there are specific social problems that make them more vulnerable to drug-related problems than the general population. The groups are: Roma/Gipsy and 'Russian-speakers'.

## **Roma**

According to official estimates, there are about 3,000 Roma/Gypsies in Lithuania. Although Roma/Gypsies live in different parts of Lithuania, the biggest community lives in Kirtimai, a neighborhood in the outskirts of Vilnius. As is the case of many other European countries, the Roma of Lithuania face prejudice, disadvantage and discrimination in many areas of life, spanning from education to employment, housing, health, access to services, access to citizenship and relations with the police. These areas are analyzed in more detail below.

The health situation of the members of the Roma/Gypsy communities also testifies to their generally disadvantaged situation. Such disadvantage is linked to several factors such as poverty and unhealthy living conditions, but also reflects, in some cases, prejudice on the part of those providing the service. All inhabitants of Lithuania are covered by obligatory employer health insurance or, in case of unemployment, by the state health care system, free of charge. However many unemployed Roma/Gypsies are not registered at the state labor exchange offices and thus, with the exception of children, cannot avail themselves of the state health service free of charge, except for emergency situations. Health conditions among the Roma population are markedly worse than among the majority. Although no official statistics are available, there is an evidence of higher incidence of digestive and respiratory diseases, including tuberculosis, among Roma/Gypsies than among the population at large, and a lower life expectancy. ECRI notes that some national health programs - such as those addressing AIDS, sexually transmitted diseases,

drug dependency, and national tuberculosis - explicitly target vulnerable groups, including Roma/Gypsies.

It is also possible to meet mobile sex-workers who use drugs in Lithuania. Unfortunately, we reached neither sex-workers nor experts to assess the situation with them. AIDS has been indicated as one of the reasons for women's migration, trafficking in women and sex-work indicated by mobile sex-workers from Kaliningrad (*IOM*).

## Vilnius

In total there are 1500 registered problem drug users. There are no estimates based on surveys.

### Services for mobile drug users

- *Vilnius Center for addictions:*

**Detoxification** is free only for the citizens of Vilnius. There is a possibility for other drug users to get the service with the help of *Blue bus* social workers. Some of Roma drug users use this service.

**Methadone program** is a high threshold service. There are 4 potential mobile clients –Armenian, Georgian, 2 from Ukraine. A few years ago methadone substitution was available for Roma drug users.

**Blue bus** – a mobile needle-exchange program. Works in 3 places: Roma tabor, railway station, one street heroin spot. They provide needle-exchange, medicine distribution, counseling, social assistance. Social workers speak Russian.

- **Demetra** is operated by *Vilnius AIDS laboratory*. It provides HIV prevention among sex-workers: outreach, counseling, HIV and STI treatment. There is no information about big numbers of foreigners among sex-workers.

There are no drop-in centers or shelters for drug users.

## Roma community and drug use

People living in the community are the main providers of self-made opium for Vilnius. Opium production is the main source of income for most of the families.

As they live in the suburbs in a small village, no services and drug stores are available. Most of the inhabitants are illiterate. They speak some Russian and almost no Lithuanian. Most of them have no papers. At the first sight, their condition of health is poor (flegmonas, abscesses, etc).

There are so called *slaves* - Lithuanian opiate users who have no money for drugs and prefer to stay with tabor and become unpaid workers. For their work they get drugs for free. They usually loose contacts with the outer world and are hard to access by social services.

Drug use is widely spread among males. There is no exact information about injecting practices, but the Roma are not very much informed about HIV prevention and safer injection rules. One of the main threats is that in the process of opium preparation blood-borne viruses can be easily transmitted to big quantities of opium solution. There is a rather complicated procedure on how to get the solution clean. But usually opium is used outside, near the village, where this procedure is hard to be implemented; so drug users are at high risk of getting infected.

**Blue bus** – an outreach / needle-exchange project - does not work directly with Roma community. They focus on people who come to the tabor to get drugs. They do not like to give big numbers of syringes to Roma because equipment is often re-sold to IDUs for high prices. A special intervention is needed to organize real prevention work with the community. Outreach workers agree with this idea, though they still have some stigmatic perception of Roma as clients.

There is an experience of methadone substitution for Roma people. It all stopped because of problems of control over the process of methadone prescription and possibility that methadone may come to black market. The director of the Vilnius Center for Addictions is open to have a new attempt.

## Results of the focus group on the Roma community

Almost anyone in the encampment has no work and there is no possibility to find work for person of gypsy nationality. That is why most of the families in the community have no real sources of income. Usually there are 3 to 8 children in the family and quite often the family lives in one room with the kitchen. But in case city government offers a possibility to move to live into apartment houses, it would be very problematic for gypsy families because of lack of money to pay for services.

There have been a few projects to support integration of gypsies into the Lithuanian society, but unemployment has been and remains the main problem.

The other problem is behavior of police officers. From time to time they do searches in houses and incriminate drug dealers without well-grounded evidence (for example one of the respondents told that not long ago police had arrested one of the gypsies after they found a bottle with traces of home made heroin in the rubbish container near his house). The police officers write the reports about searches and arrest on Lithuanian language, but most of the gypsies are Russian speaking and don't understand Lithuanian language. And many are illiterate. Interlocutors don't want to talk about drug use in their community – just said that there were some inhabitants that use drugs. Some drug users undergo detoxification – someone in the hospitals in Lithuania, someone (that have money) travel to Russia for treatment and at a moment don't use drugs for 4-5 years.

Respondents also talked very unwillingly about migration to other countries – just said, that some people traveled abroad.

Two big problems were solved during the last few years: many inhabitants of gypsy nationality got Lithuanian passport or permission to live in Lithuania, and most houses in the gypsy encampment got numbers.

## Interview with a drug user

The Roma community at a moment is the biggest and almost the main homemade opiates dealing center in Vilnius. Majority of young gypsies have no profession and skills, and they only know how to make drugs from dry poppies and sell it. Older Roma say, that youngsters don't know how to tell fortune (traditional job for women) or to steal.

Around 1995, there were quite many gypsies that used drugs and were dealers, but during the last few years many of them traveled to Moscow or St. Petersburg and underwent treatment.

It is quite common that Roma people are migrating from one part of Lithuania to another, but migration to other countries among dealers is not usual. Still, not long time ago part of one of Roma community repatriated to the Russia.

