A war against people who use drugs:

the costs



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2012

EURASIAN HARM REDUCTION NETWORK

At the time of economic downturn, the limited international donors support, the priority should be to stop wasting money on interventions that have no positive outcome and usually are implemented at the expense of basis human rights. The report provides further evidence that punishment of people who use drugs not only fails to achieve any positive results but also is a tremendous waist of often limited governments resources in the region.

Michel Kazatchkine, the member of the Global Commission on Drug Policy and former executive director of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Overview:
This report aims to assess whether national funding allocated for drug-related measures achieves the goals of slowing down or reversing drug epidemics and protecting society from drug-related harms. It is based on comparing costs associated with both – law enforcement activities and public health measures such as harm reduction and drug treatment. The report draws on country costs assessments done in Georgia, Kyrgyzstan, Romania and Russia as well as analysis of data from other countries of the region, including Ukraine and Tajikistan.

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Design and publishing:
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Acknowledgements:
The author is extremely grateful to reviewers of the report: Niamh Eastwood, Mikhail Golichenko, Daria Ocheret and Stephen Rolles.
We would also like to thank the country-level information coordinators: Nino Balanchivadze, Alexandra Gurinova, David Otiashvili, Valentin Simionov, Nina Tezina, Ivan Varentsov, Alexander Zelichenko and Maxim Zelichenko, as well as all the people and experts working at the national level who helped collect and analyze the information and complete the country reports.

Citation:
Merkinaite, S. *A war against people who use drugs: the costs*. Eurasian Harm Reduction Network (EHRN), Vilnius: 2012.
Available at: www.harm-reduction.org

Donor:
The publication was prepared with financial support from the Global Drug Policy Program of Open Society Foundations. The views expressed in the publication do not necessarily reflect the donor's official positions.

Acronyms and abbreviations:

ARF	Andrey Rylkov Foundation
ART	antiretroviral treatment
EECA	Eastern Europe and Central Asia
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
NGO	non-governmental organization
NSP	needle and syringe program
OST	opioid substitution therapy
TB	tuberculosis
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
UNAIDS	Joint United Nations Programme on HIV/AIDS

Eurasian Harm Reduction Network

The Eurasian Harm Reduction Network (EHRN) is a regional organization with a mission to promote humane, evidence-based harm reduction approaches to drug use, with the aim of improving health and protecting human rights at the individual, community and societal level.

EHRN was founded in 1997 and currently brings together 340 specialists, activists and organizations working in the field of harm reduction from 29 countries of Central and Eastern Europe and Central Asia (CEECA). Members of the Network include communities (in particular, of drug users and people living with HIV), researchers, experts, drug treatment facilities, HIV service providers and governmental bodies. Activities of the Network are determined by its Steering Committee. The Network Secretariat is based in Vilnius, Lithuania.

EHRN has built up solid experience in the areas of harm reduction in CEECA, drug policy reform, HIV, tuberculosis, hepatitis C and overdose prevention. EHRN's activities include information services, training, advocacy and technical support aimed at assisting the implementation of non-discriminatory policies towards drug users, as well as improving the range and quality of harm reduction services in the region.

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Key findings

- **Punishment for petty, non-violent drug crimes**—mainly but not solely limited to criminalization of people who use drugs—**results in stigma and discrimination, and creates a political climate in which human rights norms are not applied in relation to people who use drugs.**
- Such policies **lead to police harassment, misuse of power and extortion of money** from drug users and/or their relatives.
- In most countries of Eastern Europe and Central Asia (EECA), **governments' unwillingness to allocate funds for harm reduction, opioid substitution therapy (OST), HIV and hepatitis C treatment is determined not by insufficiency of national funding**, **but by prioritization of enforcement over health approaches.**
- Such misguided priorities also have **significant (and negative) financial consequences**. For example:
  - The **Kyrgyzstan** government spends around $1.25 million per year to enforce Article 246 of the Criminal Code (regarding possession of drugs with no intent to supply). By comparison, the budget for OST programs is $500,000, and is currently covered exclusively by external donors. OST costs $500 per patient a year, while punishment costs at least $625 per each person convicted for drug possession.
  - In 2010 alone, the prosecution of drug offenders (for use and supply) cost at least $100 million in **Russia**. In comparison, under the Budget Law for 2011, HIV prevention programming is to receive less than 3% of the total $640 million to be allocated in 2012 through the Federal Budget Law for HIV, hepatitis B and C, and the government continues to prohibit internationally accepted drug treatment interventions such as OST. The government therefore will spend millions more treating people infected with HIV than it would have in protecting their health and reducing transmission.
  - **Georgia** spends around $10.5 million annually on random street drug testing and an additional $4.7 million on imprisonment of drug offenders. This not only fails to deter people from using drugs (as eventually the majority return to drug use) but also increases criminality, social isolation and stigma. Only about 10% of the estimated 40,000 people who inject drugs are currently receiving harm reduction services, yet even that small share means that up to 1,000 new HIV infections have been averted.
- Despite vast investment in law enforcement interventions, neither drug use nor the HIV epidemic has been contained. Across EECA there are an estimated **3.4 million to 3.8 million people who inject drugs, which represents the highest regional prevalence of injecting drug use worldwide**. **One in four injectors is believed to be living with HIV** in the region, accounting for 57% of all infections.

- In countries where the drugs of the choice become unavailable, **people are switching to other, potentially more harmful substances.** Such developments indicate that **punitive drug laws (prohibition of certain substances) have, at best, marginal impacts on the overall level of drug use**, **and have negative impacts on health.**
- **Prosecution and incarceration for drug-related offences is one of the key reasons behind the increase in prison populations** across the region. **Yet maintaining prisons is expensive, and many prison systems are chronically underfunded.** Among the consequences are increased HIV transmission—because drugs are easily available in most prisons, but preventive commodities such as clean needles are not—and an increase in involvement in criminal gangs as prisoners seek ways to improve their food and safety position in penitentiaries.

1. Introduction: drug-related harms and policy choices

In times of economic crisis, governments face choices on how best to balance spending and where best to direct limited resources and generate prosperity. Managing the costs of interventions to ensure the highest quality and best outcomes for the lowest possible costs is a priority.

As a 2009 World Bank study demonstrates, economic slowdowns can have disproportionate impact on stigmatized and marginalized groups and poorer segments of society[1]. As demonstrated in a 2011 article in the *International Journal of Drug Policy*, the long-term impact of the current recession on drug use is likely to result in increased prevalence of problematic drug use, including injecting (as a way to maximize "efficient" drug consumption with limited funds)[2]. This indicates how problematic drug use and related harms are driven primarily by underlying social and economic factors[3].

Simultaneously, economic crises also weaken public sector finances and governments' ability to provide an adequate quantity and quality of services, with inevitable cuts to public health and social services.

The impacts of economic recession on drug policy and drug-related budgets are hard to assess. The European Monitoring Centre for Drugs and Drugs Addiction (EMCDDA) provides a crude estimate of experienced or expected changes in drug-related budgets as a consequence of the ongoing economic recession. Across the European Union (EU), the amount of funds allocated to implementing drug-related policies has been reduced since 2008. Preliminary expenditure data available from seven countries show that the size of the cuts has varied considerably among countries, with reductions in planned expenditure clearly identified as being related to drugs ranging from 2% to 44%[4]. The budgetary decisions indicate that with less public money available, there is an even greater importance of demonstrating cost-effectiveness.

The same EMCDDA study indicates that, while social and health sector budgets are shrinking, supply reduction activities—"law enforcement" or "public order and safety"—accounted for between 48% and 92% of the total drug-related expenditures[5], meaning that the implementation of drug prohibition laws demand significant investment. Such investment has an opportunity cost for health and social services: the more state budgets are devoted to the punitive enforcement of prohibition, the less is left for health-based interventions, treatment, prevention and harm reduction.

These budget spending allocations are driven by the priorities specified in drug policies. The preamble of the 1961 United Nations (UN) Single Convention on Drugs speaks of a primary concern for "health

1 World Bank (2009). Protecting pro-poor health services during financial crisis: lessons from previous experiences. Available at http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/ProtectingProPoorFC.pdf.

2 Ben Lakhdar, C., Bastianic, T. (2011). Economic constraint and modes of consumption of addictive goods. *International Journal of Drug Policy*, 22(5) 2011.

3 Storti, C., De Grauwe, P., Reuter,P. (2011). Editorial in *International Journal of Drug Policy*, Vol 22, Issue 5: 321- 325.

4 EMCDDA (2011). Annual report 2011 – The state of the drugs problem in Europe, European Monitoring Centre on Drugs and Drug Addiction, Lisbon, 2011. Available at http://www.emcdda.europa.eu/events/2011/annual-report.

5 Expenditures for justice, police, customs and prisons were the items most frequently reported.

and welfare" but implementation is realized predominantly though drug prohibition and application of severe punishment for drug use/possession and supply. Hence, the global drug control regime, in practice realized primarily though punitive prohibitions on drug production supply and use, has historically been promoted as a policy that protects public health, on the basis that it can restrict or eliminate drug availability and deter people from drug consumption through fear of punishment.

