ECECACD
Eastern and Central European and Central Asian Commission on Drug Policy

GUIDING PRINCIPLES

TOWARDS EFFECTIVE AND HUMANE DRUG POLICIES IN EASTERN AND CENTRAL EUROPE AND CENTRAL ASIA

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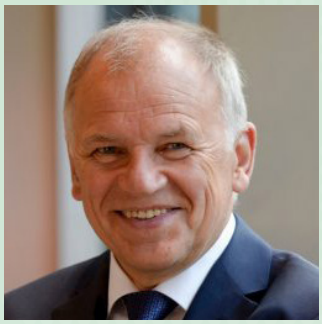

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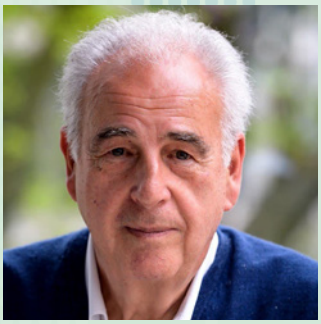

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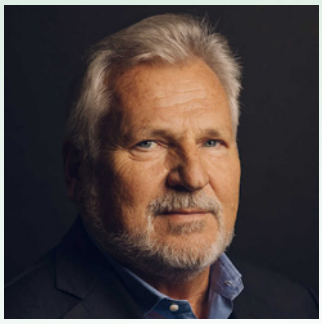

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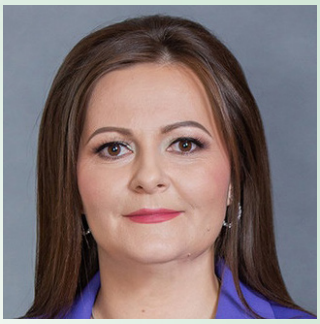

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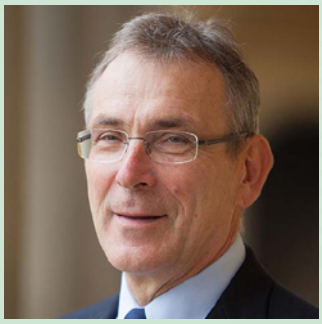

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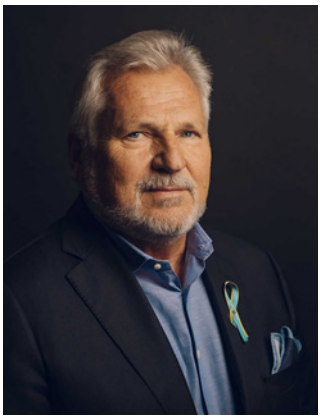
FOREWORD



The Eastern and Central European and Central Asian commission on drug policy was created in 2020 by a group of regional political leaders, policy makers and scientists to inspire and advance better drug policies in the region.

Drug use is highly prevalent across Eastern and Central Europe and Central Asia, with a prevalence of injecting drug use that is four times the global average and that of Western Europe. EECA is also the only region of the world where the incidence of HIV is increasing, largely because of unsafe drug injection practices. Criminalization of drug use and incarceration for drug-related offences are driving high numbers of prison populations in the region. Harsh prohibition law enforcement policies and stigma associated with drug use hinder the access to prevention, treatment and services within mainstream public health.

The "Guiding principles towards effective and humane drug policies in Eastern and Central Europe and Central Asia" offer key founding principles and priority directions for action to promote more efficient and humane drug policies in the Eastern and central European and central Asian region. The principles are based on evidence obtained from rigorous research and analysis as well as on best practices that have proven their effectiveness.

We hope that this principles document will be used as a source to review and reform drug policies in the region.

We are committed to working with governments, institutions, civil society and affected communities to promote evidence-based policy recommendations grounded in human rights, health and development in the region.