## Group interview with 2 police officers

*Policemen asked not to indicate their names*

In Vilnius there are 3 gypsy encampments. They differ from each other by religious beliefs (for example orthodox, catholic). There are about 60 houses and about 200 people that live in those encampments all the time. About 300 more are migrating. Most of them are migrating inside Lithuania (from one part of the country to another) and only about 10% of those 300 are migrating to the Russian region of Kaliningrad.

After 1990 gypsies were drawing in to the drug making from dry poppy and dealing. The main drug in the gypsy encampment is home made opiates from dry poppy. And it is very low possibility, that they will deal other drugs (for example heroin). And it can be said, that gypsy encampment is the main point of home made heroin dealing in Vilnius

In most cases the main dealers are women (in 7 cases out of ten 10, because traditionally in gypsy encampments women are working and bringing money and men "count money"). Usually women have several children (3 – 4 and more) and earn money. Because of that very often courts don't look very strictly to their



offence. The majority of people that live in the gypsy encampment were several on trial because of drug usage, storage or dealing. The migrating part of gypsies in encampment in most cases had problems because of drugs with police too. The reason for migration very often are the problems with the police – escape from court, imprisonment and so on. Quite often gypsies are coming to the Vilnius gypsy encampment because there is possibility to get money.

Only about 10-15% of dealers (that are gypsy nationality) use drugs. About 30% of gypsies of the Vilnius gypsy encampment are drug users.

There is part of inhabitants of gypsy encampment that are not gypsies. They are in 98% of cases - drug users. They often have no documents, money for living or drugs and are working here – making some job for gypsies and get drugs for that.

Dry poppies come from Lithuania or from Ukraine. There is unofficial data that drugs from dry poppy usually are made not in Vilnius encampment, but in other parts of Lithuania (the smell that appears while producing drugs from dry poppy is quite strong and specific). Some danger of spreading infectious diseases comes from the process of dividing the drug – to prepare the doses the dealer is using one big syringe.

## **Interview with a general practitioner in Naujininkai clinic**

There are about 200 adult persons of gypsy nationality registered that get medical services in the Naujininkai polyclinic. About 80% of them are women (because by Lithuanian law if a woman have 3 or more children, it is a large family and the women are automatically medically insured).

Many inhabitants of the gypsy encampment have no social and medical insurance and because of that they must pay for medical services except urgent medical help. They have no job, can find no job and have no motivation to register in the services for unemployment –,they can get there only medicines, but no money (by law –to get money as an unemployment, one must have a certain total work record).

Doctors show the data about adult persons of gypsy nationality that have no medical insurance but get medical services without payment in the Naujininkai polyclinic. There were about 200 of such persons every year (from 2000 till 2003). They tell that quite often persons of gypsy nationality want to get invalidity, because they can't find work or don't want to work.

Most patients of gypsy nationality, even if they can get a consultation from a doctor and a prescription of medicine without payment, very often don't buy medicine (mainly because of financial problems) or don't use it according to the prescription.

Part of Vilnius gypsy encampment inhabitants goes from time to time from a part of Lithuania to another. Only few of them sometimes are going to Russia – doctors tell, that they remember only 2 or 3 such cases, when women goes to Moscow to earn money (by tell fortunes).

# SLOVAKIA

## Slovakia: brief description

Slovakia is a country of 5 400 000 population. Public health services report of 7 000 problem drug users, but according to estimates the number of drug users is around 10 000. Most popular drugs are heroin, homemade opiates and pervitine.

Slovakia experienced a rapid increase in drug use in the early 1990's. This increase was especially noticeable in the capital Bratislava. The drugs of choice shifted from solvents, hypnotics and sedatives to injected heroin during this time period. Drug use is increasing partly because of a transition from a state directed economy. The social transition was not prepared to handle the spread of illegal drugs. Defense mechanisms were not in place at regional and municipal levels. Drug use is especially increasing among young people. The number of children born from heroin dependant mothers is increasing.

By June 2003 180 HIV cases were registered in Slovakia, and only 2 cases of HIV were related to injecting drug use (*EuroHIV*). According to estimations, in some cities HCV prevalence among drug users is about 60% (*Drug Policy Alliance*).

There are several harm reduction programs operating in Slovakia; they offer outreach, needle-exchange, counseling and testing. There also are programs targeted at sex-workers and ethnic minorities (Roma) who use drugs. Drop-in centers and night shelters are not available. Detox and rehabilitation are available through governmental institution. Methadone and buprenorphine substitution treatment is also possible, but rather limited: in 2001 only 100 of heavy heroin users were in methadone treatment.

## Methodology, data source

The study of drug use and mobility was provided by ODYSEUS, a harm reduction NGO working with injecting drug users and sex-workers. As ODYSEUS doesn't have contacts with mobile drug users, the study was focused on the following questions:

- Slovak drug users who travel to other European countries,
- Their experiences, problems and needs.

A structured interview was designed to explore these issues. Outreach workers of ODYSEUS conducted interviews, and drug users were recruited through outreach/needle-exchange programs.

Information about drug use and migration was taken from reports of *EuroHIV*, *Drug Policy Alliance* and *IOM*.

## Migration in Slovakia

In the context of European mobility, Slovakia is a transit country. People from South and East pass it on their ways from the countries of the former Soviet Union. Relatively weak border control made it easy for illegal immigrants to travel from the countries of their origin (most often Ukraine, Belarus and Moldova) to Western European countries. The situation is changing, because as Slovakia is a candidate state to enter European Union, the border control is enforced, and illegal border crossing in and out the country becomes more difficult.

According to data of *International Organization for Migration*, the major raise in Slovak migration was in 1992-1993 when a total number of immigrants and emigrants exceeded 20 000 people a year. Now the number of migrants is times less, but the amount of *irregular* migrants proportionally grew during the recent years.

The most popular countries of immigration to Slovakia during the last 10 years are the Czech Republic, Ukraine, Yugoslavia; from Slovakia – the Czech Republic, Germany, Austria.

There is a big number of undocumented migrants in Slovakia: in 2002 thousands of people from Afghanistan, China, India, Iraq, Russia, Moldova, Poland and Vietnam tried to cross the Slovak border.

In 2002 number of prosecuted foreigners was 687 (1,5% of all prosecuted persons). At the same time migrants form 8% of all prosecuted people for crimes related to drugs trafficking.

The migrants are also HIV-tested in refugee centers. Although the absolute numbers are low, the incidence of HIV positive migrants in the total new cases of HIV on the country in the last years is remarkable: for example in 2002 total number of new cases was 22, migrants – 9 (40,9%).

