SUMMARY OF RESULTS OF THE ETHNOGRAPHIC STUDY OF THE LIFESTYLE AND PRINCIPAL BEHAVIORAL MODELS OF THE INJECTING DRUG USERS IN KYIV

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LIST OF DEFINITIONS AND ABBREVIATIONS

ATS — amphetamine-type substances

ST — substitution therapy

NGO — Non-governmental organization

IDU - Injecting drug users

RESEARCH PURPOSE AND OBJECTIVES

The purpose of this operations research is to study the behavior of injection drug users and their networks in Kyiv.

This research stipulated studying injection practices and peculiarities of the networks of those drug users who inject the following types of narcotic drugs:

1) “croc” (Desomorphine);

2) stimulants (Methamphetamine);

3) opiates (liquid opium extract).

The following objectives were set to achieve the purpose mentioned above:

- Preliminary study of the existing situation with injection drug use in Kyiv and development of research instruments.
- Analysis of the peculiar features of the representatives of target group of IDUs, including:

a) routine lifestyle of IDUs;

b) marital status and peculiarities of family life;

c) interaction of IDUs with external social environment;

d) sources of income;

e) social networks and relationships among the members of such networks;

f) injection drug use practices;

g) attitude to their own health, peculiarities of solving any health-related problems (specifically focused on the practices of visiting medical institutions);

h) role of HIV service NGOs in the life of IDUs.

- Verification of the received information on the injecting drug use practices by direct observation of IDUs in the places where they cook and use drugs as well as interviewing the staff of HIV-servicing NGOs providing services to the IDUs.
- Developing recommendations on the main possible ways to improve prevention activities aimed at IDUs.

Target group of the research: young male and female IDUs (aged 18-25), IDUs close friends and relatives (husband/wife, parents, relatives etc), staff of HIV-servicing NGOs.

Research Methodology and sample
Key research methods used:

In-depth biographic interviews with injection drug users.

In-depth biographic interviews were used as the basic method to collect data. In total 22 young injection drug users (males and females aged 18-25) were interviewed in Kyiv, including:

- 7 interviews with opiate users (liquid opium extract);
- 7 interviews with stimulant users (Methamphetamine);
- 8 interviews with "croc" users (Desomorphine).

The respondents were recruited by the representatives of NGOs providing the services to this category of the clients according to peculiar features of this study sampling. Before the beginning of the interview the interviewers had a repeated screening of the respondents. The interviews were held on the NGO territory to create an atmosphere of safety and trust.

Observations in places where drugs are cooked and used for better detection of local peculiarities of risky practices and description of the mechanisms leading to the risky behavior as well as interpretation of the data received in the process of in-depth interviews.

Observations were carried out in 2 places where drugs were cooked/used. During the observations the interviewers did voice recording and written notes based on observation results.

Focus group discussions were conducted with representatives of the HIV-servicing organizations providing services to the target group. To receive different opinions on stimulant users and their community, researchers held focus groups with representatives of the organizations providing HIV testing and other harm reduction services in target geographic areas. Two focus group discussions, first — with managers of the organizations (directors or project managers — 6 respondents), second — with social workers and outreach workers (8 respondents).

When writing this report the data triangulation method was used for the data obtained during interviews, discussions and observations.

LIFESTYLE OF IDUS AND INJECTING PRACTICES

22 injecting drug users aged up to 30 took part in the study. There were 6 women and 16 men among the interviewed persons which corresponds to the total structure of the use. The injecting experience is on average is about 5-7 years. Minimal experience is 3 years, maximum — 11 years.

One of the characteristic features for IDUs of this age group is poly-drug use, changeover from using one type of drug to another type in quite a short period of time, eagerness to experiment in contrast to older drug users with long history of injections and deeply rooted habits of drug use. Thus, division of drug users into groups depending on the drug used/preferred is rather relative, and the boundaries of these groups are rather vague. Hereinafter any discrepancies among the representatives of various groups divided by the main type of drug used will be stated separately, and if there is no special indication — the characteristic feature is typical for all groups.

There are certain features typical for childhood years of most respondents:

- **Single-parent family:** many of the respondents told that their parents got divorced or one of them died when they were small. In case of parents' divorce, all the respondents stayed to live with their mothers and had almost no contact with their fathers. Thus, many of them do not know where their fathers live at the moment or what his job was.
- **Two or more children in the family.** There were slightly more respondents who told they were younger children in their families. If their elder brothers/sisters used drugs, it was an additional factor pushing respondents to drug abuse.
- **Non-satisfaction with school,** lack of any out-of-school activities (sections, clubs): most of the respondents remember their school years with no enthusiasm; they say that they used to be bored at school, often skipped classes, spending time at their friends' apartments or hanging out in the street. They also used to have conflicts with school administration. And any conflicts with school teachers or blaming others for "unfair" attitude for some respondents were the reasons of losing interest to studies and skipping school. It is worth mentioning that those who had some hobbies (sports or some school classes) first tried using drugs at a later age.
- **High-school or specialized secondary education** — only 4 persons of the respondents entered higher education institutions, but did not graduate. The highest level of education among the respondents was graduation from a vocational training school. Most of those having received this kind of education entered such schools "accidentally", because their parents wanted them to, were not interested in their profession and did not work in the chosen field after graduation.

Thus **family problems** (divorce or death of one of the parents, withdrawn relations with parents) are among the factors that could have pushed the respondents towards drug use.

Economic factor or the financial status of the family did not play a key role in the respondents' choice to use drugs. Thus, among the respondents the distribution of those brought up in dysfunctional families (parents abusing alcohol, necessity to earn one's living in the early childhood) and those raised in high-income families was almost equal. The respondents seldom mentioned economic factor as the one which directly influenced the start of drugs use, except for 2 cases when the respondents were pushing drugs at school to improve their material status.

Probably the most important factor was **the influence of the** respondents' peers. Thus, most respondents first got acquainted with drugs in a company of friends whom they usually knew as they lived in the neighborhood and who all used some light drugs on a regular basis. Almost always the first drug was Tramadol. Using it was considered normal and natural: *"everybody ate it, so my friend and I decided to try"* and not more dangerous (but surely more interesting!) than low-alcohol drinks.

Among the respondents the first experience of using Tramadol (or marijuana in rare cases) occurred at the age of 13 or 14 (rarely — 4 respondents - 11-12). Changeover to stronger drugs usually happened either in high school or after leaving school (15-18 years of age). Those who had any interests or hobbies outside of school, somewhat more often started using drugs in a new environment — in a vocational training school or a company of elder friends — while those who spent more time hanging out in the street more frequently started using drugs with the same friends with whom they started using light drugs.

"In the street. Someone said, let's smoke pot, or then like… let's scoff Tramadol. And then when Tramadol was not available anymore or we couldn't get it somehow, then someone offered to inject. So I started injecting" (F, 22, Desomorphine)

Among the reasons of drug change are: teenage curiosity, search for new "adult" feelings, and discomfort from some changes in the environment / community (e.g., when entering a vocational training school). For most respondents an important factor was the desire to be accepted in a new group and comply with the norms prevailing among others.

"It was my neighbor living next-door. Well, I kind of knew what he was doing… and I was interested — I was looking at him, and he was high, you know… so I was curious and like wanted to try it myself… So I told myself: if I pass exams, I gonna try… Yeah, it is silly, I know… So I passed the exams and then told him: "Vasya, let's make it… I wanna try". I thought I was just going to try, and that's it. So I did try, through my folly. After this first time I did not use any drugs for about a month. Then I tried again… I mean, there was a break for about a month. Then I was using drugs for the second, for the third month, and then things were off and rolling… every day. And so it lasts almost till today" (M, 23, Desomorphine)

"I had a friend who was a little older than me, and so we got acquainted with some elder guys… they were like seventeen or eighteen… And I was twelve then. They lived in a house next to ours. And like they all used drugs. Opium… So this friend of mine, she came to me and said: Have you ever tried "vint"? I said, no. And so she said: And I did, so let's take some? And we did" (F, 23, stimulants)

For most respondents the first "adult" drug was methamphetamine ("vint"). In the initial period (usually first few months) it was used orally, not systematically, once every week or two, e.g. before going to a night club. The frequency of drug use rose constantly. By the time they first tried drugs, many respondents knew some drug cooks living nearby. Often they were their neighbors and hanged out in the same company where the respondents started using Tramadol.