ALEKSANDER KWAŚNIEWSKI
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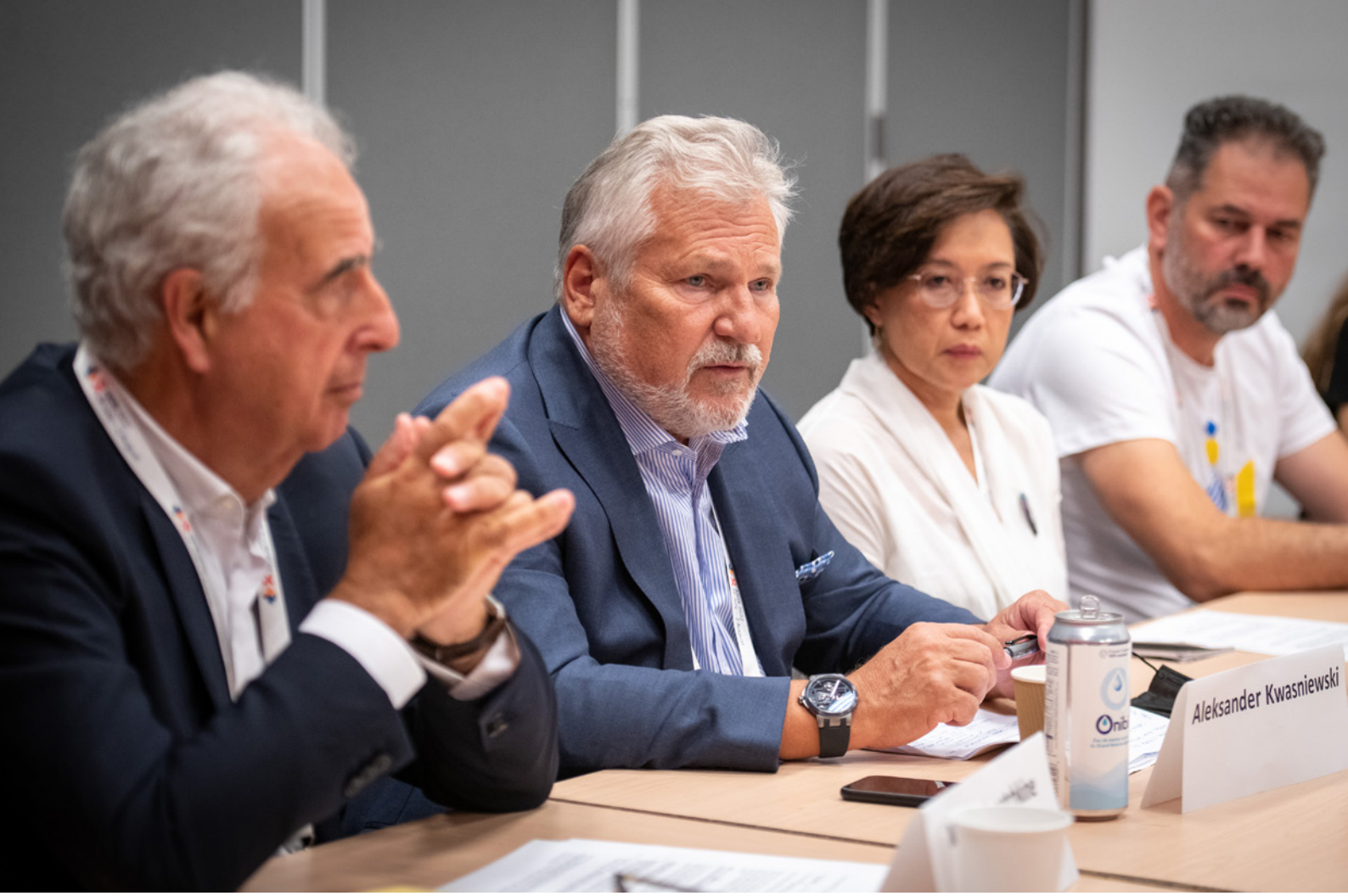


The region of Eastern and Central Europe and Central Asia (ECECA) is characterized by high levels of high-risk drug use and by slow progress towards more effective health- and human rights-based drug policies. Despite a common history as part of one Soviet bloc, the region's countries take different paths in addressing drugs, mirroring their political and cultural diversity. The Russian Federation and a few other countries have defined their drug policy mainly as a security issue, while much of Central, South-Eastern Europe, and the Baltics take more complex approaches, close to those in the European Union.

Building effective, humane and responsive drug policies is more important now than ever in ECECA. The key current external as well as internal elements affecting the drug situation in the Region are as following: Russia's invasion in Ukraine, increased opium production in Afghanistan since the Taliban's return to power[1] and increased prevalence of use of new psychoactive substances[2]. Consequently, the Commission expects increased drug availability, as well as drug consumption and drug-related health impact, on a background of increasing mental health issues. The war in Ukraine creates additional challenges and possibly, opportunities, for drug policy reform: growing economic hardship especially among the poor, reduced regional cooperation and an increasing ideological gap between repressive countries such as the Russian Federation and Belarus, and pro-democracy economies of and around the European Union.

The Eastern and Central European and Central Asian Commission on Drug Policy aims to promote evidence-based and human rights approaches to drugs. The Commission endorses and advocates for the following key principles and priority directions for action.

