

The impact of drug policy

on health and human rights
in Eastern Europe

10 YEARS AFTER THE UN GENERAL ASSEMBLY SPECIAL SESSION ON DRUGS



Contents

Suggested citation

Eurasian Harm Reduction Network (2009). *The impact of drug policy on health and human rights in Eastern Europe: 10 years after the UN General Assembly Special Session on Drugs*, ed. by Raminta Stuikyte, David Otiashvili, Simona Merkinaite, Anya Sarang, Andrey Tolopilo. Vilnius: Eurasian Harm Reduction Network (EHRN).

English language editor

Misha Hoekstra, Denmark

Design and publishing

Ex Arte, Lithuania

Photos

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The authors would like to thank all the people who agreed to give interviews, provide information, share reports, and offer feedback.

This report would be not possible without highly motivated national teams of researchers, lawyers, and policy analysts in Georgia, Lithuania, Russia, and Ukraine.

Financial seed support for this report was provided by the Open Society Institute. The views expressed herein are those of the authors and in no way reflect the opinions of the donor.

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Introduction

Eastern Europe's post-Soviet Union development, which has brought major social and economic changes to everyday life, governance, and the social sector, is coming of age. During this period, the drug issue has become visible and risen rather high on national agendas in the region. All Eastern European countries ratified the three UN conventions on drugs; in the wake of the UN General Assembly Special Session (UNGASS) and the Declaration of the Guiding Principles of Drug Demand Reduction, they also adopted the 1998 UN Political Declaration, which committed them to improving relevant national and international mechanisms.

To assess the 10-year progress in Eastern Europe after the 1998 UNGASS on the World Drug Problem, the Eurasian Harm Reduction Network (EHRN) and its national partners conducted this review. The review focuses on changes – in the levels of drug use; in public health and health care, particularly HIV, hepatitis C, and overdose; in access to drug treatment; in legislation and policy; and in human rights. These topics were suggested either by the objectives of the Political Declaration and the Guiding Principles, or by the conclusions of Beyond 2008, an NGO consultation.

Georgia, Lithuania, Russia, and Ukraine were selected for analysis. These four countries share a common history and had identical legal, health, social, and security systems some 20 years ago, when they were part of the Soviet Union. Since then they have diverged politically and economically, adding to differences in size and geography. Within the last 10 years, Lithuania (the smallest of the four) acceded to the EU and Russia (40 times more populous) joined the Group of 8 (G8), while the less prosperous republics of Georgia and Ukraine underwent political revolutions.

The sources used for this report include official national reports, a review of reports and statistical data, and qualitative semi-structured interviews with 8–10 people from each country: drug users (present or former), law enforcement representatives, public health and drug treatment specialists, researchers, human rights advocates, and representatives of drug policy decision-makers.

Increased drug use and injecting drug use

The experts we interviewed agree that drug use in all four countries rose sharply at the end of the 1990s, i.e., around the time the UNGASS took place, and this growth stabilized around 2005. Although the expert opinion suggests that the numbers of new users had been decreasing since 2000, they noted no decreasing trends in the level of drug use in any of the four countries.

In accordance with expert opinion, available statistics also indicate that the Eastern European countries have been experiencing increases in drug use over the last decade. For example, in Lithuania the number of drug-dependent people registered with the State Mental Health Center more than doubled over the last decade (*Lithuanian State Mental Health Center, 2008*). The 2004 estimates of the UN Reference Group on HIV and Injecting Drug Use indicate that two countries in the region had rates of injecting drug use that were among the highest in the world: 1.19% of the adult population in Ukraine and 1.96% in Russia. In the other two countries we have reviewed here, this index was considerably lower: 0.33% in Lithuania and 0.37% in Georgia (*Aceijas et al., 2004*).

Lithuanian national sources estimate that the number of problem drug users – i.e., injecting drug users (IDUs) and non-injecting users who are heavily addicted – was between 4,600 and 8,500 in 2007 (*Cook & Kanaef, 2008; Hay, 2007*). In Ukraine, the number of IDUs was estimated to be as high as 435,000 in 2007. In the much larger country of Russia, the national narcological register, which tracks the “official” number of people using drugs through the state drug treatment system in all four countries, had records on 224,647 users in 1999 (*Russian Academy of Medical Science, 2005*). In 10 years’ time this number more than doubled, and in 2008 it reached 538,000, of whom 90% are registered opiate addicts. However, the Russian Federal Drug Control Service estimates that the actual number of drug users in 2008 was between 2 and 2.5 million (*Medportal [Медновосту], 2008*). The experts indicate that Georgia has also been experiencing a sharp increase in drug use in recent years. In 2006, some 80,000 problem drug users lived in the country (*Javakhishvili, Kariauli, et al., 2006*). The increasing severity of the drug problem is acknowledged not only by experts but also by Georgian society at large, which considers drug use to be the greatest social problem besides unemployment (*Otiashvili, Sárosi, & Somogyi, 2008*).