The cases when the first injection drug was liquid opium extract are rarer among the respondents. If it happened, it was usually due to the fact that this type of drugs was already used by someone in their close environment (elder brother/ sister, a close friend).

As the majority of respondents had the first experience of the injecting use before desomorphine appeared on the market, there was only one respondent for whom desomorphine was the first injecting drug. We could suggest that as the accessibility of other drugs decreases the share of young IDUs changing over from oral use directly to the injecting use of desomorphin will grow rapidly.

Changeover to injections for the biggest share of respondents was semi-voluntary. According to the respondents, the key reason of voluntary changeover was the necessity/desire to enhance the experience. As for semi-volunteers, their changeover was usually initiated by the "cook", and rarer — by more seasoned/elder drug users, who were injecting at the same shooting gallery.

"There were three people aged 30 with me in the shooting gallery, they had served time in jail [the cook's acquaintances]. And they told everybody had to inject in that place. I told I do not shoot, I don't want to. It's bad to inject. So he caught my hand and injected drug in my other hand. If they were younger I would start the brawl. But as they were much older, and surely one of them had a knife I didn't want to take risk. I just injected and that was all. Then I didn't shoot for a couple of months probably. And then I wanted to do once more (M, 21, opiates).

The need to make an injection was motivated as follows:

- *"if you scoff, there will be not enough dose for your friends"*
- injections give stronger and "real" sensations
- scoffing "vint" is bad for one's health

In some cases respondents were injected by someone else without their consent, like it happened with an underage girl, who was injected by one of her "foes" from the company of her elder sister who also injected.

It is also worth mentioning that in separate cases other people (older users having an injecting experience, usually friends or older relatives of the respondent) tried to convince respondents not to start injecting drugs as it was more risky than other ways of drug use.

All the respondents say that the first injection was made with a disposable syringe and that at the moment when they started injecting the practices of shared/repeated syringe use were not wide-spread in their environment due to the fear of contracting HIV.

After the changeover to injections, most respondents gradually started to inject more frequently. A big share of

those using stimulants became “cooks” in the first year of their injecting drug use, which led to an increase in the number of injections up to several times a day.

It is rather typical for stimulant users to make breaks in their injections (due to their military service, temporary leave or the necessity to improve their health state).

“While doing my military service, I did not use any drugs. And when I came back, I remained clean. I just did not want to. But with such buddies as I had anything can happen. So I went back to using drugs. Shirka it was. Then they started bringing something like water. One of the options. And then there was the time for “croc” (M, 26, Desomorphine)

“I could use for two weeks without any breaks. Sometimes I was really carried away. Then I was coming back to senses for weeks. I used it often as we actually cooked it almost every day” (M, 21, Desomorphine)

Changeover to opiates among the respondents was most often associated with looking for something “new" or lack of access to stimulants. It rarer happened that such changeover occurred due to their wish to get off stimulants and overcome depressions caused by their use.

Today there is a **clear upward trend in Desomorphine use.** For most respondents, changeover to this drug occurred in the recent 6-8 months. The respondents name the following reasons:

- other drugs suddenly disappeared from the market, their cost went up several times in a short period of time;
- the quality of opiates went down despite of their high price;
- as compared to other drugs, Desomorphine is considerably cheaper, and its ingredients may be obtained easily and legally;
- it is easy to cook the drug at home so that it is safer than buying ready-made drugs;
- familiar cooking “recipe”;
- effect is similar to that of opiates.

The most important reasons of changeover are the **low price** and comparative **safety/legality** of buying ingredients. Besides, the respondents mentioned that when they try to buy opiates, they are sold the same Desomorphine, but at a higher price.

Desomorphine use is characterized with high frequency of injections: from the minimum of several times a week up to ten times a day. It is cooked at home usually for 2-4 people per one use, and is used at the same place where cooked. Purchase of all ingredients, including injection materials, is as a rule done jointly before the cooking process starts. The drug is most often cooked at the place of the cook, cases when it is done at the place of other drug users are rare and happen when the cook is not able to do it at his own place for some reason. During the cooking process drug users usually stay at the apartment together, but the cooking is more often done by one person, sometimes with an assistant. The drug is taken from the cooker and distributed among users with a separate syringe, which may be used for this purpose more than once, though it is usually not used for injections.

Those IDUs not having a stable source of income, but using drugs on a regular basis, were the first to change to using Desomorphine.

"It is very hard to get "vint", I just used it a couple of times. For the price it is sold, it is still hard to get it. Actually it is not possible. You've got to have a job and a good salary to use it. It's like this" (F, 22, Desomorphine)

Those respondents who have higher income and who do not use systematically, that is they do it irregularly, recreationally (in average once a week) and have stable channels to buy quality drugs have not changed to using Desomorphine as well as some "cooks" who have a possibility to get the ingredients necessary to make quality drugs.

Many respondents use different drugs depending on the amount of money they have at a certain moment and availability of drugs. It is worth mentioning that using drugs depending on the context (e.g., using "vint" before having sex or going to a disco, etc.) has almost not been mentioned by any respondents.

An additional criterion for stimulant use among female drug users is weight control. Thus, some female IDUs using several types of drugs choose "vint" to get slimmer.

"I gained nine kilos. I mean, I got really fat because I dropped smoking and have not had a cigarette in many days… Then I came to my Grandma and started eating things — so I gained nine kilos just in one month… It was terrible… And then I came back to Kyiv and so I had to lose weight. But how? So… It was all over again… I was back to it: "vint", and then "shirka" (F, 23, stimulants)

"It's like when you've got no money, you cannot get it. I start gaining weight. I really do. Like, I do not sleep at night, it is very bad emotionally. And it actually helps me lose weight. So it is good, you know, good as doping" (F, 22, stimulants)

Thus, we come to a conclusion that for many IDUs the choice of drugs at the current moment first of all **depends on their financial abilities and drug availability**.

For some respondents an important argument against changeover to using Desomorphine is high death rate observed in the recent months among their acquaintances who used this drug. Nevertheless, it may be assumed that further decreasing quality and growing prices/limited access to other drugs will overweight when selecting the drug to use.

Injection Networks

As is true for the drug use situation in general, it is not always possible to determine the difference between the users of various drugs since the boundaries between such groups are vague and depend on many factors (age, previous use experience, ability to produce the drug unaided, etc.). In general, injection networks may be characterized as follows.

Desomorphine. This kind of drug is featured by wide occurrence of at-home preparation. Average size of a user's

network is 3-7 persons, one of whom is a “cook”. Users, who do not produce the drug themselves, usually try to approach the same “cook” (normally that is a familiar person, a neighbor or a person the drug user is friendly with). It is a common case for an IDU to approach only one “cook” and make no new acquaintances, to use drugs together with the same 2 or 3 persons.

Those of the “cooks” who know how to cook only “croc” often have almost the same size network as a common drug user since it is all about production for oneself and a small circle of acquaintances.

Stimulants. Here we also see the shrinking of networks, but the reasons are different: the number of users is decreasing because of transition to more affordable and “legal” drugs (most often, “croc”); there is a trend for higher privacy of the drug users and producers / dealers due to stronger pressure of law enforcement bodies.

