

Interview with Peter Sarosi

Peter Sarosi is a Hungarian human rights and drug policy activist, executive director of the [Rights Reporter Foundation](#), advisory board member of the Eurasian Harm Reduction Association and the Steering Committee member of the [Correlation European Harm Reduction Network](#). Maria Plotko talked to Peter about the state of harm reduction in Central and Southeast Europe.

Have there been any significant developments in the region of Central and Southeast Europe since 2018? Any scale-back or scale-up of harm reduction services?

There are some improvements in some countries, for example, in Serbia, Montenegro and Macedonia. Although governments still allocate very small budgets for harm reduction, at least they are becoming more open, willing to cooperate with the civil society and end this terrible situation after the Global Fund funding ended and other programs collapsed.

There is a new outreach program in Belgrade. The Bosnian government seems to be open to give funding for harm reduction; some money was allocated in Montenegro. The financing in Bulgaria that was stopped due to some bureaucratic problem related to the funding criteria introduced by the government has been resolved to a certain extent now, and the needle exchange program operates again in Sofia, and a new drop-in centre was also opened, which [was later closed down](#).

There is still a shortage of opiate substitution medications in Romania, and the Ministry of Health is very inactive to solve this. Thankfully, there are still available programs even amid the coronavirus pandemic. [Organization Carusel has made some significant improvements](#) and recently opened a new shelter.

No real improvements happened in Hungary, apart from a new mobile outreach program in Budapest, called [HepaGo](#), which reaches those areas where needle exchange programs were shut down in 2014. The only problem is that it is financed with international money, which makes it fragile; it's not sustainable without money from the state. Injecting drug use in Budapest is decreasing, probably because people are switching to smoking synthetic cannabinoids.

More and more people use new psychoactive substances in other Eastern and Central European countries: some of them as the main drug, and some in combination with other substances. I think it is a very significant change for care systems because most of them were primarily constructed to get opiate users into substitution programs. But how do you deal with the treatment of new substances' users? I've heard that rehab programs don't work for them as well as with opiate users. We probably need to explore these short-term interventions for these users, who are sometimes much younger than heroin users. People still need help, but they need some different approaches.

You said that some governments had become more open to harm reduction. What has changed to make them do that?

I think the fact that they sit down at the negotiating table is already a good sign. In Belgrade, we presented [a study about the clients of a closed needle and syringe program](#), and the feedback from the government was very positive, they are now more friendly to the civil society and speak with them more actively. They still can't offer much, but at least they have some budget for harm reduction programs. In most cases, I think this change happens because of the pressure and advocacy by the civil society. But these bureaucratic machines are very slow. After years of advocacy, it gets to the stage when the implementation of programs is in the hands of decision-makers. A few years ago, we formed [the Drug Policy Network South East Europe](#), and it took us two more years until ministries started implementing real measures.

Are these measures mainly related to the "old harm reduction", or do they also involve new services, like drug checking or drug consumption rooms?

Some organisations in Eastern and Central Europe started doing drug checking in nightlife settings and during festivals. In Western Europe, however, liquid chromatography machines are now used in festivals. I think many organisations in our region could also afford them. The real barriers are not financial. Money could be collected through fundraising or crowdsourcing campaigns. There are a lot of wealthy middle-class people going to these festivals. It's not a big deal to raise the money. I think that the real problems are legal barriers and police practices.

Are these the same barriers for introducing new harm reduction approaches in general? To open drug consumption rooms or change service packages in harm reduction settings?

In an environment where you don't even have resources to operate traditional harm reduction services, like needle and syringe programs or opiate substitution, you don't have funding for anything else. It requires stable, sustainable funding from the government to run these programs. It's not something you can just start and see what happens. The second issue is the attitude of governments. They don't want to risk this kind of public controversy. Even in the progressive Czech Republic, conflicts arise with residents who oppose needle and syringe programs. It's a kind of political risk for leaders in our societies with a lot of conservative-minded people to introduce an innovative program.

You said that because people don't inject so much, they need different harm reduction. What do you think prevents the existing services from changing their packages?

They are changing. At least in Hungary, they are changing. For example, if there is less demand for needles, they will distribute some other things. At the moment, these are COVID-specific things, like masks, gloves, disinfectants. There is also a demand for social help. Many people are still living with Hepatitis C, and they need help to get into treatment. That's why we called our new project *HepaGo*. People who injected drugs before didn't have access to treatment. This is what this project helps to achieve in collaboration with hepatology doctors.