Honestly speaking I don't see any reasons [why the drug use level might have decreased over the last few years].... I don't see any fundamental changes over these years which could have influenced attitudes of young people. Still, success is not accessible for all, and [a] considerable amount of young people, especially living in province[s] or [economically or socially] “depressed” parts of the country are doomed to fight for survival. Social and economic uncertainty, demographical

[and] political threats, and infections – all these issues are still in place.... More and more education is not free of charge anymore. It is hard to get a good job. Inflation is increasing.... [There are s]till a lot of divorces, unemployment, homeless people. And we are talking about hundreds of thousands, millions of people. We speak about social orphanage. These [developments] are inside of our populations and [they keep] accumulating. Do you understand? And it is naïve to hope that this could be overcome by [drug use] prevention programs at schools.

—Expert on the social and legal aspects of drug use, Russia

Changes in the drug market and the region’s continuing integration into the international drug trafficking network has led to a shift in the substances used in the region. During the last decade, all the countries in the region moved beyond “softer,” plant-based drugs produced locally (cannabis, homemade opiates). The injecting of opiates, especially heroin, has become very popular since the end of the 1990s. In many places, heroin replaced homemade opiates and even non-opiate drugs. In Georgia, nearly half of all IDUs consume buprenorphine, which is not legally available (*Otiashvili, Zabransky, et al., 2008*). The people interviewed in also indicated an increase in the use of amphetamine-type stimulants, especially among young people.

Drug use is rapidly increasing among young people. And it spreads to better-educated parts of the society. Use of such drugs as stimulants is not under discussion anymore.... That's part of clubbing culture.... We need to start thinking about that.

—Drug user, Lithuania

Statistics confirm that use of methamphetamine and other amphetamine-type stimulants, homemade as well as laboratory-produced, has been rising over the last years in all four countries (*Cook & Kanaef, 2008; Otiashvili, Zabransky, et al., 2008*).

A variety of factors have contributed to the increases in drug use and in problematic drug use, ranging from social and economical factors, to the unavailability of services for drug users, to the growing accessibility of drugs.

Although the overall upward trend in drug use has been firmly established for all four countries, there remains a substantial lack of adjusted, scientifically based data that would allow comparison of drug use prevalence for different years and the region’s different countries. The estimates and numbers that are available are based on different indicators, methodologies, and incommensurable population samples. Though all four countries based their projections of drug use levels at the end of the 1990s on their narcology registers, changes in register numbers indicated more about the activity of law enforcement mechanisms and changes in registration methods than actual changes in the number of drug users.

National priorities in drug policy

The last 10 years in the region have also been marked by an increase in drug policy. All four countries now have national policy documents or, as in the case of Georgia, guiding principles for drug policy. Lithuania and Russia have been developing and implementing multi-year strategies since the late 1990s (*Government of the Russian Federation, 2005; Seimas of the Republic of Lithuania, 2004*). It is noteworthy that, over the years, they have focused more on measurable indicators and earmarked specific funds for their implementation. In Ukraine, a policy concept document was adopted for 2002–2010, and policy objectives were also defined in the law. In Georgia, national policy guidance was defined even later, in 2007 (*Javakhishvili, Kariauli, et al., 2006*). As in Ukraine, it utilized technical support from the European Union to analyze the drug situation, assess legislation and interventions, and articulate policy.

By comparison, in the HIV field, all of the focus countries except Russia have national programs, coordinating bodies, and dedicated budgets, and efforts to better plan, implement, and evaluate activities were underway almost immediately after the HIV epidemic started.

In three of focus countries, with the exception of Lithuania, national drug strategies or policy guidance documents, the main priority is drug control (supply reduction), through suppression of drug production, combating drug trafficking, and strengthening legal measures. In Lithuania, the national strategy integrates efforts that focus on drug supply, drug demand (chiefly through primary drug prevention), harm reduction, research, information, and coordination (*Seimas of the Republic of Lithuania, 2004*). The national strategies of Lithuania, Georgia, and Ukraine include a newer approach that was not represented in national policy before: harm reduction, either as a separate or an integrated pillar. Ukraine adopted a specific law on harm reduction in 2008. In addition, most of the region's HIV programs now address drug users' health. Russia, Lithuania, and Georgia have also created large separate departments to coordinate the fight against drugs (drug control committees).