For instance, many stimulant users have noticed that the situation had changed recently — the atmosphere of “everyone inviting and treating people” had disappeared, socialization and making acquaintances at the points of sales had become rarer. Users of stimulants are more willing to buy and sell only among familiar and trusted people as compared to Desomorphine users. They more often purchase a prepared drug, while the components are bought by a “cook” or a user who has connections in pharmacies.

Since stimulants and Desomorphine are produced in a similar way, some of the “cooks” produce both types of drugs. Also, some combine / mix the use as well: “you can do it in turns, but some do it first into one arm, and then into another one”. The number of “cooking sessions” for such producers may reach up to 10 a day, and so the size of their networks is much bigger.

“If I produce Desomorphine, I definitely make “vint” as well. Because I got all the components. I only need to get the pills somehow, that's all" (M, 21, stimulants)

At the same time, there is a significant share of "vint cooks", who do not shift to the production of “croc”. Most often, these are users who started producing stimulants from “higher quality” products. Some of them have stopped “cooking” when syrups became the only available components left, and some — when Desomorphine appeared (at the same time, some of such IDUs presently consume Desomorphine, but prefer not to prepare it, using services of a “trusted” acquaintance). Among the reasons of such behavior we may name both fear of law enforcement bodies and “professional pride” of IDUs, who prepared “quality vint” and are unwilling to take risks to produce a simpler drug that everyone can afford, a drug that “takes no skill to produce”.

Opiates. Respondents virtually do not produce home-made opiates because of the unavailability of components and labor-intensive production process. A far-reaching system of dealers is operating, and here is the same tendency towards stricter privacy. Before now users used to go purchasing in groups or could buy and bring a big dose for further reselling, but at present moment they usually purchase small doses — for one or two persons. The customer may not know the seller and may buy the drugs through a familiar middleman who delivers it to the customer's place.

Purchasing via Internet or through ATMs when there is no personal contact between the customer and the seller is gaining popularity (this is more common for opiates, powders, for instance, Methadone).

Irrespective of the type of drug produced, it is quite difficult to get to an apartment where production / sale is going on: owners employ a system of advance phone calls, sophisticated meeting schemes designed to protect the participants from possible attending of militia or new people who might prove to be informers. Such secrecy also leads to shrinking of the networks.

"There, in the Internet, you make an arrangement with a guy and go make a payment, you pay the money and then send a text message with the payment code — there is a serial number. The guy checks that the money has been transferred, and then you receive a text message telling where it is hidden. And you go and collect it. It may be hidden in an entrance of an apartment building, or inside a bench. It's different every time" (M, 24, stimulants)

Financial and Social Support

Most of the interviewed IDUs at the time of the research were living with their parents and had not had an experience of independent life. As it has already been mentioned above, many of the respondents live in single-parent families, most of them do not keep in touch with their father or may not know about his whereabouts. So they share an apartment with their mothers, very often the apartment is shared by more than two generations of family (respondents and their siblings, parents — more often, only mother — and grandparents).

Moreover, those brothers or sisters who are married or are in permanent relationship and have children more often live separately, while those who are not in permanent relationship live with their parents even being fully adult. In case IDUs live with their family, it is their relatives who usually provide them with basic material support: give them accommodation and food.

Most IDUs do not have a permanent job, they often switch jobs after a short time (usually from two weeks to two months), do odd jobs, sometimes commit crimes (theft, mugging). The reasons for leaving their jobs are usually conflicts with colleagues and management, failure to respect schedule due to drug use, sometimes — theft cases at work. Several of the respondents have never had a job. The material support this category receives from their families is particularly important since it is their only source of money (including the money they spend to buy drugs). The amount of money provided depends to a large extent on the relatives' knowing of the drug use. Thus, if the use has become known, relatives stop trusting the respondent and may limit financing. They may also install a safe box in the flat to keep valuables in.

Another category of IDUs that is less numerous in this age group are people living separately from relatives with a permanent sexual partner. It is the partner who provides most of the financial support, but respondents of this category also more often have a source of income of their own in form of a permanent or temporary job. Here, a relative changeability of situation is characteristic: a respondent may live with a partner for several months, and then end the relationship, or alternate living together and going back to

relatives subject to the respondent's emotional situation. I.e. the house of parents / grandparents is seen by the respondents as a "fallback position", a place where he or she can return in case of failure and receive at least minor support from other sources.

Another kind of material support provided by relatives is childcare performed, partly or in full, by parents of the respondent or his/her partner.

"I live separately with a boy-friend. And my Mom lives with my child. We all live in Obolon district. Because it's a little bit too hard to live with a child. You need to get used to it. The child needs to be looked after" (F, 24, Desomorphine)

IDUs may also receive financial support from acquaintances / friends. In comparison with the two previous sources of income, this one is rare and unstable. Only some of the respondents could tell they had such acquaintances. Virtually always those are friends who do not know about the respondent's use of drugs. For female IDUs these can also be "gallants", "dates". It should be accentuated that such a "gallant" provides the female with money not in exchange for sexual services, and may not even have sexual relations with her.

More often, acquaintances / friends of an IDU are a source of free drugs. Thus, many of the respondents (especially among the users of "croc" and much more rarely among the users of "shirka" or "vint") mentioned that their acquaintances treat them with drugs free of charge. Widespread occurrence of this practice among the users of Desomorphine can be explained by relative cheapness of production of this drug. Among the users of more expensive drugs, such "treat" more often is, in fact, a payment for a service (drug production, transportation, etc.). However, such cases happen, especially when the drug use is irregular, recreational.

"They usually bring it to me… a lad visits me, I know him — he has been using drugs for a long time now. So he comes and says: want some? I say: yes, I do. So he treats me to it. That is, many of them treat me now. I do not go and buy — not anymore. I try to drop it somehow, but they keep on bringing me something" (F, 21, opiates)

Emotional Support

At least half of the respondents believe they do not have a person to ask for an advice / emotional support. At the same time, male respondents tend to claim they do not actually need such support because they have no emotional problems (such attitude reflects a common opinion that display of emotionality is something disgraceful for a man, and does not mean the absence of emotional problems and real need of support).

For those respondents, who actually can ask for advice / support, the source of such is most often their mother. We also need to note a higher level of emotional restraint in

men. Thus, while women talking about possible sources of support name a sister or a female friend, men tend to look for emotional support only from their mother or someone who substitutes her ("There is a couple of persons I can trust. There is aunty Aliona, she is the mother of my friend who got me hooked on "vint". It all had happened to him already"). Thus the real need for emotional support in males may be even stronger than in females as the often have no socially approved ways to obtain the same.

Females also may find a source of emotional support in their permanent sexual partners, while for males this is less common, though some of the respondents did express such expectations.

"And now I am with a boy, that is, we are dating, and he is not a drug user, and he, like, he's helping me. He knows I used to shoot up. Yes. He helps me to avoid meeting those people. He crashed my phone and threw it away, he destroyed the SIM card. Thanks to him, I've been feeling alright during the last six months. Well, I am concealing something from him, I did shoot up now and again, but not as I had used to, not like that" (F, 22, Desomorphine)

"I did that more often then, and my wife started noticing. That was it, we just broke up and that's all. I just showed no initiative after that. She said, like, we get divorced — that's all. I had some hard feelings too. I thought she could help me somehow. She could support me, and not just leave and wait until I do something". (M, 21, Desomorphine)

Strong material and emotional dependency on family (and above all, on mother) is one of the reasons why IDUs of this age category do they best to hide the fact of drug use, being afraid of losing the support. Most of the respondents have confirmed that their family / partner do not know about their use of drugs or do not understand the real scale of it. Thus, many respondents, when asked by the relatives, tell they "smoked pot" or "drank". When relatives find out about any instances of injections, the respondents try to hide places of new injections (by injecting the drug into armpits or other concealed areas).

Besides, even if an IDU's family members know about the drug use, they usually do not possess sufficient information on the problem to give a quality advice.