The current drug control regime is guided by the myth that the state can protect both individuals and wider society from drugs and drug-related harm using police enforcement. Fifty years after the adoption of the International Drug Control framework it is clear that prohibition law enforcement has also failed in its primary goals of eradicating drug use and protecting health:

- Global trends in drug use—particularly high-risk use—have risen consistently over the past half-century[6]. Specifically, a 2011 Global Commission on Drug Policy report as well as a report commissioned by the European Commission suggest that opiate consumption increased between 1998 and 2008[7] and that illegal drugs generally became cheaper and more available over that time[8]. Clearly the primary goals of reducing availability of and demand for drugs were not achieved through punishment of users.
- Even worse, attempts to eradicate drug markets can have significant adverse consequences on health and social problems. Enforcement-focused policy has increased the risks associated with drug use, tilting the market towards ever more potent and risky products often cut with contaminants, and encouraging high-risk behaviors (such as injecting) in unsupervised and unhygienic environments. As a result, users suffer avoidable health problems, including overdoses and poisonings, and dramatically increased risk of contracting blood-borne diseases such as HIV and viral hepatitis.
- The focus of drug enforcement on drug use and possession has led to numerous human rights abuses as people who use drugs, or who are arrested or suspected of drug offences, are frequently subject to various forms of cruel punishment. Common abuses include death threats and beatings to extract information, extortion of money or confessions through forced withdrawal without medical assistance, and restricted access to health care[9]. Drug laws serve

6 European Commission, Trimbos Institute, Rand Europe (2009). A report on global illicit drug markets 1998-2007. Available at http://ec.europa.eu/justice_home/doc centre/drugs/studies/doc/report_short_10_03_09_en.pdf.

7 The Global Commission on Drug Policy estimates that opiate use increased by 34.5% percent from 1998 to 2008. This figure should be interpreted with caution as the statistics did not factor in population growth; thus it is a measure of the size of the market growth rather than a rise in prevalence. See note on methodology in Global Commission on Drug Policy (2011). War on Drugs. Report of the Global Commission on Drug Policy. Available at www.globalcommissionondrugs.org/Report.

8 For example, EMCDDA Statistical Bulletin, 2011, Figure PPP-1. Indexed trends in EU retail prices for major drug types, adjusting for inflation, 2004–2009, see www.emcdda.europa.eu/stats11/pppfig1.

9 Stuikyte, R., Otiashvili, D., Merkinaite, S., Sarang, A., Tolopilo, A. (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. Eurasian Harm Reduction Network: Vilnius. For more on the impact of law enforcement–driven approach to drugs on human rights, see Count the Costs briefing (2011), The war on drugs: undermining human rights, Available at www.countthecosts.org.

as a way of controlling the population rather than substances by putting people who use drugs on registries, thus further restricting their civil, political and economic rights[10].

> *One of the priorities is to stop wasting resources on the failed "War on Drugs" that has turned into a war against people and communities. This war must end. Resources should instead be devoted to providing, to everyone who needs them, evidence-based and human rights-based interventions that prevent problematic drug use, treat drug dependence and ensure harm reduction services for people who use drugs.*
>
> **Michel Kazatchkine**, then-Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, in a statement endorsing the 2010 Vienna Declaration

Evidence shows that many of the health risks associated with drugs, although created or exacerbated by the legal/policy environment in the first place, can at least be minimized by harm reduction measures. There is good evidence to demonstrate how countries that have introduced harm reduction and health strategies in the early years of HIV epidemics have experienced low rates of HIV among drug-using communities compared with those countries that have relied heavily on repression and zero-tolerance approaches—many of which are now experiencing large-scale and growing HIV epidemics. For example, countries that developed health-based approaches to drugs (i.e., harm reduction), such as the United Kingdom, Switzerland, Germany and Australia, currently record HIV prevalence among people who use drugs under 5%[11],[12],[13]. In most of Eastern Europe and Central Asia (EECA), however, harm reduction approaches were developed in late 1990s at the earliest, remain limited in scale and often operate only with international support in hostile national policy environments. As a result, the region experiences the highest HIV epidemic among people who inject drugs; across EECA, one in every four injectors is believed to be living with HIV and unsafe injecting accounts for 57% of all infections[14]. The most notorious case is Russia, where more than 1% of the adult population is infected with HIV[15] and estimates show 80% of HIV cases are related to drug injecting[16]. Harm reduction approaches such as OST remain against the law in Russia.

10 Shields, A. (2009). The effects of drug user registration laws on people's rights and health: key findings from Russia, Georgia, and Ukraine. Open Society Institute. Available at www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/drugreg_20091001.

11 Global Commission on Drug Policy (2011). War on Drugs. Report of the Global Commission on Drug Policy. Available at at www.globalcommissionondrugs.org/Report.

12 Killias, M., Aebi, M.F (2000). The impact of heroin prescription on heroin markets in Switzerland, Global Drug Policy Program report on Switzerland, *Crime Prevention Studies*, Vol. 11. Available at http://www.popcenter.org/library/crimeprevention/volume_11/04-Killias.pdf.

13 Schatz, E., Schiffer, K., Kools, J. (2011). The Dutch treatment and social support system for drug users, IDPC briefing paper. Available at www.idpc.net/publications/idpc-paper-dutch-drug-treatment-program.

14 UNAIDS and WHO fact sheet on Eastern Europe and Central Asia (2009). Available at http://data.unaids.org/pub/FactSheet/2009/20091124_fs_eeca_en.pdf.

15 UNAIDS estimate among adult population, 2009. Cited in UNAIDS country profile. Available at www.unaids.org/en/regionscountries/countries/russianfederation/.

16 Information Bulletin No. 33 of the Federal Scientific-Methodological Center for the Prevention and Control of AIDS in the Russian Federation. Moscow, 2009. (Информационный бюллетень 33 Федерального научно-методического центра по профилактике и борьбе со СПИДом Российской Федерации, Москва, 2009. С. 13.) Available at www.hivrussia.ru/files/bul_33.pdf (Russian only).

Current policies are implemented at the cost of health, rights and well-being of individuals and societies. Moreover, the law enforcement–dominated policies demand substantial investment, and in the context of the economic downturn it is safe to assume that without the appropriate support for health and social services, there will be increased need for i) application of law enforcement measures, in case the numbers of people who use drugs continues to increase; and ii) greater health expenditures based on health costs associated with treatment and management of drug-related harms.

At the same time, the prohibitionist approach, framed as a "war" against a threat to society itself, has led to the political consensus and common understanding that drug enforcement should be pursued at *any cost*. Naturally, if the public is sufficiently convinced that is the right policy choice, scrutiny of cost and cost-effectiveness becomes a marginal concern. However with the growing evidence suggesting that enforcement contributes to the harms associated with drug injecting, such cost evaluation becomes crucial. Over the past half century of global prohibition, such scrutiny by national governments has been largely absent.

Within this context the report aims to outline the costs of implementation of prohibitionist laws, namely criminalization of people who inject drugs in countries of EECA, and facilitate dialogue on the effectiveness of investment into the prohibitionist drug policy approach.

1.1 Principles for effective drug policy

Current policy approaches are based on what turns out to be a flawed assumption: that punishment will effectively deter people from using drugs. Evidence suggests that enforcement-related deterrence is a marginal factor in drug-taking decisions, which are driven primarily by social, economic and cultural factors with inequality and social deprivation observed as key drivers of problematic use in particular[17]. Any policy is based on the expected outcome it has to have and the objectives it has to achieve; however, there are principles that should lie at the core of any policy planning, including the following:

(1) Policies should be based on solid empirical and scientific evidence, reducing harm to health and promoting welfare of individuals and society.

(2) Policies should be cost-effective—i.e., aimed at achieving maximum positive impacts (on chosen indicators for minimization of drug related social and health harms) for the lowest cost. Thus investment in targeted and evidence-based prevention services will lead to long-term savings in treatment costs.

(3) Policies should be human rights–based: each person is entitled to health, fair trial, freedom from torture or cruel, inhumane treatment and discrimination. Every country of EECA cited in this report is a member of the UN, and thus is bound by the UN Charter and the key human

17 MacCoun, R., Reuter, P. (2002). The varieties of drug control at the dawn of the twenty-first century, Annals of the American Academy of Political and Social Sciences (issue co-edited by Reuter and MacCoun); Rolles, S. (2009). A comparison of the cost–effectiveness of the prohibition and regulation of drugs, Transform Drug Policy Foundation, 2009. Available at: *www.tdpf.org.uk/CBA%20New%202010.pdf.*

rights treaties guaranteeing these rights. Human rights implications must remain central in all policy and law development and implementation, as well as monitoring and evaluation.

> *Individuals who use drugs do not forfeit their human rights....Too often, drug users suffer discrimination, are forced to accept treatment, marginalized and often harmed by approaches which over-emphasize criminalization and punishment while under-emphasizing harm reduction and respect for human rights. This is despite the longstanding evidence that a harm reduction approach is the most effective way of protecting rights, limiting personal suffering, and reducing the incidence of HIV....We must opt for treatment that is evidence-based, and be responsive to the views of those in need of treatment.*
>
> **Navanethem Pillay**, United Nations High Commissioner for Human Rights [18]

Any and all policies regarding drug use should be evaluated against these principles and reformed accordingly.

1.2 Methodology

The findings in this report are based on country cost assessments for Georgia, Kyrgyzstan, Romania and Russia that were conducted by in-country partners in 2011–2012. The report summarizes the cost of implementation of legislation on drug use and drug possession with no intent to supply, as identified by relevant country administrative and criminal codes. These costs are evaluated against the objective of drug prohibition policy—the levels and dynamic of drug use and health-related harms. Quantitative data related to the budgets were collected from relevant ministries and governmental agencies using written communication and interviews with representatives. Additionally in Kyrgyzstan a survey was conducted among OST patients in Bishkek with the goal to assess the social benefits of the program.

All "$" figures are US dollar amounts, based on exchange rates with national currencies during the period the assessment was conducted.

18 Navanethem Pillay, United Nations High Commissioner for Human Rights, High Commissioner calls for focus on human rights and harm reduction in international drug policy, March 10, 2009.