National drug strategies in Eastern Europe often raise concerns among experts about the key components they may lack: concrete and measurable goals, effectiveness indicators, monitoring, evaluation, and transparency. Moreover, many actions included in these strategies are underfunded and thus remain unimplemented (*Javakhishvili, Kariauli, et al., 2006*). While civil society is involved in the drug issue in the region, its efforts are mainly limited to developing prevention, treatment, rehabilitation, and harm reduction services – not drug policy (*Vienna NGO Committee on Narcotic Drugs, 2008*).

In the last decade, all four countries saw increases in governmental and international funding for drug prevention and treatment. The effectiveness of the government allocations is ques-

tionable, however. For example, a few years ago in Georgia, 60% of the money earmarked for the health care of drug users was devoted to testing arrested individuals for drugs (*Otiashvili, Sárosi, & Somogyi, 2008*). Moreover, government spending was only €9 annually per problem drug user. A different picture is found in Lithuania, where government spending for drug services in the public health is relatively high, an estimated €500 for each problem user,¹ though this figure remains substantially less than the EU average of €2000 (*Postma, 2005*). Much of the public investment in drug services is part of the response to HIV, with its attendant limitations. For example, in all countries of the region, money for piloting the drug treatment method of opioid substitution therapy has come from HIV prevention budgets (*Vienna NGO Committee on Narcotic Drugs, 2008; Subata & Stuikyte, 2005*).

Lithuanian funding of its drug strategy may appear overly weighted to the side of drug demand and harm reduction, which receive 3–4 times more money than law enforcement. However, this apparent financial priority does not reflect the actual overall priorities in public expenditure on the drug problem, as it does not cover funding for police and prison efforts that are included in their general budgets. In Georgia, when economic research was conducted in 2003 to assess all state spending on drug control, including what was in the public health, police, prison and other sector budgets, it revealed that law enforcement was receiving the vast majority of all funding on the issue (89%) (*Shatirishvili et al., 2005*).

¹ The calculation is based on funding for the drug treatment and rehabilitation budget for 2007 (*Government of the Republic of Lithuania, 2007*).

Drug legislation, criminal law, and human rights: trends and consequences

By 1999, all four focus countries had ratified the three UN drug conventions and established a legal framework for dealing with the production, selling, import, export, use, and circulation of narcotic and psychotropic substances, defining substances that could and could not be used for medical, scientific, and other purposes and the extent of restrictions. All the countries have specific laws on narcotic and psychotropic substances and special provisions in their administrative and criminal codes for punishing non-compliance.

The major changes in Lithuanian drug law after 1999 were related to the legislative review conducted for accession to the European Union. The new criminal code reduced punishments for drug-related crimes. Some changes also affected the scheduling of narcotic substances. For example, poppies with low levels of tetrahydrocannabinol were legalized, and some new synthetic drugs were added to the schedules.

In Ukraine, legislation on narcotic substances was reviewed in order to improve access to narcotic and psychotropic substances. Initially, the state had a monopoly on them, and a restrictive licensing system prohibited actors in the private sector from even applying to store narcotic substances. As in Lithuania, the country reduced punishments for petty crime, but these changes did not affect drug-related crimes, which is reflected in the growing proportion of drug-related crimes in the total of all crimes detected in Ukraine. In 2003, there were 201,100 people convicted for crimes, 29.9% of them for drug-related crimes; by 2007, the number of convictions dropped nearly by a quarter, with 31.0% of the total being drug-related (*Supreme Court of Ukraine, 2003 & 2007*).

Georgia is the only one of the four countries that continues to explicitly criminalize drug use, though at the same time it also has special provisions in law prohibiting discrimination on the basis of health status. The punishment for drug use in Georgia has grown over the last 10 years. The fines for drug use are also the highest of the countries reviewed, amounting to about two months of the average salary for a first misdemeanor and at least four months' salary for further misdemeanors. By contrast, the comparable fines are 2% and 4% of average monthly wages in Russia and 0% and 28% in Lithuania. In Ukraine, drug use is punishable as an administrative misdemeanor and only if it is done in public (close to sporting events, schools, etc.) or in a group, and the punishment is almost never applied if there are no other crimes. The Georgian state actually profits handsomely from drug-related offences, with fines totaling an estimated € 10 million in 2007 alone, or about € 2.9 per inhabitant (*Otiashvili, Sárosi, & Somogyi, 2008*).

There is no point in applying criminal liability in case of drug use. [The drug user faces psychological and health problems therefore s/he should be treated as a sick person. I think that punishment for use won't have desirable results, and prevention of use can... [Putting a drug-dependent person in a prison ... I don't think it will do him/her good, most probably on the contrary.