Therefore, the respondents cannot get any support or advice regarding their drug abuse and emotional problems. The only exception is women whose sister or female childhood friend(s) are using drugs. It should also be mentioned that, regretfully, the quality of the advice and information provided to each other may not always be satisfactory.

"Actually, I can ask my Mom for any kind of advice. Except for this, of course" (M, 25, Desomorphine)

In this situation, NGO workers play an important part being a reliable and perhaps the only source of support and information for many of the respondents, the only way to re-socialize.

"I ask Lena very often. Whenever I need an advice. My mother is a person who does not know much about it. Anything she may tell I know myself. I know in advance anything she can say. But I can ask Lena. It happened very often. If I need to know something — Lena is a good adviser"
(F, 24, Desomorphine)

Regretfully, the potential sources of emotional support IDUs have (first of all, their family) are virtually unused and difficult to approach for NGOs.

Sexual Relationships

First Sexual Experience

Most respondents were 15-18 years old when they had their first sexual intercourse, and it was in no way related to the drug use, except for a couple of cases of using Tramadol together and one case when a female respondent participated in group sex under the influence of alcohol and pharmacy stimulants.

Relationships

At the moment of the research, approximately equal shares of respondents described their personal life as more or less long-term relationships with permanent partners or said that they did not have a permanent sexual partner. The most frequently named reason for this was a recent break-up with the previous permanent partner. Only individual male participants said that they practiced sex with incidental partners because they did not wish to get involved in long-term relationships.

Virtually all participants were quite negative about short-term and incidental sexual contacts; they were telling that such behavior was not characteristic for them. Their own sexual relationships of this kind (occurring only among male respondents who use opiates or "vint") they explained by incident or by their female partner's attractiveness (she was a "real model", "actress").

Many respondents said that while they were in long-term relationships with a permanent partner, they never or almost never had sex with others. The respondents explained this not with their concerns about health or risk mitigation, but, again, by immorality of promiscuous behavior.

Relationships are considered to be long-term / permanent if they go on for more than one to three months on average. Partners may live both together or separately. Few of the respondents already have children. Virtually in all such cases children live separately from the respondents: with mother of the child — ex-partner of a male respondent or with a grandmother — mother of a female respondent. The respondents stated breaking of the relationships and being unprepared to continuous child care to be the main reasons of such separate residence.

When the research was conducted, two of the female drug users were pregnant (different terms), fathers being their ex-partners with whom they had broken up. Both women planned to raise the children independently, using support of

their relatives. Also, both female IDUs saw the pregnancy as a motive to try to get off of drugs since it could harm the child and become a barrier in upbringing.

Choosing a partner, virtually all male respondents would prefer a woman who does not use drugs. Many of male participants of the research stated they had never or almost never had sex with female IDUs. Among the main reasons of such choice the respondents most often indicated the fact that they condemn drug use by women, because such behavior is disgusting for them since it does not conform to their image of their potential life partner and "future wife". Besides, the respondents marked lack of sex appeal of female IDUs who age faster because of the drug use. Therefore, a significant part of the respondents have sexual relationships with non-using female partners and try to hide their drug use from them.

"This is probably… you could say, this is selfish, but girls using drugs are… for me that's just… Though guys using drugs are no better, but girls — I have never had anything with them. Not even dating" (M, 23, Desomorphine)

Female IDUs, in turn, most often have or have had sexual relationships with male IDUs. Some of the respondents found it hard to imagine relationships with a sexual partner who does not use drugs. Most often, permanent partners of the interviewed women were "cooks", but we need to emphasize that female respondents distinguished their experience of living together or sharing drug use with a "cook" from payment for drugs with sexual services or with housework.

The average number of permanent sexual partners with whom they have had relationships for both men and women is about 3. The number of incidental partners is rather hard to estimate, because the respondents tend to conceal cases of such condemned behavior.

Desomorphine users. They are the least sexually active category. This can primarily be explained by the fact that they are always busy due to the specifics of their drug use (as they need to inject frequently) and by the way the drug impacts their body. Thus, some of the respondents noted that while using opiates or stimulants could stimulate their sexual desire, Desomorphine did not have such effect, and sexual relationships became relegated to the background. Therefore, if a respondent does not have a permanent relationship or such relationship breaks, he/she is unlikely to search for a new sexual partner.

"Rarely. In general, when you use it, you don't really feel the desire. Especially when it's "croc", it's like a morass" (M, 25, Desomorphine)

Users of opiates or stimulants may practice sex under effect of the drug, but more often it is sex with a permanent partner at home. More often, those of the respondents who had been regular users / producers of stimulants were the ones who had the experience of incidental sex. Presently, according to the respondents, such cases are extremely rare because this type of drugs is expensive and hard to get, which leads to more confined production / use.

Sex in Exchange for Money or Drugs

Situation, when a woman at a point of sale offers sexual services in exchange for money or drugs is most familiar to the respondents with the longest drug use experience (most often, users of opiates) and, it seems, becomes less common. More common for the present moment is a situation when there is a woman at a "cook's" flat who more or less permanently lives there and obtains drugs in exchange for the housekeeper functions she performs: cleaning, food cooking, etc. Such a woman does not necessarily have sexual relationship with the owner of the flat.

Virtually all male respondents said that they had never bought female sex services and had little knowledge regarding such a situation. However, almost all women had received multiple propositions of this kind. In some cases they had had to flee, and they believe that the situation of forced sex in exchange for drugs is a common situation. At the same time, female respondents stated that they had never rendered such services because such behavior "contradicts to their principles". Besides, the fear that such behavior may become a common knowledge is another barrier, since this fact decreases a woman's chances for relationships with a "good" partner.

"That is, my taboos are sex for money or for drugs. That's my taboo I have not broken yet, that's my limit. And I believe I will never cross this line in future" (F, 24, Desomorphine)

"Well, there were cases when I was offered to do it; I remember I was lying in bed at home, I could not get up, and I was told: do you want, you know, to make a zig-zig and get the drug? And I was, like, get lost… leave me alone… I would rather do tough it out for three days and get better, and then go and get some, and that's it, than do such things. That's disgusting. Many people had to pass it… A friend of mine does it all the time. Though, she seems to have stopped doing it. I tell her: who would need you? People will start gossiping, and when a normal guy learns you are a drug user and you made sex to get the drug… he'll pick up on it right away" (F, 21, opiates)

Risky Sexual Practices

As we can see, such risky practices as incidental sexual contacts under the influence of drugs or sex for money / drug occur among users, but these practices are not considered to be normal and neither they are. The research shows that the most common risky practice is unprotected penetration sex with a permanent partner (in case of male IDUs — with a non-using female partner).

Thus, most of the respondents of both genders have practiced unprotected sex with both present and previous partners. In approximately the same number of cases respondents stopped practicing safe sex after some period (usually after the relationship was considered "permanent", i.e. in 1-3 months) or at once, since such conduct was a sign of "trust", of serious intentions. Decision on "trusting" a new partner may depend on many factors, for example, the circumstances of getting acquainted, appearance, sex appeal, etc.

M. When you started dating, did you protect yourself, did you use condoms?

R. No.

M. Why?

R. I don't know. He looked decently. So I had no fear. If I had any concerns, I would have told him. But I had not" (F, 24, stimulants)

Considering unprotected sex to be a form of trust is typical for most of the respondents: they tell they are fully confident in their partners. Here, trust means absence of sexual contacts with other partners, but other risks are not taken into account. Proving their confidence to their female partner, some of male IDUs stated that they almost always know "where she is now and what she is doing", they said they were controlling their female partners.

Some of the respondents started having unprotected sex with a new partner after they had shown each other health certificates stating they had no STIs, HIV or hepatitis. After this, most of the respondents tend not to make tests for such diseases often, except for the cases when they change their partner or have incidental sex.