2. The costs of drug policies in EECA

The EECA region is home to an estimated one quarter of all people who inject drugs worldwide and has the fastest growing HIV epidemic related to unsafe injecting. The United Nations Office on Drugs and Crime (UNODC) estimates the total number of opiate users in EECA is between 3.4 and 3.8 million people[19]. The UN Reference Group on HIV and Injecting Drug Use also suggests that there are around 3.7 million people who inject drugs in the region, with Eastern Europe having the highest regional prevalence of injecting drug use worldwide[20].

Yet although these challenges and trends have been evident for more than a decade, drug laws and implementation policies have not eased in most countries. Most laws and policies remain punitive and repressive, thereby leading to further stigmatization of and discrimination against people who use drugs as well as increased health harms. Rigid law enforcement and criminalization also have financial consequences, especially for governments. Aggressively pursuing people who use drugs, prosecuting them and imprisoning them is costly. It also has little success in the ultimate goal of reducing drug use in general, let alone among those imprisoned—the vast majority of whom return to using in the absence of comprehensive, evidence-based treatment support such as harm reduction. The health impacts of failing to prioritize policy reform are also costly. The costs of treating people living with HIV and other chronic health conditions are far greater over time than preventing infections in the first place.

Using scarce resources wisely should be a priority in efforts to address drug use and drug-related harms, especially in EECA. Existing policies and strategies have had devastating social, health and economic consequences; continuing in a "business as usual" way will only make things worse.

2.1 Drug law enforcement costs

Georgia has some of the harshest drug laws in the region. According to the Criminal Code, possession of *any amount* up to one gram of heroin is considered to be a "large" amount of drugs punishable with imprisonment from 7 to 14 years. One gram of heroin is considered by law to be a "very large" quantity, and those convicted of possession can be imprisoned for 8 to 20 years, or even for life. Sentencing for non-violent drug crimes is thus vastly disproportionate in comparison with violent offences; for example, murder is punishable by imprisonment from 7 to 15 years.

Georgia spends around $10.5 million annually on random drug testing, one of the most oppressive and expensive methods used to implement drug-related legislation. Police are allowed to stop people on the street and bring them in to be tested based solely on police officers' own judgment.

19 UNODC (2011). World Drug Report 2011: United Nations Office on Drugs and Crime: Vienna. Available at http://www.unodc.org/unodc/en/data-and-analysis/WDR-2011.html.

20 The Reference Group to the United Nations on HIV and Injecting Drug Use (2010), Consensus statement of the Reference Group to the United Nations on HIV and Injecting Drug Use 2010. Available at www.idurefgroup.org/publications

The costs include all staff and personnel time as well as basic sustenance throughout the period of detention, from detainment to drug testing through court appearance[21].

In 2008 alone, some 50,000 people were forced to undertake drug testing; of those, more than 19,000 were positive, which led to 1,605 prison sentences based on evidence provided from urine strip tests (whose results are considered to be only partly reliable at best). According to international standards, results of such rapid tests cannot be accepted as judicial evidence and should always be confirmed by standard laboratory methods[22]. Yet that follow-up step has never been practiced in Georgia, and the results of these rapid and inaccurate tests are used as one of the main sources of evidence in court. Thousands of people are forced to pay heavy fines or are imprisoned based on urine strip test results alone.

The zero-tolerance approach to drugs has had no impact on levels of drug use, which underscores the inefficient use of law enforcement time and resources[23]. It is safe to conclude that the two police branches (patrol and criminal police) involved in "street hunting" for people who use drugs are using law enforcement budgets from activities that should be unrelated: improving public order and safety. According to some calculations, a patrol policeman spends over eight man-hours (more than a day) per one arrest for testing[24]. This indicates that the hunt for people who use drugs is prioritized over police time spent on other, more serious crimes. At the same time, such a policy approach has other negative consequences, including the following:

- It increases the size of the prison population, thus placing further burdens on the state budget. The number of people sentenced for drug-related offences more than doubled between 2006 and 2008[25].
- It increases drug-related health risks, as prison settings are recognized to be an environment of increased risk[26]. Only one prison in Georgia has a treatment program (a mixture of OST and detoxification), and thus only a limited number of incarcerated people who use drugs have access to treatment support.

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21 The costs include the *amount of time* the police officers spend discharging their official duties (for the patrol and criminal police); *the number of tests* conducted in a given period of time (for the drug testing department); *the number of cases* tried by the Public Prosecutor's office and the courts or *amount of time* spent by them on those cases (for the Public Prosecutor's office, as well as the courts); and time spent in prison *(or, rather, prisoner-days)*during the year and related services rendered to inmates (for the penitentiary department). Otiashvili, D., Kirtadze, I., Tsertsvadze, V., Chavchanidze, M., Zabransky, T. (2012). How effective is street drug testing. Alternative Georgia: Tbilisi.

22 United Nations International Drug Control Program (2001). Rapid on-site screening of drugs of abuse. Scientific and Technical Notes, Vienna.

23 Results from the survey among people detained based on the drug-use charges showed that 89% of the study participants did not stop using. See Otiashvili, D., Kirtadze, I., Tsertsvadze, V., Chavchanidze, M., Zabransky, T. (2012). How effective is street drug testing. Alternative Georgia: Tbilisi.

24 Otiashvili, D., Kirtadze, I., Tsertsvadze, V., Chavchanidze, M., Zabransky, T. (2012). How effective is street drug testing. Alternative Georgia: Tbilisi.

25 A comparison of data from 2006, 2007 and 2008 reveals a sudden and sharp increase in the number of drug-related criminal proceedings in Georgia. The disproportionate increase in minor crimes compared with a small increase in what is classified as major crime suggests that first (and larger) increase resulted from intensified police activity generated by the practice of massive random searches of young men and their testing for the presence of illegal drugs. European Center for Monitoring of Drugs and Drug Addiction, Country overview: Georgia. Available at www.emcdda.europa.eu/publications/country-overviews/ge.

26 Jurgens, R., Ball, A., Verster, A. (2009). Interventions to reduce HIV transmission related to injecting drug use in prison. The Lancet, Vol. 9, Issue 1, pp. 57-66.

- It increases the criminal environment. Fines for drug offences exceed the average monthly salary in Georgia. Many people convicted and their relatives and friends cannot afford to pay such high fines, and thus they become involved in criminal activity (such as theft) to get the necessary funds and ensure that the convicted individual does not go to prison.

Although in **Russia** drug use per se is not criminalized as in Georgia, possession without intent to supply in amounts exceeding 0.5 grams for heroin, opium or desomorphine is considered a crime and is punished by incarceration for up to three years[27]. At the same time it is important to emphasize that even where drug use is not a criminal offence, most countries apply administrative liability for it; in Russia, drug use can therefore result in 15 days arrest, which according to the European Court on Human Rights is equal to criminal liability.

Experts estimate that in 2010 alone, prosecution for all drug offenders (demand and supply) cost an estimated $100 million in Russia[28]. That amount covers most expenses from the moment of arrest to the court decision, including those associated with operational-search measures, detention, preliminary investigation and court appearances (including payment for lawyers). It does not include the costs of pre-trial detention, incarceration after conviction or executing non-custodial sanctions, such as community service, fines, etc.[29]

More than half of all cases are related to drug possession with no intent to supply, which refers primarily to people who use drugs rather than traffickers. This highlights the fact that Russia prioritizes punishment of people who use drugs in its war against illegal drugs, a situation further underscored by the following:

- In 2010 about 108,000 people were convicted for drug crimes (under Articles 228–233 of the Criminal Code)[30]; of them, nearly two-thirds (no fewer than 64.7%) were convicted for drug possession with no intent to supply[31]. More than 104,000 people were charged with fines and administrative arrest for mere drug use or possession of drugs in tiny amounts (e.g., 0.5 grams of heroin or less).[32]
- Russian laws define "large" and "extra large" amounts of drugs to be much lower than the average quantity necessary for daily use. That is because for some narcotic drugs, such as heroin, marijuana or methadone[33], the "large" and "extra large" amounts are determined not by the weight of the pure substance but by the weight of the entire mixture seized[34].

27 Article 228 of the Criminal Code of the Russian Federation, 1996.

28 As per research on the drug change costs conducted in the framework of this report's preparation. In more detail: The cost of drug law enforcement in Russia (draft country report, 2012).

29 The cost of drug law enforcement in Russia (draft country report, 2012).

30 Information of Judicial Department at the Supreme Court of the Russian Federation. Судебный Департамент при Верховном Суде РФ. «Отчет о работе судов первой инстанции по рассмотрению уголовных дел за 12 месяцев 2010 года». Available at www.cdep.ru (Russian only).

31 Information of Judicial Department at the Supreme Court of the Russian Federation. Судебный Департамент при Верховном Суде РФ. «Количество лиц, осужденных по статьям УК РФ в 2010 году. Приложение к отчетам по формам № 10, 11». Available at www.cdep.ru (Russian only).

32 Information of Judicial Department at the Supreme Court of the Russian Federation. Судебный Департамент при Верховном Суде РФ. «Отчет о рассмотрении федеральными судами общей юрисдикции и мировыми судьями дел об административных правонарушениях». Available at www.cdep.ru (Russian only).