## **Slovak mobile drug users**

For drug users in Slovakia there are most popular destinations for going abroad: Austria and the Czech Republic. The capital of Austria – Vienna – is only several hours from Bratislava. Many Slovaks go weekly to Vienna for shopping, work, and studies. There is a big number of students who prefer to get an education in Austrian universities, and there may be a proportion of drug users among them.

The second destination – the Czech Republic – is so popular also because of traditional links between the two countries. For years it has been one state, languages are similar, and among Czech people attitudes to Slovaks are very tolerant. This route of migration goes through the Czech city of Brno where mobile drug users can use harm reduction services.

The most important reason for this migration is to have a job opportunity. As Slovak economy is still in a weaker situation than the ones of Austria and Czech Republic, the problem of unemployment is more serious here.

The other reason of migration is tourism – drug users go to West and North for vacations and just to spend their free time. In this respect, the Netherlands is a very popular country among Slovak drug users. The period spent abroad is usually not longer than one month.

The study showed that 6 users out of 13 approached do **not** use drugs abroad, because they feel fear of police or they want to take a rest from the “cycle of drug-hunting”.

Slovak drug users abroad are usually not in contact with medical and social institutions and services. The reason is mainly the distrust they acquired by the experience of contact with Slovak institutions. It is not exception that the only trustworthy caseworker for them is the outreach worker.

## Bratislava

The capital of Slovakia - Bratislava is a city with a population of 500 000, around 4 000 of them being registered as problem drug users.

There are 2 NGOs working directly with users and offering harm reduction services: ODYSEUS and *Prima*. There are 2 outreach/needle-exchange programs, and no drop-in centres in the city. There are also programs for sex-workers and ethnic minorities, provided by these NGOs.

Methadone substitution is provided by a governmental clinic, and mobile drug users can get into a program, but they have to pay. Buprenorphine is also possible for money. There are also 4 detox centres, and a governmental rehabilitation program, that is also required by foreign drug users.

During the study ODYSEUS started to provide counselling for Slovak drug users that are going to other countries. Consultations are aimed to:

- Provide the clients with information on harm reduction and drug treatment institutions and available services in different European country (including title, address, phone number and working hours). The contacts are available for them also in a written form.
- More detailed information about services with strong recommendations to use them, especially services which are not available in the Slovak republic like drop-in centres, shelters, etc.
- Prevention of human trafficking and recommendations what to do in the case a person is trafficked. The information is also in written form including the contacts of organizations, which can be helpful.

ODYSEUS also uses monthly magazine INTOXI, where they put profiles of different organizations working abroad in the field of drug use and sex work.

According to the interviews with Slovak injecting drug users, some tendencies can be figured out:

- The European destination of migration of Slovak drug users includes Germany, Poland, Belgium, the Netherlands, Switzerland, Austria, and Denmark.

- Reasons for migration are vacations, raising money, going with the family/friends, tourism, and sex-work.
- Drugs that are *injected* abroad are heroin, homemade opium, cocaine, pervitine, and amphetamines.
- Drugs used by other routes of administration (*snorting, swallowing, smoking*) are cannabis, MDMA, heroin, cocaine, pervitine, and amphetamines.
- Drugs are usually bought with the help of local/mobile drug users.
- Drugs are often used in public buildings, flats of other drug users, streets, parks, squats, and in clubs.
- Drugs are most often used together with the mobile drug users from the same country of origin.
- Needles and syringes are either bought in pharmacies, or taken from other drug users; several drug users reported of needle-sharing during their stay in foreign countries.
- Slovaks don't usually use services for drug users: methadone / buprenorphine substitution, needle-exchange, drop-in centres and detox/rehabilitation services.

One of the question of the interview was “What kind of services or assistance would you like to get when travelling?” Here are a few ideas of Slovak drug users about services needed for mobile drug users in Europe:

- Needle-exchange programs
- Drop-in centres – in the centre of a city
- Counselling – for example, what to do if one loses his documents
- Providing of legal information (drug laws, immigration policy) specific for the country of stay
- “Services-under-one-roof” – including night shelters, food, medical professionals

All services are expected to be confidential, transparent (known to travelling drug users) and should have a mediator talking the Slovak language.

## Case descriptions

### ***Male, 17 years, from Bratislava (Slovakia)***

The user got into contact with us through his uncle he lived with after he returned from *Reedukačného centra pre mládež* (Re-educational centre for juvenile). He does not live permanently in Bratislava, therefore the contact with him is irregular. He usually shows up once in 3 months.

He started to use heroine when he was 9 years old. He tried homemade opium, methadone, amphetamines, pervitine, cocaine, ecstasy, LSD – everything between the age of 12 and 17. With the help of methadone obtained with by his uncle from black market he wanted to stop using drugs. He has two treatment attempts - once in mid-term in-patient programme, and being for 3 week a client of substitution program (subutex). Currently he uses heroine and pervitine.

He was 3 times abroad. In 1999 he left with his uncle to Austria and in 2002 to Germany. In both countries the source of his income was theft. In 2003 he went with his mother to Italy. Mother's ambition was that he stopped to use drugs. But at this time he wasn't interested to stop, so he was using the drugs secretly.

He regularly visits NEP and the program for syphilis anti-bodies tests. He seeks contact with the staff of Odyseus. Personally he is very open, likes to talk. He misses the social contact with non-using people. As he is in the adolescence period he speaks a lot about the relationships and fears from his own future.

### ***Female, 35 years, Slovensko, Bratislava***

The client is in contact with the outreach project for 9 months. In the beginning she is very communicative. After half-year from the contact she was diagnosed with syphilis in one service of our projects. She despatched syphilis treatment independently. At this time she started to avoid contacts with outreach workers. After a period of two months she became open to contacts with outreach workers. Currently there is a strong suspicion that she has serious psychiatric problems – delusions and she now bounds strongly with one of the (female) outreach worker.

She started to use drugs in the age of 22 in Italy. In this time she tried heroine, cocaine and marihuana. Currently she uses benzodiazepines. She never injects drugs. She considers changes in her life – to quit drugs, to return to Italy and to stop



to work in sex-business.

In 1992-1998 she was abroad. She lived in Italy, the country she always wanted to go. The country and the mentality of people living there always attracted her. Her expectations have been fulfilled. She was spellbound by the country and she got to know many friends (she would like to return to them). She worked in Italy as hostess in bars – she took care of guests and increased their expenses in the bar.