Though some respondents confessed they had infected their partner or had been infected by a partner, most probably, through unprotected sex. We can also trace some longer chains (from one permanent male partner through his female partner to her next permanent male partner).

Attitude to Health, Knowledge of Risks and Risk Avoidance Strategies

Most of the IDUs showed some knowledge of possible HIV / Hepatitis C risks. At the same time, HIV knowledge level has proven to be higher, since it is the ways of HIV transmission that the respondents use as the basis for risk evaluation. However, they do not take into consideration that their conduct might be unsafe because it might lead to getting infected with hepatitis.

Having noted the recent growth of popularity of such type of drug as Desomorphine, we should pay attention to the fact that part of the respondents had lack of knowledge about the specific effects of this drug to the body and the health risks for the user which this drug invokes, as well as about the possibilities to mitigate such risks.

Generally speaking, groups of users of other drugs know well about the presence of this new substance, Desomorphine, on the market. Most of the respondents are familiar with some Desomorphine users and know about the deaths caused by the use of this drug. Despite all this, not all the respondents (including Desomorphine users themselves) fully understand the effects of the use and the possible risks connected with the specifics of this drug, including the risk of overdosing.

An important fact is that a big number of slang names of this drug ("croc", "electroshirka", etc.) cause confusion for some IDUs. Knowing about the risks of the use of Desomorphine, they may fail to know that Desomorphine and "electrichka" are the same substance.

Evaluating the risk of getting infected with HIV / Hepatitis C, every single respondent talked, first of all, about the possibility of getting infected through **sharing of syringes**. Here we should mark the good work of the NGOs and previous syringe exchange initiatives, after which sharing or re-using of a syringe is always considered by IDUs as very risky.

The respondents underlined that they always tried to use only their own new syringe. There are still some situations when it proves impossible, but we may conclude they are exceptions. It happens only where there is a lack of syringes:

- In places of detention.
- At the sale points with active trade going on / where a flow of customers is present. Such situation is more typical for the use of Desomorphine and is caused by the need of frequent use.
- When the drug is used in places situated far from pharmacies (this is more typical for opiates, but is the rarest situation).

Having faced such a problem, the respondents tried to protect themselves by various means. They:

- boiled the syringe (for example, when sharing it in a prison);
- used the syringe before all the others did;
- re-used their own syringe only (keeping it in a pocket in order not to lose or confuse it);
- shared the syringe only with their permanent sexual partner or a person whose HIV status was known to the IDU.

"I always use clean syringes. Though, when I served my time in jail, there were five of us who used one syringe. We cleaned it with boiling water, we boiled it… I did it myself, if somebody failed to boil it, I took it and boiled it" (M, 26, opiates)

"I can use mine many times. Until the needle gets blunt. Many times. But not a borrowed one. Well, it depends. If I know the person. If that person is healthy, I can share. But that's extreme. When there's no choice" (M, 21, stimulants)

Apart from the risk of getting infected through a syringe, respondents know that **infections** may be transmitted through **the drug itself**. However, most of them believe they have no influence on that factor.

Thus, IDUs believe that the most dangerous is the use of purchased opiates which, as their experience shows, may be infected on purpose or due to a cook's negligence. At the same time, very few of the respondents who use or used opiates have tried to reduce the exposure to the infection. Usually, it was done by boiling of the purchased dose of the drug. Most of the respondents have never heard of such a method and have never used it.

The process of cooking stimulants is believed to be safer, because there is a popular belief among IDUs that the acid the drug contains "burns out" the infections, sterilizing the product cooked.

"If "vint" does burn something, even some diseases, because this is acid, junk, opium does not… there is nothing, and the risk is high, since people are different… I knew a boy who sold

"shirka", he had HIV, and he could make injections to himself and then use the same spike to extract some drug and sell it"
(F, 23, stimulants)

The respondents see no risks in the technology of Desomorphine production. From their point of view, it is the safest drug, since it is produced right in sight of the user, and the "cook" is usually an acquaintance whose services IDU uses regularly and with whom the IDU may socialize and be friends, which decreases the likelihood of purposeful transmission of any infections.

Apart from using a personal syringe, another efficient risk reduction strategy is, as respondents believe, having sex with one permanent partner only. By combining these two methods, most of the respondents trust they do everything possible to protect themselves.

"I use my own syringe. I have a 100% confidence in my man. I don't sleep with anybody else. No matter how bad you feel, or even if you don't have a syringe, you can get it from someone. Or buy, just in case. So, this is it. Nothing special"
(F, 24, Desomorphine)

That is, by lowering the risk through avoiding some risky practices, users omit a lot of others, connected primarily with unprotected sex and lack of knowledge about the risks caused by at-home production of drugs.

The production risks are more important for drugs cooked at home, that is ATS and Desomorphine (the necessity of a more frequent use and, accordingly, the risk of omitting the usual precautions in order to minimize the cooking time).

Principal risks are the following:

- re-use of production vessels (so called "furick");
- failure to observe any sanitary regulations during production;
- no boiling of product foreseen in the production process;
- re-use of the extraction syringe.

"R. Naftizin bottle is made of glass. It is thoroughly washed before each time… with tap water. They shake it up, pour the water out, that's all. Then they wipe it with toilet paper, and it's done.

M. How many times can it be used?

R. If you use it carefully and observe all the precautions, it can be used many times. A hundred times even"
(M, 25, Desomorphine)

Risks associated with Desomorphin use

At the drug market Desomorphine is also known as “croc”, “electroshirka”, “godichka”, “electrichka”.

The respondents named the following characteristics of this drug:

High toxicity of the drug. NGO workers say that Desomorphine is the most toxic drug from all those available at the local market. This type of drug causes irreversible changes and destruction of human body in a very short period of time (according to the respondents, the average period is one year), leading to the death of drug users. In the recent year the respondents have seen a considerable growth in the rate of mortality among IDUs, in particular among Desomorphine users. The respondents mentioned that the main causes of drug users’ deaths were sepsis and overdose.

“I talked to one client, who… first, he is losing his vision. That is a side effect of “croc”, many clients say that. Besides, they say that cold turkey symptoms are very intense. Even those drug users who have used “shirka”, heroine, and then started using “croc”, they also say they’ve got cold turkey. Strong abstinence — I mean physical, not talking about the psychological… I'm not even talking about it”

Short-term and instable effect. The effect of Desomorphine is similar to the effect of liquid opiates, and may be even stronger. At the same time, its duration is much shorter and averages two or three hours.

“Those who take Desomorphine, they are kind of depressive, like really flabby. When they use opiates, they are kind of better, there is at least some go. And with Desomorphine, like he comes, sleepy. And then he goes away as he is not interested in anything, he is in apathy. I mean, the emotional side is really hard there. They do not want anything, just cook it and inject asap” (social worker, NGO)

High level of dependency. Drug users get used to Desomorphine after its first doses, with the level of dependency being higher than that of other drugs.

“I have read in Wikipedia that codeine causes dependency, which is five — six times stronger than regular opiates, and that it is very toxic. And the psychological dependency from it is stronger as well. Moreover, they develop needle mania and inject every two hours” (social worker, NGO)

The respondents mention that changeover to the use of Desomorphine is typical for all the main groups of injection drug users.

“We've got a good example — there is a client who told us about nine months ago that he will never ever inject this nasty thing — “electroshirka”. Really, he has never tried it before, but then finally started injecting “electrichka”. As a result, he lost forty kilos in three months, and his groin started putrefying. And now one of his joints has putrefied. We took

him to a clinic, and they said he had to pay five thousand bucks to have a new joint. So we are going to take him there on Monday… I mean, we will have to get people helping him as he is not able to walk and we will have to transport him" (social worker, NGO)

The respondents also underlined that today rather often the **first experience of injections** is also associated with the use of Desomorphine due to its wide spread and easy access to it.