—Staff member, Drug Control Department, Lithuania

[Should drug use be punishable?]

No. First, there are a couple of aspects to look at from the criminal liability perspective. First of all the fact of drug use itself is not recognized as creating a threat to society. Secondly the reasons [for] drug use must be kept in mind, not the fact of use itself. The negative consequences in the country result from the causes of use and not the fact of use.

—Legislative expert, Drug Control Department, Lithuania

Possession of small amounts of drugs without intent to traffic is generally an administrative offence in the four focus countries. It carries low fines in Russia and extremely large ones in Georgia, with the possibility of imprisonment in Lithuania and Georgia. Definitions of small, large, and extra large amounts also vary by country, thus affecting the gravity of punishment. Over the decade we are looking at, all four countries tended to increase the size of what they defined as the smallest amount. Nonetheless, a given amount – sometimes only the trace of a drug – that is considered small in one country might be large or extremely large in another. For example, in the case of buprenorphine, which features on the WHO Model List of Essential Medicines, small quantities according to Lithuanian and Ukrainian legislation can qualify as large amounts in Georgia and extra large amounts in Russia. Similar mismatches can also be found for amphetamine and morphine. While such definitions may be advisory in nature, they nevertheless affect police and court actions substantially. They also show why extreme caution should be exercised in comparing statistics on “minor” and “major” drug offenses among countries. The assignment of quantities for heroin possession is cause for particular concern, and in all countries except Lithuania, by definition there *is* no such thing as a small amount (e.g., for personal use), only significant amounts. In general, drug quantity definitions have been strongly criticized by academics and human rights groups (*Gruodyte, 2004*).

The extra large dose of drugs defined in legislation is a daily dose for [the] drug user.

—Drug user, Georgia

In Russia, a major revision of the criminal law affecting drug users took place in 2003–2004, along with a revision of the definitions for small, large and extra large amounts. The new definitions replaced what were known as the Babayan Tables, recommendations that had been issued

by a commission without legal authority yet used throughout the justice system in Russia (and named for its author, a long-standing member of the International Narcotics Control Board). These revisions had a substantial impact on criminal justice in general, leading to a 22% decrease in the overall Russian prison population in comparison with 2001 (*Federal Executive Service of the Penitentiaries of the Russian Federation, 2009*).

Eastern European and Central Asia prisons contain large numbers of drug users. In all four focus countries, the overwhelming majority of people convicted for drug-related crimes are in prison for possessing small amounts of narcotics or other psychoactive substances without intention to sell (*Otiashvili, Sárosi, & Somogyi, 2008*). In Georgia, almost a quarter of those convicted of drug-related crimes are there for simple drug use, and nearly 40% of all imprisoned women are there for violating drug laws. Among the four countries examined, only in Ukraine and Lithuania does legislation foresee alternatives for imprisonment, as provided for in the UN drug conventions, yet even there, the courts often ignore these alternatives.

Human rights are grounded in [the] country's constitution but government does not enforce them. Therefore human rights are often violated, especially those of people using drugs or living with HIV.

—Militia (police) employee, Ukraine

Government policy towards drug users has not changed at all. The cruelty towards drug users [has] increased and human rights are violated constantly.

—Drug user, Ukraine

Courts are used to certain things, so they do not care for evidence. [The t]estimony of the drug user is not worth anything and is not listened to.

—Drug user, Lithuania

All four countries have ratified a series of UN and European conventions on human rights, including those that enumerate the rights to health, non-degrading treatment, justice, and non-discrimination. Each of them has also secured its citizens fundamental rights in its constitution. Yet the drug-related legislation and strategy documents of these countries leave human rights out. The only rights mentioned in any of the national drug strategies that we analyzed are children's rights, which the Lithuanian program refers to. The importance this program attaches to children's rights is reflected by its reference to the Action Plan of UNGASS on Children 2002 (*United Nations, 2002*) (though it makes no mention of the UNGASS on World Drug Control at all). The Georgian and Russian programs mention human rights only in the context of their restriction due to drug use or dependency.

Most of the interviews conducted and literature reviewed mention rights violations, particularly abuses involving access to drug treatment; interactions with police; access to health after arrest, during police investigations, and in jail; testing for drugs; and access to other health and social services. One example of the clash between human rights and criminal law is found in Georgia, where the Law on Patients' Rights forbids discrimination on the basis of health status, but where drug use, including chronic addiction, is punishable in itself. In Georgia, forced drug testing also affects the rights of many non-users – in 2007, for instance, 62% of the people tested for drugs tested negative but had to spend four or more hours to be tested in a police station (*Otiashvili, Sárosi, & Somogyi, 2008*).