Currently she is in regular contact with the outreach workers, visits NEP. She contributes to magazine INTOXI with her poems and comments for improvement of the magazine content. In past she was regularly tested for syphilis anti-bodies, but as she passed the treatment in last months there is no reason to test her for anti-bodies these days. She regularly visits the club “Podchod” which is targeted to female sex workers with the aim to support the self-help of the women. In the club she is active and helps with the decorations.

***Male, 26 years, Slovensko, Puchov***

9 months ago in the city Puchov was established a branch of Odysseus – needle-exchange at flats of drug users. The impulse came from drug users. The man is one of the very first users we established the contact. After 3 months of program’s work he became an employer of the project.

His drug carrier started when he was 15 years old. In the age 15-16 he tried heroine, homemade opium, pervitine, MDMA, ecstasy and marihuana. Currently he uses pervitine and marihuana, occasionally ecstasy. His pervitine use is under control.

Since 1996 he travels regularly to Austria for the purpose of work. In 1998 he spend 2 weeks in the Netherlands for vacation. In 1999 with friends from the hometown he travelled to Italy for 2 months, where he also worked. In Italy he got infected with hepatitis C via commonly shared injecting equipment. After his return he was diagnosed as HCV+ in the hygienic centre. Now he has finished interferon treatment and is waiting for the results (if his health status regarding HCV gets better). He travels regularly to the Czech Republic– Puchov is less than 50 km from the Czech border.

In the needle-exchange program his duties are to provide needle-exchange at the flats and to participate at working and educational meetings. He perceives his

involvement in the project very positively He kept long time aloof from contact with people, because he felt guilty, that they got HCV from him. By working in the project he's regaining the self-respect. He stopped keeping aloof from friends, found work and also increased his own interest about his health.

## ROMANIA

### Romania: brief description

Romania is a country of 22 456 000 population. According to the data of *UNICEF* there about 30 000 of problem drug users in the country, but estimations of local NGO are twice as big – 60 000 (2004). The year of 1999 was noted for an increase in drug use Heroin users form 93% of all illegal drug users, and other popular drugs are amphetamine, ecstasy and cannabis (*EMCDDA*).

Drug use is illegal in Romania, and if an illegal drug is consumed in public, one can be sentenced to prison. By 01/01/2004 there were 3400 of drug users in Romanian prisons.

According to the national *Ministry of Health*, 5920 HIV cases have been registered (end 2003). *World bank* assumes that the estimated number of PLWHA may be 5 – 10 times more. The role of drug injecting route of transmission is hard to measure: according to different sources proportion of drug users among PLWHA is from 0,2% (*USAID*) to 10% (*ALIAT*).

Harm reduction services started to operate in 1999, and from 2001 this approach got governmental support in Romania. In the *HIV/AIDS National Strategy* several components are planned: needle-exchange, substitution treatment, counseling, centers of support, and educational programs for drug users. In the proposal for *Global Fund* there is information about 7 needle-exchange programs all over the country. Substitution treatment is not highly available; the program is only in Bucharest, high-threshold, methadone pills only.

## Methodology and data source

Information was collected by ALIAT – a harm reduction organization operating in Bucharest. The main focus of the research was:

- Situation with mobile drug users in Bucharest
- Routes of migration from Romania
- Problems of Romanian drug users in other European countries

## Migration in Romania

Romania is an important transition country of the Central Europe. Routes of migration from CIS, Middle East, and Southern-Eastern Asia join here. Romanian Department of Customs reports of 1 100 000 of foreigners who entered the country in 2003.

Roma people are not regarded as a mobile population in Romania. They became naturalized population of the country in the 17<sup>th</sup> – 18<sup>th</sup> century. Before the 2<sup>nd</sup> world war they lived in communities determined by jobs. Some of them had documents and the others were not official citizens. During the 2<sup>nd</sup> world war they disappeared, and after that they came back, and more of them that left. During the Soviet time they were in a good position, and they were doing underground business. They were trafficking gold and firths and leather. Communists tried to gather them in groups to have a better control.

## Mobile drug users

For mobile drug users the most attractive place in Romania is the capital - Bucharest. That's why data presented in this chapter is typical for the whole country, though it is based on observations of NGOs working in the capital.

According to the findings and observations of *ALIAT*, there may be around 800 of mobile injecting drug users. Approximately 50% of them stay in Romania for long period of time (years), 40% stay during several months, and only 10% of mobile drug users pass the country on their way to other European countries. The reasons for migration are transit to the West, employment, sometime – tourism.

Most of mobile drug users are male (72%), and 90% is between 18 – 35 year old. Around 7% are students. National background of mobile drug users is various. For

example there are big communities of Chinese and Arab injecting drug users in Bucharest.

95% of mobile drug users use heroin, and 90% of them inject. Estimated proportion of homeless is 15%, and 70% of mobile drug users are involved into different criminal activities.

Sex-workers form a small group of mobile drug users. They come from the Republic of Moldova, Albania, Ukraine, China, and Middle East. In general there are more than 10 000 of sex-workers in Romania, 20% of them being injecting drug users. There are less than 5% of foreigners among them.

In Bucharest the total number of sex-workers is approximately 5 000 people, and around 30% of them use injecting drugs. According to the estimates of *ALIAT* the number of mobile sex-workers/IDUs in the capital is around 100 people.

Club drug users are a small group in Romania. According to the information of *ALIAT* in Bucharest around 700 people use club drugs, and only 7% of them are foreigners, who come from Bulgaria and Hungary. Their mean age is 17 years, 40% females. The most common drug is ecstasy.

Though Roma people of this country are not mobile, they are one of the most vulnerable populations in Romania. Official number of Roma population in Romania is 535 250 (end of 2003), but Roma organizations give another number – 1,2 – 2 million people.

Before 1994 heroin traffic from Asia to Europe was *Middle East – Turkey - Yugoslavia – Western Europe*. After 1994 it changed greatly: *Middle East – Turkey – Romania – Hungary - Western Europe* and *Middle East – Turkey – Balkans – Slovenia – Italy*. That is how Romania became one of the countries on the heroin transit way.

For some historical and social reasons, Roma were one of first main groups that transported heroin from Turkey to Hungarian borders through Romania. One of the first population affected by injecting heroin use were their children.