33 These drugs are included in the List 1 of the Schedule of Controlled Substances.

34 Federal Drug Control Service board meeting on 10 March 2011. Available at www.narkotiki.ru/gnk_6891.html

It is important to note that Russian law enforcement agencies—including the Federal Drug Control Service (FDCS), which has an annual budget of $73 million[35]—often use drug charges as a way to silence political opponents, including human rights activists and journalists. A few examples:

- Since August 2011 Russian law enforcement agencies have been trying to suppress activities of the Andrey Rylkov Foundation (ARF), an organization that promotes and defends human rights of people who use drugs in Russia. First, ARF activist Irina Teplinskaya was planted with a tablet of methadone when she crossed the border from Ukraine to Russia in August 2011. Then in early 2012 the ARF website was shut down by the FDCS, which claimed that the information about OST posted on the ARF website should be categorized as drug propaganda, and thus prohibited under Russian drug laws[36].
- Political activists Taisiya Osipova was prosecuted based on falsified drug charges by an anti-extremist police unit. In December 2011, despite obvious violations of procedural and substantial laws, Osipova was sentenced to 10 years in prison[37].
- In April 2011 Evgeny Konyshev was planted with drugs by representatives of the "City Without Drugs" Foundation after he openly testified on a federal TV channel about the Foundation's ineffective and inhumane practices under the pretence of drug treatment. Despite multiple violations of procedural and substantial laws committed during the pre-trial investigation, by the end of February 2012 Konyshev remained in pre-trial detention facing a charge of possession of "extra large" quantity of heroin (2.72 grams) with no intent to sell[38].
- In 2010 anticorruption activist Denis Matveev was sentenced to six years imprisonment based on false accusation of drug trafficking after he reported corruption in his city involving police officers and members of the mayor's office[39].

By comparison, **Kyrgyzstan** has changed its drug policies to take the focus off people who use drugs and place it primarily on drug trafficking and supply. Significant positive legislative changes in 2007 led to a more humane legal framework for drug control. For example, the threshold for the amount of drugs required for legal proceedings to be instituted was raised by a factor of dozens. In this area, government policy in Kyrgyzstan is the most progressive in Central Asia[40]: the current Criminal Code Article 246 establishes criminal liability for drug possession without intent to supply at a range from 1 to 10 grams of heroin, which is higher than comparable policies in other EECA countries. However, though these changes are important, the possession of drugs for personal use without intent to supply is still not decriminalized. One consequence is that if a person is caught twice within a year with a small amount of drugs, he or she can be imprisoned for up to two years (as specified by Article 246, Part 1 of the Criminal Code).

35 As per Federal Drug Control Service of the Russian Federation www.fskn.gov.ru.

36 Information note regarding retaliation of the Government of the Russian Federation against the Andrey Rylkov Foundation for Health and Social Justice, Moscow, 2012. Available at www.rylkov-fund.org.

37 More information on this case is available at http://spasem.org/ (in Russian only).

38 More information on this case is available at ttp://narcophobia.ru/keysyi-evgeniy-konyishev/ (in Russian only).

39 Golichenko, M. (2011) Denis Matveev: drugs as a tool for political repressions: a case study from Russia". Available at http://rylkov-fond.org.

40 For example, the amount for which possession without intent to supply becomes a criminal offence now starts at 1 gram for heroin; previously , people could be sentenced to more than one year in prison for possessing as little as 0.3 gram of heroin.

As in Russia, the amount of illegal substance that implies legal action to be taken is measured by the weight of total seized mixture rather than by the amount of active ingredients. Drug control experts in Kyrgyzstan say that this approach is necessary because there is no money to buy the special equipment required for detailed chemical tests to work out the exact components of mixes. This means that when courts deal with cases of possession without intent to supply, they are not able to give a real evaluation of each case and determine how serious the breach of law is, which in turn means that the principle that punishment should depend on the amount of forbidden substance found is impossible to apply. This in practice allows criminalizing people with a high tolerance for illegal substances—the very individuals likely to be the most problematic dependent users and in need of support.

Though since 2007 the number of criminal cases related to possession has decreased in Kyrgyzstan, the implementation of Article 246 costs at least $1.25 million per year. That sum includes, among other things, costs associated with pre-trial detention, a period that can last up to two months. People arrested on drug charges are almost always kept in jail until their court appearance because law enforcement personnel assume they are unreliable and will not show up for their trials.

> *As practice shows, the number of trials focusing on drug possession of large amount of drugs is relatively small, and even fewer people convicted for large amounts are imprisoned. This indicates that the resources allocated to both the Ministry of Interior and the State Drug Control Service are wasted on crimes for possession of small amount of drugs*
>
> **Alexander Zelichenko**, director of the Central Asian Drug Policy Center

2.2 Effect on drug markets

The levels of drug consumption in EECA are stable despite criminalization and vast investment in prohibition efforts. The persistently high levels of use indicate that there is a large illegal drug market generated by illicit trade and boosted by corruption.

Tajikistan borders Afghanistan, and therefore receives substantial external financial support for drug control. Despite vast investment in eradication of drug trafficking[41], the availability of heroin remains high. Research indicates that between 2005 and 2009 the price of heroin dramatically

41 According to the report in 2004–2010, the EU Border Management Programme in Central Asia (BOMCA) supplied Tajikistan with technical support estimated at about $16 million. The US government has also confirmed a commitment to provide $7 million for strengthening Tajikistan's law enforcement and security for the years to come. See for example: UNDP Tajikistan (2010). BOMCA: assistance in border management, Cooperation – Special Enclosure to Asia-Plus, No. 15. Available at www.undp.tj/files/UNDP_15_eng(1).pdf; US State Department, Bureau for International Narcotics and Law Enforcement Affairs, International Narcotics Control Strategy Report. Volume I, Drug and Chemical Control (2011).

decreased. For instance, the price of one dose of poor quality heroin is roughly $1 or less, and prices of high quality heroin have declined (thus increasing access to higher quality doses)[42].

In parallel the health harms associated with drug injecting are also increasing. HIV transmission risks have soared in parts of the country due to the widespread availability and low price of heroin, coupled with high prevalence of risky injecting practices among the estimated 25,000 people who inject drugs in Tajikistan[43]. For example, assessment in Kulyab, a region in the southwest part of the country with high availability of heroin, found that HIV prevalence among people who inject drugs increased sharply from 18% in 2007 to 34.5% in 2009. According to a survey of seven cities in Tajikistan conducted in 2009, the level of HIV prevalence among people who inject drugs in Kulyab was the highest in the country[44].

Corruption among the police is reportedly rampant as a result of low police salaries combined with access to easy drug market profits. As one user noted in a 2011 report, "Law enforcement agencies do in fact supervise a 'drug policy' in the country—one where they provide the dealers with heroin."[45] Testimonies of people who use drugs indicate that police officers often provide protection to their favored dealers while arresting his competitors, supply heroin to dealers and provide them protection even while arresting users. Many of those arrests are for mere possession and stem from police planting drugs or other paraphernalia on people who inject drugs, steps they may take simply to fulfill arrest quotas.

A similar trend has been observed in **Kyrgyzstan**, where the low salaries of law enforcement officers are often the main reason for harassment, abuse and misuse of power against people who use drugs. Cases have been reported of police officers planting drugs on people and falsely increasing the amount seized, and then seeking to extort bribes from people who use drugs or their families under threat of criminal prosecution[46].

In countries of region where decreased availability of heroin is being documented, the restrained access to heroin did to lead to decreased drug use. Instead, it forced people who use drugs to switch to other substances that may be more dangerous and associated with riskier injecting practices.

For example, in **Russia** one of the successes claimed by the Federal Drug Control Service in recent years is the decreased availability of opiates (a development most observers associate with decreased production in Afghanistan)[47], and that trend was confirmed in a 2011 survey on the drug

42 Analysis in different regions of Tajikistan shows that in Kulyab high purity heroin cost $4,000 to $5,000 per kilogram in 2005, while in 2009 the price decreased to $3,000 to $3,500 per kilogram. In the capital of Dushanbe, meanwhile, the price per kilogram declined over the same period from a high of $4,700 to as low as $3,700.

43 Latypov, A. (2011). Drug dealers, drug lords and drug warriors-cum-traffickers: drug crime and the narcotics market in Tajikistan (translated and summarized by T. Dempsey). Vilnius: Eurasian Harm Reduction Network. Available at www.harm-reduction.org.

44 Latypov, A. (2011). Drug dealers, drug lords and drug warriors-cum-traffickers: drug crime and the narcotics market in Tajikistan (translated and summarized by T. Dempsey). Vilnius: Eurasian Harm Reduction Network. Available at www.harm-reduction.org.

45 Latypov, A. (2011). Drug dealers, drug lords and drug warriors-cum-traffickers: drug crime and the narcotics market in Tajikistan (translated and summarized by T. Dempsey). Vilnius: Eurasian Harm Reduction Network. Available at www.harm-reduction.org.

46 Eurasian Harm Reduction Network in cooperation with the Canadian HIV/AIDS Legal Network, the Association of Civil Society Support Centers, and also the Central Asian Centre for Drugs Policy (2011). Implementation of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem. Kyrgyz Republic. A special report form the 54th Commission on Narcotic Drugs. Available at www.harm-reduction.org.

47 UNODC reported a 48% decrease in opium production in Afghanistan in 2010, in UNODC (2010) Afghan Opium Survey, 2010, United Nations Office on Drugs and Crime: Vienna, December 2010. Also, see the Report Andrey Rylkov Foundation for Health and Social Justice (2011). Drugscene — Russia in 2010. Moscow.

scene carried out by ARF. However, that can hardly can be considered a successful intervention in regards to reducing overall drug use as many users moved on to more available (and cheaper) drugs, many of which were more dangerous to their health.

Most notably, opiate-dependent people often switch to highly toxic self-made opiates prepared with codeine-containing medications and some readily available chemicals such as petrol, phosphorus from matchboxes, iodine and hydrochloric acid. Injecting of toxic opiates can lead to deep vein thrombosis, limb amputations and other severe medical complications; also of concern is the higher risk of HIV transmission due to increased injection frequency[48].

In **Romania**, similarly, an increase in the use of new psychoactive substances[49] was documented starting in 2007[50]. Within three years, such substances became the most popular drugs on the market. These patterns are explained by the legal status of the substances used to prepare the injectable drug. To some extent this means that components can often be purchased legally at pharmacies relatively cheaply[51] and police have no easy entry point to intervene. Also of note is that people who inject drugs are often switching from heroin to such emerging new psychotropic substances—e.g., piperazines, cathinones or other synthetic products, most of them amphetamine-type stimulants.