Psychologists' help is essential in the case of new psychoactive substances because of psychosis, aggressive behaviour associated with them. Also, most of these people live on the street, and they face a lot of social issues. We should realise that harm reduction is not only about HIV and hepatitis C, but it's about different kinds of help to people who live on the margins. They need other types of support as well, like helping them to find housing and normalise their social relationships.

You said that some new networks had been formed in the Southern subregion. What kind of networks?

I had in mind the Drug Policy Network South East Europe. They organise conferences for regional harm reduction actors, provide help on the country level, publish reports. It would be useful if people from this and other networks, like the Eurasian Harm Reduction Association, could visit countries to sit down with local politicians, bureaucrats, researchers and civil society. This would provide local NGOs with an opportunity to talk to governments and set agendas. Such a model would be useful in the future after the pandemic is over.

What is the civil society's role, and what do they advocate for in different countries?

Budget is still the main issue. It's a year to year survival for programs, which limits the scope of advocacy because you have to fight for the very resources that enable you to operate. You don't really have the capacity, energy and staff to fight for other things. The funding for harm reduction in the region is unstable. That is also one of the reasons we don't have enough innovations or don't open drug consumption rooms or implement naloxone programs. Governments primarily aim at banning substances and don't care about providing support to drug users. And I see a lot of uncertainty among service providers in light of these changes in the drug market. The readily available harm reduction models that used to work are not enough.

Who funds the services? Are there governments or other international donors besides the Global Fund that do this in the region?

Most of the funding comes from national or local governments. I don't know any significant international financing of services coming to the region right now. I know organisations that have conducted successful fundraising or crowdsourcing campaigns. The new drop-in centre in Sofia was opened with the fundraised money. I also know organisations in Hungary that work with marginalised Roma people, not only drug users, who have led some successful crowdsourcing campaigns. It is not a lot of money, not enough to run organisations, especially if they provide lifesaving, public health and social services that the government should fund. Crowdsourcing opportunities won't substitute the stability of government funding.

Do any organizations advocate for the decriminalization of drug possession, drug use or the human rights of people who use drugs?

There are not that many. There was a [decriminalization campaign](#) in Lithuania in 2017, but I don't remember any others. You need to have liberal or socialist governments to have a successful campaign in this area. I don't see any countries now where anybody could say that there is at least a 50 per cent chance to lead a successful advocacy campaign in the fields you mention.

But it doesn't mean you shouldn't do it.

You are right; it doesn't. It doesn't mean that you should not deal with criminal justice and criminalisation of people, because these are critical issues. I see efforts being made to add alternatives to incarceration systems. In Poland, for example, they are talking about more alternatives and also how to link the criminal justice system to the treatment system.

Would you agree that most organisations in the region primarily work on the provision of services and funding, but not drug policy and advocacy?

I think some organisations do advocacy on top of providing services, and some don't even understand why advocacy is crucial in the first place. What they do is not always advocacy—they try to make some behind-the-scenes pacts with governments. Only very few organisations, maybe one third, are brave enough to organise campaigns like [Support don't Punish](#) on the 26 of June. Even when they do, it's sometimes very weak. In general, advocacy is very weak in the region. Only very few organisations do real advocacy; and mostly on funding and services. They don't want to take the risk of being political to talk about criminalisation. Harm reduction services are much easier for people to swallow than decriminalisation. It's not easy for many in the government to understand that these people need help; they should not be punished in the first place. We don't see much of this attitude in the region.

You said that organisations must be brave to do advocacy. What kind of consequences could they face? Will they lose funding if they speak about decriminalisation, or is there more to it?

That's the main fear. Most of these organisations are very much dependent on government funding, and they are afraid to lose it. I wouldn't say that this fear is unfounded in the environment of very scarce resources. Governments tend to support organisations that they find more manageable and conforming to their expectations. That's why there is a need for bravery to speak up for decriminalisation. You can be labelled a "political civil society", which in some countries like mine, are called "Soros agents" [the Hungarian-born American billionaire philanthropist George Soros finances many liberal and progressive causes] or be accused of wanting to legalise drugs. I think many service providers want to avoid being labelled as a radical organisation.

But harm reduction is mentioned in policy documents and is featured in national health packages.

Many national drug strategies do mention harm reduction. Some countries mention surprisingly progressive things, for example, in some Balkan countries. I've heard that some national drug strategies there have been copy-pasted from EU documents. But it doesn't mean, of course, that these documents are implemented, despite all these references, existing mechanisms for funding or

alternatives to incarceration. They are simply not used. Or if they are, not on the full scale. It is not a priority for governments.

But why do they have all these policies but don't implement them?

