



European Monitoring Centre  
for Drugs and Drug Addiction

EMCDDA TRENDSPOTTER BRIEFING

**Responsiveness and preparedness  
in addressing drug-related needs  
of displaced Ukrainians in EU countries  
bordering Ukraine**

July 2022

## Contents

Executive summary .....	3
Introduction .....	6
Study methodology and parameters .....	7
Data sources and limitations .....	8
The drug-related situation in Ukraine and projected impact on demand for drug services in the European Union.....	9
Unprecedented displacement and flows of Ukrainian citizens .....	9
Insight into problem drug use and its consequences in Ukraine .....	10
Impact of the invasion on drug services in Ukraine .....	12
Projected drug-related health care needs in bordering EU countries: results of a simple modelling exercise .....	13
Actual reported demand for and provision of drug services in EU countries .....	14
Responding to the needs of displaced Ukrainian citizens with drug-related problems.....	18
Mobilisation, needs assessments and monitoring .....	18
Women represent the majority of new treatment entrants in bordering countries .....	23
Screening, testing and treatment of infectious diseases among displaced people with drug-related problems .....	25
Challenges in the provision of drug services to displaced Ukrainian citizens .....	26
Client-level challenges .....	26
Service-level and systemic challenges .....	28
Implications for responsiveness and preparedness .....	30
Conclusions.....	33
References.....	34
Annex 1. Projected drug-related health care needs for displaced Ukrainians with drug-related problems in bordering countries.....	39
Methods.....	39
Results.....	40
Annex 2. Conditions for displaced people fleeing the war in Ukraine to access drug services .....	46
Acknowledgements .....	52

## Executive summary

**Introduction:** On 24 February 2022, Russia invaded Ukraine, with devastating social, political, economic and health-related consequences. Over the following months, millions of people were displaced from their homes within Ukraine, with many fleeing the country. As of June 2022, for example, it is estimated that nearly 4 million people have crossed the border into Poland.

Neighbouring countries have therefore needed to provide support and care for millions of Ukrainians, predominantly women, children and the elderly, who have been displaced by the conflict. Despite the mobilisation and support of the international community and non-governmental organisations (NGOs), this has created considerable challenges for existing social and health support services. From a public health perspective, one immediate priority for the countries bordering Ukraine has been to ensure continuity of medical care for the displaced population. The focus of this rapid report is to consider the implications of recent developments for the provision of services for those needing treatment or other interventions to respond to drug-related problems. Of particular focus here are the issues of providing continuity of care for those displaced requiring access to opioid agonist treatment or infectious disease treatments.

**Aim and method:** The purpose of this rapid assessment study is two-fold. First, the study audits the initial service response to the needs of displaced Ukrainians in neighbouring EU countries. Second, it identifies factors that may help EU countries to be better prepared for possible future needs in this area, either associated with further population displacement, or more generally because of the vulnerabilities of those who have experienced displacement. An important caveat is that this is a complex and rapidly evolving situation and the findings reported here are necessarily preliminary.

The analysis present here is based on the following information sources: a search of open source literature; a survey of 24 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) national focal points; three focus groups with representatives from bordering countries, international organisations and Polish health workers; a mathematical modelling exercise; and information from recent expert meetings conducted by the EMCDDA.

**Findings:** In the 4 months since the Russian invasion of Ukraine, it is estimated that nearly 8 million people have fled Ukraine, of which over 5 million are estimated to have crossed the border into the EU. Of those fleeing Ukraine, approximately 90 % are women, the elderly or children.

Before the war broke out, it was estimated that in 2020 in Ukraine there were around 350 000 people who inject drugs (PWID) and 280 000 people using opioids. Only around 6 % of those using opioids were enrolled in opioid agonist treatment (OAT) services (about 17 844 OAT clients as of May 2022). Approximately 15 % of these OAT patients were women. An unknown number of opioid users were receiving other

forms of intervention, with some recent data suggesting that around 50 000 may attend some form of outpatient care annually.

In addition, injecting drug use, and associated blood-borne infections, remain a significant public health challenge in Ukraine, with HIV prevalence among PWID in 2020 estimated at 20 % (with 20 % of cases women). Studies suggest approximately 64 % of PWID are likely to test positive for hepatitis C virus (HCV) antibodies.

The information initially available suggests that between February and May 2022, in line with simple statistical projections, relatively low numbers of displaced individuals have sought continuation of OAT services in bordering countries (e.g. nearly 100 patients in Poland). This is likely to reflect the fact that within Ukraine, PWID and those receiving OAT are predominantly male, while those displaced are currently disproportionately women and children. Similarly, according to national experts, the number of displaced people who use drugs (PWUD) from Ukraine accessing infectious disease services — when available — was also low and below the expected level.

The low rate of OAT treatment provision within Ukraine is an issue of potential concern for the future, especially if patterns of displacement change and more males are displaced in the future. This implies that there is a potentially high level of unmet need that may require greater provision of treatment support, low-threshold and/or harm reduction services.

While to date the demand for drug services from those displaced from Ukraine has been modest, the findings of this study suggest that challenges are observable and a number of issues have been identified that act as potential barriers to providing care. These include linguistic and cultural barriers; administrative preconditions for accessing services without charge; limited OAT medication quotas and supplies in some bordering countries; difficulties in determining OAT medication equivalencies between those commonly prescribed in Ukraine and those prescribed in the host countries; ensuring continuity of care to those in a temporary situation or in transit within the EU; stigma resulting in a reluctance to disclose drug use and seek help; child protection fears resulting from disclosure of drug use; and uncertainty for service providers around funding and reimbursement for services delivered. In addition, responding adequately and ensuring continuity of care is made more challenging by the pre-existing low availability of OAT and harm reduction services in many of the countries bordering Ukraine.

**Way forward:** Services that are already stretched have had to respond to some increased need. However, to date the numbers of displaced persons from Ukraine identified as requiring OAT provision in bordering countries have been relatively modest and overall appear to have been successfully managed within existing provision capacity. However, from a short-term perspective, a number of challenges are apparent that will need to be addressed if adequate responses are to be maintained and the situation in terms of displacement of individuals is not to increase further. Importantly, continued monitoring and a commitment to providing care are

needed from both national and international stakeholders, accompanied by the provision of appropriate resources. Attention is needed to ensure the availability of adequate OAT medication and treatment capacity. Measures are needed to support services to ensure they have appropriate financial, linguistic and translation capacities.

In addition, and reflecting the potential mobility of displaced persons, it will be important to put in place efficient communication channels between services providers to support continuity of care for patients who relocate either within neighbouring countries or to other parts of the EU. This is likely to be especially relevant for ensuring continuity of care for those patients receiving OAT and/or antiretroviral therapy (ART).

The reported numbers of displaced people from Ukraine in other EU countries are now growing. From a longer-term perspective, Member States will need to be prepared for increased drug-related needs among this population. This will be particularly the case if population dynamics change, resulting in more displaced male individuals. More generally, for both existing and future displaced people, more complex health needs may become apparent over time due to the trauma experienced by many of those fleeing the war. It is likely that in some key locations, dedicated and culturally appropriate treatment, support and harm reduction services will be needed.

## Introduction

The Russian invasion of Ukraine on 24 February 2022 has been responsible for the largest displacement of people in Europe since World War II. In the subsequent 4 months, it is estimated that around 8 million people have fled the war in Ukraine, of which an unprecedented 5 million people have crossed the borders into the European Union. As of 16 June, approximately 3.5 million Ukrainians had registered for temporary protection or similar national protection schemes in EU countries.

The EU and its Member States, especially those bordering Ukraine, have initiated a rapid humanitarian response, providing urgent support to meet the health and social needs of those fleeing the country. This report focuses on the responsiveness of these countries in meeting the health-related needs associated with drug use among displaced persons. An unknown proportion of those displaced will have established drug-related problems and will require medical care for opioid dependence, in particular OAT, as well as for prevention and treatment of drug-related infectious diseases. To date, it appears to be largely countries bordering Ukraine that are reporting the uptake of displaced PWUD into national drug services. However, the situation is evolving rapidly and other EU countries already have, or will have in the future, a need to respond to drug problems among displaced persons. Therefore, the purpose of this rapid assessment study is two-fold. First, the study audits the initial service response to the needs of displaced Ukrainians in neighbouring EU countries. Second, it identifies factors that may help EU countries to be better prepared for possible future needs in this area, either associated with further population displacement or more generally because of the vulnerabilities of those who have experienced displacement.

This rapid assessment study was conducted over a 6-week period in April and May 2022. The primary aim was to provide a rapid snapshot to increase our understanding of:

- the number of people with drug-related problems fleeing Ukraine and their need for care, with a focus on displaced PWID, people who use opioids, and people with drug-related infectious diseases, or who are in contact with drug treatment services and harm reduction services where continuity of care and support are provided;
- the demand for and utilisation of specialised drug treatment, OAT and harm reduction interventions by the displaced population with drug-related problems in bordering EU countries;
- the main short-term challenges in providing care for displaced persons and the potential barriers to accessing care and support in the countries bordering Ukraine;
- the key medium- and longer-term actions needed to improve preparedness on the part of EU countries as a whole for possible future challenges in this area.

## Study methodology and parameters

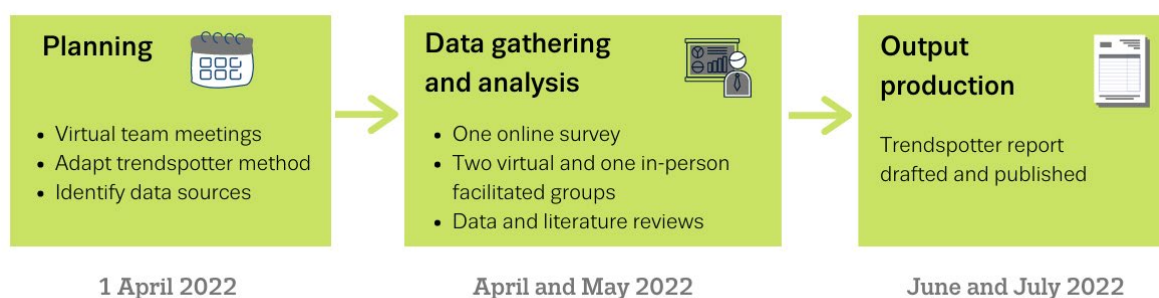
The study utilised the manual-based EMCDDA trendspotter methodology (EMCDDA, 2018). This multimethod rapid assessment approach is based on the triangulation of a range of investigative methodologies and data collection from multiple qualitative and quantitative sources with a systematic analysis incorporating the use of expert opinion. For the purposes of this study, the approach was adapted to suit a rapid online investigation (Figure 1).

**Geographical scope:** For practical purposes, this study limited its focus to Member States bordering Ukraine, which are those that have been most clearly impacted in the first months following the invasion. Specifically included are Hungary, Poland, Romania and Slovakia (Figure 2). In some analyses, information from Czechia and Bulgaria has also been included. Information on the situation in Moldova and Georgia is not included here but will be investigated in a separate EMCDDA study.

**Population:** The population of concern were displaced citizens from Ukraine with drug-related problems who have fled Ukraine since the start of the Russian invasion in February 2022. Documented or undocumented Ukrainian nationals who resided in the EU prior to the war were not covered in this study.

**Interventions:** This study focused primarily on drug-related interventions for people with high-risk patterns of use, including drug treatment and harm reduction services, as well as interventions focusing on the prevention and treatment of drug-related infectious diseases.

FIGURE 1  
Adapted trendspotter methodology, June 2022



**FIGURE 2**  
**Geographical focus of the study**



### Data sources and limitations

This rapid assessment is built on a rapid review of the available international literature, including grey literature and open sources; the analysis of existing epidemiological data; an online survey; three focus groups; and information presented at EMCDDA Expert Technical meetings (Problem Drug Use and Treatment Demand Indicator meetings).

In addition, a simple mathematical model was developed to attempt to estimate the total number of displaced adult high-risk drug users (female and male) from Ukraine who have arrived in bordering EU countries since the start of the Russian invasion and who might need drug and/or infectious disease services. The model incorporates the available information on the prevalence of drug use and related



harms and treatment in Ukraine before the war; estimates of the numbers of displaced people coming from Ukraine and arriving in bordering EU countries; and a mobility factor (an estimate of the relative risk of leaving the country for PWID in Ukraine compared to the risk for the general population). The full methodology, limitations, results and interpretation of the model are presented in Annex 1.