Now some of Roma are still involved into drug trafficking, and many drug users among them. They also form one of Romanian population of drug users that move *from* Romania to the Western countries. Priority countries are Germany and Northern Europe, like Sweden and the Netherlands. In general, Roma are more willing to go to the Western Europe than other people living in Romania.

## **Services available for mobile drug users in Bucharest**

There are 2 outreach projects operating Bucharest: *ALIAT* and *ARAS*. They provide counseling and needle-exchange, mobile needle-exchange. Registration for clients is anonymous, and the ALIAT project is also targeted at mobile drug users as a specific target group. ALIAT also works in places where Chinese and Arab immigrants gather. *CRISS* – a community-based Roma organization in 2003 started collaboration with ALIAT as a social program for drug users.

In Bucharest 2 organizations offer drop-in centers for drug users: *ALIAT* and *Open doors*. Drop-in centers provide needles and other safer injection paraphernalia, HIV, HBV and HCV testing, HBV vaccination. Drop-in centers accept mobile drug users. Registration is also anonymous.

There is methadone maintenance program *LSM4*. Substitution treatment can be offered to mobile clients, but in general access to the service is rather low. Buprenorphine as substitution is not available at all. Detox is available in all psychiatric hospitals, and can be provided to immigrants. There are no after-care centers or other options of drug treatment at Bucharest.

Harm reduction programs for inmates, ethnical minorities or club drug users are not available in the city.

## **Romanian mobile drug users**

During the study of AC COMPANY 23 interviews with Romanian drug users were taken at ALIAT drop-in center in Bucharest. The main focus was routes of migration of drug users from Romania, their risky behavior, problems and need.

Most popular places of visit of drug users from Romania were Italy, Hungary, and Turkey. The other countries of visits were Greece, Austria, Spain, France, Germany and the Czech Republic. The main reason for migration was employment, especially for going to Turkey, Hungary and Italy. Tourism, visit to friends/relatives and immigration were also mentioned.

All of respondents were injecting heroin users and clients of the needle-exchange program and drop-in center in Bucharest. Traveling abroad they also used mainly heroin by injection (also home-made opiates in Turkey). Only one of respondents reported that he had *smoked* heroin. Drugs were usually got with the help of other drug users, both native and mobile ones.

Respondents told that they got new needles and syringes most often from others drug users; pharmacies were not mentioned the most usual source of new injecting equipment. Several respondents mention that they shared needles and syringes with their friends, and disinfected them either with bleach or alcohol.

Only 3 of 23 drug users said that they had used needle-exchange services during their visits. Substitution treatment, detox, drop-in centers, and social/medical assistance programs were not used.

The most difficult problems were related to law enforcement structures. When one of the users was asked about his main problem during his last visit to Europe, he answered: "Constant fear of police".

Romanian drug users that took part in this small survey suggest that the following services should be available for mobile drug users in Europe:

- Needle-exchange programs,
- Injecting,
- Night shelters,
- Laundry,
- Social assistance (including employment),
- Assistance in prisons,
- "Language mediators".

# **Special report ESTONIA:**

## **SEX-WORK AND MOBILITY**

*This part has been prepared by Yuri Kalikov and is dedicated to the problem of mobile sex-workers in Estonia. It gives understanding of the situation with sex-work in Estonia, involvement of mobile communities, and drug use among other problems of mobile sex-workers in the country. It also gives historical overview of the problem of sex-work in Estonia.*

### **Overview of developing prostitution and sex business in Estonia since 1991, estimation of the number of SW**

After the collapse of the Soviet Union, unforeseen opportunities for all sorts of activities opened for the people of Estonia. The beginning of the 1990s saw the commencement of the first undertakings offering sexual services in rented apartments. Such undertakings offered services on the premises or the possibility to order girls by phone to hotel rooms, to private parties etc.

Uncontrolled sex business activities were at their peak in 1994-1995 and started to decrease in 1996, that was related to the changes in legislation, formation of a more stable market and changes in the public opinion towards the more negative. Also, small companies and undertakings ran out of business and prostitutes had to relocate into hotels, saunas, night clubs and other businesses that officially had other purposes.

The phenomenon has mainly disappeared from the public arena and has been linked to the criminal world. Prostitution and sex business tend to be financed, controlled and regulated by organized criminal structures, with the help of corrupt officials; this makes it difficult to identify the houses that accommodate such undertakings. Sex workers do not reveal much of the background of their jobs. Classical forms of prostitution combine with the other forms of the sex business, to such an extent that it is often impossible to draw clear lines between prostitution and such activities as escort services, strip-tease bars, and premises providing different types of erotic massage and erotic and pornographic magazines and films.

Also, changes in the geography of the service occurred. The sex business is now firmly located in Tallinn, other big cities (Tartu) and holiday or summer resorts (Pärnu, Haapsalu) where there are more wealthy clients (tourists, foreigners). Prostitution has crossed the borders of Estonia, with the numbers of girls searching for a better income abroad.

The exact number of brothels and sex service firms and the number of women employed are very difficult to estimate because the situation changes daily. Today, there are approximately 50 - 70 brothels in Tallinn and a few in the other major cities (Narva, Pärnu - summer resort, Tartu). Between 5 and 20 women work in each brothel.

**The migration of sex business employees** (mostly of Estonian and Russian origin) from Estonia to Finland, Germany and Sweden as well as to other countries has increased, especially after cancellation of visa requirements to several countries (last example - Schengen countries). But during the last year there are cases when sex workers from Russia, Latvia and Moldova come to Estonia with different kind of visas with the reason of bigger income and better work conditions.

The customers of sex business in Tallinn and Pärnu are primarily visitors from Finland, Sweden and other Europe countries, and also local Estonian and Russian men. Finnish sex magazines, for example, carry detailed articles about Estonian brothels, telephone numbers and prices.

**Procuring and pimps** are totally common. Prostitution is clearly a part of organized crime and the drug trade in Estonia. The advertisements with invitations for sex work to the Dutch, German, Finnish sex clubs are very common in local (Russian and Estonian language) newspapers.

The main motivation for young women and girls are economical reasons, financial support of parents, families, children, solving individual economic problems, one part of the girls come to the sex business with the only one reason - to earn money for buying drugs.

The average pimp has little regard for the sex worker health, and large number of young women involved; intervention is still very difficult. There are 'call-girls', sex



companies as apartments, saunas, brothels and massage saloons, with advertising of their activities in local newspapers with contact telephone numbers.