The mistreatment of drug users, including torture and appalling physical conditions, has been observed for Russia, Ukraine, and other countries in the region, both at the time of apprehension and while in custody. It has been documented that Ukrainian police subject drug users and sex workers to physical and psychological abuse, including severe beatings, electroshock, partial suffocation with gas masks, and threats of rape, in order to extort money or information. “Police needing to fulfill arrest quotas find drug users in particular especially easy targets for arrest or ill-treatment. Police use drug addiction as a tool to coerce testimony from drug users, who may succumb to pressure to admit to false charges when faced with painful withdrawal symptoms in custody” (*Human Rights Watch, 2006*).

Drug legislation has also affected the availability and use of narcotics in medicine. A review of the usage levels for opioid painkillers has shown that in Eastern Europe these levels are extremely low, well below European and world averages for morphine consumption. This situation is particularly marked in Georgia, Russia, and Ukraine. Prescription rules cause the low consumption and “rational prescription” of opioids, so that instead, medications are dispensed that are “unrealistic, totally unpractical, and outdated.” Strong “opioidophobia” exists in these countries, and doctors are afraid of being put in prison if they prescribe morphine. In Georgia, it is possible to dispense opioid medications for home-based palliative care through a very limited network of police-based pharmacies (*Stjernswärd, 2005*).

Access to drug dependence treatment

Despite an increase in the number of drug treatment facilities over the last decade, the expansion has not kept pace with the increase in drug use and addiction in Eastern Europe. Coverage rates for dependence treatment remain extremely low in the countries of the region. Data indicate that only 1.6% to 9% of the people estimated to be in need can access dependency treatment in the focus countries (Cook & Kanaef, 2008; Georgian Research Institute of Addiction & New Way, 2008).

Probably the main problem is lack of government interest in dependence treatment. The system is well ... [adapted to] other illnesses such as diabetes, asthma, depression, or schizophrenia. Patient[s with these illnesses] can get help from a health facility, get a medical consultation, and continue treatment, [all of] which is fully or partially covered [by the state]. No such system exists ... [for] dependence treatment.

—Drug dependence treatment specialist, Lithuania

Moreover, the treatment that *is* available is often ineffective. Scientific and humane approaches are to a large extent still novel in dependence treatment, as it has been institutionalized and practiced in the region, with the possible exception of Lithuania. One of the common methods inherited from the Soviet system is detoxification (management of withdrawal symptoms) with neuroleptics. The countries of the region are still unwilling or unhesitant to implement evidence-based guidelines.

Over the last decade, much energy has been accordingly expended in these countries to confirm and reconfirm available evidence, to confront myths, to highlight the guidance of international organizations and the experiences of other countries, to convince stakeholders that “untraditional” methods do not contradict the UN drug conventions, and then – if major partners can be convinced – to pilot interventions in order to demonstrate their applicability in local contexts and evaluate the results. Unfortunately, successful pilots – of opioid substitution therapy, for instance – have often proven politically impossible to scale up rapidly. Experience in Eastern Europe has shown that it is necessary to win the approval of a large number of stakeholders in order to put such treatment methods into practice. The debate about how to deal with dependency – what works and what does not – extends far beyond the medical community, involving as it does the active participation of law enforcement, prison administration, the general public, legislators, municipal politicians, etc. In Ukraine, the introduction and scale-up of methadone

treatment was possible only after the country’s president and vice prime minister publicly called on the state law enforcement agency and other stakeholders not to interfere.

In Russia, problems with the effectiveness of drug treatment are readily apparent in the national drug program charged with introducing new methods of drug treatment and increasing the length of remission for drug-dependent people who undergo treatment. According to the program itself, the government spends more than 1 billion Russian rubles (around € 22 million) annually on drug treatment for more than 50,000 people, yet 80%–90% of the people who complete treatment start using drugs again (Government of the Russian Federation, 2005). Russia remains the most striking example of deep-rooted opposition to world’s best practices in drug dependence treatment. Despite the principles adopted by the national program, and although leading international organizations such as WHO and other UN agencies recognize substitution therapy with opiate agonists (methadone and buprenorphine) as the most effective and scientifically proven method for treating opiate dependence and preventing the negative health consequences of dependence, Russia continues to oppose opioid substitution therapy and it remains to illegal in the country (WHO, UNAIDS, & UNODC, 2004). Implementation of substitution therapy has also been quite slow in other countries of the region, including Ukraine. Despite statements by the government vowing to greatly expand these programs, substitution treatment remains limited to pilot programs, thereby restricting access to treatment for the vast majority of those in need. Coverage of substitution treatment in Lithuania is also limited, with only 395 patients enrolled in 2007, out of several thousand in need (Lithuanian Drug Control Department, 2007), despite a large WHO study demonstrating the effectiveness of the treatment in Lithuania and other countries (Cook & Kanaef, 2008; Hay, 2007;). It is worth noting that, where substitution therapy began as part of HIV prevention efforts, in Lithuania and very recently in Georgia, these programs are also considered part of national drug treatment efforts and included in the relevant budgets.