An online survey was conducted between 11 April and 3 May using the EU Survey platform. It was sent to heads of national focal points from the EMCDDA Reitox network, and replies were received from 24 countries: Belgium, Bulgaria, Czechia, Denmark, Germany, Estonia, Greece, Spain, France, Cyprus, Lithuania, Luxembourg, Hungary, Malta, Netherlands, Austria, Poland, Portugal, Romania, Slovenia, Slovakia, Finland, Sweden and Norway. It included 20 questions covering the provision of drug services to displaced people fleeing Ukraine; access to drug services; access to infectious disease testing and treatment; and service preparedness and monitoring issues.

In addition, three focus groups were conducted. One focus group was held with representatives from national focal points in Bulgaria, Czechia, Hungary, Poland, Romania and Slovakia. A second was conducted with Polish health professionals working in the drugs field. A third was conducted with health care professionals from Member States bordering Ukraine and representatives of international organisations operating or coordinating drug-related activities in the region.

A number of limitations need to be taken into consideration when interpreting the results of this study. First, there are the inherent limitations that come from a rapid assessment exercise conducted with a limited number of participants. Currently, the amount of additional information available to inform discussions on this topic is very limited. In addition, the situation is an extremely dynamic one and may change rapidly. All findings reported here should therefore be regarded as preliminary and will need to be reviewed as more information becomes available.

## The drug-related situation in Ukraine and projected impact on demand for drug services in the European Union

### Unprecedented displacement and flows of Ukrainian citizens

As of June 2022, in just over 4 months following the Russian invasion, an unprecedented number of nearly 8 million people have crossed the border from Ukraine, of which over 5 million crossed into the EU <sup>(1)</sup>. According to reports from the United Nations High Commissioner for Refugees (UNHCR), a large majority fled to bordering EU countries. For example, by June 2022, over 3.5 million border

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(1) <https://data.unhcr.org/en/situations/ukraine>

crossings from Ukraine into Poland had been reported by the national Polish authorities since the start of the invasion. As of 16 June 2022, a proportion remained in these countries <sup>(2)</sup>, with around 1.1 million in Poland, 88 000 in Romania, 78 000 in Slovakia and 24 000 in Hungary. Some moved onwards to other countries, including Germany (780 000), Czechia (374 000), Turkey (145 000), Italy (129 000) and Spain (120 000). A significant number of those displaced also returned to Ukraine during that period. It should be noted that there is some uncertainty about the numbers and destinations of those fleeing the conflict in Ukraine.

The majority of displaced people (approximately 90 %) are reported to be women, children and elderly citizens. There has also been considerable internal displacement of those living within Ukraine. Assessing population flows with any accuracy is challenging both because of the difficulties in collecting robust data during a crisis situation and because there is considerable fluidity in cross-border movement, with some of those fleeing to neighbouring countries subsequently returning to Ukraine (UNHCR, 2022). In this context, the UNHCR considers that it is too early to draw conclusions on definite trends about cross-border movements, especially as the situation in Ukraine remains highly volatile.

### Insight into problem drug use and its consequences in Ukraine

The prevalence levels of injecting drug use, and of associated blood-borne infections, in particular HIV and viral hepatitis, have for some years represented a serious public health challenge in Ukraine. According to the latest available data (Table 1), it is estimated that some 350 000 people in the country inject drugs (Sazonova et al., 2020), with approximately 19 % of these being women (Titar et al., 2021). There are an estimated 280 000 opioid users in the country. The same study of 6 000 PWID in 12 Ukrainian cities found the most commonly injected drugs include illicit street methadone in crystal/powder form (57 %), opium poppy in liquid form ('shirka', 'black pill') (24 %) and amphetamine in powder form ('fen') (20 %). In addition, injecting various pharmaceutical medicines, including sedatives and barbiturates, was reported by 12 % of the sample and injecting 'bath salts' (MDPV, mephedrone) by 11 %.

Ukraine has the second-largest HIV epidemic in Eastern Europe and Central Asia, with an estimated 210 000-330 000 people living with HIV (UNAIDS, 2020). A large proportion of new HIV infections continue to be traced back to injecting drug use. In 2020, injecting drug use accounted for 38 % (5 960 out of 15 621) of new HIV diagnoses in Ukraine with documented transmission mode (ECDC and WHO, 2021).

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<sup>(2)</sup> The total number of refugees from Ukraine recorded across Europe reflects the estimated number of individual refugees who have fled Ukraine since 24 February 2022 and are currently present in European countries. When an official estimate is not available, the figure provided corresponds to the sum of registrations for temporary protection or similar national protection scheme and the number of asylum applications lodged by refugees from Ukraine. See [https://data.unhcr.org/en/documents/details/91338#\\_ga=2.172858275.1230501724.1656616615-1679155297.1656616615](https://data.unhcr.org/en/documents/details/91338#_ga=2.172858275.1230501724.1656616615-1679155297.1656616615)

HIV prevalence among the estimated 350 000 PWID stood at 20 % prior to the invasion, with approximately 68 % testing positive for HCV antibodies (Titar et al., 2021). Ukraine is also one of nine countries globally with a high burden of rifampicin-resistant or multidrug-resistant tuberculosis (RR/MDR-TB), with PWID being an at-risk population group (ECDC and WHO, 2022).

**TABLE 1**  
**Summary of key drug-related data in Ukraine**

Key Ukrainian epidemiological data	Estimates	Year
PWID (est.)	350 000	2020
Female PWID	19 %	2020
HIV prevalence among PWID	20 %	2020
HCV prevalence among PWID	68 %	2020
People who use opioids (est.)	280 000	2020
Number of OAT patients	17 844	1 May 2022
Female OAT patients (%)	15 %	1 May 2022
OAT coverage (%)	6 %	1 May 2022
People who use opioids in drug treatment	49 500	2020
People who use opioids in drug treatment other than OAT (est.)	70% of 49 500	2020

Despite efforts to increase access to and uptake of evidence-based drug treatment and harm reduction services, coverage of OAT has remained at low levels since the first pilot was launched in 2004, and coverage is currently estimated at 6 % of the estimated 280 000 opioid users in the country. Government figures indicate that 17 844 people were receiving OAT as of 1 May 2022, an estimated 15 % of them women (PHC, 2022a). The majority of OAT patients (88 %) receive methadone hydrochloride (pills), while 12 % receive buprenorphine (sublingual pills) (PHC, 2022a). Many OAT patients have additional treatment needs due to high rates of

comorbidity with HIV, HCV, hepatitis B virus (HBV) and/or TB (PHC, 2022a). In addition to the national OAT programme, it is estimated that between 5 000 and 7 000 individuals were receiving this treatment in 13 facilities in the private sector in Ukraine by 1 June 2022 (personal communication from the Public Health Centre of the Ministry of Health of Ukraine). However, this number may be higher as the private sector is not obliged to report client registrations to the Ministry of Health. There are some indications of higher numbers: for example, a recent unpublished study in one north-eastern city, Kharkiv, reported over 2 000 clients receiving OAT in the private sector (personal communication from Bromberg et al., Yale University). Furthermore, reports indicate that in 2020, outpatient care associated with opioid use was provided to over 49 500 individuals, of which an estimated 70% received treatment other than OAT, with a further 20 000 receiving support for cannabinoid use, 5 900 for stimulant use and 23 800 for polydrug use (Sukhovii, 2022).

## Impact of the invasion on drug services in Ukraine

The immediate humanitarian needs of people in Ukraine include shelter, nutrition, water and sanitation, along with essential, chronic and acute healthcare needs including medications and essential services. The war has had a devastating effect on health infrastructure in the country, with nearly 650 health facilities destroyed as of May 2022 (Kyiv School of Economics, 2022). All forms of health services, including drug-related treatment, harm reduction and infectious disease interventions, have faced significant disruptions, especially in the first 2 months after the invasion.

OAT is legally forbidden in Russia, and discontinuation of OAT was one of the first measures introduced in Crimea by Russia in 2014 after its annexation. It is assumed that OAT in the currently occupied territories has therefore been discontinued. A breakdown in service provision for people with substance use disorders clearly has associated increased risks of drug-related harms, including overdoses and transmission of infectious diseases.

Reports suggest that as of 1 June 2022, 16 out of a total of 202 OAT sites had ceased to operate in Ukraine (PHC, 2022b). Logistics specifically ensuring the availability of, and access to, a supply of OAT medicines appear to represent the main initial challenge to continuing service delivery. According to the Ukrainian Public Health Centre (PHC) of the Ministry of Health (2022b), continuation of OAT for the 1 384 internally displaced persons who were on the OAT programme is a challenge, with 2 895 OAT patients, as of 1 June, at risk of dropping out of the OAT programme because of the crisis situation. As of 1 June, the PHC also reported that it is aware of 68 individuals who have applied to be enrolled on an OAT programme outside Ukraine since the start of the invasion, and a further 56 individuals who have already successfully enrolled on OAT programmes abroad (PHC, 2022b).

Other major public health concerns in Ukraine include the ongoing COVID-19 pandemic, increased risk of outbreaks of polio, measles and TB, and severe

psychological impacts of the invasion, including war-related trauma, anxiety and depression. Of particular concern are the increasing reports of sexual violence against Ukrainian civilians, especially women, by the Russian army. Trauma and associated deterioration of mental and psychological health may drive or exacerbate problem use of alcohol and drugs among the affected population.

Taken together, the data points to the high proportion of women among the millions of Ukrainians having entered the EU since February 2022. There are therefore potentially several thousand Ukrainian women using opioids who have fled and sought refuge in the EU. Given that the number of women in OAT in Ukraine is low, many of these will not have been in OAT before leaving the country. It is therefore also expected that the number of those in OAT in Ukraine and seeking continuation of OAT in the EU will also be low (see next section). However, it is not known whether women who use opioids are more or less likely to have left the country than those who do not use opioids.

### Projected drug-related health care needs in bordering EU countries: results of a simple modelling exercise

An important question for national service planners in EU Member States is what they might expect in terms of future service demand resulting from the influx of Ukrainian citizens into neighbouring countries. In order to inform this question, a simple mathematical model (see Annex 1) was developed to estimate the number of displaced adult high-risk drug users from Ukraine who have arrived in bordering EU countries from the time of the Russian invasion to 5 May 2022 when the projections were calculated, and who might need drug and drug-related infectious disease services.

There is likely to be considerable uncertainty in this model because of the limitations of the data used to inform it. Nonetheless, it is useful to exploit the data available, despite these limitations, to inform a discussion on the potential boundaries of possible needs for health service provision. Projections from the model suggest that somewhere between 2 658 and 10 630 displaced PWID had arrived in Poland by 5 May 2022, while between 724 and 2 898 displaced PWID had arrived in Romania, between 466 and 1 863 in Hungary and between 331 and 1 324 in Slovakia during this period. Also, while only 19 % of PWID in Ukraine are women, projections suggest that at least 50 % of PWID arriving in the EU were women. This reflects the higher proportion of women in the flow of displaced people (an estimated 83 % of displaced Ukrainians are female) and will have implications for services.

The projected numbers of displaced OAT patients arriving in neighbouring EU countries were relatively low (from 195 patients in the lower scenario to 782 in the higher scenario, reflecting the low OAT coverage in Ukraine). They may nonetheless represent a significant burden for the existing OAT services in hosting countries. In Hungary, for example, where 508 patients were on OAT before the current crisis, the projected inflow of 87 displaced OAT patients in need of treatment continuity (higher

projection) would correspond to nearly a 20 % increase on the OAT provision capacity. Similar significant increases to national OAT systems are projected for Romania, Hungary and Poland.

Recognising the high number of PWID not in OAT services in Ukraine, projections at the national level for bordering countries raise issues of insufficient capacity and potential service challenges. In Romania, for example, the model projected that between 546 and 2 183 displaced PWID using opioids but not on OAT in Ukraine could have arrived in the country. As a comparison, in Romania in 2020, there were 1 879 OAT patients, corresponding to an OAT coverage of 9 % at the national level. This is an important issue, bearing in mind that a significant increase in displaced PWID out of treatment, coupled with limited availability of harm reduction and OAT services in hosting countries, increases the risk of localised HIV outbreaks and/or an increase in drug-related deaths in these countries.