DRUG POLICIES WE NEED

PRINCIPLE 1:
BASE DRUG POLICIES ON EVIDENCE

An evidence-based approach is fundamental for countries in order to pursue more effective drug policies, provide value for money, and prevent negative collateral consequences. However, historical legacy and the dominant interpretation of international drug conventions have shaped systems where science and data only play a secondary role in policy and legislative decisions on drugs. Czechia together with Switzerland remain the only countries in the world that have used scientific evaluation for testing hypotheses before changing its drugs legislation[3]. While in Switzerland, a rigorous independent scientific evaluation validated the four pillars national drug strategy and innovative interventions such as heroin-assisted therapy[4], in Czechia, an evaluation commissioned by the National Drug Commission of the Government, found that the "implementation of a penalty for possession of illicit drugs for personal use did not meet any of the tested objectives" and generated significant avoidable social and economic costs. Hence, Czechia remains the only country in the Region, where the results of the research were used to reverse ineffective legislation.

A balanced policy approach in terms of public health and law enforcement implies an evidence-based proportionate distribution of public investments and support across drug policy pillars.

PRINCIPLE 2:
PRIORITIZE PEOPLE'S AND PUBLIC HEALTH

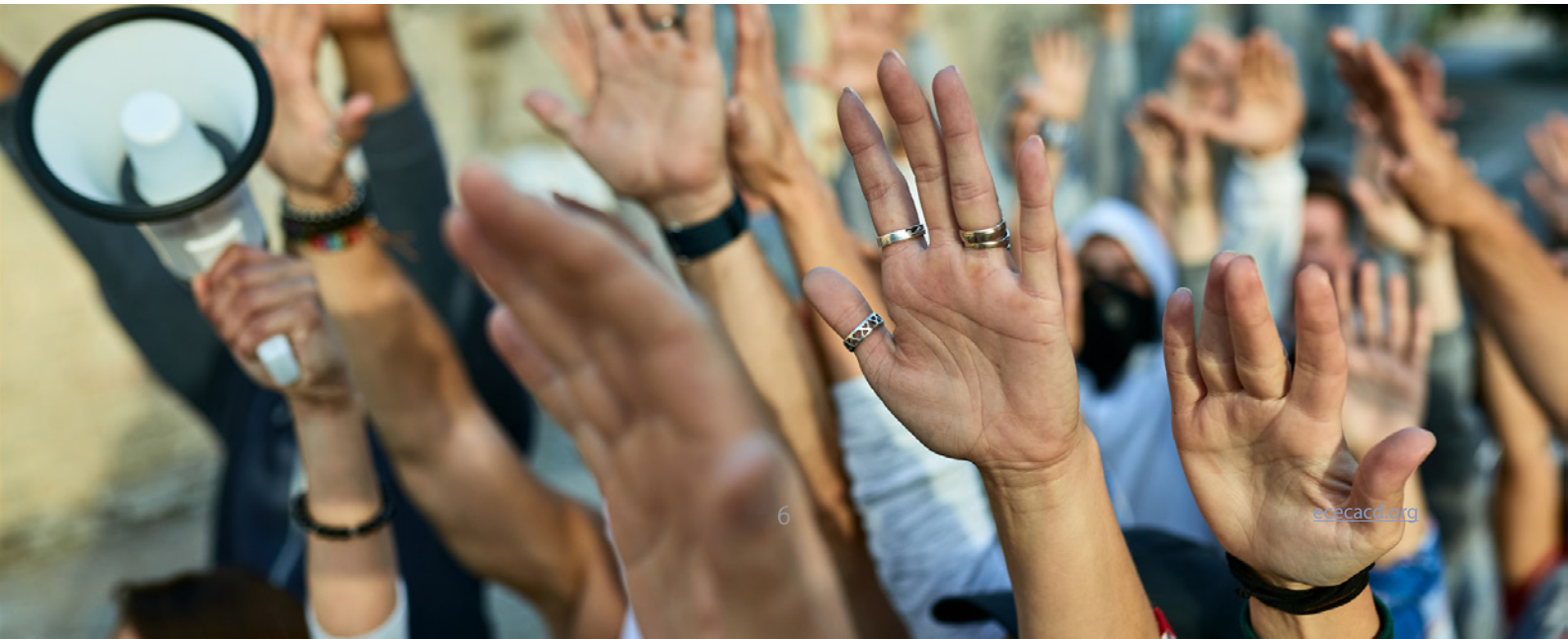
People's and public health outcomes should be given a central place in shaping drug policy. "Drug use is neither a medical condition nor does it necessarily lead to drug dependence," while drug dependence is a chronic disease[5]. It is therefore important that, following scientific evidence, drug use, problematic drug use and drug dependence are differentiated in drug policy responses. Most people who use drugs do not experience problematic drug use. However, injecting drug use or long duration or regular excessive use of drugs such as opioids, cocaine and/ or amphetamines are often problematic, associated with harms and risks for individuals and their communities. In Eastern Europe, injecting drug use is estimated to be 4-times higher than the global average and that of Western Europe[6]. One quarter of people who inject drugs in ECECA live with HIV, two thirds are infected with hepatitis C virus; multi-drug resistant tuberculosis and overdose experience are highly prevalent; one third has a history of incarceration, every tenth has been engaged in sex work and had unstable housing[7]. WHO and UN agencies recommend implementing harm reduction strategies "to prevent