The significant additional factor which causes the users to change over to desomorphin is the cooking method. As it is similar to the ATS cooking method already familiar to many IDUs, this way ensures that not only opiates, but ATS users change over to desomorphine despite the fact that desomorphine and ATS have opposite effect.

"Vint" and "croc" are cooked in a similar manner. Some clients used to cook "vint", so this scheme is close and well-known to them… The procedure is almost the same, and many of them say that they just used to cook it this way, and just changed from "vint" to Desomorphine"(social worker of an NGO).

The cases of changeover to the use of Desomorphine are particularly wide-spread **among young drug users taking codeine-containing substances** due to the following reasons:

- When drugs are used orally, after some time drug users need bigger amount of the same drug to achieve the desired effect, causing increase in the cost of drugs. And to cook an injection solution using Desomorphine cooks need fewer of the same tablets, which in turn leads to the lower cost of one dose.

"Young people get addicted to "croc" as it is cooked from the same ingredients they used to scoff".

- Stable and fast-developing dependency from codeine-containing substances: "even after the tablets are used for a short time, they become dependent, and do not stop on taking only those tablets".
- Taking tablets in big amounts has a serious adverse effect on the body, in particular on gastrointestinal tract. Drug users think that when they start injecting they thus reduce the negative effect on gastrointestinal tract.

Peculiarities of Desomorphine Use

Short period of the drug effect causes more frequent injections - up to 7-8 injections a day. According to NGO workers, such frequent injections are associated with additional risks for IDUs.

Frequent administration of the drug leads to the adverse effect on the vascular system, veins get injured soon and sepsis develops.

The risks of getting infected with HIV/Hepatitis C elevate, as the constant need in big amount of syringes leads to sharing or using syringes repeatedly.

Besides, due to frequent injections the drug does not have enough time to get off the body, so it is accumulated, and every new dose may be the reason of overdose; the chances of overdose are considerably higher among Desomorphine users as compared to the users of other drugs.

"They inject and they wig out. I mean, they do not get over it yet, but inject again. And then they are just dead. The risk of overdose grows heavily" (social worker, NGO)

To achieve the desired effect, drug users often increase the dose and use additional narcotic substances (Tropicamide medication is used most often), which is one of the factors leading to both overdoses and stronger adverse effect on the body.

The respondents say that using Tropicamide is another problem area for Desomorphine users as the cases of Tropicamide use are widely spread and the negative effect of the drug on the body is rather serious, which, when combined with Desomorphine use, creates very high risks for the health and life of IDUs. According to the observations of social workers, Tropicamide has a negative effect on the skeletal system of the body. Using the drug leads to irreversible health-related consequences from the tenth dose already: destruction of bone tissues and disruption of soft tissues.

"When they mix "croc" with Tropicamide, they just nut up; they can't really understand what they are going. They do not even control what syringes they use to inject" (social worker, NGO)

"Now it is all so easy — you just go to a pharmacy and buy Tropicamide. It is sold like everywhere. You can buy those eye drops in any pharmacy" (social worker. NGO)

The Process of Cooking Desomorphine

According to the observations of NGO workers, Desomorphine is usually cooked and used together in groups of 3 to 7 drug users. There is a strict division of duties, allowing to speed up the process. There are also cases when the drug is cooked and used individually.

As for timing, cooking the drug takes 30 minutes to two hours, depending on the skills of cooks and the number of people involved in the process.

The main equipment needed includes a syringe, a cooker ("furick") which is a glass flask from medical substances, a syringe to pick up the ready-made drug, a protecting cover of a syringe needle used as the basis of a filter, and some cotton wool/cigarette filter/soft tissue paper as the filtering element.

Ingredients: codeine-containing substances (Codterpine, Cofex, Flucold, Codesan, Pentalgin or others), water, iodine, red phosphorus, acid, chlorine.

According to the respondents, the process of cooking Desomorphine is associated with the high risk of getting infected with HIV/Hepatitis C. The key risk factors are as follows:

- multiple use of the cooker;
- intake/transfusion of the drug from the cooker is done with drug users' syringes which are used repeatedly;
- absence of any heat treatment stage in the cooking process (the ingredients are warmed up to fasten the reaction, but without boiling).

"Anybody can tuck an infected syringe into this furick, and it's done — the whole solution is infected" (NGO social worker)

"It is more about hepatitis, I think. In this situation it happens frequently" (NGO social worker)

Another risk factor for drug users is absence of a fixed formula for cooking Desomorphine. The drug is usually cooked "by eye", and often cooks make experiments with the formula, increasing the risk of overdose and rising toxicity of the drug.

"They inject with a dirty drug: if there are any dregs, they are happy that they will get a good high" (NGO social worker).

Changes in the Structure of IDUs

All the participants of focus group discussions shared the opinion that in the recent years there has been significant changes in the drug scene of Kyiv. First of all, these changes were related to the structure of drug use. In the recent two - three years there has been a considerable increase in the number of pharmacy drug users. According to the estimations of the respondents, the share of pharmacy drugs in the general structure of drug use is 60% to 80%. The most wide-spread drug in the pharmacy group is Desomorphine, its share comprising about 80% of the total scope of pharmacy drugs used, with the number of users giving preference to this drug constantly growing.

The key reasons to start using this type of drug named by the respondents:

- **Regulatory and legislative policies** aimed at restricting access to more traditional drugs — opiates and ATS (amphetamine-type substances) — with one of the main consequences of such policies in practice being large share of IDUs starting to use cheaper and more dangerous narcotic substances, first of all Desomorphine.
- **Restricted access to opiates and ATS i**n its turn leads to a significant growth of prices both for the ready products and their separate components, which also makes IDUs look for cheaper analogues.

"It is very difficult nowadays to buy poppy straw. The quality of ready-made "shirka" is very low, many dealers mix it with Tropicamide or with "croc". (NGO social worker)

- **Appearance on the market of accessible medical drugs containing codeine,** used as the main component to cook cheaper narcotic drugs:
- Low price — as of the date of research, Desomorphine was the cheapest drug. According to the respondents, the cost of one dose was at least two-four times lower than the cost of other popular injection drugs.
- Safety — officially codeine-containing medical drugs are not classified as narcotic substances, so their purchase and transportation does not lead to criminal responsibility, which makes cooking and using Desomorphine safer as compared to other types of injection drugs.
- Wide spread and accessibility of codeine-containing medications, which are used to cook Desomorphine (Codterpinum, Codesan, Codeterp, Cofex, etc.), in pharmacies. The range of codeine-containing medications is very wide and it constantly grows. Besides, it is very important that they are over-the-counter (OTC) drugs.

"One can easily buy narcotic drugs in pharmacies, everything is very well from the point of view of access — they are very accessible… Very. Sometimes I think that if in my time we had such an easy access to various pharmacy drugs, I wouldn't have given up drugs myself". (NGO outreach worker).

Besides, many respondents, when talking about the reasons of the growth in Desomorphine use, mentioned such a factor as unintended purchase. Thus, social workers told that it often happens that drug dealers lie to their clients when selling them ready-made narcotic drugs, and instead of an original drug (liquid opium extract or "shirka") clients buy clean Desomorphine or "shirka" mixed with Desomorphine.

Another important factor is the easy process of cooking Desomorphine and similarity of this process with cooking stimulants based on pharmacy drugs.

Injecting drug use among the youth

In the recent five years there has been a growing trend in the number of drug users in Kyiv, most of all among underage young people. The respondents underlined that drug abuse is now much younger: the first experience of drug use more and more often happens when a future drug user is around 14-15 years old, while just about five years ago the age of 16-17 was more typical.

According to the respondents from among NGO workers, the key reasons of the growth in injection drug use among underage young people are as follows:

- Crisis, economic instability, and general decline in the governmental social policy: high level of unemployment and lack of activities for youth, in particular those aimed at drug abuse prevention.
- Easy access to ingredients for narcotic drugs, including those available in pharmacy chain.