Finally, projections around drug-related infectious diseases raise some additional concerns. The projected number of displaced PWID living with HIV who arrived in Poland ranged from 633 to 2 532, while the estimated number of displaced PWID already on ART ranged from 342 to 1 367. Over 60 % of these are likely to be women due to the large number of displaced women and the higher prevalence of HIV among women in Ukraine. These results also suggest that in addition to the need for ART and direct-acting antiviral (DAA) treatment continuity, there are also likely to be unmet needs among displaced PWID for testing and initiation of HIV and viral hepatitis treatment.

Based on pre-conflict surveys, typically around 18 % of PWID tested positive for both HIV and HCV antibodies (Titar et al., 2021), and 21 % of PWID who were HIV+ had received TB treatment in the past 3 months (Sazonova et al., 2020). This suggests that co-infection is common among PWID in Ukraine. Focusing on TB, and based on the number of detected cases among PWID in Ukraine (Kamenska et al., 2019), the projected number of displaced PWID with TB arriving in neighbouring EU countries was estimated to be relatively low (ranging from 21 to 83); nonetheless, given the transmissibility of this disease, this is important from a public health perspective. Further projections are available in Annex 1 of this report.

## Actual reported demand for and provision of drug services in EU countries

### **OAT is the main service provided while demand/uptake for harm reduction interventions appears low**

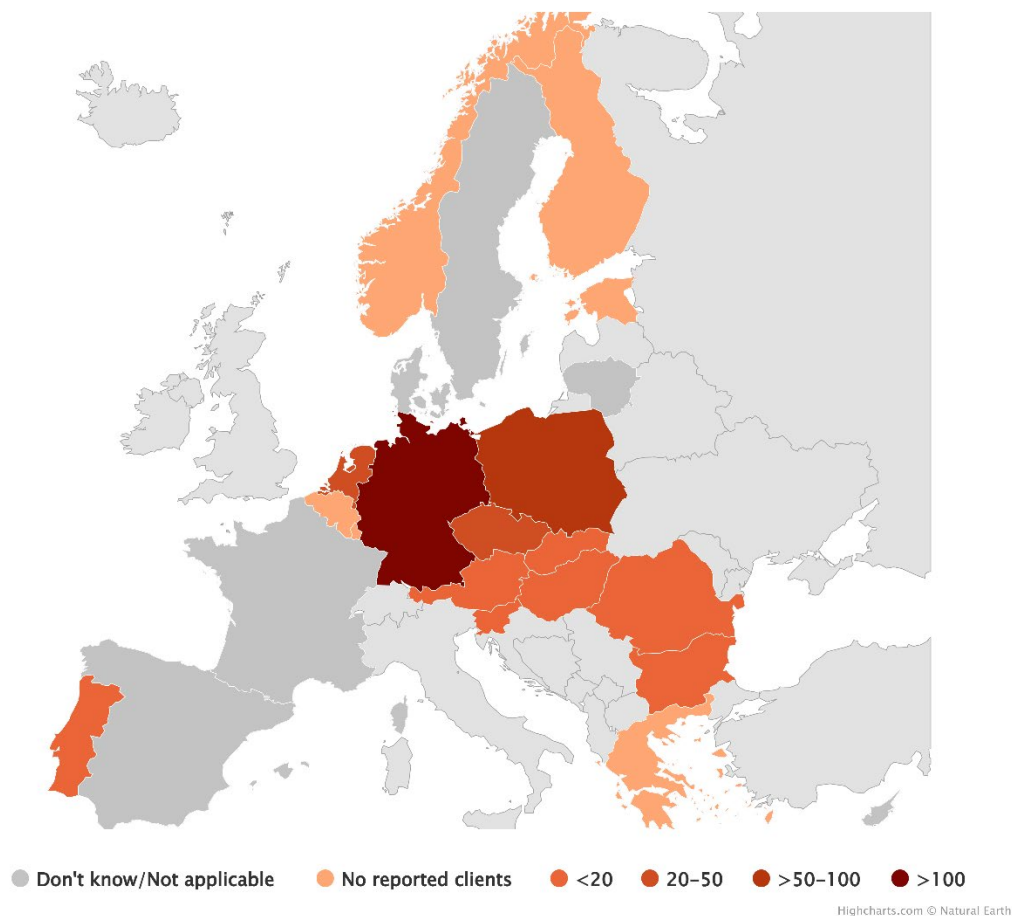
Overall, 4 months after the start of the conflict, reports on the numbers of displaced Ukrainians who have accessed drug services in bordering Member States is in line with the lower end of the model's projections. The limited information available also suggests that elsewhere in the EU, the number of displaced persons accessing drug treatment has been low. It should be noted that reliable monitoring of the provision of



drug treatment and other drug services during a crisis situation is challenging, so some under-reporting is possible. In addition, if the mid- to higher-end boundaries of the model are considered, this could suggest that there are unmet treatment needs, either because of barriers to help seeking or because of a lack of access to care.

The information available also indicates that OAT is the main type of treatment provision provided to displaced Ukrainians with opioid-related problems. Poland has reported around 90 displaced persons entering OAT and Czechia about 30 clients (Figure 3). By mid-May 2022, the number of displaced Ukrainians known to have received OAT in other EU countries bordering Ukraine was low (fewer than 10 clients in Romania, Hungary, Slovakia and Bulgaria). Germany, the Netherlands and Portugal have also reported some displaced Ukrainians having accessed OAT, and it is likely that treatment has also been provided in other European countries, although it is currently not possible to quantify their numbers.

**FIGURE 3**  
**Expert estimates of the number of displaced people from Ukraine receiving opioid agonist treatment in the EU since February 2022**

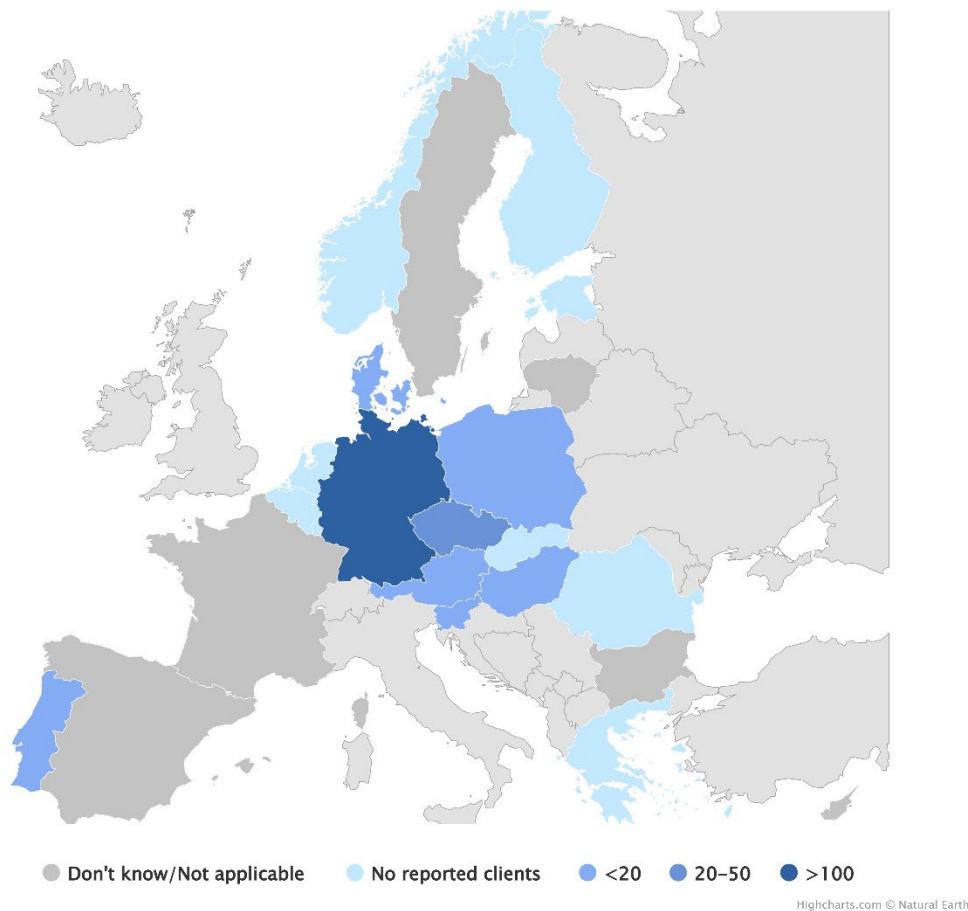


Source: Online survey among Reitox national focal points between 11 April and 3 May.

Responses from the survey of national focal points indicate that fewer than 100 displaced persons from Ukraine have entered other forms of drug treatment (e.g. psychosocial drug treatment, detoxification, etc.) for any drug problem. Fewer than 20 cases were reported by countries bordering Ukraine.

The estimated number of displaced Ukrainians accessing harm reduction and low-threshold services is also reported to be low (Figure 4). According to national experts, there have been few requests made to services providing drug paraphernalia (e.g. needle and syringe exchange). Where some demand was noted, it was more likely to be from displaced persons accessing low-threshold and outreach services providing health and social support and referral. An important caveat here is that robust information is often not available on the social characteristics and nationality of those receiving these sorts of interventions.

**FIGURE 4**  
**Expert estimates of the number of displaced people from Ukraine in contact with low-threshold harm reduction services in the EU since February 2022**



Source: Online survey among ReitoX national focal points between 11 April and 3 May.

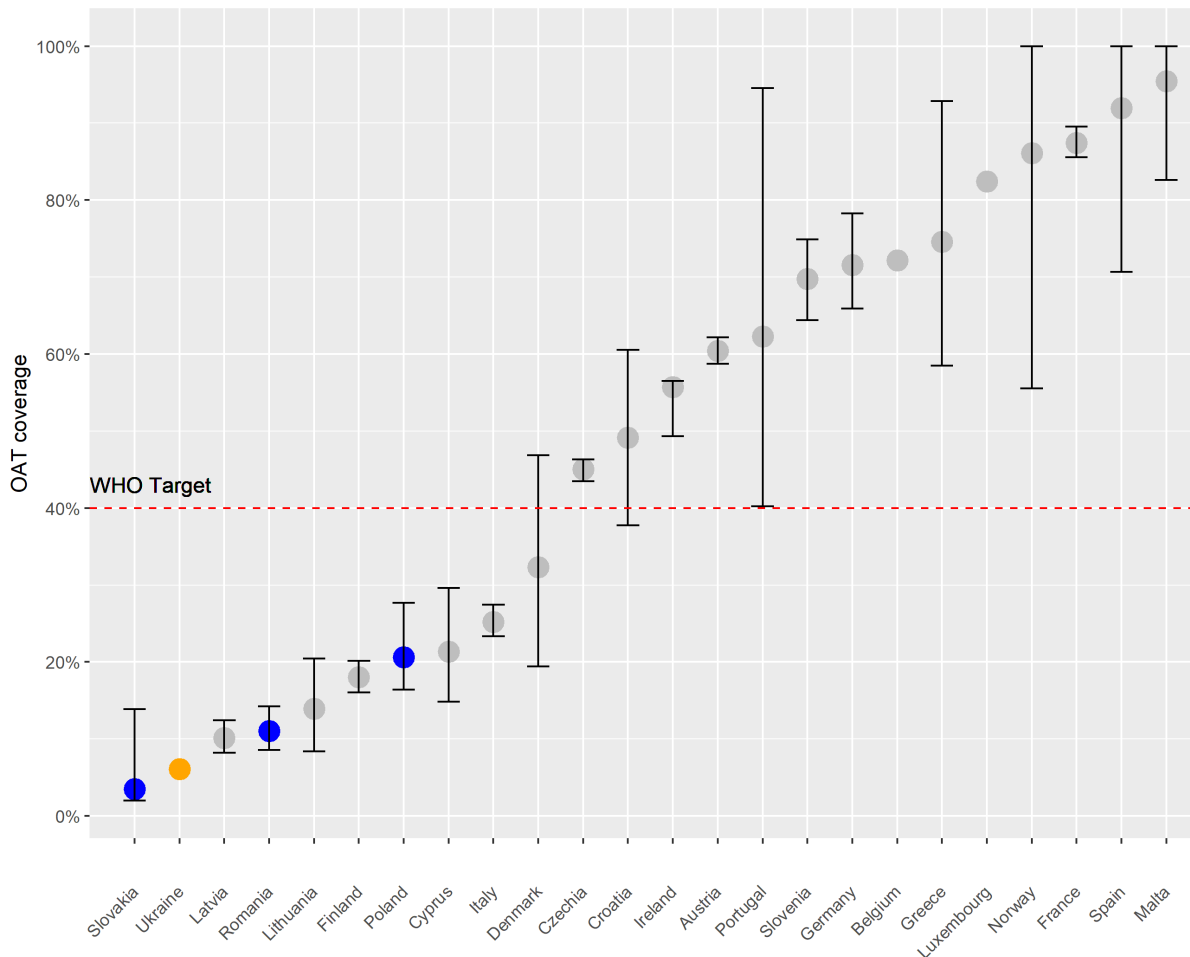


## **Possible factors influencing low drug service uptake**

An early priority for services in Ukraine and their international counterparts was to ensure continuity of care within the EU for those in OAT and ART. In some neighbouring countries, policies were adapted to facilitate entry to drug treatment, free of charge and with minimal administrative requirements (see Annex 2). In some cases, this included displaced persons being fast-tracked into OAT, despite pre-existing waiting lists, or being referred to other OAT providers with available OAT slots. This may have encouraged some Ukrainians already in OAT to seek refuge in the EU in order to avoid potential war-related medication shortages or disruptions to their treatment. However, the numbers doing so appear low, and as noted earlier, overall reported OAT uptake was at the lower end of expected projections (see Annex 1). A number of factors may help to explain this.