I think it's a kind of nature of policymaking: it's much easier to adopt guidelines and recommendations than implement them. Governments can claim success by issuing a new rule or strategy, tick the box of having a national drug strategy in the form of a comprehensive, balanced document. They can tell the media and people, "We are working on a drug policy, we have a strategy". But they are not so eager when it comes to allocating resources for their implementation. Monitoring and evaluation are also missing in most countries. In Hungary, four organisations working in rehabilitation, treatment, prevention and harm reduction, united in the Civil Society Forum on Drugs. We did an independent civil society evaluation of the implementation of our national drug strategy and produced a report based on focus group research and interviews with service providers. But governments don't make any efforts to evaluate their policies.

Could you identify any good advocacy efforts in the subregion? Also, what do you think works when you speak to governments?

What works very much depends on the attitude of each particular government. For example, Poland has a very conservative government, but at least they have the National Drug Agency, which kind of counterbalances these conservative tendencies, and they can maintain support for harm reduction programs and civil society. The conferences on drug policies that the [Polish Drug Policy Network](#) organised in the previous years in different cities was a beneficial civil society initiative to show that drug policy is not only about national governments. Some issues could be solved on the local level. They also trained a lot of municipal authorities and professionals.

Super conservative governments now rule in many countries, but there are liberal city mayors. When the national government is inaccessible, we can go to city authorities. We have been doing this in Hungary, and a lot has been achieved in local governments. Some of them now support harm reduction. One thing we have learned in the past two or three years is that we should focus more on local policies. Harm reduction was born as a grassroots initiative in European cities: Frankfurt, Zürich and others. It has always been a local thing. Possibly, it won't work in all the Balkan countries, but it does in Hungary and Slovakia. Bratislava has a new city mayor, and Iveta Chovancova, a former member of the Eurasian Harm Reduction Association's Steering Committee, now works for the city administration and helps promote harm reduction programs from the inside. The next harm reduction conference will be held in Prague, and I see the city also supports this conference.

Could you talk more about the Roma population and drug use in the region. I understand it's a big problem.

I wrote an [article](#) about this some time ago that sums up the scope for this issue. There are large Roma populations in Slovakia, Czech Republic, Hungary, Romania, Serbia and Bulgaria. In Hungary, for example, seven percent of the population is Roma. Most of them are likely unemployed and don't have access to essential services, suffer from segregation in schools and places they live in.

The situation is similar in other countries with large Roma populations. Even though drug policies claim to be colour-blind, but there is racial profiling in the region. When we speak about this, we usually think about the US and Afro Americans and Latino Americans, but we don't talk about what is happening in our region. We don't talk about the trauma of people who have a much greater chance to be arrested for drug use and be imprisoned. You can see in many cities across the region that nine out of ten people in needle exchange centres are Roma. We don't have enough studies and research about this, but Roma constitute a big part of the poor. Sometimes existing programs don't reach out to these communities because they operate in city centres, while these people live in segregated areas. And if you don't have culturally appropriate outreach programs to bring help to their part of the city, you don't even see them. They become completely invisible. I think we need to work more on this.

If we researched how much Hep C or HIV affect these populations, we would indeed find that they are disproportionately affected.

What about other groups, like women or young people or men who have sex with men? Are there any specific services for these groups in the region?

I see very few services targeting these populations. The only needle and syringe program for women in Hungary was closed in 2014. The research on women done last year by [Zsuzsa Kaló](#) in Hungary found that the country's treatment system is not friendly to women and don't always meet their needs, especially if children are involved. Women don't have a place to leave their children when they go to services. There is also the problem of domestic violence. If their partners are also drug users, women don't always want to go to the same service. Women are pretty much dependent on their partner for assistance and getting drugs.

Most specific services target sex-workers. They sometimes overlap, of course. Only one program in Hungary provides shelter and services explicitly for pregnant women who use drugs. It's similar in other countries, I think. The only exception could be migrants and refugees, which is a massive issue in Balkans now. I've heard about programs that go to refugee camps for HIV and Hep C testing or reach out to drug users.

What about young people who use drugs? Do any programs address their needs?

In my experience, most such organisations are set up and operated by young people who are party drug users. Therefore, all their services are linked to the party scene. I don't see the same for marginalised injecting drug users. Youth organisations are mostly for psychedelic drug users. I have always admired this organisation in Belorussia *Legalize Belarus*. In a country like Belarus, it's impressive. These idealistic young people do good things, but they are not harm reduction service providers.

Let's talk about some specific services, like the opioid agonist treatment (OAT). Are there any problems with take-home dosages, mandatory drug checks?