**Street prostitution** like phenomenon (as it exists in Latvia, St. Petersburg or Helsinki) does not exist in Tallinn. But report of NGOs, working with risk group, show growing number of cases, when adolescent street children offer sexual services mostly for foreign tourists in area of harbour and big supermarkets.

**Male sex work** in Estonia is quite more hidden and taboo issue in mass media and society. It is no estimation how much young men work in sex business, even work in abroad. In Estonia it is mostly concentrated in capital and can be divided on four main parts:

- Brothels, sauna's, massage parlours

3-4 years ago usually only in the biggest brothels and clubs it was possible to "order" a male prostitute, mainly man working for the female clients. Last observations of local advertisement in news-papers clearly show that in Tallinn at the moment there is one brothel, where the boys provide sexual services only for men proposing in their ads massage, escort etc. They constantly put work announcements on gay or date web pages, spread their stickers in gay sauna, bars, and hotels.

Also in Tallinn there are from 2 to 4 saunas, massage saloons where sex workers from both genders provide sexual services for clients. In general prices for male sex worker services is 1,5 -2 bigger then for a female prostitute.

- Internet

It is comparatively high number of advertisements in Internet – from the unambiguous proposal various kind of sex activities for money to request for dating with wealthy men, who have no financial problems and can "support" them. Sometimes young boys through the Internet search for older men, who can finance their studies, pay for apartments or cover their debts, have sexual relations (temporary or long time) with them. Also some young guys search for jobs in travel or model agencies, striptease bars, and ask for the roles in pornographic movies. Quite often were observed proposals for anal and oral sex without condoms for bigger amount of money.

Very common there also are advertisements of clients, including foreigners, in Internet with the promises to pay for guide, escort services for young men during weekends.

- Weekend prostitution

Because of a very small gay scene in Estonia – the only cities, which have some gay clubs and bars, are Tallinn and Tartu – a lot of young men, including students during the weekends come to Tallinn for few days. Sometimes in Internet they suggest to pay for getting them by car to capital having sex with client, sometimes they ask about place to stay for some nights and promise to pay having sexual intercourse with owner of apartment.

- Sex work abroad

The part of the male sex workers working abroad is not estimated and probably is not very significant, but through the partners of sex workers projects network the specialists from AIDS Information & Support Centre receive information about some cases of working in sex business mostly in Scandinavia, but also in Germany, Spain and Denmark.

## **General social and demographic characteristics of women employed in sex-business**

Changes have also taken place in the structure of prostitution, most noticeably in age and ethnic background of sex business employees.

Whereas in the beginning of the rise of prostitution there were equal numbers of Estonians and Russians involved, the share of non - Estonians at present is considerably larger. This has evidently been caused by integration problems on their part.

As far as the migration of prostitution is concerned, it should be pointed out that sex business employees of Estonian nationality now proceed mostly to Stockholm or Berlin (no visa needed, tough competition on the «Finnish» market between woman from the Baltic States and Russia, Russian sex business employees continue working in Finland).

Then prostitution was at its peak, more than half of the sex workers were under 18, and now their share has dropped to 26-27%. At the same time constantly the cases of only 15 or 16 years aged sex workers have been observed, the youngest girl, who

was visited “Seastar-I” project services in Tallinn was 14 years old. Approximately half of the sex business employees based in Tallinn come from other regions with high unemployment rate.

During the “SEASTAR” project period (01.12.1996 to 31.09.1999), nearly 1200 sex workers were counselled and given information on safer sex. A total of 382 sex workers filled in an anonymous questionnaire on their first visit; on the basis of these questionnaires the following conclusions can be drawn:

- 26,5% of girls who filled the questionnaires were less than 18 years old. Usually they are 18-24 years old - 46,4%, from 24 to 30 years old - 16% and 11,1% older than 30 years.
- 45% of sex workers are from the capital, 53% from other places in Estonia and only 2% from other countries.
- Majority of the girls in sex business are Russians - 83%, 11% - Estonians, 6% - other nationalities (from Finland, Byelorussia, Ukraine, Poland, Armenia, Kazakhstan, and also Jew, Gypsy and other nationalities)
- The educational level of Estonian sex business employees is relatively high; only 23% of them have not finished high school; only 4% have uncompleted high school education, 47% have completed high school and 23% have completed applied school education, university degree - 1%, uncompleted university degree 2%.
- The marital status: 9% are married, 26% divorced, 65% single and 39% are mothers of one, two or more children; some are the only supporters of their families.
- Sex work is short-term occupation, and sex workers tend not to be involved in it for a very long time: 16% of respondents have been working for less than 1 month, 42% from 1 to 6 months, 23% from 6 months to one year and 19% of them more than one year.
- On the question about they plans for future girls answered as follows: 45% pointed half of year, 37% - one year, 10% - two years, 8% - three years and longer to be involved in sex business.
- The interest for working abroad is quite constant. 54% of the respondents intended to continue their work abroad - 52% of them in Finland, 40% in Germany, 8% in other countries.

- Knowledge of safer sex was insufficient: 6% of the respondents did not use condoms at all and 26% in the middle of the project did not use condoms all the time.
- 30% were sexually abused in the childhood (under 16 years old). 40% of sex business employees fall victim to violence and sexual abuse when working.
- Only 9% do not use alcohol at all, 42% use every week, 19% - every month, and 30% answered that not very often. 90% of sex workers smoking.
- The question about drug use was answered 321 sex worker and the results were very alarming - 28% of the girls use drugs. From those, who use (89 sex workers): smoking - 57%, injecting - 45%, orally - 45%

## **Law enforcement in Estonia, legal regulations and institutional control**

It is no special law concerning prostitution in Estonia. It is no national policy and no state programs or project financed by state regarding prostitution.

Unexpectedly effective has been paragraph 201 of the Penal Code “Allowing illegal activities in a persons dwelling”, due to which many small brothels (commonly with very hard and violent work conditions), usually managed by former sex workers gave up their activities. Paragraph 202 of Penal Code “Involvement of minors in criminal activities or prostitution” has had a positive effect, reducing the number of adolescents in sex business.