It is possible that the reported low uptake is partially linked to both the limited availability of services and the barriers to accessing care. OAT coverage in the countries bordering Ukraine is typically estimated as only being below 25 % of the target population potentially in need of care (Figure 5) (EMCDDA, 2021). The geographical availability and the coverage of needle and syringe exchange programmes and other harm reduction measures is also relatively limited when compared to measures in other EU countries. It is possible that the relative lack of service availability and other barriers may limit help seeking and lead them to possibly remain hidden from services, or have even encouraged some people to transit to countries in which service availability is greater. Further research is necessary to assess and understand the factors that influence the reported low uptake of drug services.

**FIGURE 5**  
**Coverage of OAT (percentage of estimated high-risk opioid users receiving the intervention) in Ukraine in 2022 and in the EU in 2020 or latest year available**



Source: EMCDDA, 2022.

## Responding to the needs of displaced Ukrainian citizens with drug-related problems

### Mobilisation, needs assessments and monitoring

From the onset of the invasion of Ukraine, a wide range of international, European and national stakeholders mobilised resources to coordinate the response to the humanitarian crisis. At EU level, on 4 March 2022 the European Council, following the proposal of the European Commission, activated the directive giving those

fleeing the war in Ukraine the right to temporary protection in all EU Member States (Box 1).

### **Box 1: EU temporary protection for people fleeing the war in Ukraine**

Temporary protection is an exceptional EU measure to provide immediate and temporary protection in the event of a mass influx or imminent mass influx of displaced persons from non-EU countries who are unable to return to their country of origin (European Commission, 2022a).

On 4 March 2022, as a result of Russia's military invasion of Ukraine, and following the proposal of the European Commission, the Council adopted a Decision (Council of the European Union, 2022) to activate the Temporary Protection Directive, giving those fleeing the war in Ukraine the right to temporary protection in the EU. It means that they will immediately be given a residence permit for the duration of the protection, and access to employment, to suitable accommodation and housing, to education for persons under 18, to social welfare and to banking services (European Commission, 2022a). Beneficiaries of temporary protection also have the right to medical care, including for emergency and essential treatment of illness. Necessary medical assistance is to be provided to persons with special needs <sup>(3)</sup>, while children are assured of healthcare, including preventive care, mental health care and psychosocial assistance, to secure each child's best interests and well-being.

Once the public healthcare system of the host Member State considers them fully insured, beneficiaries will also be entitled to receive the European Health Insurance Card, which gives the right to necessary healthcare treatment during a temporary stay in another Member State (European Commission, 2022b).

Furthermore, as visa-free travellers, they have the right to move freely within the EU for a 90-day period after being admitted into the territory.

On 18 March 2022, the Commission presented the operational guidelines to support Member States in implementing the Directive and the Council Decision (European Commission, 2022c). It covers a list of issues such as the eligibility criteria (persons covered/not covered by the Council Decision), how to proceed with children, including unaccompanied minors, and the right to move freely between Member States, registration and provision of information. The guidelines also help Member States' border guards to efficiently manage arrivals at the borders with Ukraine while maintaining a high level of security. On 16 May, the Commission launched a dedicated phone helpline in Ukrainian and Russian to provide information and assist those fleeing the Russian invasion of Ukraine. A dedicated webpage (European Commission, 2022d) was also created to provide those fleeing the war in Ukraine with practical information on their rights in the EU.

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<sup>(3)</sup> As per Directive 2001/55/EC (Art. 13/4), persons with special needs could be unaccompanied minors or those who have undergone torture, rape or other serious forms of psychological, physical or sexual violence.

In addition, the Commission set up a 'Solidarity Platform' to collect information and examine the needs identified in the Member States, and to coordinate the operational follow-up in response to these needs. The platform will also facilitate the organisation of transfers of people within the EU to Member States that have reception capacity.

In the drugs field, EU agencies (e.g. the European Centre for Disease Prevention and Control (ECDC), the EMCDDA), international organisations (e.g. the World Health Organization (WHO), the Eurasian Harm Reduction Association, and other international civil society organisations), and national public institutions and NGOs in EU countries and Ukraine rapidly set up platforms to coordinate actions and facilitate networking between stakeholders.

One of the first priorities was to ensure continued access to OAT and HIV medicines for those in need, especially those who were already receiving these treatments in Ukraine. At the international level, organisations compiled contact information about available services in the different Member States and created dedicated information hubs and centralised online information points in Ukraine for patients seeking information as well as for professionals seeking to refer patients travelling or in transit to the EU.

In many eastern EU countries, OAT is only usually legally provided within the public drug treatment system. In almost all EU countries there are no legal requirements to access harm reduction interventions, such as needle and syringe exchanges, although the availability of these types of services is variable. In line with the European Council directive, most EU countries eased the legal conditions for accessing free-of-charge drug services. Responses from the survey of national focal points suggested that in most EU countries, minimal conditions have been imposed on displaced patients wishing to access OAT or other drug treatments (see Annex 2). These generally included identification, proof of temporary protection status, and possibly proof of prior drug treatment in Ukraine.

Raising awareness among displaced Ukrainians about the availability of drug services was also identified early on as an important need. Posters and leaflets in Ukrainian and Russian were produced to raise awareness and promote available drug services, and were made available at relevant locations (e.g. train stations, border crossing points, etc.). A range of online platforms in the Ukrainian language (web sites, social media, messaging applications) were also established to facilitate the uptake of care. One such platform is the WHO-supported 'European Test Finder' website<sup>(4)</sup>, which enables people to find the nearest place to access OAT and to be tested and treated for a variety of infectious diseases in countries across the WHO European region (Figure 6). Another example is the HelpNow application, which was

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(4) <https://www.testfinder.info/>

developed at the onset of the Russian invasion by the Alliance for Health with the aim of digitally connecting vulnerable populations, including PWUD, to essential health services in Ukraine and the EU (Figure 7 and Box 2).

Establishing communication channels with Ukrainian NGOs and Ukrainian health authorities was also a key requirement for facilitating the continued provision of OAT and HIV medications. People on OAT who were living in Ukraine and planning to go to another European country could apply to the Ukrainian PHC to be enrolled on an OAT programme outside Ukraine. The PHC would then liaise directly with European partners to facilitate enrolment and assure that the patient had the necessary medical documentation. In Europe, if patients did not have their medical records available, Ukrainian public health centres could also, on request, provide relevant information about patients' treatment history (prescribed medications, dosages, etc.).

FIGURE 6  
WHO-supported 'European Test Finder' website

European Test Finder | testing & treatment for HIV, hepatitis, TB & STIs

Натисніть тут, щоб дізнатися більше про послуги щодо ВІЛ-інфекції, гепатиту, туберкульозу та опіоїдної замісної терапії для людей, які тікають від війни в Україні »  
Find the nearest place to get tested and treated for infections listed below.  
More sites are constantly being added.

Please select a country ?  
All

City  
(Please type the name in the local language)

Type of services  
(By selecting more than one type of service from the list, your search results will show only sites which match all the services selected)

- HIV testing
- HIV treatment (ART)
- Viral Hepatitis testing
- Viral Hepatitis treatment
- STI testing
- Tuberculosis services
- Opioid substitution treatment (OST)

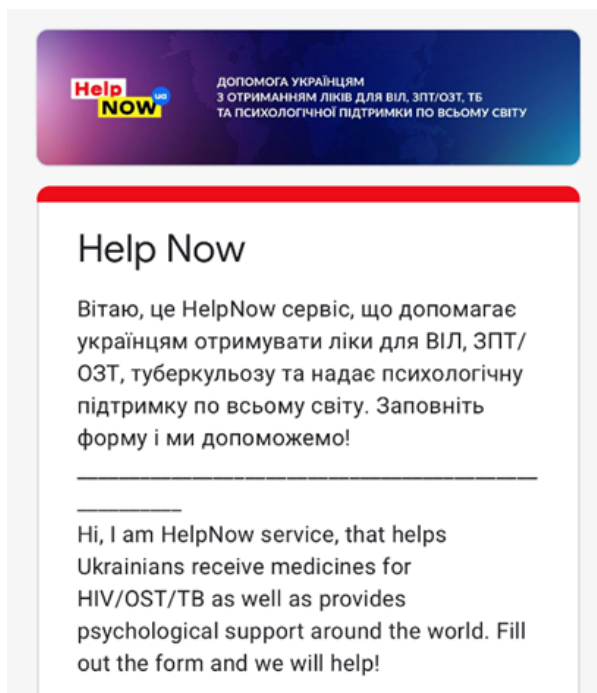
SEARCH

Other drug-related initiatives in EU Member States include helplines in Ukrainian and Russian set up by national authorities and NGOs in Poland, Slovenia, Germany and Czechia. In Hungary, a hotline with interpreters is available for drug treatment professionals to facilitate communication with displaced patients. In addition, Slovenia, Austria and Czechia have conducted needs assessments to rapidly assess the current capacity of their drug services to respond to the actual and potential demand by those displaced. Six other Member States are planning to carry out similar assessments. The majority of Reitox national focal points surveyed have also

reported that monitoring systems or monitoring initiatives (e.g. facility surveys) are in place or are planned to improve the monitoring of the utilisation of drug services by displaced persons.

FIGURE 7

### HelpNow application developed by Alliance for Health



#### **Box 2: HelpNow — connecting vulnerable displaced populations to essential services in Ukraine and in the EU**

The HelpNow service was developed by the Alliance for Health, and launched on 2 March 2022. It supports individuals from vulnerable displaced populations, including PWID, men who have sex with men, and sex workers, who face challenges in accessing treatment and other essential services. In addition to the HelpNow Hub resource portal ([HelpNow.aph.org.ua](http://HelpNow.aph.org.ua)), there are virtual hubs in Poland (HelpNow PL Hub) and Germany (HelpNow DE Hub), as well as focal points in Hungary, Italy, Romania, Slovakia and Czechia, and also access to an online clinical consultation service 'Help24' ([www.help24.org.ua](http://www.help24.org.ua)).

The HelpNow service can be accessed via email, website, Telegram, Google form, Instagram and Facebook. In the first 2.5 months following the invasion, over 1 000 requests for support had been received from people from Ukraine. Among these were 425 requests for help facilitating access to OAT. As of 30 May 2022, only a minority of requests (37 %) had originated from people still resident in Ukraine, with the majority (63 %) originating from EU countries, including Poland, Germany, Czechia, Italy, Spain and the Netherlands.

## Women represent the majority of new treatment entrants in bordering countries

Experts in countries bordering Ukraine report that the majority of clients accessing drug services are women. In Poland, for example, it is reported that only one third of those accessing OAT are men. All new OAT clients had previously been in treatment in Ukraine. Female displaced persons are often accompanied by children, and therefore require a range of social support services in addition to OAT (e.g. housing, education and employment).