major public and individual health harms, including HIV, viral hepatitis and overdose, that do not necessarily imply stopping drug use"[8]. Harm reduction interventions include the provision of clean syringes and needles, opioid agonist therapy, and the availability of naloxone for opioid overdose reversal. The scale at which harm reduction is implemented is far too low for impact across ECECA. As a result, Eastern Europe and Central Asia remains only one of two regions in the world where the HIV epidemic continues to grow, with one third of new HIV cases being transmitted through injecting drug use[9].

Funding for harm reduction programs largely depends on international support. Despite overwhelming scientific evidence and WHO recommendations on harm reduction, national funding is lagging across the region, threatening the sustainability of programs. In Romania, for example, needle and syringe programming has largely been discontinued following the closure of international grants. At the same time, injection of new psychoactive substances expanded dramatically and the number of new HIV diagnosis attributed to injecting drug use increased by more than 14 fold[10,11].

PRINCIPLE 3:
PROMOTE HUMAN RIGHTS IN DRUG POLICY

Using drugs should not be grounds for liberty deprivation or restriction of political, economic, social and cultural rights. However, several countries continue using 'drug user registries' as a condition for state-paid drug services. Those registers impose restrictions on applying for certain positions, parental rights, driver's license; their data can be shared with law enforcement. While torture and other cruel, inhuman, or degrading treatment or punishment are explicitly prohibited in the UN and European conventions, the police in the region has been documented to use forced abstinence to extract confessions from people using drugs[12]. The criminalization of drug use and possession provides a background for police corruption and reduces the likelihood of people who use drugs reporting violations of their rights. Many other human rights-related concerns include discrimination in health settings, limitations to women's access to drug services, unresolved social problems such as safe housing and employment, restriction of evidence-based information associated with anti-drug propaganda laws have been widely documented across EECA[13,14]. National drug strategies in the region foresee few if any measures to monitor and address unlawful practices towards people who use drugs. The International Guidelines on Human Rights and Drug Policy developed by UNDP, WHO, UNAIDS and several UN Member States may serve as a normative guidance in policy-making[15].



PRINCIPLE 4:
END CRIMINALIZATION OF DRUG USE AND POSSESSION

Decriminalization of drug use and possession for personal use are being recommended by WHO[16], UNAIDS[17], the UN System common position on drugs of 2018[18] and supported by systemic scientific reviews[19]. Penalizing people who possess drugs for personal use does not prevent people from using drugs. Applying criminal sanctions to people for drug possession and use while causing no harm to others is disproportional. A criminal record hampers reintegration of people into society; criminal penalties contribute to over-incarceration which is among the highest in the world in the Russian Federation and several other ECECA countries and to the spread of infections. People with drug dependence, a chronic and relapsing disorder [20]would particularly benefit from decriminalization. In addition, according to a cost-effectiveness modeling study conducted in Belarus, Kazakhstan, Kyrgyzstan and the Russian Federation in 2021[21], decriminalization could save up to 12 billion Euros a year in these countries over 20 years. This amount would be sufficient to scale up HIV and drug treatment programs to effectively curb the HIV epidemic for no added cost. Removing prosecution of drug use and possession for personal use would help shifting the focus of law enforcement from people who use drugs to fighting drug trafficking and money laundering.