- Influence of social environment (friends, acquaintances, classmates), where drug use is so wide-spread that it is perceived as something like using low-alcohol drinks.
- Promotion of a certain lifestyle/leisure activities in mass media, where show business and club life are directly associated with drug use.
- Development of Internet as one of the most accessible and uncontrollable sources of information. Thus, according to the respondents, information about narcotic drugs and ways to cook them is most often searched in the Internet; besides, the same means is often used to purchase narcotic drugs.

"Primary prevention of drug dependency at schools is not in place. It just does not exist… And parents do not have any information about this issue either" (social worker, NGO)

"It is absolutely easy to find a recipe to cook any drug in the Internet. And most drugs can be cooked from substances which are easily accessible. I mean, everything is so open — just read it, you are welcome" (social worker, NGO)

According to NGO workers, peroral way of using codeine-containing substances is the most wide-spread way of drug administration among underage young people of 14-15 years old due to the following reasons:

- Absence of any prevention activities among underage young people focused on the peroral way of drug use, lack of information about the harm and the negative consequences of pharmacy drug use;
- It is a way of drug administration widely spread in the social environment of young people — among their friends, acquaintances, and classmates;
- Easy access — drugs can be bought in any pharmacy;
- Easy administration — "you just buy a pack of Codterpine tablets in a pharmacy and pop them just in the street, followed with Cofex syrup, and no veins are damaged";
- Misconception that when drugs are taken orally, there is no physical dependency;
- Absence of any tracks of shots allows hiding the fact of drug use from relatives;
- Misconception that the peroral way of drug administration has a lower negative impact on the body:

"When outreach workers stand at their point next to a pharmacy, they call the groups of school students "cruisers". I mean, those schoolchildren come in large groups, take the tablets as soon as they come out of the pharmacy, and go to school" (NGO social worker)

"Earlier all the young people used to take Tramadol. Just all of them — youngsters from schools, colleges… When Tramadol was prohibited, it was easily substituted with Codterpine. Those children buy five or even ten packs. They lose their vision, but this drug is still popular among youth now»
(NGO social worker)

This observation is especially important as the non-injecting use of codeine-containing pharmacy drugs by the adolescents can be easily changed for injecting use of desomorphine and this the IDUs number is growing.

With all this being said, social workers point out that underage young people are the most hard-to-reach age group for NGOs. They have a low level of awareness about the risks associated with drug use, and about the activities and services of relevant NGOs. Besides, one of the key obstacles is their fear of publicity.

"School students are afraid that if they come to our organization, some people they know will see them there and will tell their parents or teachers at school"
(NGO social worker)

"These children think this way: why do I need any help, I am not drug dependent. Of course I am not drug dependent, I use just a little bit. They think that if they do not inject, they are not drug users" (NGO social worker)

Changes in the Structure of IDU Networks

According to the respondents, there have been certain changes in the structure of IDU networks in the recent years. As of the date of research, the following peculiarities have been noticed:

In general, IDU networks have become more widely spread in residential districts, with no concentration being observed in separate districts.

There is a reduction in the number of "well-known and ongoing" drug dens due to the strict control from the side of law enforcement bodies.

The networks of opiate users are small, with about two to five people in one den, who are "trusted and reliable".

It should be noted that the very concept of drug den was transformed. The places where desomorphine is used are not a meeting and communication place for IDUs but rather operate as a shop.

"There are no more drug dens actually. There used to be ones, where everybody got together, talked, you could meet half of Kyiv there. Now it is easy: you've got money, so we meet, inject, and say good-bye to each other" (NGO social worker).

As drugs are often being cooked non-stop due to the need of their frequent use, money to buy a new dose is **got through selling a part of the drug cooked** or by providing the services of cooking drugs, getting a share of the ready drug from the customer. In this case the number of customers may be rather big. The "cooks" are interested in visitors coming as for them such visitors are the key source of getting a new dose. Those who visit drug dens try not to stay there for a long time and after taking their drugs they usually leave the den. Thus, we can say that the nature of interaction in the networks has changed, with a den not longer being a place to meet others and interact. The need of frequent drug use and the fear of law enforcers make IDUs spend as little time staying at the den and communicating with each other as possible.

"If we take a Desomorphine drug den, you can meet the whole city there. The one who cooks starts his morning from cooking drugs and ends his day doing the same. He has not got any free time. It is a non-stop process. The drug effect lasts for two hours, so there is a non-stop flow of visitors. Everything has changed due to the fact that if they cook "vint", they inject and the high lasts for one or two days, so they talk to each other, party together. And with the 'croc' there is a constant flow of drug users and non-stop process of the drug being cooked all the time. They inject every day. From one such drug den I took five or six boxes with used syringes every week: 500 or 600 syringes weekly" (NGO social worker)

Wide Spread and Easy Access to Drugs

The popularity of desomorphine had been steadily growing during the last two to three years due to decrease of available channels for purchasing ingredients for liquid opium extract and "shirka". Pharmacies are the main place where the components to cook desomorphine are purchased.

The information about the places where "shirka" can be bought is thoroughly hidden and protected by those who know it and who try to restrict access of new people, fearing that a new person may be an informant of law enforcement bodies. Such points are mostly known to the IDUs having many years of drug using experience, and young people have almost no access to them.

Recently the quality of the ready-made drug ("shirka") has fallen significantly. The respondents pointed out that it is often mixed with cheaper drugs, most frequently — with Desomorphine or Tropicamide. At the same time, access to the components of "shirka" is very limited among IDUs, so most of them have to buy the low-quality product sold in a ready-made form.

The most widespread schemes of ready-made opium purchase according to the information provided by NGOs workers is the mediated and direct purchase.

First scheme, "Mediated", includes the following stages:

- Getting in touch with a dealer through telephone or Internet.
- Transferring money through an ATM.

- Getting information about the place where the drug may be found. In this case the sale of ready-made drugs is maximally anonymous.

Second scheme, "Direct purchase or purchase through a mediator from a dealer or a producer ("from a pusher" or "from a cook"), consists of the following:

- Getting a joint dose in a syringe or condom depending on the purchase volume;
- Distribution of the drug among the buyers at the place of purchase or at one of the buyers' home.

This restricted access to "shirka" forces IDUs to change to the widely available desomorphine.

Experts say that as the use of Desomorphine goes up, more and more IDUs start cooking drugs themselves as it is easy, safe (you cook it yourself at home, so there are no risks to face militia), and cheaper.

In general, the respondents unanimously note the restricted availability of the raw ingredients used to cook "shirka" on their own from the point of view of a typical IDU:

"If I know where I can buy the real poppy straw, I will never tell anyone. I will better go quietly and buy just for myself"
(NGO social worker)

"There is no poppy in Kyiv now. It is true, you just can't buy poppy today. So you are not able to cook "shirka" for yourself"
(NGO outreach worker).

Institutional Experience

Healthcare

Almost all the respondents had to come across healthcare institutions at some moment. Personal experience and impressions vary from positive to extremely negative ones. Initial expectations of almost all the respondents had been negative. Based on their own previous experience or experience of their friends, IDUs rather expect that they will be stigmatized and refused medical aid — in part or completely. Therefore, friendly attitude of doctors and high quality medical aid are considered to be exceptions. At the same time, though, positive experience also influences further expectations and the readiness to go to doctors.

"I don't know about other hospitals, but there they asked me right away: 'Have you used drugs?', and I said 'Yes'. And they told me all about it. Some of the people I know who were in other hospitals say they were intimidated there. They were told that they would live out one year at most with diet if they keep using drugs. Here we were told that it's 15 years without diets. They told us everything as it is. Good staff works there"
(F, 24, Desomorphine)

The second problem apart from the possible negative attitude is the expensiveness of services and medications in state-funded, and all the more in private healthcare institutions.