From the 1<sup>st</sup> of September 2002 new legislation came into the force:

*Provision of opportunity to engage in unlawful activities, or pimping. (PC Art. 268)*  
*– Pimping, or providing premises for the purposes of illegal consumption of narcotic drugs or psychotropic substances, for organizing illegal gambling, or for prostitution, is punishable by a pecuniary punishment or up to 3 year's of imprisonment. For an offence provided for in this section, the court may impose a fine to the extent of assets as a supplementary punishment pursuant to Art. 53 of this Code*

Although this enforcement is complicated and the number of court cases, which sentence pimps and owners for years of imprisonment is very little, a existence of this law ended the virtually useless discussions on legalizing or banning prostitution. The discussion about legislation in the Parliament is only about range of taxes, which the state wishes to collect from the sex business employees.

## **Social and medical assistance**

It should be pointed that providing social and medical services for sex workers is still not in agenda of the state. Till the beginning of 2003 it was only one temporary attempt to organize services for sex workers, financially supported and initiated by Tallinn City Government (3 months project), which was not a success.

Notwithstanding the fact that working with high-risk groups such as sex workers is one of the aims of National AIDS Prevention Program accepted by Ministry of Social Affairs, for 2004 financial resources for implementation of any activities are not allocated in budget. Till this moment EU programs, international networks, SOROS foundation, Global Fund Against AIDS, Tuberculosis & Malaria, and other international funds and agencies financially support all projects and services, and all activities undertaken.

## **Trafficking in women**

It is very hard to estimate the number of trafficked woman in country, because it is no official statistics or research provided on this issue.

Estonia is mostly country of origin of trafficked woman and in some way country of destination, because in prostitution in Tallinn and bigger cities are involved previously young girls from the countryside and smaller cities. If 5-7 years ago it was a number of cases when women were coming from Byelorussia, Russia, Latvia, now nearly all trafficked woman are local. Thanks to stronger border regulation the number of foreigners trafficked is insignificant – some cases per year.

The ways of trafficking are various: we have a wide range of destinations of trafficked women from Estonia. But most «popular» are Finland, Sweden, Poland, The Netherlands, Spain, Italy, Norway, Denmark and Germany. And also Thailand, Greece, Cyprus, Japan, and USA.

They are trafficked for the following purposes:

- To work in sex business,
- As a domestic workers, nannies, householders etc.
- To work as striptease dancers, dancers, waitresses etc.
- For the marriage with purposes of sexual or labour exploitation.

Very often women, failed by promises of high income, security, medical insurance, good work conditions, have no intentions to work like prostitutes, but the circumstances they find themselves abroad, make them face a very difficult choice, which arises from the absence of legal status (tourist visas, end of visas, passports), financial situation (no money for the return home); physical or psychological violence.

The main way of recruiting women is the advertising of «marriage agencies», «employment companies», and direct invitations for sex work in advertising newspapers. There are very few individuals who work independently on sex market, it is all the time some mediator (pimp, owner of club, driver, bodyguard etc.) between sex worker and client. The attempts of some women start to work individually, advertising in newspapers, mostly end unsuccessfully because of threat of violence and financial pressure.

The traffickers are mostly local criminal persons with a criminal background, or ex-prostitutes; also on this field there are very active traffickers from Finland, Russia, Germany, and Holland etc. There are clear links between traffickers from country of origin (Estonians, Russians) and countries of destination (owners of clubs, agencies, hotels, bars etc.)

Very different attitudes regarding the problem of trafficking in woman, violence and sex work were overviewed in society. But if 3-5 years ago the articles and reports in mass media were a sensation, now prostitution theme is quite «usual».

# Central European Survey of Harm Reduction at Raves

*This chapter contains a summary of report prepared by Zsolt Geresdi and Bea Gyalog (Blue Point Counselling Centre, Budapest, Hungary). It is dedicated to the problem of mobility, rave-scene, and harm reduction services that can respond to these problems in the countries of Central Europe.*

We explored the scene of clubbing and parties in Central Europe, involving main patterns of drug consumption at raves; existence, work and structure of harm-reduction services on the field. Over this descriptive level, we put a focus on needs and obstacles of both the mentioned organisations and party people.

## Identification of Services

We have contacted drug-related organisations in Bulgaria, Croatia, the Czech Republic, Hungary, Poland, Romania, Slovakia, Slovenia. Organisations from Croatia, the Czech Republic, Hungary, Poland and Slovenia have responded. We have identified Services in Croatia, the Czech Republic, Hungary, Poland and Slovenia, and sent our request to participate. We have received data from one Croatian, one Czech, one Hungarian, and one Polish Service.

Country	Services identified	Services participating
Bulgaria	0	0
Croatia	1	1
Czech Republic	1	1
Hungary	2	1
Poland	2	1
Romania	0	0
Slovakia	0	0
Slovenia	1	0

It seems that there is no Service available in Slovakia. For Bulgaria and Romania, we have no information. The Slovenian service identified did not participate in the survey, so we have data from four countries, one Service each country.

In Hungary and Poland, we have identified two Services each. One major Service based in the capital (Budapest and Warsaw), and one smaller scale Service operating in a smaller city (Krakow and Pécs). In both countries, the major service from the capital has participated in our survey.

## **Findings of the Study**

We have used a questionnaire to gather our data. We have asked if our respondents have any empirical data on their clients, but knowing the difficulties of data gathering in this field, and the possible negative impact that such data gathering could have on harm reduction work, we have encouraged them to rely on their personal working experiences and impressions, if there is no quantitative data available. Two Services have ever made any form of empirical research.

So we have developed a questionnaire with several open-ended questions to investigate the following:

- Structure, legal standing and funding of Services
- Workers employed
- Work on the field (e.g. at raves, in clubs)
- Clients (with a focus on mobile drug users)
- Obstacles, needs and future plans

Our findings are summarized below.

## **Organisations**

All four services are relatively new; the oldest one started in 1999, the last one - in 2003. All the four are operated by NGOs.

Two services are financed by governmental or city level institutions, but there seem to be problems with the funding. One of these services tries to apply for grants from



the business sector, the other one tries to receive some funds from the Netherlands Embassy. At a third Service, the trends are reversed. They were funded by the business sector for years, and applied for EU funds through their government only this year. The fourth service is financed from private funds and public grants. One service also tries to self-finance by selling its services to profit-oriented drug prevention and health education enterprises, and had some success in the past.

## Workers

Volunteers are employed widely at all four services. Two services operate with a team of volunteers only, one service has a staff of 10 volunteers and 10 paid workers, and one service “cooperates with volunteers”. Two respondents have noted that their volunteers come from the rave scene.