One major obstacle to access to drug services is a practice common to the region: that of the “narcological register,” the national drug user registry inherited from Soviet narcology (its system of health services for drug dependence) (Subata & Uscila, 2007; Levinson & Torban, 2008). Inclusion in the register presents users with several problems: restrictions of their civil rights for a rather long time after successful completion of drug treatment; breach of health care’s principle of confidentiality; social problems, including employment and driving restrictions; sharing of data with law enforcement and other agencies; etc. Inclusion in the register is a prerequisite for free health services for addiction, such as detoxification in Lithuania, Russia, and Ukraine. Users who wish anonymous and confidential treatment have almost no access to free services. In Georgia, anonymous treatment is guaranteed by law, but government funding for dependence treatment has not been available until recently. Private programs are very expensive, and the majority of those in need cannot afford them.

Other drug-related health consequences and the response to them

The last 10 years brought a public health catastrophe in the growing population of IDUs: high levels of infectious diseases (most notably HIV, hepatitis C, and tuberculosis) and overdose deaths. The worsening health problems in this population are exacerbated by a lack of access to primary health care, and by stigma and discrimination in health care settings. The experts and the literature we consulted confirm that such health problems are related to the implementation of legislation targeting drug users and an absence of political will to take seriously the health of socially marginalized groups such as drug users. As the situation in Russia shows, entrenched problems among drug users can also affect a country's general demographic situation (*World Bank – Europe and Central Asia Human Development Department, 2005*).

Ten years ago, Georgia, Lithuania, and Russia reported proportionally fewer HIV, hepatitis, and fatal overdose cases among IDUs. In the case of HIV, where the best data are available in relation to the health problems associated with injecting drug use, only Ukraine was experiencing high HIV rates among IDUs in 1998, registering almost 20,000 HIV cases by the end of the year (*EuroHIV, 2000*). Within the decade, the region's IDUs were devastated by the rapid spread of HIV, as well as the hidden spread of hepatitis C and overdose. Today, Eastern Europe and Central Asia has the fastest growing HIV epidemic in the world. Nearly 90% of the region's 1.5 million people living with HIV (PLHIV) live in Russia and Ukraine. According to UNAIDS, up to 60%–80% of PLHIV in the region are IDUs (*UNAIDS & WHO, 2006*). HIV prevalence rates among IDUs as high as 64.5% and 74% have been recorded in some Russian and Ukrainian cities. Rates of hepatitis are even higher, ranging from 70% to more than 90% in the four focus countries (*CEEHRN, 2006*).

... it will be hard for me to think of a person with whom I used to use drugs or who uses drugs and who does not have HIV or hepatitis. It would be easier to think of someone who does have [one of them].

—Drug user, Russia

Overdose has become another major cause of morbidity and mortality among drug users in many countries of Eastern Europe and Central Asia. Limited data confirm that the appearance of heroin resulted in a sharp rise in fatal overdoses in the analyzed countries. In Russia alone, 9354 overdose deaths were documented in 2006, an increase of nearly 2.5 times since 2003, when 3943 overdose deaths were registered (*Koshkina [Кожкина], 2008*). In Saint Petersburg, ambulance services estimate that 10% of overdoses have fatal outcomes. Several epidemiological studies con-

ducted in 2002–2008 among Russian IDUs found that in different cities, from 8.4% to 53% of IDUs interviewed had experienced an overdose during the previous year. Regional research by EHRN last year also confirmed that overdoses are the main cause of death among people using drugs in the region (*EHRN, 2008*).

The major reasons for these high costs for individual and public health are risk-taking behaviors and a lack of tools, knowledge, and skills – and thus services – to address them. There are only 65 drug services that provide needle and syringe exchange in Russia, 7 in Lithuania, and 6 in Georgia. The Global Fund to Fight AIDS, Tuberculosis and Malaria estimates that programs targeting HIV prevention among IDUs, such as those that provide sterile injection equipment, cover only 2% of the IDUs in Eastern Europe and Central Asia (*IHRD, 2008*). In the meantime, risky injecting behavior remains widespread among users of different substances in Georgia, Russia, and Ukraine (*UNAIDS & WHO, 2006; Anonymous, 2008*). The incidence of injecting risk behaviors is comparatively low in Lithuania, which introduced various harm reduction measures including needle exchange, condom distribution, outreach, opioid substitution therapy, and other effective drug treatments earlier than the other countries (*Amato-Gauci, Mimica, & Murauskiene, 2006*).