The Romanian government's response has focused on further criminalization but with no increase in support for harm reduction services for people who use drugs. In 2009–2010, the government criminalized 44 new substances, including mephedrone, in an attempt to contain their use and restrict their availability. In 2011 it also issued a new emergency ordinance that amends the current legislation on drugs. The new provision simplifies the procedures for amending the lists with controlled substances, which means that it is now easier to criminalize a new substance.

Such steps have done little to address the health concerns and needs of people who use drugs. While the availability of newly scheduled substances decreased, new, unscheduled and potentially more harmful substances quickly appeared[52] about which almost nothing was known. At the same time, the use of these psychoactive substances resulted in increased behavioral and health risks. Daily injection rates reportedly tripled[53] and injection-equipment sharing among people who inject drugs increased. According to OST providers in Bucharest, demand for their services decreased as the services did not correspond with the emerging needs of the people who use drugs[54]. Service

48 Andrey Rylkov Foundation for Health and Social Justice (2011). Drugscene — Russia in 2010. Moscow.

49 These refer to new psychoactive substances identified as a narcotic or psychotropic drug, in pure form or in preparation, that are not controlled by the 1961 United Nations Single Convention on Narcotic Drugs or the 1971 United Nations Convention on Psychotropic Substances, but which may pose a public health threat comparable to that posed by substances listed in these conventions. For more see EMCDDA (2005). Brief: Monitoring new drugs, European Monitoring Centre for Drugs and Drug Addiction: Lisbon. www.emcdda.europa.eu/attachements.cfm/att_40149_EN_Monitoring_new_drugs.pdf.

50 Botescu, A. (2011). Evaluating new synthetic drugs' use risks concerning children and youth in Romania. Research report, UNICEF Romania.

51 For example a dose of heroin, representing 1/12 of a gram, costs between $15-$18, compared with $6-$12 for 0.25/0.5 gram of synthetic stimulant. Personal correspondence with Romanian Harm Reduction Network, February 2011.

52 Simionov, V. (2012). Country report on count the costs, Romanian Harm Reduction Network (draft).

53 UNODC (2010). HIV, HBV and HCV behavioral surveillance survey among injecting drug users in Bucharest, Romania. United Nations Office on Drugs and Crime: Vienna.

54 Simionov, V. (2012). Country report on count the costs, Romanian Harm Reduction Network (draft); UNODC (2010). HIV, HBV and HCV behavioral surveillance survey among injecting drug users in Bucharest, Romania, United Nations Office on Drugs and Crime: Vienna.

providers in both community and prison settings reported difficulties in dealing with the change in use patterns. Because harm reduction and treatment services have traditionally been tailored for opiate users, most of the services and personnel working at harm reduction programs are not prepared to address the rapidly changing drug use behavior patterns associated with high-intensity stimulant injecting.

In 2011 Romania reported an increase in HIV cases among people who inject drugs. According to data collected until the end of January 2012, the Department for Monitoring and Evaluation of HIV/AIDS Infection in Romania recorded 114 new HIV cases among people who inject drugs; compared with 2010, when just seven cases were recorded, that is a significant and worrying increase[55]. Most cases reported were registered among young men (under 34 years of age) and had confirmed CD4 cell counts at diagnosis higher than 500 cells/mm3, suggesting recent infection[56]. The increase in new HIV cases is thought to be related to limited availability of existing harm reduction services as well as extended use of new psychoactive substances, which tends to require more frequent injecting.

These patterns indicate that the availability of and access to dangerous drugs is increasing, rather than decreasing. Evidently the dynamics of a largely unregulated trade mean that supply will always meet demand as people find other ways to obtain and use drugs, even when access to existing supply routes is successfully restricted. The use of legal substances also proves that people will find a way to use in order to avoid contact with law enforcement, even if using them puts their health at greater risk.

2.3 Health consequences and their cost

Most governments in the region are struggling with the burden of the health consequences of drug use. Across EECA overall, around one quarter of all people who inject drugs are living with HIV[57]. This rate, which is several times higher than the HIV rate among the overall population, makes it clear that services targeting people who inject drugs (such as harm reduction) should be of priority importance to contain the burden of expensive HIV treatment costs.

HIV-related TB remains a serious challenge for the health sector's response to HIV. HIV-positive people are especially vulnerable to the impact of TB and multi-drug resistant TB, which is a leading cause of death among people living with HIV and AIDS. Hepatitis C is particularly common among people who inject drugs; from 60% to 90% of people who inject drugs in nearly every context have hepatitis C[58]. Yet hepatitis C remains almost entirely unaddressed throughout the region, with

55 National Infectious Disease Institute, Department for Monitoring and Evaluation of HIV/AIDS in Romania, February 2012, provided by Romanian Harm Reduction Network, January 2012. Available at http://cnlas.ro/date-statistice.html.

56 Eurosurveillance (2011). Human immunodeficiency virus in injecting drug users in Europe following a reported increase of cases in Greece and Romania. Vol. 16, Issue 48, Dec 2011. Available at www.eurosurveillance.org/Public/Articles/Archives.aspx?PublicationYear=2011.

57 UNAIDS and WHO fact sheet on Eastern Europe and Central Asia (2009). Available at http://data.unaids.org/pub/FactSheet/2009/20091124_fs_eeca_en.pdf.

58 EHRN (2007). Hepatitis C among injecting drug users in the new EU member states and neighboring countries: situation, guidelines and recommendations. Eurasian Harm Reduction Network: Vilnius. Available at www.harm-reduction.org/images/stories/library/hepc_report_08_en.pdf.

governments lacking surveillance systems and treatment guidelines. In addition, despite existing international studies showing that success rates of hepatitis C treatment among people who inject drugs are comparable with other patients, injecting drug use is often a criterion for excluding people from treatment programs in the region's countries[59].

Most policymakers fail to take such considerations into account when setting priorities. Although most countries are able and willing to invest a lot of money into the prosecution and punishment of people who use drugs, they invest far less in prevention services. Moreover, the lack of supportive political environment increases detention of people who use drugs and participants of needle and syringe programs (NSPs) and OST programs, thereby limiting the impact of harm reduction services.

2.3.1 Virtual prohibition on harm reduction

According to the State Law on Federal Budget in **Russia**, the government plans to spend nearly $640 million on HIV, hepatitis B and C prevention, testing, diagnostics and treatment in 2012[60]. However, only 3% of this budget is planned for HIV prevention ($20 million). Russia is therefore spending large amounts on treatment of HIV and other viral infections, but is spending virtually nothing on their prevention, including evidence-based approaches to HIV prevention such as NSPs and OST.

The main reasons cited for restricting the opportunity of drug users to obtain medical and social aid, including prevention services, are the legislative barriers and official policy course that emphasizes reducing supply through law enforcement and reducing demand by promotion of "healthy lifestyle". The Strategy of the Anti-Narcotic Policy of the Russian Federation until 2020[61] and the plan to implement the strategy reaffirmed that approach. The 10-year plan restricts all activities and advocacy associated with harm reduction and other evidence-based services for people who use drugs. OST and NSPs are considered antithetical to the strategy because they are "attempts to legalize substitution therapy with use of narcotic drugs and promotion of drug use under pretext of syringe replacement". Non-governmental organizations (NGOs) are prohibited from providing information on OST and other treatment and prevention measures opposed by the government. Such restrictive policies clearly indicate that the punishment and social isolation of people who inject drugs is the basis of state's strategic approach to drug demand reduction. These policies have high financial and social costs.

The inaccessibility and poor quality of services pertaining to the treatment of drug dependence in Russia have been extensively documented. Treatment methods reported include flogging, beatings, punishment by starvation, long-term handcuffing to bed frames, "coding" (hypnotherapy aimed at persuading the patient that drug use leads to death), electric shock, burying patients in the ground

59 Ocheret, D., Bikmukhametov, D., Sultangaziev, A., Matuizaite, E. (2012). Where are we now regarding access to hepatitis C treatment in Eastern Europe and Central Asia? Key findings and recommendations of EHRN report, Assessment of HCV treatment accessibility in EECA, Eurasian Harm Reduction Network: Vilnius.

60 Federal Law # 371FZ of 30 November 2011, "On the Federal Budget for 2012 and the planned budget for 2013 and 2014".

61 Strategy of the Anti-Narcotic Policy of the Russian Federation until 2020. See http://graph.document.kremlin.ru/page.aspx?1;1285491 (in Russian only).

and xenoimplantation of guinea pig brains[62]. The practice and acceptance of such methods clearly indicate that the government's approach does not correspond to international drug treatment guidelines.

Such methods are not only cruel but ineffective. As the Russian Federal Drug Control Service has acknowledged, over 90% of drug treatment patients return to using illegal drugs within one year[63]. As a result of the ineffective government approach to drug treatment and care, Russia has one of the largest numbers of people who use drugs—government estimate reaches 5 million[64], while UNODC's 2009 World Drug Report estimated that 1.6 million people use opiates[65]. Meanwhile, the number of people living with HIV in Russia continues to rise; in 2010 alone, a total of 58,633 new HIV cases were officially registered in the country[66]. Injecting drug use has long been the predominant risk factor, with around 80% of all HIV cases registered in the country from 1987 to 2008 associated with the use of injecting drugs[67]. The government's refusal to respond adequately to the main transmission risk means that most of the funding goes to the management of the consequences rather than prevention of new infections. It is clear that 3% of the entire budget cannot possibly reach the most vulnerable population in an effective manner, and even the 3% spent on prevention is spent inefficiently.