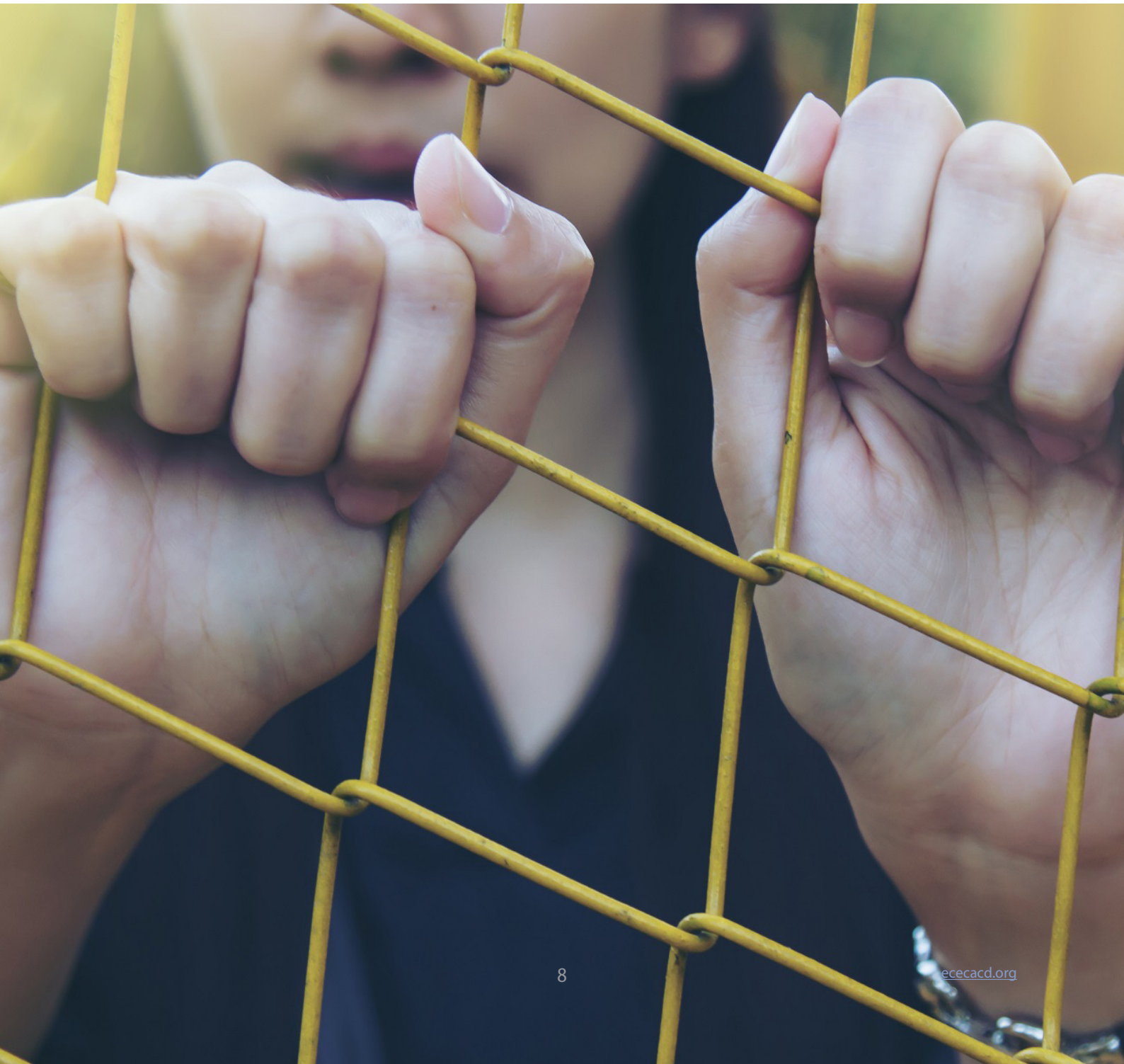
All countries of the region have administrative or/and criminal sanctions for drug possession for personal use, differentiating the punishment based on defined thresholds of drug amounts that distinguish small amount from large amount. Georgian law[22,23], does not define small quantities for drug possession for the absolute majority of narcotic and psychotropic substances, therefore even the residue of such substances in syringes, automatically triggers criminal liability of up to twenty-year prison sentence. Possession of more than one gram of a controlled substance can carry a longer prison sentence than murder or rape.

In addition to negative consequences of criminalization of drug possession with no intention to sell, drug use itself remains an administrative offence in Armenia, Azerbaijan, Estonia, Georgia, Hungary, Latvia, Moldova and the Russian Federation[24]. In the Russian Federation, alone, however, 90,000 people annually are prosecuted for drug use, with more than 40,000 people sentenced to serving prison sentences.