Lately there is some [national] support [for harm reduction programs]; since 2006 Ministry of Health [has been] regulating harm reduction services. There are 11 harm reduction programs now functioning, but access is restricted geographically. Municipalities should finance harm reduction programs, but they don't do that except [in] Vilnius and Klaipeda.

—Drug addiction treatment specialist, Lithuania

Access to HIV treatment is becoming better, but for now it remains problematic: according to UNAIDS and WHO, the Eastern Europe and Central Asia region has the second lowest access to HIV treatment in the world, worse even than sub-Saharan Africa, the region most affected by HIV. Substantial progress has nonetheless been seen here in recent years, particularly in Russia where between 2006 and 2007 the number of people on treatment doubled (*WHO, UNAIDS, & UNICEF, 2008*).

With treatment access so limited, IDUs are usually not the first to receive treatment. In 2006, more than 70% of the reported HIV cases in Eastern Europe were among IDUs, yet they represented only 39% of those receiving antiretroviral therapy (*WHO, UNAIDS, & UNICEF, 2008*).

Georgia is a positive exception, since it covers all HIV treatment needs and IDUs comprise the largest proportion of the 346 patients now on antiretroviral therapy. Progress has also been observed in the other countries of the region, with the portion of IDUs among HIV patients increasing in recent years. For example, in Lithuania the proportion of IDUs among people receiving HIV treatment climbed from 10% in 2004 to an estimated 25% in 2006 (*WHO, UNAIDS, & UNICEF, 2008; Matic et al., 2008*).

Even though substantial gaps persist in the response to HIV, the progress thus far is inspiring: from grassroots political commitment and organizing to the first disease-focused UNGASS in 2001; through various European and Eastern European conferences, the adoption of national HIV strategies, and the formation of decision-making bodies with PLHIV involvement; to actually funding and developing services and mobilizing the communities directly affected by HIV. No similar commitment has arisen in response to the other two health disasters that affect IDUs, hepatitis C and overdose.

Every second drug user has hepatitis C, and none of them knows what kind of illness it is or how it could be treated.

—Drug user, Georgia

In spite of widespread infections with hepatitis C, particularly among “experienced” IDUs, testing and diagnostics for hepatitis C in the region is poorly linked to existing services for drug users. Moreover, these drug services have only limited knowledge to provide on living with hepatitis, liver care, and available treatments. So far, access in Ukraine to interferon and ribavirin therapy, the internationally recommended option for hepatitis C treatment, is very limited. In Russia there is funding from the state for this expensive treatment, but only for people who have both HIV and hepatitis C. The Lithuanian government pays for a limited number of treatment regimens, both in prison and the general population (CEEHRN, 2006). In Georgia there is no state funding for hepatitis C treatment at all, and patients must pay full price.

Drug overdoses often occur after a course of drug dependence treatment or after release from a correctional facility. This tendency is especially marked in countries and regions where there are no opioid substitution treatment programs. Infrastructure weaknesses can also impede access to emergency services, most typically in rural areas and in regions with transportation or fuel restrictions. Even in the big cities of Eastern Europe – though to a lesser extent in the Baltic states, like Lithuania – not all ambulances are equipped with naloxone, which is often critical in reversing the effects of overdose. Although health care professionals are trained in how to counter overdose in the majority of Eastern European countries, limited access to naloxone decreases the practical value of these skills. In addition, drug users often fear police involvement that may result from calling an ambulance, and they therefore are frequently unwilling to seek help in the case of overdose (EHRN, 2008).

Recently, a few innovative overdose prevention programs have started in a several Eastern European and Central Asian countries. Several organizations in Russia and Ukraine are providing trainings on overdose prevention, overdose management, and first aid; they also dispense free naloxone.