Throughout 2010 and 2011, harm reduction programs were closing all over the country because the government had not fulfilled its promise to finance them after grants from Global Fund ran out. The Ministry of Health claims that there is no need for harm reduction as the situation with HIV is improving in the country due to effective state policy and programs[68].

> *You can't stop the epidemic in Russia until the last barrier is overcome—stigmatization of injecting drug users.*
>
> **Michel Sidibé**, UNAIDS Executive Director, at the MDG 6 Forum in Moscow, Russia in 2011

Russia is an extreme case in many ways given its strict legal prohibition on any form of OST whatsoever for any reason. It is not entirely alone, however. In most other EECA countries, governments' inability to allocate funds for harm reduction programming (including OST), HIV treatment and even

62 Anrey Rylkov Foundation (2011). Atmospheric pressure. Russian drug policy as a driver for violations of the UN Convention against Torture, Shadow Report to the UN Committee against Torture in relation to the review of the Fifth Periodic Report of the Russian Federation. Report prepared by the public mechanism for monitoring drug policy reform in the Russian Federation, in cooperation with the Andrey Rylkov Foundation, Canadian HIV/AIDS Legal Network and the Eurasian Harm Reduction Network.

63 Federal Drug Control Service of the Russian federation Director Ivanov, V. (September 16, 2009). Interview for RIA Novosti (www.ria.ru); Professor T. V. Klimenko (2009). "On the Russian Drug Control Strategy" (Профессор Т.В. Клеменко (2009). «О государственной антинаркотической стратегии Российской Федерации»). Available at http://stratgap.ru/includes/periodics/comments/2009/1124/3841/detail.shtml (Russian only).

64 Interview with head of the Federal Drug Control Service (February 4, 2010). Rossiyskaya Gazeta, Federal issue No. 5101 (22). Available at www.rg.ru/2010/02/04/igly.html (in Russian only).

65 UNODC (2009). World Drug Report 2009, United Nations Office on Drugs and Crime: Vienna.

66 As per Federal AIDS Centre. Available at www.hivrussia.ru/stat/index.shtml (in Russian only).

67 Information Bulletin No. 33 of the Federal Scientific-Methodological Center for the Prevention and Control of AIDS in the Russian Federation. Moscow, 2009, p. 13. (Информационный бюллетень 33 Федерального научно-методического центра по профилактике и борьбе со СПИДом Российской Федерации, Москва, 2009. С. 13.) See www.hivrussia.ru/files/bul_33.pdf (in Russian only).

68 Letter from Deputy Minister V. Skvortsova to the Head of Federal AIDS Center V.Pokrovsky, 8 October 2010; letter from the Head of Department of the Ministry of Health, M. Shcevireva to Anya Sarang, president of Andrey Rylkov Foundation.

treatment for hepatitis C is determined not by insufficiency of national funding, but by inadequate national priorities. Political leadership is lacking in support of prevention services for people who inject drugs, and as a result international donor mechanisms are the biggest source of funding for evidence-based services for people who use drugs. Yet the reach and effectiveness of donor investments are limited by existing law enforcement policies that do not create supportive legal environments for protecting the health of people who inject drugs.

2.3.2 Impacts and developments in countries with limited harm reduction access

In some places in the region, governments struggling with negative health consequences are introducing harm reduction services with international support and under pressure from civil society and international donors. For example in **Ukraine**, the country with the highest adult HIV prevalence in all of Europe, total annual HIV/AIDS spending has increased over the past few years, totaling for example $30 million in 2011 compared with $23 million in 2009[69]. Yet HIV prevention programming among vulnerable populations comprised less than 1% of all HIV/AIDS expenses in 2010–2011 even as HIV among people who use drugs continued to increase[70], which underscores the fact that most harm reduction interventions are dependent on international financial support.

In September 2010, a new Concept of Drug Policy through 2015 was introduced that does not stipulate any measures for drug treatment. One month later, the government amended the drug laws and criminalized possession of extremely low amounts of narcotic substances—for example, for "acetylated opium" (0.005 grams vs. 0.1 grams in wording previously used), "opium" (0.1 grams vs. 0.5 grams), "acetic anhydride" (2 grams vs. 250 grams), "norefedrine" (0.3 grams vs. 0.3 kilograms) "ephedrine" and "pseudo-ephedrine" (0.6 grams vs. 30 grams).

Judicial practice in Ukraine proves that in certain cases even traces of these drugs in a used syringe may be enough to bring a person to criminal liability under p. 309 or p. 311 of the Criminal Code of Ukraine, which could lead to up to three years of imprisonment. As many of those substances, especially acetylated opiate, are commonly used in Ukraine by people who inject drugs, this amendment virtually makes drug dependence equivalent to being a criminal.

In September 2011, the District Administrative Court in Kyiv, Ukraine dismissed a claim filed by the International HIV/AIDS Alliance in Ukraine to invalidate provisions of the Ministry of Health's order approving such low thresholds. According to Alliance court papers, the provisions have greatly impeded HIV prevention efforts among people who inject drugs. The organization observed that since the change, the amount of needles collected though NSPs had decreased due to fear of criminal prosecution for illegal drug possession, thus raising the likelihood of a surge in new HIV cases in the

69 According to HIV/AIDS program for the period 2009–2013.
70 State HIV/AIDS Budget, according to HIV/AIDS program for the period 2009–2013.

country[71]. The court's decision was based on its reasoning that since drug use is classified as an illegal action, drug users who choose to commit the crime should be held accountable[72]:

> *The court does not agree with the plaintiff's statements about reducing access to state-guaranteed services on exchange of used syringes for injecting drug users because of the threat of criminal responsibility stipulated by the Articles 309 and 311 of the Criminal Code of Ukraine, since the laws prohibit drug use without a doctor's prescription.*
>
> From court decision in September 2011

The **Romanian** drug policy described in the National Anti-drug Strategy 2005-2012 aims to create "a functional integrated system of institutions and public services which will ensure the reduction of the occurrence and prevalence of drug use in the general population, adequate medical, psychological and social assistance for drug users and streamlined activities for preventing and countering the trafficking and production of illicit drugs and precursors."[73] However, the government's strategy to reduce drug-related harms relies almost exclusively on donor funding to provide limited harm reduction services for people who inject drugs. For example, donor support is used to provide NSPs and OST programs, including some harm reduction programming made available in 10 of 38 prison facilities[74].

Such reliance on international support raises concerns about sustainability and adequate integration with HIV treatment services provided largely by governments. Political leadership is often lacking to strategically prioritize the services for people most vulnerable to HIV. This leads to lack of coverage of and access to harm reduction services. The coverage of people who inject drugs remains extremely low: in 2009, less than 5% of injecting drug users in Bucharest received OST services, and by mid-2011 estimated OST coverage had risen only slightly, to 9%[75].

In addition, such a policy approach places a major burden on the state's health budget. The government invested an estimated $66.4 million in treatment for HIV and other opportunistic infections in 2010[76], a sum comprising the majority of HIV-related funding in the country. While the increased funding for HIV is a sign of overall improved government commitment to HIV, the increase is also the consequence of poor strategic decisions that fail to prioritize prevention among most-at-risk groups such as people who inject drugs. The cost of providing ART and treatment for

71 Statement of claim (administrative suit) on declaring invalid (unlawful) the Ministry of Health of Ukraine's Decree # 634 of 29.07.2010, "On defining amounts of some narcotic substances and precursors" (unofficial translation). According to an Alliance assessment, there was a decline in collected syringes from 28% to 15% between the fourth quarter of 2010, when the new tables were introduced, and the second quarter of 2011. International HIV/AIDS Alliance in Ukraine (2012). Summary report of the performance under the "Support for HIV/AIDS Prevention, Treatment and Care for Most Vulnerable Populations in Ukraine" program supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria in the second half of the year 2011 (and over the whole year 2011).

72 Court ruling, District Administrative Court of Kyiv 8 Str. Komandarm Kamenev, building 1, 01601, September 13, 2011, №2a-6089/11/2670 (unofficial English translation, International HIV/AIDS Alliance Ukraine).

73 National Anti-drug Strategy 2005-2012, Adopted by the Government: Bucharest, 2005.

74 Simionov, V. (2012). Country report on count the costs, Romanian Harm Reduction Network (draft).

75 Final evaluation, HIV/AIDS prevention and care among injecting drug users and in prison settings in Romania, Daan van der Gouwe, November 2011, provided by Romanian Harm Reduction Network, January 2012.

76 Simionov, V. (2012). Country report on count the costs, Romanian Harm Reduction Network (draft).

opportunistic infections per patient totals an estimated $8,062 per year[77]. In light of the increase in HIV cases among people who use drugs reported in 2011, treating 114 people newly diagnosed with HIV will cost $919,068 based on that per-patient estimate. Many of those infections would have been averted, and the government's treatment-related budget reduced substantially, if adequate efforts had been made to meet the needs of people who use drugs, which would have included scaling up and supporting harm reduction services.

There are approximately 40,000 people who inject drugs in **Georgia**, but only 4,000 of them are covered by harm reduction services. OST and NSPs are largely funded through Global Fund; they cover only a few regions and at best cover up to 10% of people in need[78]. The state budget of Georgia allocates just $700,000 for treatment programs for people who use drugs at the same time that $10.5 million per year is spent enforcing rigid drug criminalization policies (as noted previously in this report). The skewed priorities are extremely costly from a public health and budget perspective, as criminalizing people instead of supporting them in effective drug treatment not only costs more money but increases health risks.

2.4 Costs associated with imprisonment

There is a common assumption that imprisonment helps improve the drug situation for two main reasons: i) by deterring other people from using drugs, and ii) by preventing further drug-related harms to the society through the isolation of people at high risk of transmitting HIV and other infectious diseases as well monitoring them closely in closed environment.