In most countries, maybe except the Czech Republic and Slovenia, the main issue has always been accessing services. But with the shrinking number of opiate users in some countries as Hungary, the situation is changing. Still, regulations are very restrictive. Many people are pushed to detox or are not able to access the type of therapy they prefer, e.g., they are forced to take Suboxone when they want methadone or buprenorphine. Sometimes these decisions are not based on the needs of clients but are dictated by agreements between pharmaceutical companies and service providers. Many clients in Hungary were not happy when services switched from pills to liquid methadone.

OAT programs sometimes feel like very rigid systems that are more serving the people who are providing the service rather than those who receive it. Because of these restrictions, some people opt to get a prescription from doctors to buy the therapy they want in pharmacies. But there are not many of them; only those who can afford this. Most still get their treatment from state- or NGO-run programs. I think that the COVID-19 pandemic can change this rigidity, help break down these barriers. We hear that the rules are changing in many countries now, and people are allowed take-home dosages for more extended periods of time.

Is there any difference in terms of quality of services or clients between NGO- and state-run substitution clinics?

Most state-run clinics I have visited in the region are in hospitals. They are approachable for those who live in cities. With NGOs, it's a mixed picture, but they are less prevalent. For example, in Hungary, I think only one or two NGOs do that. In most other countries, especially in the Balkans, it is still very much doctors in white coats in hospitals.

Do clients prefer NGO-run sites?

I never asked clients this specific question but think that they would much rather go to a drop-in centre rather than to a clinical, sterile, bureaucratic setting that is not user friendly and has this kind of authoritarian atmosphere. A lot of people are queuing in these hospitals, and there are conflicts. The black market for methadone is a considerable problem in many countries. Dealing happens near these large hospitals. We had a lot of reports about people robbed by some violent gangs after leaving a hospital, who take their methadone. I think it is safer and more friendly to have decentralised OAT centres. It would also be great if general practitioners or psychiatrist could prescribe methadone to be obtained in pharmacies.

Why do you think it's so hard to scale up these services?

Again, I think it's more an ideological rather than a financial barrier. Many governments say that there is not enough money. I don't think it's the issue. When governments start to prioritise, they always find the money. But these issues are not something that politicians can gain political capital with; they are not popular. They cannot sell it as a political product. It's similar to renovating prisons. They can say that money is spent to build new jails to put more people into them, but not that the new jails are more humane for inmates.

Why do you think it's so politicised? We're speaking about health issues.

Because drug use is a [moral issue](#), many don't perceive it as a public health issue like diabetes. Most people still condemn drug use, stigmatise it. I don't think this attitude would much change if drugs were legalised. This label would remain because people perceive that it is drug users' fault: You are morally inferior if you use drugs, and you don't deserve to receive this funding because you are less than me. I am a normal person, pay my taxes, but you don't. Why do you deserve more? Why shouldn't we give the money to kindergartens? Alcoholism is perceived as part of our culture, but drugs are viewed as something alien.

What about barriers to services and their quality?

As I have mentioned, restrictive rules primarily prevent people from being admitted to programmes. Also, people are often prescribed very low doses. And we know that insufficient quantities don't work. We have been trying to change this in Hungary for a long time without real success. Some responsive doctors prescribe sufficient doses, but most of them are very conservative, with the abstinence-minded mentality, who push people to reduce their dose. Another issue is limited slots for substitution treatment. Of course, it's different in each country. In Hungary, if hospitals admit more people, they must cover these expenses from their budget, they do not receive this normative fund from the state budget. That's why there are waiting lists. People must undergo one or two unsuccessful attempts to quit, and only then they are admitted into programs. But it depends on doctors—their attitudes remain the most significant barrier.

What about polydrug use? If you're a polydrug user, can you enter the program?

It also depends on the doctor. Some programs require urine tests, and you can be kicked out if you use other substances. A good professional with a normal mindset would not kick out someone just because he or she smoked marijuana. It depends on the professionalism and humanity of doctors.

What about the quality of services? How comprehensive are they?

Most hospitals conduct motivational interviews for people who want to quit and have ties to rehabilitation centres. OAT programs are often accused of being “pill meals.” But it's not true. Most programs are making serious efforts. I have never seen an OAT that kicks you out because you refuse to go to group meetings or counselling. If clients don't need this type of personal interaction and just want to pick up their medicine, they can go to a substitution clinic without having interactions with any other services for years. But if you want, there are possibilities.

Are there groups of OAT clients who advocate for the improvement of the quality and coverage of services?

This area is very underdeveloped, and there are very few groups like that. This is one of the critical problems in our region that service providers don't make much efforts to encourage community involvement. Mostly because it would need additional financial, time and energy investments. You need to have resources and capacities to do this. Advocacy organisations can't do this alone. But if you are a service provider, I think it could be done with the training of peer leaders. Some young people organisations are working in the field of psychedelics or cannabis, but not with marginalised communities.