Polydrug use, including problem alcohol use, is reported to be common among this treatment group. Additionally, drug professionals' impressions were that female clients arriving more recently, compared to those who arrived in the first 2 months, often present with higher levels of vulnerability, characterised by more frequent reports of war-related trauma, post-traumatic stress disorder (PTSD) and sexual violence (Box 3). It is thought that this is because in the first 2 months of the war, large numbers of women were displaced from the western and northern regions of Ukraine, with citizens from occupied areas in the east and south of Ukraine only reaching EU borders in later waves. This unexpected influx of female clients, with or without children, in bordering countries has raised significant issues in terms of drug service provision (Box 4). This should be viewed within a wider context in which many drug services are utilised more by male clients and may not be particularly sensitive to responding to the needs of women or addressing childcare issues. The availability of drug services offering specialist services to women using drugs remains limited across Europe, and this is especially so in most Eastern European countries.

In addition to direct contact between services in Ukraine and in destination countries, reception centres and health facilities for displaced Ukrainians have also acted as points of referral. Self-referral was also reported, but to a lesser extent.

### **Box 3: Gender and trauma-informed interventions for displaced people**

There is strong evidence that displacement is a destabilising experience with acute and long-term effects, as observed in many humanitarian tragedies. There is also increasing concern about sexual violence and human trafficking against women and children who are displaced from their homes in Ukraine. International organisations active in Ukraine and bordering countries have highlighted the risks of PTSD, especially among the most vulnerable groups (UN Security Council, 2022). They note that displacement is strongly associated with trauma and chronic stress (RTI, 2020).

The effect of war on children has many negative implications, including increased risk of mental health disorders, distress resulting from forced separation from parents, and fear for personal and family safety. Enduring the consequences of



war is largely irreconcilable with the developmental needs of this phase of life, and the impact has a gender differential, with young women being considered particularly vulnerable (Bürgin et al., 2022).

Many studies have shown a correlation between trauma and substance use disorder. High rates of PTSD are found among people experiencing drug problems, and this may be a greater issue among younger populations (Kuksis et al., 2017). Some studies have also show that women and girls escaping from war are particularly vulnerable to becoming victims of trafficking and have higher risks of experiencing gender-based violence, induction to sex work, sexual exploitation, and other forms of exploitation (European Parliament, 2022; Pail, 2021).

It is therefore important that interventions provided to displaced populations are trauma- and gender-aware. In practice, this may be translated into a more proactive approach to identifying needs and referring on to other appropriate services. Trauma-informed services have been defined as practices where service delivery is influenced by an understanding of the impact of interpersonal violence and victimisation on an individual's life and development. This approach has been reported as being valuable to responding to women with substance abuse disorders (Elliott et al., 2005; Molina and Whittaker, 2022). Factors that should be considered in managing the reception and integration of displaced people include providing adequate support for the adjustment in gender norms, roles, identity and relationships that often accompany integration into a new country (UNHCR, 2021; Kilinc et al., 2022).

More generally, gender-related differences in the refugee experience need to be considered when planning the reception, referral and integration of displaced people. Responses range from basic measures such as providing female hygiene products and ensuring that safety measures are in place for women and girls in camps, to the provision of job search assistance for women that includes non-stereotypical livelihood initiatives, or the option for displaced persons to choose the gender of their service provider.

#### **Box 4: Ensuring accessible and gender-sensitive drug services**

Service responses for displaced women who use drugs need to consider whether they are best provided in women-only or mixed-gender programmes. All services should be welcoming, non-judgmental, supportive and physically and emotionally safe; they should also support the maintenance of positive connections with children, family members and significant others. Providing support for childcare is also important, as is responding to the needs of pregnant women and, where appropriate, referral to services providing gynaecological care or other support for women's health issues.

It is also important for drug services to take measures to reduce the barriers to care for women involved in sex work, which may require providing services outside of normal office hours, and proactive outreach. Collaboration between drug



treatment and mental health services to address co-occurring substance use and mental health needs is likely to be especially important for managing female clients who have experienced war-related trauma.

## Screening, testing and treatment of infectious diseases among displaced people with drug-related problems

For many years the prevalence levels of HIV, viral hepatitis and TB among PWID in Ukraine has been reported as high (Titar et al., 2021). The modelling projections included in this report highlight potential for take-up of infectious disease services in bordering countries (see Box 5).

The majority of national experts reported that infectious disease services — including vaccination; HIV, viral hepatitis and TB diagnosis and treatment; and condom distribution — were accessible to displaced Ukrainians with drug-related problems. In Romania and Bulgaria, a special order from the Ministry of Health has been adopted to support the provision of free-of-charge medical treatment, including ART, to displaced Ukrainians. To obtain this treatment free of charge, it is necessary for displaced people to have temporary protection status and an official identification document.

At the time of the analysis (May 2022), the reported numbers of displaced PWUD from Ukraine accessing infectious diseases services in bordering EU countries were very low: four displaced clients receiving OAT in Slovakia also required ART; 20 patients, some of whom were on OAT, required HIV care in Romania; and two patients seeking drug services in Czechia were linked to ART continuation. Even less information was available for other infectious diseases, but HIV and HCV testing activity for PWUD was reported by experts from Poland and Czechia.

An important caveat here is the general lack of robust data on infectious disease testing, linkage to care, and treatment among displaced PWUD. This means that there is considerable uncertainty on the real numbers of displaced persons who have used HIV, viral hepatitis and/or TB services. It is likely, however, that some of the barriers identified as restricting drug treatment access will also be relevant here. Some anecdotal information does exist. It has been suggested that more than 1 300 displaced Ukrainians have registered for HIV care in Poland, where services are able to provide a similar treatment regimen than the one offered in Ukraine (personal communication from Dr Parczewski at a European Centre for Disease Control agency meeting), although it is not known how many of these are PWUD.

### **Box 5: What infectious disease interventions may be needed by displaced PWUD?**

Displaced people living with HIV who were on ART treatment require free and easily accessible treatment continuity, while those who were not yet on antivirals require easy access to HIV testing and linkage to care (ECDC and EACS, 2022). This is also true for viral hepatitis (hepatitis A virus (HAV), HBV, HCV), which disproportionately affects PWID. Efforts are needed to ensure that displaced drug users already on treatment for HBV and/or HCV should be able to continue treatment. Voluntary testing and appropriate therapeutic follow-up should also be more generally available (ECDC and EASL, 2022). Continuity of care and the initiation of antiviral treatment for those in need not only protect the health of displaced patients but also reduce the risk of further transmission. In terms of prevention, HBV and HAV vaccination should also be offered to displaced people, as should free and non-discriminatory access to drug treatment and harm reduction services.

While universal screening for TB among displaced people is not recommended, systematic latent TB infection testing and treatment may be considered for at-risk populations, including PWUD (ECDC and WHO, 2022). As for other conditions, continuation of TB treatment with adequate regimen should also be ensured to protect the health of displaced patients, to limit disease transmission and to minimise the development of MDR-TB. In addition, newly diagnosed active TB cases require isolation and should trigger contact tracing and other appropriate public health protection measures. It is important to note that PWUD are more likely to present with co-infections, and this needs to be addressed in their case management.

## **Challenges in the provision of drug services to displaced Ukrainian citizens**

A number of challenges and barriers in providing drug services, both OAT and other interventions — such as harm reduction and infectious disease services to the displaced population from Ukraine — were identified in this study, and a few tentative solutions put forward.

### **Client-level challenges**

**Linguistic issues:** As many of those fleeing Ukraine will not speak the language of the host country, this represents a significant barrier to service access and delivery. While it was reported that interpreters were available in some services, the overall availability of such facilitators remained limited. Reducing linguistic barriers to service uptake and delivery must therefore be regarded as a key requirement for providing care.

**Ensuring continuity of medical care:** A number of challenges were raised by professionals aiming to ensure continuity of treatment for displaced citizens.

Some of the barriers were administrative. Most EU countries have some minimum legal requirements to enable access to OAT, ART and other essential care. These may include having been granted temporary protection status and being registered in the state insurance system. This can result in delays to treatment entry, or even discourage uptake. Administrative processes can be delayed because of a lack of translation services, or because of missing documentation. Despite the mitigating measures described above, administrative barriers to accessing care were reported.

In this context it can be noted that the standardised protocol on clinical management and medical data-sharing provides principles of clinical management and describes how data related to care can be shared among healthcare professionals working with refugees from Ukraine who are living with HIV and who are seeking care in other European countries (WHO, 2022).

Other challenges were linked to language barriers. For example, the lack of a clinical consent form in Ukrainian was reported as a barrier to receiving OAT. Clinical management practices, such as the requirement for urine testing, could differ in the host country and Ukraine, and this will also need to be adequately communicated.

Some respondents also reported difficulties in switching clients from the prescribed OAT medication in Ukraine to the one available in the host country. This conversion from one medication to another was reported to pose a challenge for clinicians as well as for clients (Box 6).

Providing cultural mediation services can help address these sorts of problems. Cultural mediators are professionals who facilitate the communication (including interpretation) between people speaking different languages and coming from different cultural backgrounds. They can provide information on different sets of values, assumptions and sociocultural conventions by clarifying culture-specific expressions and concepts that might give rise to misunderstanding. They can facilitate the adaptation to OAT protocols and procedures in the reception country that may be different from those in Ukraine, as well as differences in drug laws and cultural or societal norms towards drug use in the host country.

**Stigma and child protection fears:** Anxieties linked to disclosing drug use or seeking support from drug services out of fear of being deported, losing opportunities or rights to accommodation and other privileges, or even losing custody of their children were reported as barriers, especially for women, to disclosing their drug use and HIV and/or HBV/HCV status. There were some anecdotal reports that harm reduction services may have been accessed indirectly via intermediaries, out of fear of stigmatisation.

**Gender sensitivity:** As noted earlier, providing gender-sensitive services is likely to be important, given the characteristics of the displaced population. European drug

services have often been developed in the context of a predominantly male service-using population, and a lack of awareness about the need for gender-relevant or gender-sensitive services is still sometimes evident. We would therefore reiterate that consideration should be given to providing women-only, trauma-informed, non-stigmatising, gender-responsive treatment in which attention is also given to addressing childcare needs.

**A population on the move:** The temporary living situation of many displaced Ukrainians upon arrival has caused difficulties for the provision of adequate treatment for chronic health conditions generally, as well as for drug dependence. As some clients were in transit to other EU countries or unexpectedly returned to Ukraine, this caused particular challenges for service providers in ensuring adherence and continuation of treatment between countries and preventing misuse and health risks associated with unsupervised or interrupted use of OAT medications.

The need to support a frequently mobile population, including patients who are in transit to other countries, also resulted in delays in OAT and infectious disease treatment. There are reports of clients facing difficulties in obtaining rights to treatment in a host country because their first country of entry to the EU was different. Displaced people in transit also need sufficient medicines to cover several days or weeks of travel. In their joint statement on ensuring high-quality viral hepatitis care for refugees from Ukraine, the WHO, the ECDC and the European Association for the Study of the Liver (EASL) state that antiviral therapy for the total course of HCV treatment with DAA and/or at least 90 days of HBV antiviral therapy should be provided in case of onward transit to other countries (ECDC and EASL, 2022).

## Service-level and systemic challenges

National health systems in countries bordering Ukraine have had to rapidly adapt and respond to the health-related needs of an unprecedented large influx of civilians within a short period of time. It should also be noted that these health systems, including drug services, were already suffering from the impact of the 2-year-long and ongoing COVID-19 pandemic.

**Funding issues:** Uncertainty around funding and reimbursement for OAT and other drug services was identified by experts as problematic. From the start of the war, there were declarations from government agencies that health services would be free of charge for displaced Ukrainian citizens. However, this study found that in some instances, no additional funding had yet been made available to treatment and harm reduction services to meet potential additional costs. At the same time (and despite the EU directive on temporary protection), it was reported that in some cases only limited information appears to have been provided by national health insurance schemes on the reimbursement rules for the services delivered to these clients.

**Potential impact of quotas:** In some countries, existing anti-diversion regulations establish quotas of available OAT medications provided at centre level. Any unexpected increases in service provision (e.g. 10 % in Poland) of the allocated quota requires lengthy and complicated administrative procedures for the treatment centre to obtain a licence to provide more OAT. Due to the pre-existing low number of OAT clients, the quotas were in some instances very rapidly met through the unexpected demand from displaced clients. Some OAT programmes close to the Ukrainian border considered this to be a significant obstacle to continuity of care. This suggests that these procedures should be reviewed, especially if the need to provide care increases in the future.