PRINCIPLE 5:
REDUCE AND AIM AT ENDING INCARCERATION FOR DRUG OFFENCES

Eastern Europe and Central Asia have one of the highest rates of incarceration globally[25]. Drug offences and non-violent property crimes related to drug use (some call them economic-compulsive offences) significantly contribute to these over-incarceration rates. In 2020, the proportion of incarcerated people convicted for drug offenses and drug-related crimes ranged between 10% in Montenegro and 35% in Latvia[26]. In most countries, the proportion of women serving prison sentences for drug offences is higher, reaching 40% in the Russian Federation[27]. Incarceration has been shown to be ineffective in addressing drug use and drug use disorders. Prisons have also been shown to be high-risk environments for infections such as HIV, viral hepatitis, tuberculosis, and COVID-19; there is also drug use in prisons and a high prevalence of mental health conditions,

including depression and suicide[28,29]. In Eastern Europe and Central Asia, HIV is estimated to be 8 times higher in the penitentiary system than in the general population, with documented HIV outbreaks in Lithuanian, Russian and Ukrainian prisons[30]. Harm reduction services in closed settings are only available in a few countries of the region[31]. WHO and UNODC[32] outline pathways for developing alternative measures to criminal justice, including decriminalization for small drug offences, conditional sentencing and alternatives to imprisonment with diversion to drug treatment and social support programs. Some of those measures are implemented in the region, for example, the police redirects people with drug use disorders to opioid agonist therapy in Vilnius, Lithuania[33] and to harm reduction services in Estonia[34]. Alternatives to conviction or punishment have been shown to further reduce re-offending, promote social reintegration and re-direct people in need to treatment programs[35].



PRINCIPLE 6:
ENSURE ACCESS TO EVIDENCE-BASED TREATMENT FOR DRUG DEPENDENCE

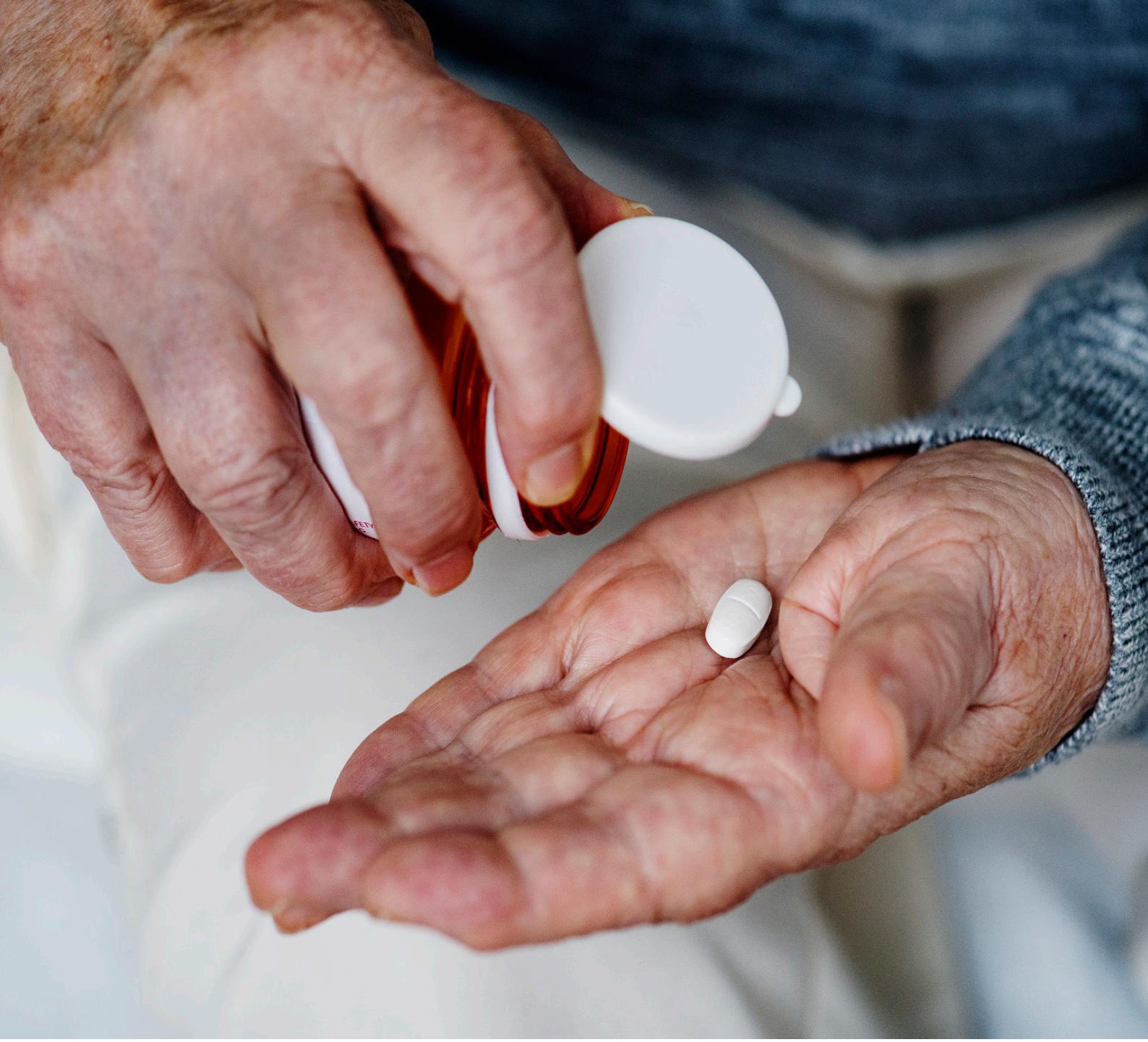
Evidence-based treatment for drug dependence should follow international standards. Treatment should be voluntary with informed consent, offering an integrated set of care that addresses health, social and legal needs, be based on realistic, individualized treatment plans, be appropriate and accessible, particularly for women and prisoners, allow an easy entrance, avoid automatic involuntary discharge as a disciplinary measure for failed drug tests, and offer outreach and low-threshold interventions for people not motivated for structured forms of treatment[36,37]. Opioid agonist therapy (OAT) is the most effective and cost-effective maintenance therapy for managing opioid dependence and for a comprehensive public health response to HIV, tuberculosis and hepatitis C among people who inject drugs. Its extensive evaluation in the region provided positive results.