All four services provide training for their workers, but there are two different approaches employed. Two organizations provide an initial training to their new volunteers. Trainings include topics like first aid, harm reduction, risk behaviors in the field of drugs and sex, and drugs info. One organization does not provide an initial training because of high fluctuation of volunteers, but provide monthly supervision sessions led by a clinical psychologist and drug treatment doctor. The fourth organization combines these two methods; they provide an initial training and also follow-up trainings.

## FIELD WORK

The Croatian respondent describes their appearance, which is very similar to most other services: *We have a stand in preferably quiet place on party with our information leaflets, fresh fruits and min. of two workers. Other 2-4 workers patrol the dance floor and help people feeling sick by taking them out of the crowd on fresh air and providing them water or expert help if needed. All our workers have identity cards hanging from their neck.*

Only the Czech model is different in a major way, because it is centered on pill testing: *Three pairs of volunteers providing pill testing and one supervisor. Each clubber requiring testing fulfills a questionnaire while testing; and being talked to about his knowledge of drugs and his patterns of consumption. Finally, the clubber gets the result and information leaflets of drugs he uses.*

Two services work in double teams. All services mentioned either ID cards or logos, which make the service recognizable.

All four services provide information leaflets and free condoms. Counseling and first aid is provided by three services. Free drinking water and some form of nutrition (fresh fruits or candies and sweets) is provided by two services. One service provides earplugs, and one does pill testing, another one offers a place to relax, to chill out.

The frequency of appearances in the last year varies widely, from 7 to 56 raves and club events in the last 12 months.

Three services get invited to events via personal contacts. One of the services even includes a techno music promoter in their team. Promoters contact the fourth service.

All four organisations provide their services to club owners and rave organisers for free.

## **Clients**

Services have 10 to 100 clients on average; this largely depends on the size of the event. At least 50% of these contacts are longer than 5 minutes.

Feeling sick because of drugs, and looking for reliable information about drugs are the two major problems of clients of all four services. Two respondents especially note drug overdoses, and one notes concerns about pill quality. Two services report that their clients also open up about their individual problems at home, at school, or at relationships.

Ecstasy is reported by all four services to be the most commonly used drug by their clients, with amphetamine (speed) following close behind. Drugs are often combined, mostly with alcohol and cannabis, but sometimes ecstasy and amphetamine is also combined. Other drugs reported to be used (usually in combination with ecstasy or amphetamine): LSD, PCP, GHB, GABA, magic mushrooms, cocaine, heroin.

### ***Mobile drug users in the rave scene***

None of the four surveyed services have records of mobile drug users. We can only rely on guesses and rough estimations. The Croatian service encounters some tourists on the seaside, Italians mainly. In Poland, they have mobile club drug users especially from Eastern Europe, like Russia and Ukraine. The Czech respondent reports that less than 5% of their clients is foreigner, but does not report where they come from. Hungarian respondents report less than 1% at an average event, saying that they are mostly European students staying in the country. During big festivals (especially Pepsi Island) this percentage could rise to as high as 10%, including people from all over the world.

### ***Obstacles, needs and future plans***

One organisation mentions a will to provide condoms, water and pill testing. Other two organisations would find pill testing useful, their main obstacle is a negative attitude from police, government or organisers. Another organisation would like to offer consultation via the Internet.

The two major obstacles are negative attitudes of party organisers (reported by all four respondents, although one of them said only “very rarely”) and legal, governmental or police issues (reported by three respondents). The Croatian respondent mentions a lack of volunteers, because of a decline of the rave scene.

Future plans include workshops about making music, creative writing, party decorations; pill testing (or improving the efficiency of pill testing); education activities; setting up a mobile chill out in a minibus; improve cooperation with police and organizers.

## **Discussion**

Due to highlighting differences and common problems we might find it easier to make further researches on these themes or find a solution.

All asked services provide information leaflets and free condoms; and most offer counseling and first aid. But only two of them provide nutrition or free drinking water, which is very surprising; considering that the most commonly used drugs are

ecstasy and amphetamines, reported by all services. Three services provide initial training, and two provide follow-up trainings for volunteers. We might consider, whether the quality of work depends on trainings.

Working methods have a huge variety, but party people and their problems are the same: feeling sick, or sharing psychosocial problems.

Main obstacles are financial problems (all services are NGOs); negative attitude of party organizers, government or police; these are the needs of services.

# RECOMMENDATIONS

Findings of AC COMPANY research team in Central Europe show that the problem of mobile drug users exists, is not addressed and requires a rapid response on different levels.

Current situation of high level mobility and high prevalence of drug use in the countries of Central Europe may lead to such outcomes as spread of HIV epidemic and hepatitis C, and further stigmatization of mobile communities of drug users and their involvement into criminal activities.

Today the public health systems of Central European countries are not prepared to give a response to the actual needs of foreign drug users. In most of the countries there are gaps in legislation and/or regulations regarding provision of drug treatment and HIV care to migrants.

Recognizing that the situation as regards drug use is part of a social, economic, political and cultural international context, underlining the Declaration of Commitment on HIV/AIDS adopted by the UN General Assembly, we want to draw more attention of the international community, governments and care providers to the complex problem of drug use and mobility.

## **International level**

We recommend that the problem of drug use and mobility be addressed on the level of United Nations, especially on the Commission on Narcotic Drugs, as one of the specific issues of drug demand reduction.

We recommend that the states of Central Europe act as cosponsors of resolutions to call UNODC to focus on the problem of mobile drug use on the international and country levels, and also to call UNAIDS to provide recommendations on HIV/AIDS prevention among injecting drug users who are illegal migrants.

We recommend that international studies of drug use and mobility be provided to estimate the number of mobile drug users in the region, their social and health status and access to public health and social systems.

## **Country level**

We recommend that governments pay more attention to the problem of drug use among mobile communities and include strategies of response in national HIV and drug policy plans.

We recommend that provision of drug treatment and HIV care to migrants be regulated on country level, and drug users without health insurance and citizenship get treatment according to the recommendations of the World Health Organization.

## **City level**

We recommend that municipal institutions collect and analyze information about mobile drug users in their cities, and to organize special programs targeted at this population for prevention and treatment purposes.

## **Program level**

We recommend harm reduction services such as outreach, needle-exchange, drop-in, contact centers and shelters to provide rapid situation assessment of drug use among migrants in their areas. We also recommend harm reduction services to provide staff trainings related to interventions targeted at mobile drug users, and to employ cultural mediators to assist outreach workers and care providers in their contacts with mobile drug users.