**Pre-existing service limitations:** Perhaps unsurprisingly, the current humanitarian crisis has highlighted a range of pre-existing systemic problems regarding OAT and harm reduction provision in the countries dealing with the greatest influx of displaced people. Typically, the availability of OAT and harm reduction services remains limited to large cities. In Romania, for example, OAT is available only in the capital, Bucharest. In addition, a high threshold can be set for accessing OAT. This is reflected in the low OAT coverage levels reported by a number of countries in this area (EMCDDA, 2021). Waiting lists often exist for national citizens to access this form of treatment. Fast tracking of new arrivals can therefore potentially cause tensions with existing clients who are on long-standing waiting lists. It was reported that in order to access drug treatment, some new Ukrainian clients had to be transferred to cities where OAT provision was available. This could be some distance from their accommodation and/or the other social support services they are utilising. It is also likely that some displaced clients with potential treatment needs have not been able to access care as they have moved to areas where it is simply not easily available.

#### **Box 6: Challenges for European medics in providing OAT medications to displaced populations**

Methadone and buprenorphine are the two first-line medications used for OAT in Ukraine. About 86 % of people on OAT in Ukraine are prescribed methadone hydrochloride in capsules, 1.7 % methadone hydrochloride as an oral solution and 12.3 % buprenorphine hydrochloride as sublingual pills.

The availability of OAT medication and its pharmacological forms can differ in the EU countries bordering Ukraine. In Bulgaria, Poland, Slovakia and Hungary, OAT programmes predominantly prescribe methadone in the form of an oral solution, while in Romania, only the tablet form of methadone is available (EMCDDA Statistical Bulletin, 2022). In these countries, access to buprenorphine for OAT is currently limited. In Czechia, buprenorphine is the most commonly prescribed medication in OAT programmes. In Hungary, about 30 % of all OAT clients receive a combination of buprenorphine and naloxone.

Clinicians have needed to rapidly consider the therapeutic implications of the differences between the medications, or formulations of different medications, that they are used to prescribing and those commonly used in Ukraine. In particular, they have needed to calculate dose equivalents. In addition, there may be challenges for clients who will have to adjust to different clinical practices, such as daily dispensing rather than receiving take-home doses of medication (Meteliuk et al., 2021).

Clinicians in this study reported issues associated with managing the transition between different medications used for OAT. There are a number of known significant risks, communication issues and patient management concerns that such transitions can raise. It is important that clinicians consider these adequately. This can be challenging, as equivalences of doses between methadone and buprenorphine are in general not sufficiently described in the literature, despite the large amount of scientific literature available for the dose equivalences between other opioid medications (Walker et al., 2008; Weschules and Bain, 2008; WHO, 2009). Moreover, recommendations that are available for this procedure may not be easily applicable to the practical challenge of rapidly responding to the immediate needs of displaced populations (Ghosh et al., 2019).

### Implications for responsiveness and preparedness

For organisations with a remit to support PWUD, the initial focus of the response has been to try to ensure continuity of essential drug and infectious disease treatment and medications, while raising awareness of the availability of harm reduction and other drug treatments and support services. The analysis from this study suggests that the current situation in terms of OAT provision in the countries is mostly adequately managed, with the caveats that the information available to make this assessment is limited and it is likely that there is some level of unmet need that is difficult to quantify.

**From a short-term perspective**, in order to ensure adequate responsiveness to the acute and rapidly changing needs of the displaced population, stakeholders at national and international level will need to maintain and sustain current levels of drug-related support in EU countries bordering Ukraine and, over time, possibly in other countries that receive significant numbers of displaced persons. Monitoring of service provision and uptake, and needs assessments exercises, supported by efficient communication between the different sectors involved in drug-related health services, are therefore likely to be key activities.

A range of barriers for accessing and delivering care to displaced persons have been discussed in detail above. Some of these could be relatively easily addressed, such as clarification and communication with service providers around reimbursement rights, and processes put in place to support displaced patients. It is also important that governmental agencies ensure the availability of OAT medications and that

these medications are easily available to individual services in case of unexpected increases in demand.

Language barriers and the need for interpretation and translation services appears to remain problematic for many countries. These issues may become greater in the future and could impact on more countries. From a preparedness perspective, it is therefore important that all EU countries assess their potential future needs in this area and put contingency plans in place. In bordering countries, some of the language barriers have been overcome by employing Ukrainian staff or volunteers already residing in the countries as translators, and setting up drug-related helplines in Ukrainian and Russian or with interpreters available to facilitate communication.

As some displaced citizens are transiting from the countries bordering Ukraine to other EU Member States, issues with ensuring continuity of care for OAT and ART will remain challenging. Consideration should therefore be given to how to support those receiving this treatment who are considering relocating within the EU. In this context, it would be advisable to promote among relevant national health professionals the WHO protocol on clinical management and medical data-sharing for refugees from Ukraine living with HIV (WHO, 2022).

**In the medium term**, and from a preparedness perspective, it is important for EU Member States to consider and, where necessary, establish contingency plans for possible future increases in service demand generated by displaced persons from Ukraine. The message from the analysis presented here is that services for this group need to be appropriate for women who use drugs, and for clients who have had traumatic experiences and who, over time, develop increasingly complex needs. Some countries bordering Ukraine are already reporting the arrival of new populations from eastern and northern Ukraine consisting of women and men who have been both psychologically and physically traumatised. Over time it is likely that we will see more patients with severe comorbid mental health and drug problems that require a more resource-intensive level of care and support than earlier arrivals. This situation is compounded by an overall sense of fatigue among health professionals and social workers as a consequence of the long-lasting COVID-19 pandemic and their front-line role in keeping services operational during that period.

At the national and regional levels, policymakers and services planners will need to assess potential service gaps and available human resources in those services most impacted or likely to be impacted in the future by the unplanned arrival of displaced persons. More broadly, and acknowledging the current challenging economic situation faced by most EU countries, this will require ensuring appropriate funding for maintaining core drug services while finding resources where these are required for those fleeing the conflict.

There is speculation that in the medium term, more men will be displaced. An estimated 85 % of PWID or those who use opioids in Ukraine are male, and this is likely to increase the need for drug-related interventions. As most people who use opioids in Ukraine are not accessing treatment services, there is likely to be

considerable unmet treatment need among this population and an immediate need to provide harm reduction provision, especially given the relatively high rates of HIV, HCV and TB reported among PWID in Ukraine. Outreach services operating in Europe will also need to remain vigilant for signs of hidden populations of displaced persons from Ukraine within the communities of PWUD they work with. Similarly, vigilance is needed for any signs of infectious disease outbreaks so that appropriate measures, such as screening, testing services and access to ART and DAA medications, can rapidly be put in place.

**In the longer term**, if the flow of displaced people into the EU continues, western EU countries are likely to be increasingly impacted, and this study noted that some are already beginning to report increased numbers of clients accessing their services. However, it is hoped that the majority of those currently displaced will soon be able to return to Ukraine, although some are likely to stay in the EU. At this stage, the longer-term implications remain unclear. Drug services other than OAT for these populations in bordering countries will be a necessary focus of the longer-term preparedness activities. Ensuring service availability and appropriate linguistic and cultural adaptation of relevant materials will also remain important issues for all EU countries with large Ukrainian diasporas, as these represent favoured destinations for those fleeing the war.

At the time of writing (June 2022), experts from bordering countries report that the current OAT provision for displaced populations in these countries remains manageable. However, pre-existing barriers in accessing OAT have reportedly caused tensions and challenges at service level and it is clear that for vulnerable health systems, just a small increase in client demand causes structural and capacity problems. Such problems may intensify in the longer term if case numbers increase over time.

Any efforts made by national stakeholders to streamline and improve OAT regulations, access and availability will undoubtedly help the current situation. Initiatives aimed at reducing waiting times and increasing the geographical coverage and availability of treatment, as well as of harm reduction interventions, will be an important focus. Such efforts would clearly benefit all patients who are in need of these interventions, long-term nationals and recent arrivals alike.

Finally, the unprecedented displacement of millions of people from Ukraine into the EU and the geographical proximity of the war has resulted in unprecedented solidarity from all Member States. The rapid mobilisation and dedication by drug professionals and social workers in bordering countries and beyond has been exceptional. However, the current crisis comes on top of a long and continuous history of migration within and into the EU, including both economic migrants and individuals fleeing war zones. While a small number of countries that are perhaps historically more accustomed to responding to large influxes of migrants report a relative rapid mobilisation and adaptation of provision to meet the current challenges, in general the current unexpected situation has revealed more limited anticipation



and preparedness for future shocks and unexpected events in EU health systems. Some of the lessons learned from the current crisis dovetail with those associated with the response — characterised by adaptability, flexibility and person-centred service delivery — to the recent COVID-19 pandemic and its impact on drug services.

More pragmatically, the need emerges for integrated approaches to ensuring culturally sensitive responses to the needs of diverse and fluid population flows, as well as for migration and war trauma specialists to be available to drug services. Bearing in mind the complex needs of more recent clients, stronger mechanisms for coordination between drug, health and social services will need to be in place to ensure the implementation of adequate responses for these displaced citizens with a wider range of health and social support needs. Any learning here and improvements in this respect within drug treatment systems and service provision will undoubtedly benefit future waves of migrants into EU countries, whether from Ukraine or from elsewhere.

## Conclusions

This study has provided some insight into the initial responses and challenges experienced by drug services in EU countries bordering Ukraine, which are doing their utmost to respond to a major humanitarian crisis. As we write this report, the current situation is characterised by high levels of uncertainty, with some fundamental questions remaining. There is uncertainty as to how the situation will develop in terms of numbers leaving Ukraine, numbers returning home and the movement of people from bordering EU countries further into Western Europe and beyond. There is also a question about whether the number of displaced men from Ukraine will increase in the coming months. Are we correct in our predictions of the numbers potentially in need of services, are we over-estimating, or are we missing populations, for example more affluent people who were paying for drug treatment within the private sector in Ukraine and continue to do so in the host country? If the flow continues into bordering countries and there is more demand, will those systems be able to absorb these populations? With little evidence as yet of demand, how far should countries go in preparedness planning? How might we use this crisis as an opportunity to shine a light on existing structural weaknesses in drug service provision and ensure these are adequately addressed?

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## Annex 1. Projected drug-related health care needs for displaced Ukrainians with drug-related problems in bordering countries

A simple mathematical model was developed to estimate the number of displaced high-risk drug users from Ukraine who have arrived in bordering EU countries since the beginning of the Russian invasion on 24 February 2022 and who might need drug services (harm reduction, drug treatment) and infectious disease diagnosis and treatment for some of the most prevalent and/or relevant drug-related infectious diseases (HIV, HCV and TB). Other health-related issues (including vaccine-preventable diseases, non-communicable diseases, mental health, nutrition) are equally important for displaced people (ECDC, 2022) — including drug users — but were not covered by this model.

### Methods

This model has three components. The first consists of the background prevalence of drug use and related harms and treatment in Ukraine before the war. This includes the prevalence of injecting drug use in the country, the prevalence of HIV and HCV among PWID, the yearly number of TB disease cases detected among adult PWID and the coverage of OAT and ART among this key population in Ukraine, stratified by gender <sup>(5)</sup>. These data were derived from the most recent epidemiological studies conducted in Ukraine (Table 2).

The second component consists of the total flow of displaced adults coming from Ukraine and arriving in bordering EU countries (Poland, Slovakia, Hungary and Romania) from 24 February to 5 May 2022, stratified by gender. The source of the data on the flow of displaced Ukrainians was the UNHCR dashboard and reports (Table 2).

The third component added to the model was an exogenous mobility factor describing the relative risk of PWID in Ukraine fleeing their country compared with risk for the general population. This parameter varied from 1 (assuming the same probability of fleeing Ukraine for PWID and the general population) to 0.25 (assuming a 75 % lower probability of fleeing Ukraine for PWID compared to the general population). This lower value for the mobility factor (used for the lower estimates) is thought to be a more realistic scenario given the socioeconomic characteristics and geographic distribution of PWID in Ukraine.