Such assumptions do not stand up to reality. Evidence shows that after release from prison at least 9 out of 10 drug users begin using again, especially if they are not provided with relevant rehabilitation programs, treatment services and thorough care[79]. Such data offer clear proof that punishment and especially imprisonment are not effective ways to reduce a society's drug-related harms[80]. Punitive measures are even less useful in EECA because few comprehensive treatment and care services are available for those in prison or released from prison.

Incarceration often makes things worse. Drugs are widely available in most prisons, and HIV transmission is a serious risk given the difficulty in obtaining clean injecting material and other prevention commodities such as condoms. In **Tajikistan**, for example, the number of HIV cases in prisons is steadily rising. Personal testimonies indicate that heroin is fairly easy to find now in prisons[81].

77 Cost estimation based on data from the National Health Insurance House (2011). Information obtained by Romanian Harm Reduction Network in response to request.

78 Javakhishvili, D., Sturua, L., Otiashvil, D., Kirtadze, I., Zabransky, T. (2011). Overview of the drug Situation in Georgia. Adictologie, 11(1), 42-51.

79 Leukefeld, C., Tims, M. (1992) National institution of drug abuse and research, monograph series (118): Drug abuse treatment in prisons and jails, 1992.

80 UNODC (2003). Investing in drug abuse treatment: a discussion paper for policymakers, United Nations Office on Drugs and Crime: Vienna.

81 Latypov, A. (2011). Drug dealers, drug lords and drug warriors-cum-traffickers: drug crime and the narcotics market in Tajikistan (translated and summarized by T. Dempsey). Vilnius: Eurasian Harm Reduction Network. Available at www.harm-reduction.org.

Data from **Kyrgyzstan** also suggest that drugs are widely available in prison settings, with reports of drug use varying from 20% to 50%[82]. Prisoners often reportedly have injected dimedrol, a particularly caustic and dangerous substance, and suffered life-threatening injuries.

Russian drug policy, based on punishment, isolation and stigmatization of people who use drugs, has not led to a decrease in the number of people who use drugs. The country has the second-largest prison population in the world, with between 850,000 and a million people in prison each year.[83] Repressive laws, including those related to drug-related crimes, are partly responsible for the high incarceration rate, which in turn means that prisons are overcrowded and conditions highly unsanitary[84]. Incarceration remains the main form of punishment for drug users, including those who commit theft and other crimes solely in order to finance addiction that they cannot address because of lack of access to effective treatment. Research shows that in different cities, 28% to 65% of drug users have had prison experience[85].

Imprisonment carries high financial and social costs:

- The imprisonment of 1,605 people detained in 2008 on the basis of positive drug tests in **Georgia** cost $4.7 million, and overall costs for imprisonment in the country continue to surge in response to new, punitive policies. In the past few years the prison population has increased four-fold (from 6,000 to 24,000)[86].
- In **Kyrgyzstan** prisons, people who use drugs have no access to effective drug treatment in prison settings due to the low coverage of such services. With no alternatives, inmates often get involved in criminal activity in order to sustain drug use. Involvement in such gangs often continues after release, especially if an inmate has debts stemming from drug use[87].
- In **Romania** drug laws set no threshold for personal possession; therefore, a person detained with traces of drugs may get a prison term from two to five years depending on the substance. Around 2,000 people are imprisoned each year for drug-related crimes, and the rate of people detained for drug crimes is increasing compared with other crimes. The cost of maintaining a person in prison is about $712 a month, or $8,544 a year. By comparison, methadone treatment costs $234 per month for one person[88].

82 Zelichenko, A. (2006). Rapid assessment in prisons, CARHAP (The Central Asian HIV/AIDS Programme): Bishkek.

83 Word Prison Population List, 8th ed. by Walmsey R. International Centre for Prison Studies.

84 Bobrik, A., Danishevski, K., Eroshina, K., McKee,M. (2004) Prison health in Russia: the larger picture. *J Public Health policy*, Vol. 26, No. 1 (2005):30-59.

85 Sarang, A., Rhodes, T., Platt, L., Kirzhanova, V., Shelkovnikova, O., Volnov, V., Blagovo, D., Rylkov, A. (2006). Drug injecting and syringe use in the HIV risk environment of Russian penitentiary institution. Addiction, 101(12):1787-1796.

86 International Centre for Prison Studies. World Prison Brief – Georgia. Retrieved on February 10, 2012. Available at www.prisonstudies.org/info/worldbrief/wpb_country.php?country=122.

87 Zelichenko, A., Zelichenko, M. (2011). The evaluation of government expenses on existing drug policies. Country Report (Оценка затрат государства и общества на существующую наркополитику. Отчет о проведенном исследовании), Central Asian Drug Policy Center, Bishkek, available in Russian.

88 The estimate for OST treatment was provided by the Romanian Harm Reduction Network and is based on costs listed according to the National Catalogue of Drugs for Human Use, authorized to be marketed (April 2011).Costs do not include staff, premises maintenance, etc.

Inhumane conditions in prisons and the cost of imprisonment for society

Imprisonment can be especially dangerous physically and mentally for people who require health and social services. The European Court of Human Rights in numerous judgments focusing on Ukraine, Russia and Georgia has ruled that lack of space, poor sanitary conditions and inadequate access to medical service amount to violation of the right to be free from torture, inhumane or degrading treatment or punishment[89].

In Kyrgyzstan, the prison system is so underfunded that not only do inmates rarely receive adequate health services, but often suffer from poor nutrition. The amount spent per person, about $3.50, includes all prison-related expenditures from salaries for staff to food budgets. Research indicates, however, that a higher amount (about $3.90 per person) is needed to ensure minimum nutrition and hygiene standards. Relatives and friends of those convicted under Article 246 contribute as much as $340,000 a year in total in an effort to provide people in detention (before court decisions) and approximately $ 1.1 million to provide convicted prisoners with sufficient food for drug-related sentences averaging four years.

Not all prisoners have relatives who are able and willing to contribute additional funds, however. In such cases the rights of prisoners to basic health, nutrition and hygiene conditions are systematically violated. Those inmates are also more likely to get involved with criminal gangs in desperation to find sources for adequate food and other services, developments that increase criminality among people imprisoned only for drug possession[90].

89 See for instance *Kalashnikov v. Russia*, no. 47095/99, ECHR 2002-VI; *Melnik v. Ukraine,* no. 72286/01, ECHR March 2006; *Ramishvili and Kekhereidze v Georgia,* no. 1704/06, January 2009.

90 Zelichenko, A., Zelichenko, M. (2011). The evaluation of government expenses on existing drug policies. Country Report (Оценка затрат государства и общества на существующую наркополитику. Отчет о проведенном исследовании), Central Asian Drug Policy Center, Bishkek, available in Russian.

3. Potential effects of alternative policies and redistribution of funds

Social stigma and punitive legal environment hinder implementation of basic HIV/AIDS activities throughout much of the region. Therefore a key step toward containing the epidemic is construction of a political environment supporting changes in social and political norms. This ideally would include reviewing laws, legal policies and practices as well as more strategically and effectively reducing the stigma associated with drug use and HIV. The goal of such policy reforms would be to achieve results such as a reduction in drug-related harms based on the implementation of more humane and cost-effective policies and practices.

3.1 Decriminalization

Supporters of continued criminalization of people who use drugs claim that decriminalization—in particular, the removal of criminal liability for drug use and drug possession for personal use—would lead to greater drug use and more drug-related harms. In practice, decriminalization has had a quite different impact, as can be seen in the case study on Portugal below[91].

Portugal: policy change and its effects

In the late 1990s Portugal had the highest rate of drug-related deaths due to HIV in the EU and the second-highest HIV prevalence among people who inject drugs[92]. Drug-related deaths had increased by 57% from 1997 to 1999[93].

It was within this context that in 1998 a government-appointed Commission for the National Anti-Drug Strategy recommended decriminalization with the goal to reduce drug abuse and use[94]. The decriminalization law of 2001 applies to possession and use of all illicit drugs—including cannabis, heroin and cocaine—but it is restricted to possession of up to 10 days' worth of a drug. Daily doses are defined as 0.1 gram each of heroin, ecstasy and amphetamines; 0.2 grams of cocaine; and 2.5 grams of cannabis. Consequently, the possession of 1 gram or less of heroin is not criminalized. In conjunction with its decriminalization legislation, Portugal also passed new harm reduction measures in 2001 to better coordinate and bolster drop-in centers, shelters, mobile health units, prescription programs, syringe-exchange schemes, and other initiatives for dependent drug users[95]. Altogether, the policy change

91 For drug decriminalization trends in the world, see Rosmarin, A., Eastwood, N. (2012). A quiet revolution: drug decriminalization policies in practice across the globe. Release: London.

92 EMCDDA (2000). Annual report on the state of the drugs problem in the European Union. European Monitoring Centre for Drugs and Drug Addiction: Lisbon. Available at http://www.emcdda.europa.eu/.

93 Instituto Portugues da Droga e da Toxicodependencia 2000.

94 Van het Loo, M., Van Beusekom, I., Kahan, J. (2002) Decriminalization of drug use in Portugal: the development of a policy. *Annals of the American Academy of Political and Social Science* 582, Cross-National Drug Policy (July 2002).

95 EMCDDA (2011) Drug policy profiles – Portugal. Available at www.emcdda.europa.eu/publications/drug-policy-profiles/portugal.

promoted approaching each drug case individually and offering reference to treatment, care and support services rather that punishment.

The impact on drug trends suggests that Portugal experienced a small increase in lifetime drug use among adults following decriminalization[96]. Yet the country's level of drug use still remains generally below the European average, and a decrease in use prevalence among some particularly vulnerable groups has been recorded. For example, after a slight increase leading up to and immediately after decriminalization, lifetime usage among 15-16 year olds decreased between 2003 and 2007[97].