Governments don't adequately implement monitoring mechanisms. The Czech Republic has some kind of quality accreditation for drug prevention programs, but not for harm reduction. I don't see any significant efforts to monitor and evaluate these programs.

Why do you think there are no working monitoring mechanisms? It would make sense because the governments fund them.

Countries have different protocols. But again, it requires money to implement them. The first thing governments should recognise is that it's also their responsibility to ensure that these programs operate according to quality standards. Professional guidelines in Hungary foresee that each harm reduction program needs to employ at least two half-time workers and a professional worker. There are standards for the professional education of these people. But it is not enough to pay their salaries from the funds the government provides to these programs. It's a contradiction: the professional guidelines say that you need to have this and that, but there are no resources. When governments don't provide sufficient budgets for these services, they will not pay attention to the quality evaluation because they know that it is impossible to achieve the standards with existing resources. Harm reduction programs are happy if they can produce base salaries for the staff and for the safe disposal of needles, which requires a lot of money. They don't have money for extra services, like psychologists or gynaecologists. It's a resource issue.

Can you talk more about the new psychoactive substances and amphetamine-type stimulants?

The primary stimulant in our regions is still amphetamine. But the new psychoactive stimulants are also coming, especially in Poland, Hungary, Romania. In Slovakia and the Czech Republic, pervitin (methamphetamine) prevails. In Hungary, most injecting drug users use cathinone-type new stimulants. The trend of synthetic cannabinoid use can be seen in many countries: in prisons, among homeless or Roma people. Most marginalised groups massively turn to synthetic cannabinoids because they are cheap, readily available, and they just knock you out: you don't feel the pain and suffering of everyday life. It's an "ideal" drug for the poor. These new synthetic stimulants and cannabinoids are dealt with separately, not in one group.

And what about overdose prevention and access to naloxone?

In most countries, naloxone cannot be taken home or distributed because of the protocols allowing only a professional doctor to administer it. It's only available in emergency units, and nasal naloxone is missing entirely. I don't see any real efforts to introduce naloxone, maybe only in the Baltics, in Estonia, not in other countries. When we had the heroin crises about ten years ago, service providers advocated for naloxone, but not anymore. I don't think that it is a part of any advocacy efforts.

What is happening with drug use and harm reduction in prisons? Is there any new research about these issues?

The prison issue is still a white spot in most countries. No OATs exist in Hungarian prisons. But even in the countries where they do, access to them is very low. Needle exchange is absent entirely. Most prisons don't address drug issues at all, sometimes provide some counselling, Narcotics Anonymous or something like that. Prisoners increasingly use new psychoactive substances because it's much easier to smuggle them in and it is much more difficult to test them. Prisoners were banned from receiving postcards in Hungarian prisons because there were many instances when they were soaked in drugs. Letters to prisoners are now xeroxed. Sending tobacco is also not allowed because cigarettes were often infused with cannabinoids. I think that synthetic cannabinoid issue is the biggest problem

in prisons where the use of new psychoactive substances is widespread among the population. The rate of people incarcerated because of drug use in our region is not very high, but laws are very restrictive, sentences are disproportionately severe, and alternatives to incarceration are underdeveloped and underused, even if they exist in laws.

Is there a problem with legal help for people who use drugs and interact with law enforcement?

In some countries, such as Poland, this is a problem of training law enforcement. The legal framework for alternatives exists, but judges and prosecutors don't use it. I know that the Polish Drug Policy Network has made efforts to train judges and prosecutors. In Hungary, the law allows people to opt for six months in an outpatient program in the case of small amounts. About 90 per cent of people who are sent to this program are occasional cannabis users who don't need any treatment. Even if one of these alternatives exists, there are no real filters in place, like in Portugal, when only problematic cases are referred to treatment. There is no need to treat those who don't need this.

My last question is about hepatitis C, HIV and TB treatments. What are the major problems?

After the HIV outbreak in Romania, we didn't see more outbreaks in the region. Testing and counselling are still very low, especially in some countries like Hungary. Even if people are tested positive, how to ensure that they go to treatment? With the new hepatitis C treatment, there is some money from the big pharmaceutical companies, which is a positive thing. In Slovakia, they gave some money for harm reduction organisations to help drug users to get into hepatitis C treatment. It also later happened in Hungary. The biggest problem is in those countries where there is no harm reduction, or its coverage is limited, like Hungary or the Balkans, where it is hard to get treatment for these people. I wonder how many people, who were infected with Hep C five or six years ago, will develop cirrhosis or even die needlessly when they could otherwise be saved? This is devastating to see.