For each neighbouring EU country of arrival, age group and gender, the model estimated the total number of displaced adults (female and male) who inject drugs

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<sup>(5)</sup> With the exception of TB incidence and ART coverage among PWID in Ukraine, not stratified by gender.

from Ukraine who might need drug and/or infectious disease services using the following formula:

Number of displaced people with condition  $X_{f,m} = [\text{Flow of displaced people}_{f,m}] * [\text{prevalence of condition X in Ukraine}_{f,m}] * [\text{adjustment factor for mobility}]$

## Results

The results of the model are shown in Figure 8. The black bars show the lower projections (more realistic scenario) for the different conditions (estimated number of displaced Ukrainians who are PWID, PWID using primarily opioids, patients on OAT, PWID who are HIV+, PWID on ART, PWID chronically infected with HCV, PWID with active TB). The grey bars show the estimates for the higher projections (assuming the same mobility factor among PWID and the general population). The blue bars show the estimated total number of high-risk opioid users, PWID and patients on OAT in the hosting countries prior to the 2022 Russian invasion.

While these results are derived from a simple mathematical model, the limitations of which are described below, they highlight a number of important points with regard to the scale of the current crisis and the needs and demands for drug services in hosting countries.

First, the highest share of displaced high-risk drug users arrived in Poland. Based on the model's projection, it is estimated that between 2 658 and 10 630 displaced PWID have arrived in Poland since 24 February 2022, corresponding to 64 % of all displaced PWID arriving in bordering EU countries. This naturally follows from the fact that Poland has received the largest flow of displaced Ukrainians arriving in the EU (1.9 million adults out of the 3.2 million adults as estimated on 5 May 2022).

Second, while only 19 % of PWID in Ukraine are women, the model estimated that 50 % of PWID arriving in the EU were women. This reflects the higher proportion of women in the flow of displaced people (an estimated 83 % of displaced Ukrainians are female). This will have implications for services.

Third, while the projected number of displaced OAT patients arriving in neighbouring EU countries is relatively low (from 195 patients in the lower scenario to 782 in the higher scenario, reflecting the low OAT coverage in Ukraine), they could nonetheless represent a significant burden on the existing OAT services in hosting countries. In Hungary, for example, where 508 patients were on OAT before the current crisis, the projected inflow of 87 displaced OAT patients in need of treatment continuity (higher projection) would correspond to a 17 % increase in the line list of patients.

Fourth, the projected total number of displaced PWID not on drug treatment was high compared to current levels of harm reduction and drug services provided in hosting countries. In Romania, for example, the model projected that between 546 and 2 183 displaced PWID using opioids not on OAT had arrived in the country. As a comparison, in 2020, before the Russian invasion of Ukraine, there were 1 879 OAT



patients, corresponding to an OAT coverage of 9 % at the national level in Romania. PWID need access to harm reduction services such as needle syringe programmes to reduce the risk of blood-borne infections, and people who inject opioids should have access to OAT to reduce the risk of overdose death and infectious diseases.

Finally, the number of PWID living with HIV and/or HCV who had not been linked to antiviral treatment in Ukraine is projected to be higher than the number of displaced PWID on ART and/or DAA. For example, the projected number of displaced PWID living with HIV who arrived in Poland ranged from 633 to 2 532, while the number of displaced PWID already on ART ranged from 342 to 1 367. These results stress that in addition to the significant needs for ART/DAA treatment continuity, the needs in terms of testing and initiation to HIV and viral hepatitis treatment among displaced PWID could be even higher. Note that co-infections are common among PWID in Ukraine. Based on pre-conflict surveys, 18 % tested positive for both HIV and HCV antibodies (Titar et al., 2021), and 21 % of HIV+ PWID had received TB treatment in the past 3 months (Sazonova et al., 2020). Focusing on TB, and based on the number of cases detected among PWID in Ukraine (Kamenska et al., 2019), the projected number of displaced PWID with TB arriving in neighbouring EU countries was relatively low (ranging from 21 to 83), but should nevertheless be considered, as this would require resource-intensive isolation, treatment (continuation and initiation) and contact tracing. Note that in 2020, 32.6 % of all bacteriologically confirmed pulmonary TB cases in Ukraine were RR/MDR-TB (ECDC and WHO, 2022), typically requiring longer isolation and treatment periods, as well as more complex treatment regimens.

The model's assumptions and parameters are described in the Methods section and in Table 2. They all come with degrees of uncertainty and limitations. First, only primary, and not secondary, flows of displaced people to bordering EU countries were considered. For example, many displaced people first arriving in bordering EU countries have then moved to other EU Member States. Second, there are reports of displaced people going back to Ukraine as the military situation evolved over time. This would have led to an overestimation of needs in bordering countries. Third, based on available reports, we estimated that 17 % of displaced Ukrainians were men. Due to the martial law in place, many of these men would be elderly citizens, and less likely to be PWID. This would have led to overestimation of the number of male PWID arriving in the EU. Fourth, the fact that co-infections among PWID are common implies that the total estimated number of individual PWID in need of infectious disease care is less than the sum of disease-specific estimates. However, while this would translate into lower numbers of patients to treat, co-infections are often more complex and resource-intensive to manage. Finally, and most importantly, the mobility of PWID, and how it differs from that of the general population, is unknown. A mobility factor ranging from 1 (higher projection) to 0.25 (lower projection) was applied. Despite the lack of data on this aspect, it is assumed that the lower projection might provide more realistic estimates.

TABLE 2

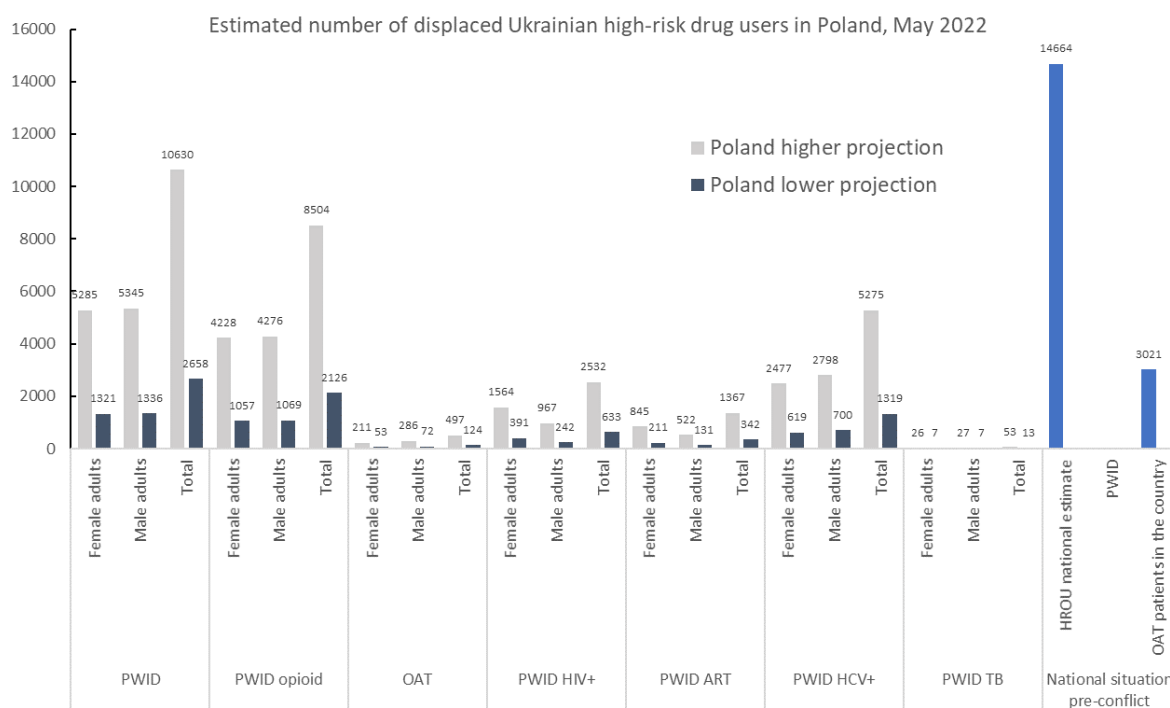
**Parameters of used to estimate the number of displaced Ukrainians who use drugs in need of harm reduction services, drug and infectious diseases treatment, in Poland, Romania, Hungary and Slovakia, May 2022**

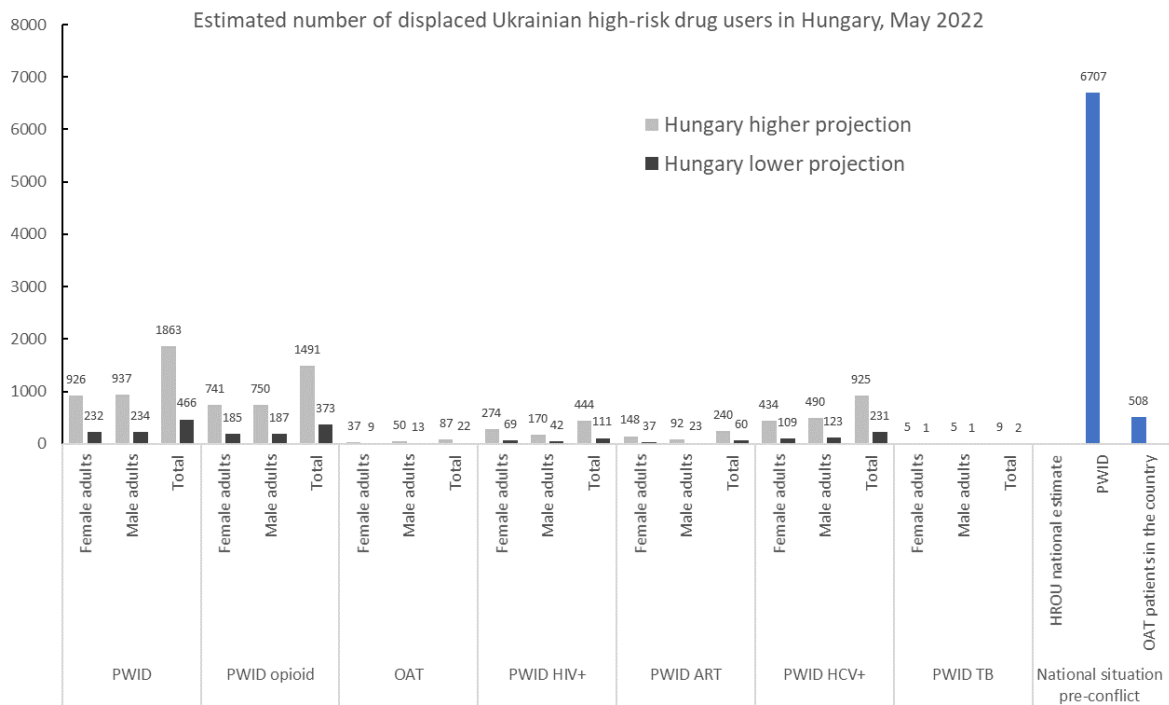
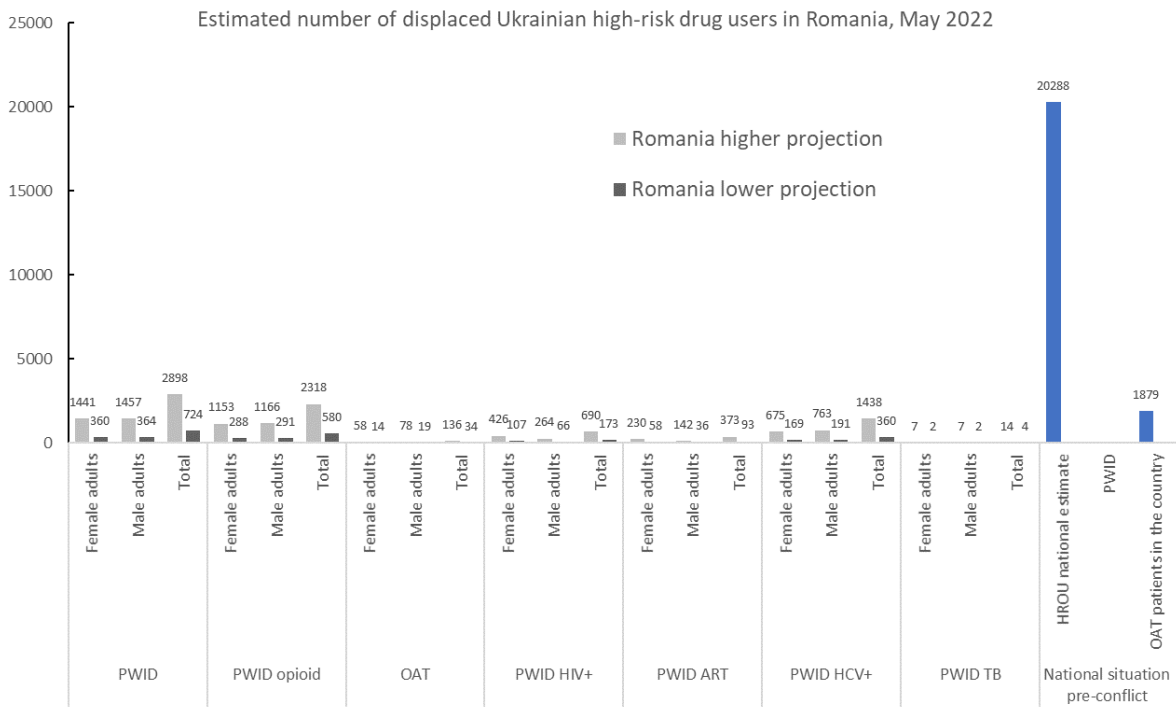
Parameter	Value	Source
Population of Ukraine	43 733 759	United Nations Population Fund, <a href="https://www.unfpa.org/data/UA">https://www.unfpa.org/data/UA</a>
Proportion of children <15 in Ukraine	0.16	United Nations Population Fund, <a href="https://www.unfpa.org/data/UA">https://www.unfpa.org/data/UA</a>
Proportion of women in Ukraine	0.53667	The World Bank, <a href="https://data.worldbank.org/indicator/SP.POP.TOTL.FE.ZS?locations=UA">https://data.worldbank.org/indicator/SP.POP.TOTL.FE.ZS?locations=UA</a>
Number of PWID in Ukraine	350 300	Sazonova et al., 2020
Proportion of women among PWID in Ukraine	0.19	Titar et al., 2021
Number of OAT patients in Ukraine	17 844	Public Health Centre of the Ministry of Health of Ukraine, 2022c.
Proportion of women among OAT patients in Ukraine	0.149	Public Health Centre of the Ministry of Health of Ukraine, 2022c.
HIV prevalence among female PWID in Ukraine	0.296	Titar et al., 2021
HIV prevalence among male PWID in Ukraine	0.181	Titar et al., 2021
Proportion of HIV+ PWID on ART in Ukraine	0.540	Titar et al., 2021
HCV antibody prevalence among female PWID in Ukraine	0.625	Titar et al., 2021
HCV antibody prevalence among male PWID in Ukraine	0.698	Titar et al., 2021
Estimated proportion of viraemic infection among anti-HCV+	0.75	Grebely et al., 2014
Number of detected active TB cases per 100 000 screened key population (including PWID) per year in Ukraine	1 191	Kamenska et al., 2019
Flow of displaced adults from Ukraine to EU countries since 24 February 2022	3 237 079	United Nations High Commissioner for Refugees, <a href="https://data.unhcr.org/en/situations/ukraine">https://data.unhcr.org/en/situations/ukraine</a> , Accessed on 05/05/2022
Proportion of children among displaced people	0.4	United Nations High Commissioner for Refugees,