Many prisoners use drugs before their detention, and most of them continue using while imprisoned, though their use now occurs in a riskier environment. Other users are in prison when they try drugs for the first time (Sarang et al., 2006). Research in Georgian prisons found

that 41% of prisoners had used drugs at least once while serving their sentence and more than half of this group said that they shared syringes with other prisoners (Gamkrelidze et al., 2005). Drug-related health problems are particularly widespread in prison. According to several data sources, HIV prevalence in the four focus countries is 10 times higher in places of detention than in the general population (Cook & Kanaef, 2008). Yet services for drug users are often even more limited in these closed settings than outside. Drug treatment services are extremely limited, as are harm reduction measures, including the provision of condoms and sterile injecting equipment (Sarang et al., 2006). Of the focus countries, only Georgia guarantees prisoners universal access to HIV treatment, though it is also widely available in Lithuania. Voluntary counseling and testing is available in all prisons in Lithuania (Cook & Kanaef, 2008) and in Russia, where testing is not officially mandatory but conducted on most prisoners anyway.

[Did you receive medical HIV treatment in prison?]

No. What medical help? ... After that I “did time” in detention camp. We had to be given two ... vitamins in a week ... yellow and round ... and soybean milk also, but I did not drink it, not even once. I heard that it should be brought to us but I did not succeed [in overcoming my disgust to] taste it.

—HIV-positive drug user, Russia

People with tuberculosis appear in jail, which is not equipped for diagnostic[s] and treatment. Prisoners with tuberculosis are brought to guarded buildings which do not have conditions needed for them. Medical personnel and other staff are afraid of infection so they do not come close. The food is given with the help of sticks to avoid any contact. So the treatment process is not controlled. A lot of people live there for years, a lot of them die.

—Politician, Ukraine

Conclusions

The region of Eastern Europe and Central Asia has experienced a major increase in drug use, including injecting drug use, in the last 10 years. Problem drug use has expanded beyond opiates to some new drugs, such as amphetamine-type stimulants. It is estimated that between 1% and 2% of the Russian and Ukrainian populations inject drugs.

The countries of the region have not adequately responded to the increase in problem drug use. None of the four national drug treatment systems analyzed – in Georgia, Lithuania, Russia, and Ukraine – can meet more than 9% of the treatment demand. Not only are these systems much too small in scale, but they are also crippled by a tradition of the ineffective Soviet approach to drug dependence. This approach focuses on managing withdrawal symptoms instead of using the full range of evidence-based treatment options that have been developed, and on controlling known users through a national register that links treatment with law enforcement. Still, progress has been made: the countries *have* introduced some of the new approaches to drug dependence recommended by the international health, scientific, and drug control community. But the introduction of these methods is inadequate in scale and lacks institutional support. The national bodies charged with responding to drug dependency are not committed to treating it, unlike bodies responsible for other health conditions. Most of the new policies and services – including needle exchange, user outreach, counseling on safer injecting behavior, condom distribution, links to drug treatment services, and opioid substitution therapy – were introduced not because of any committed response to drug use and problem drug use, but because of the region's devastating HIV epidemic. The "opioidophobia" reported in governmental responses, even among health professionals, limits not only the efficacy of drug services but also medical use of narcotics, notably in pain management for cancer patients.

National drug policy in these four countries is largely focused on supply reduction, a priority that is reflected in national policy documents and funding. While more countries are now paying attention to drug demand and giving harm reduction a larger role in national policy, drug policy in the region remains unbalanced.

Lithuania is the most successful of the countries analyzed, with lower levels of drug use and a reformed drug policy that balances health, drug regulation, criminal regulation, and enforcement, resulting in fewer health and socioeconomic problems for users. Georgia and Ukraine appear to have undergone more political and programmatic developments in the drug field in recent years, albeit often after long delays. Russia has on one hand been investing in its response to drugs, voicing its commitment to this response, and promoting its approach actively in the international arena. On the other hand, however, the prevalence of drug use, the rate of drug-related crimes, and the levels of drug-related problems (such as HIV) are higher than in the other three countries, while Russia is also less open to new approaches in reducing drug demand and drug-related harm.

In sum, the UN conventions on drugs and 10 years of the UNGASS agreements have not had a major impact on managing the levels of drug use, controlling demand, or implementing harm reduction in Eastern Europe, nor have they done much to build a commitment to rational, evidence-based approaches to helping the large part of society that IDUs in the region comprise. In some countries, like Russia, the conventions and international debates have even been selectively used to undermine some of the scientific approaches. On the other hand, the European Union experience and legally non-binding HIV declarations have substantially contributed to a balanced commitment to the reduction of drug demand, drug-related harm, and drug supply in the region. It is up to national governments and societies to find the best ways to serve their people without discriminating on the basis of health, social, or economic status, and international agreements should facilitate and not restrict these efforts. Governments now have another chance to improve the international legal frameworks on drug use. The first step needed is an open, active, non-judgmental discussion and evaluation of existing responses with reliable data, in which participants exhibit the courage to stand up for drug policy that is effective, humane, economically rational, and transparent.

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