Only very few countries in the region have achieved the WHO medium level of access for at least 20-40% of the estimated number of people with opioid dependence to OAT[38]. Georgia became a recent exception: in 2017, it fully replaced international funding of OAT with state funds and increased coverage to reach 31% of people with opioid dependence[39].

Such evidence-based approach has not been part of the Soviet narcology tradition, which required full abstinence as the proof of treatment success. Five out of 7 "detox" methods currently applied by the Russian narcology public drug treatment system are not recommended by international standards[40]. Across the region, drug services at fee in private sector are widespread but have little if any accountability or adherence to quality standards and have even been shown in some cases to violate basic human rights[41,42].

PRINCIPLE 7:
ENSURE ACCESS TO CONTROLLED SUBSTANCES FOR MEDICAL PURPOSES

An effective and efficient drug policy should ensure full access to controlled substances as medicines. Morphine, methadone, and buprenorphine are included in the WHO Model List of Essential Medicines, recognizing their critical role for pain management and palliative care and in the treatment of drug dependence. However, according to the Atlas of Palliative Care, Central and Eastern Europe and Central Asia (except for Slovenia, Czechia, Slovakia and Hungary) remain significantly behind in terms of access to and the uptake of morphine and other opioid pain treatment. Tajikistan, Uzbekistan, Armenia, Azerbaijan, Kazakhstan and Ukraine failed to reach even 1 mg per capita per year. For comparison, Austria, Germany, the Netherlands and Switzerland use above 250 mg per capita per year. The causes of such low uptake in EECA lie in myths and biases against opioids among health professionals, and patients, restrictive regulations imposing high legal liability and bureaucracy on health professionals, pharmacies, and patients, and high law enforcement oversight[43]. There is a still limited but increasing scientific evidence of the health benefits[44,45], of medical cannabis use for addressing chronic pain and various neurodegenerative and immunodeficiency disorders[46]. Countries in the region like Croatia[47], North Macedonia[48], Slovenia[49], have already legalized medical use of cannabis or cannabinoid medicines, while others like Ukraine[50] has recently been moving towards those steps.



PRINCIPLE 8: ENSURE PARTICIPATION OF CIVIL SOCIETY AND AFFECTED PEOPLE IN POLICY MAKING

People who use drugs and the broader civil society working on drug policy, human rights and access to health, can offer unique first-hand experience in debating on drug policy reforms. They are best positioned to understand the dynamics in drug markets and the realities what works and what does not work on the ground.

Governments should build open and constructive relationships with civil society and engage people who use drugs in helping shape policies that directly affect their lives. Drug policy monitoring systems could also greatly benefit from community-driven data.

ELEVEN PRIORITY DIRECTIONS FOR ACTION

As countries have their own cultural and political contexts, their policy paths, approach and pace to reform drug policies will be different. The Commission however recommends the following priorities for action for consideration by countries of the region.

Our recommendations include conducting independent reviews of critical areas of national policies and legislation relating to drugs and setting directions towards drug policy reforms:

1

End criminal and administrative penalties for drug possession and use with no harms to others.