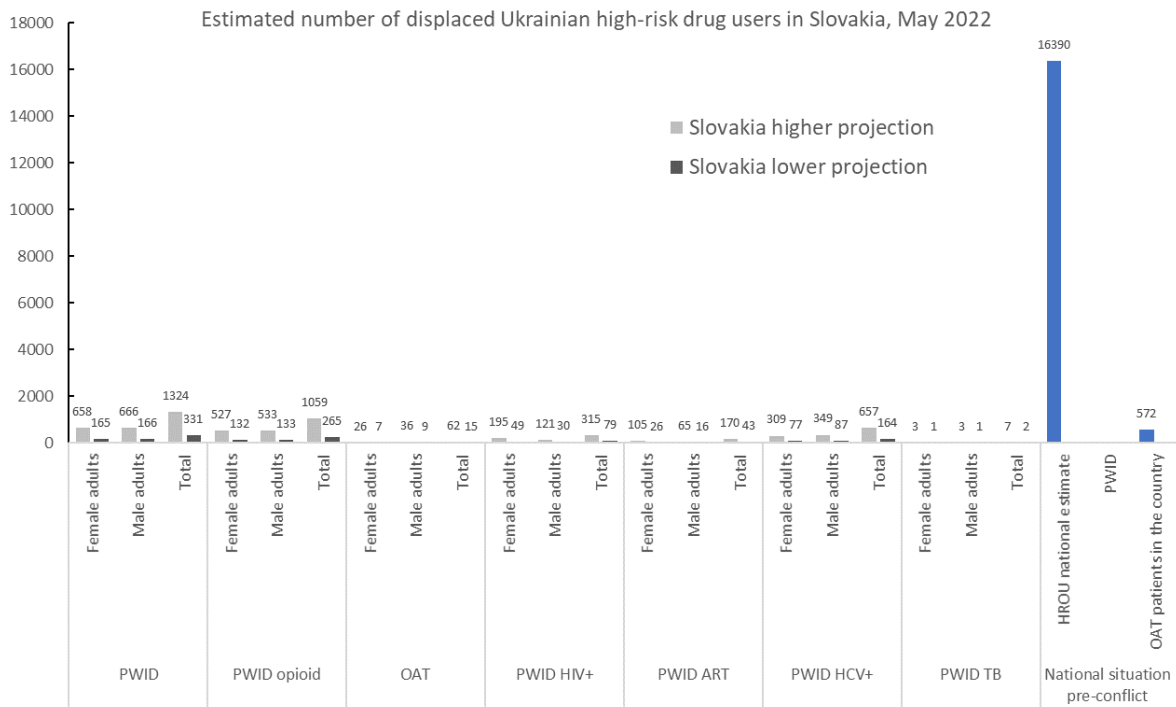
Parameter	Value	Source
		<a href="https://data.unhcr.org/en/situations/ukraine">https://data.unhcr.org/en/situations/ukraine</a> ,
Proportion of women among displaced people	0.83	United Nations High Commissioner for Refugees, <a href="https://data.unhcr.org/en/situations/ukraine">https://data.unhcr.org/en/situations/ukraine</a> ,
Relative risk of PWID moving out of Ukraine (upper)	1	This assumes the same probability of fleeing Ukraine for PWID as for the general population.
Relative risk of PWID moving out of Ukraine (lower)	0.25	This assumes a lower probability of fleeing Ukraine for PWID as for the general population.

FIGURE 8

**Estimated number of displaced Ukrainians who use drugs in need of harm reduction services and drug and infectious diseases treatment, in Poland, Romania, Hungary and Slovakia, May 2022**







## Annex 2. Conditions for displaced people fleeing the war in Ukraine to access drug services

TABLE 3

Conditions for displaced Ukrainians to access drug services (OAT, drug treatment other than OAT, and harm reduction interventions) free of charge in the EU Member States and Norway

Country	Opioid agonist treatment (OAT)	Conditions	Drug treatment (other than OAT)	Conditions	Harm reduction	Conditions
Austria	Yes	<p>There are differences between Austrian provinces. For example:</p> <p>Province Oberösterreich: Dependent on a doctor's assessment to continue the treatment. If available, a confirmation of the treatment carried out in Ukraine.</p> <p>Province Salzburg: a certificate of registration from the province of Salzburg as well as the following results:</p> <ul style="list-style-type: none"> <li>- routine laboratory tests (blood count, liver, kidney, electrolytes)</li> <li>- hepatitis serology (Hep-C-AK, HCV-RNA, HBs antigen)</li> <li>- HIV serology</li> </ul>	Yes	Similar to OAT with differences between Austrian provinces	No	

Country	Opioid agonist treatment (OAT)	Conditions	Drug treatment (other than OAT)	Conditions	Harm reduction	Conditions
		<p>- resting ECG</p> <p>- other existing doctor's letters / previous medical findings. Emergency treatments are possible without preconditions.</p> <p>Province Vorarlberg:</p> <p>If a Ukrainian refugee has a special need for care and treatment due to a disability or illness, this must be clarified with the basic care office.</p> <p>In the context of integration assistance, a specialist medical diagnosis with a professional opinion is required for the necessary integration assistance measures.</p> <p>Vienna: Registration in the federal state and associated health insurance.</p>				
Belgium	Yes	In order to obtain free medical care, they need to register at the registration centre of the Immigration Office. They then receive a temporary protection certificate. They have to register with a sickness fund, which allows them to consult a general	Yes	Same as OAT	No	

Country	Opioid agonist treatment (OAT)	Conditions	Drug treatment (other than OAT)	Conditions	Harm reduction	Conditions
		practitioner, dentist or another healthcare provider for medical care.				
Bulgaria	Yes	<ul style="list-style-type: none"> <li>- Status of temporary protection</li> <li>- Identity document</li> <li>- Medical certificate for participation in an OAT programme (optional)</li> </ul> <p>The main requirements for admission to an OAT programme are:</p> <ul style="list-style-type: none"> <li>- Dependence on opiates</li> <li>- 18 years of age</li> <li>- History of regular opiate use for at least 1 year</li> </ul>	Yes	There are no conditions for emergency situations; temporary protection status is needed for other drug treatment.	Yes	n.a.
Cyprus	No		No		No	
Czechia	Yes	1. Need to be registered as 'refugee/displaced' by the official system within a few days of arrival so that they can have health and social services for free (those that are covered by health insurance, etc.).	Yes	Need to be registered as 'refugee/displaced' by the official system within a few days of arrival so that they can have health and social services for free (those that are covered from health insurance, etc.).	No	



Country	Opioid agonist treatment (OAT)	Conditions	Drug treatment (other than OAT)	Conditions	Harm reduction	Conditions
		2. Need to have a receipt/confirmation from a Ukrainian doctor that they were in OAT treatment in Ukraine (ideally stating the dose).		No conditions apply if they use private treatment centres and pay on their own.  (This is the same for all residents/people with permanent or temporary residence in the country, not only for displaced Ukrainians.)		
Denmark	Yes	A special 'Ukraine-law package' was adopted in the parliament. According to the law, Ukrainians will be able to obtain a temporary residence permit in Denmark. Once they are registered in the National Register of Citizens and their health insurance card has been issued, they will be entitled to health benefits, including rights to free OAT and other drug services.	Yes	Same as OAT	No	
Estonia	No		No		No	
Finland	Don't know		Don't know		Don't know	
France	No		No		No	
Germany	Yes	Registered as refugees and have health insurance	Don't know		No	

Country	Opioid agonist treatment (OAT)	Conditions	Drug treatment (other than OAT)	Conditions	Harm reduction	Conditions
Greece	No		No		No	
Hungary	Yes	Must be permanent residents of Ukraine	Yes	Same as OAT	No	
Lithuania	Yes	Registration at the Migration Department is required to receive healthcare services free of charge.	Yes	Same as OAT	No	
Luxembourg	No		No		No	
Malta	No		No		No	
Netherlands	No	No information	No	No information	No	No information
Norway	No		No		No	
Poland	No		No		No	
Portugal	No		No		No	
Romania	No		No		No	
Slovakia	Yes	In order to be reimbursed by the health insurance company, they must have the status of temporary protection.	Don't know		No	
Slovenia	Yes	Must apply for refugee status	No		No	
Spain	No		No		No	

Country	Opioid agonist treatment (OAT)	Conditions	Drug treatment (other than OAT)	Conditions	Harm reduction	Conditions
Sweden	Yes	Adults who seek asylum or hold a valid residence permit with temporary protection have the right to emergency medical care and other care that cannot wait, which is determined by the (regional) health services. Children and young people under the age of 18 are entitled to the same healthcare as other children living in Sweden. As a main rule, a patient needs to be 20 years of age to qualify for OAT. If there are special reasons, a patient may be prescribed such treatment even when they are not yet 20 years old. A patient who is prescribed drug-assisted treatment for opioid dependence must also have been assessed to have been opioid dependent for at least 1 year by the prescribing doctor.	Yes	Same as OAT	Yes	Same as OAT and a passport or other form of identification is also required to access needle and syringe exchange programmes.

Source: Online survey among Reitox national focal points between 11 April and 3 May.

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