Predetermined negative expectations and previous experience always lead to IDUs trying to avoid seeking medical aid and, whenever possible, to solve their problems on their own. Most often it concerns the adverse effects of badly made injections: IDUs often open and operate on abscesses with utility tools at home unaided or with the assistance of their friends.

"Once I woke up in the morning, all swollen, and it hurt so much, I was barely able to get to a polyclinic. I was sitting in the queue with tears in my eyes, I was sitting there and crying. Then I went in to this surgeon and said: - Here, and I showed him. He said: - How long have you been doing this and what is the drug? Go to militia. - No, I won't. Then I told him about it. He examined me and said: - Well, we'll have to cut it. I said: - Cut, doctor, cut it. And he took a business card and wrote a list of things to buy for the surgery, and it covered both sides of the card. I threw this card and said: - Go to hell. I ran back home, steamed the skin out in the bathroom, took nail scissors and tore all those things out. Yes, I did all the surgery on my own" (M, 25, Desomorphine)

Rehabilitation Experience

Some IDUs (most often users of opiates) have some experience of visiting / passing treatment at different rehabilitation centers. Usually this treatment was semi-voluntary and was initiated by respondent's relatives.

There were the following reasons for this decision:

- cases of overdosing or abrupt deterioration of health of the respondent or his/her partner;
- detention by militia and necessity to get treatment in order to avoid criminal prosecution.

All the respondents having such experience have visited, on average, not more than one rehabilitation centre. None of them has completed any rehabilitation program. Most often, IDUs dropped out of the program within 1-2 weeks after its start.

The most frequently mentioned motives were unreasonably strict regime (according to the respondents), "meaningless" tasks, etc. High cost of staying at the rehabilitation centers has often been an additional argument against continuation of the treatment.

"It was a religious centre. There was a pastor, and we all were brothers and sisters… Just like that. And they somehow suppressed me, they took away my cigarettes. I say: let me smoke just a little bit. And they — no! And that's all… there was no TV. No radio, too. So, you see, just four walls, loosely speaking, they are praying — and nothing else. It really put

a lot of pressure on me… And so I left… They didn't want to let me go, I was even going to jump from a balcony. It was the seventh floor. I say — that's it, I'll jump, it's gonna be only worse for you"

"I have spent two months there. I did nothing of what they were telling me to do. Absolutely nothing. It doesn't work. It doesn't work" (M, 25, Desomorphine)

Some respondents also mentioned that they had encountered unwillingness of administration of the centers to return the money after their early termination of treatment.

The most important reason of their failed rehabilitation, according to the respondents, was the lack of motivation.

Very few users (opiates or Desomorphine) of this age category have the experience of seeking help at institutions offering detoxification / substitution therapy. For IDUs it is very important which drug is used in the substitution therapy program. For example, Methadone is believed to be more harmful than "shirka", and this can be a reason to refuse from participation in an SMT program. There is more confidence in Buprenorphine, but the programs using it are usually too expensive, and by no means affordable for every user.

"I wasn't sure I would give it up. I mean, right now. I did it for my relatives only. And only to shrug it off a bit"
(F, 24, Desomorphine)

Law Enforcement Bodies

Stiffening legal control after selling prescription drugs at pharmacies and growing / selling of opium poppy has led to upsurge in market prices of opiates and stimulants. The opportunities to purchase the ingredients or prepared drugs are becoming rare and risky due to the formal and informal steps taken by law enforcement bodies.

More than half of the respondents have the experience of interaction with militia officers. Most often it was the experience of arrest during production ("vint") or transportation ("shirka") of drugs. Actions taken by militia in such cases included beating up, threats of imprisonment and extortion. Besides, some respondents tell that many sale points are informally controlled by militia.

Absence of any negative personal experience of interaction with law enforcement bodies is considered to be a big luck. It is understandable then, that IDUs tend to switch to cheaper and less risky (from the legal point of view) drugs like Desomorphine, even if it harms their health.

"Syringes — whatever, I buy them to make injections to my dog. Cofex is a medicine against cough. Nothing illegal. Yes, they may arrest me and make some threats. But if you have something on you… some ready-made drugs — that's the end of the game, of course" (M, 23, Desomorphine)

Several respondents already have a criminal record and experience of imprisonment, most often connected with drug use directly (they have been convicted for production or distribution) or indirectly (convicted for robbery).

"It has happened, but money solves problems. No record whatsoever… There were problems, but money does solve them. Yes. They caught me with "vint", I paid one thousand dollars… but what for? They kept charging me"
(F, 23, stimulants)

"I got out of prison three years ago… I stood trial three times. For production, for robbery, and for mugging. Twice they couldn't prove it, but one time they got me convicted"
(M, 21, stimulants)

HIV-servicing NGOs

Most often the respondents mentioned they use such services as syringe exchange, HIV/Hepatitis C testing on the territory of NGOs or in mobile clinics. Many of the respondents visit or have visited peer support groups. They consider their experience of using NGO services to be positive. The respondents appreciate the opportunity to talk to NGO workers to get an advice or consultation on various issues, or simply to socialize.

Among the services that NGOs lack, the respondents most frequently named more accurate Hepatitis tests, wider range of medical services, creating better opportunities / programs for re-socialization.

Most often, the respondents got to NGOs through some of their acquaintances who had already been a client of the organization. However, many had met outreach workers before and had known about the existence of such organizations. The cases when the first visit was made at the client's discretion were very rare. The barriers were the fear of publicity, the fear that they might be seen by people they know, and indecisiveness. When a respondent did come to the organization at his/her own discretion, the stimulus was often the opportunity to pass free testing or get free syringes.

"They were standing near the pharmacy while I was walking with my sister. She had learnt about them earlier. They gave her this card. It said, like, get tested for HIV. And syphilis. And hepatitis. Like, free of charge. She took it and got some free syringes. Near the pharmacy." (F, 22, stimulants)

PRINCIPAL CONCLUSIONS OF THE STUDY

1. The study results showed that there are drug scene changes going on in Kyiv. Thus, in connection with the opiates sales curtailing and price increase IDUs change for cheaper drugs — desomorphine, pharmacy stimulants etc.
2. Among the interviewed IDUs the poly-drug use is widespread — use of different drugs, substitution of the drugs which are hard to access with more available ones.
3. The widespread practice involves the sale of the opiates mixed up with desomorphine or tropicamide. IDUs buying such "dirty" drug do not know about this and are not aware of possible health risks.
4. There is a tendency that among young drug users the injecting use of drugs is initiated from desomorphine.
5. The networks of IDUs using desomorphine or stimulants are not large. As a rule, they include 3-7 trusted persons. IDUs using desomorphine are not eager to expand the circle of the people with whom they cook and use drugs.
6. The large number of the "new" drugs recently emerged have spawned a variety of slang terms which are unknown or confusing for IDUs. The consequences of using and "unknown" drug for IDUs may include overdose, poly-drug use, health risks.
7. Neglecting the solution infection risks during drug cooking is quite widespread among the cooks of home-made drugs. The cooks re-use production vessels to cook and distribute the drug. The vessels are washed poorly and not disinfected properly. The cooking process of separate types of home-made drugs does not envisage boiling which can also be a risk factor.
8. Among the IDUs there are clinging myths regarding sexual behavior and drug using practices which may be conducive to risky behavior. Thus they do not use condoms with the partners whom they trust or in whose health they are sure. The trust is based on the partner's healthy appearance or long history of personal acquaintance. Besides, there is a belief that if an acid is used while cooking drugs, it can kill all infectious agents. Thus they may be used through joint syringe or without preliminary boiling. Another myth is connected with the belief that the drugs cooked using some acid are safer, if administered by injecting and not per os.
9. Among IDUs self-treatment of abscesses, blisters including "home surgery" is widely spread. this situation is caused by unavailability of medical services because of the paid medical services, high price of medicines, queues in medical facilities etc.