2

Decrease and aim at rapidly ending incarceration for minor drug offenses. While engaging in that direction, urgently develop alternatives to incarceration, working with the criminal justice system, law enforcement, health and social protection services, drug policy experts and relevant civil society representatives.

3

Increase investment in proven public health measures to reduce the negative consequences of drug use and those of misguided drug policies, namely: needle and syringe programming, overdose prevention and management, opioid substitution therapy as well as pharmacological assisted therapy for stimulant users, harm reduction programs in prison settings, AIDS, TB and hepatitis C treatment.

4

Undertake (under the auspices of the ombudsman) an independent review of human rights compliance of national drug laws and policies.

5

Call on WHO to conduct a review of the national narcology program and of its funding, as a basis for improving access of people in need to the best standards of care for people with drug-dependence. The review should also include national harm reduction programs and overdose prevention programs, including in prison settings.

6

Conduct a critical review of national investments in health, social and law enforcement programs relating to illicit drugs and of current criteria of effectiveness and cost effectiveness of drug policies, to instruct relevant policy and budgetary decisions.

7

Open a public and parliamentary debate on access to controlled medicines. Together with health professionals, law enforcement, WHO and UN agencies, international experts and civil society, develop a roadmap to fight 'opioidophobia' and overregulation and take appropriate measures to ensure appropriate and equitable access to opioid analgesics.

8

Remove drug use registers, compulsory treatment acts and other legislative and policy instruments that come as barriers to access to care and social services for people using drugs.

9

Include measures to reduce stigma, eliminate discrimination, and misconceptions about drugs in national drug strategies.

10

Capacitate civil society to offer its vision in drug strategy and drug policy reform planning.

11

Set up continuous and flexible monitoring systems to adapt policy responses to dynamic evolutions of the national drug scene and to extraordinary situations such as the political conflicts war and migration context associated with the war in Ukraine.

To implement those directions, a constructive dialogue on evidence- and human rights- based drug policies should be opened at national level including multi-disciplinary voices from Government, State institutions, academia, civil society, private sector, UN agencies and international experts, faith, and media. Effective drug policy can change human lives for many and significantly improve public health and public safety for societies and countries in the region.

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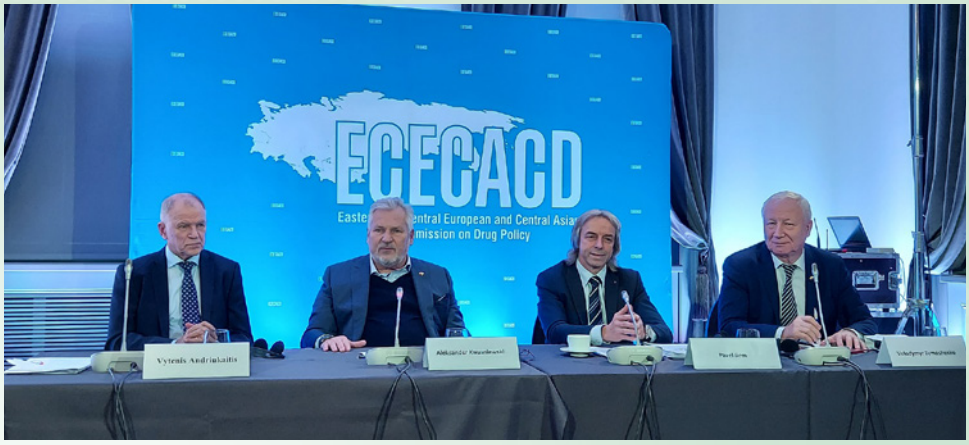
EASTERN AND CENTRAL EUROPEAN AND CENTRAL ASIAN COMMISSION ON DRUG POLICY (ECECACD)



ECECACD is aimed at bringing an informed, science-based discussion about humane and effective ways to reduce the harms caused by drugs and drug control policies to people and societies in the ECECA region.

OUR GOALS:

- Review the approaches, policies and law enforcement practices in the countries of the region
- Provide evaluation and scientific evidences regarding different national responses to the drug problem
- Develop achievable and evidence-based recommendations for constructive legal and policy reforms in the region

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PUBLICATIONS BY THE EASTERN AND CENTRAL EUROPEAN AND CENTRAL ASIAN COMMISSION ON DRUG POLICY:

http://ececacd.org/publications/

Production, trafficking and consumption of illicit drugs in EECA region (2021)

Drug laws and policies in four regions of Eurasia (2021)

Perception of drugs in Central and Eastern Europe and Central Asia: overhaul needed (2021)