The proportion of drug-related offenders in the Portuguese prison population—that is, those convicted of offences committed under the influence of drugs and/or to fund drug consumption—dropped from 44% in 1999 to 21% in 2008[98]. Consequently it can be argued that decriminalization has reduced the burden on the criminal justice system and enabled police to focus attention on more serious offences.

However, one of the greatest impacts of the policy change appears to be on public health. The number of people who use drugs who are in treatment grew and significant declines have been recorded in HIV and tuberculosis transmissions. The number of people who use drugs who are newly diagnosed with HIV decreased from 907 in 2000 to 267 in 2008, and the number of new AIDS cases fell from 506 to 108 over the same period. Experts on the ground attribute this to the significant expansion of harm reduction services in conjunction with the decriminalization policy[99].

Decriminalization is not a panacea for all of the problems associated with problematic drug use, as a country's drug policies appear to have but a minor effect on the scale of drug consumption. But what emerges is that the harms of criminalization far outweigh those of decriminalization. Decriminalization, if implemented responsibly, does appear to potentially facilitate directing more drug users into treatment, to reduce criminal justice costs, and to shield many non-violent drug users from the devastating albatross of a criminal conviction hanging around their necks for the rest of their lives[100].

96 Hughes, C., Stevens, A., Stevens, E. (2010). What can we learn from the Portuguese decriminalization of illicit drugs? British Journal of Criminology 50, doi: 10.1093/bjc/azq038.

97 Hughes, C., Stevens, A., Stevens, E. (2010). What can we learn from the Portuguese decriminalization of illicit drugs? British Journal of Criminology 50, doi: 10.1093/bjc/azq038. For a comparison with the European drug-use trend please see: EMCDDA. Drug policy profiles – Portugal. Available at www.emcdda.europa.eu/publications/drug-policy-profiles/portugal.

98 Instituto da Droga e da Toxicodependencia 2009, Relatorio anual 2008: A situacxao do paiis em materia de drogas e toxicodependencias, Vol. I—Informacxao estatistica. Lisboa: Instituto da Droga e da Toxicodependencia.

99 Hughes, C., Stevens, A., Stevens, E. (2010). What can we learn from the Portuguese decriminalization of illicit drugs? British Journal of Criminology 50, doi: 10.1093/bjc/azq038.

100 Rosmarin, A., Eastwood, N. (2012). A quiet revolution: drug decriminalization policies in practice across the globe. Release: London.

3.2 Redistribution of funds

It is likely that decriminalizing drug use and possession for personal use would have beneficial overall impacts in EECA as well. Such benefits would stem from shifting funds currently used to punish people who use drugs under current drug laws to health services for people who inject drugs. Research indicates that such redistribution would lead to more effective spending.

Drug treatment costs per drug user in the EU[101]

In selected countries of Europe, the average annual expenditure for drug treatment ranges from €550 to €4,900 ($725 to $6,460) per client. (The large difference is based on the wide range of types of treatment used, each of which has a different cost associated with it.)

In terms of unit costs (per person per day) across treatment modalities, there are clear differences between the treatment types. The highest unit costs are reported for inpatient modalities. The unit cost of inpatient psychosocial treatment is estimated to range from €59 to €404 ($78 to $533) per patient per day. Detoxification carried out in inpatient settings is reported to cost between €110 and €303 ($145 and $400). Oral substitution treatment with methadone is reported to cost the least of the other treatment modalities, with unit costs across the continent ranging from €2 to about €37 ($2.60 and $63) per patient per day. Personnel costs—for wages, extra allowances, management and administration—accounted for the greatest proportion of OST costs, which indicates that the scale-up of treatment would help increase its cost-effectiveness by maximizing the utilization of personnel.

The $4.7 million **Georgia** spends annually on imprisonment of drug offenders could cover the following interventions[102]:

- OST for 1,200 patients for a year;
- outpatient detoxification for 2,700 patients;
- inpatient detoxification for more than 700 patients;
- psychosocial consultation for 20,000 patients; and
- one-year enrolment of more than 6,000 patients in a needle and syringe program.

Analysis indicates that redistributing as above would bring a social benefit of an estimated $10.3 million[103].

Findings from an assessment supported by the Joint United Nations Programme on HIV/AIDS (UNAIDS) of the cost-effectiveness of NSPs in Georgia found that they are effective and bring significant benefits to Georgian society in terms of preventing new HIV and hepatitis C infections;

101 EMCDDA (2011). Selected issues 2011: Cost and financing of drug treatment services in Europe, European Monitoring Centre on Drugs and Drug Addiction: Lisbon.

102 Otiashvili, D., Kirtadze, I., Tsertsvadze, V., Chavchanidze, M., Zabransky, T. (2012). How effective is street drug testing. Alternative Georgia: Tbilisi.

103 Otiashvili, D., Kirtadze, I., Tsertsvadze, V., Chavchanidze, M., Zabransky, T. (2012). How effective is street drug testing. Alternative Georgia: Tbilisi.

reducing mortality related to those viruses; and ultimately saving health care costs that would otherwise be spent to provide health services for those infected. Health care savings associated with NSPs over the last 10 years were $75,000, and projections for the future suggest significant health cost savings of more than $15 million from 2010–2020 if funding for NSPs remains at the current level. In terms of public health (non-monetary) gains over the last 10 years, analysis indicates that NSPs have helped to prevent 806 hepatitis C infections, 1,064 HIV infections and 12 HIV-related deaths. In total, some 1,600 quality-adjusted life-years (QALYS) were gained from effective, evidence-based investments related to HIV and hepatitis C between 2000 and 2010[104].

As noted previously, the implementation of Article 246 of the Criminal Code in **Kyrgyzstan** (possession of drugs with no intent to supply) requires government spending of around $1.25 million annually. Both estimates clearly show the cost-effectiveness of harm reduction. OST programming for 1,000 clients costs $500,000 per year, or $1.37 per client per day. The implementation of Article 246 costs $625 per person convicted for a drug-related offence for personal possession per year. While not all people who use drugs require or want OST, there is plenty of room for scale-up given that current coverage of OST is only about 3.8% of the estimated 26,000 people who inject drugs.

It is not difficult to identify some significant cost benefits to the government from investing in OST and other evidence-based prevention and treatment services for drug users. Respondents to a survey among OST program clients in Bishkek indicated that when using they spent up to $12.20 per day on heroin. Based on that average, enrolment in OST of 1,000 people would mean a loss of $12,000 in drug profits each day for traffickers, which over a full year would be almost $4.5 million. If those illegally spent funds were spent on legal goods and services, the amount of value-added tax (VAT) collected by the government would be about $543,000[105]. The budget boost to the government would be truly astounding if every one of the estimated 26,000 people who inject drugs were on OST or another effective drug treatment regimen; if that were to happen, some $317,000 per day (about $116 million per year) would no longer be spent in the illegal drug market. The government would collect millions in VAT receipts if even a small share of those funds were spent on legal goods and services instead.

According to the same survey, two out of three OST program clients had found a legal job, a step that facilitates social integration and their active contribution to the economy. Moreover, the number of HIV cases among people who injected drugs in Bishkek since the initiation of the program has declined, a development assumed to be the biggest reason for the 17% decrease in new HIV cases in 2010 compared with 2009. Also of note was a decline over the same period in criminal activity related to drugs[106].

In **Ukraine**, more than 6,600 patients were enrolled in OST programs in 27 regions as of January 2012. An assessment of the health and social benefits of the treatment indicates that OST has

104 Wilson, D., Zhang, L., Kerr, C., Kwon, A., Hoare, A., Otiashvili, D., Tsertsvadze, V., Tavadze, L., Iashvili, E., Avila, C., Williams-Sherlock, M. (2012). Evaluating the cost-effectiveness of needle-syringe exchange programs in Georgia. UNAIDS.

105 Zelichenko, A., Zelichenko, M. (2011). The evaluation of government expenses on existing drug policies. Country Report (Оценка затрат государства и общества на существующую наркополитику. Отчет о проведенном исследовании), Central Asian Drug Policy Center, Bishkek, available in Russian.

106 Zelichenko, A., Zelichenko, M. (2011). The evaluation of government expenses on existing drug policies. Country Report (Оценка затрат государства и общества на существующую наркополитику. Отчет о проведенном исследовании), Central Asian Drug Policy Center, Bishkek, in Russian.

contributed to clients' re-integration and re-socialization. Some 30% of clients have become legally employed, about 3% went back to school, more than 16% restored family relations, some 5% set up families and more than 2.5% of clients had a child. Another notable impact is the sharp decline in criminal activity among OST clients. Results from a poll of 400 methadone program clients indicate that their participation in drug trafficking is seven times lower since starting treatment, and that rates of other crime (robbery, etc.) are four times lower[107].

A dynamic model of HIV transmission among people who inject drugs in **Russia** suggests that assuming a baseline HIV prevalence of 15%, increasing coverage of OST from 0% to 25% of all people who inject drugs could decrease HIV incidence by between 44% and 53%[108].

107 International HIV/AIDS Alliance in Ukraine (2012). Summary report of the performance under the "Support for HIV/AIDS Prevention, Treatment and Care for Most Vulnerable Populations in Ukraine" program supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria in the second half of the year 2011 (and over the whole year 2011).

108 Rhodes, T., Sarang, A., Vickerman, P., Hickman, M. (2010). Policy resistance to harm reduction for drug users and potential effect of change. , 341: c3439. doi: 10.1136/bmj.c3439.

4. Conclusions and recommendations

Current policy approaches in EECA emphasize criminalization of drug use in all respects. Yet these approaches are not only ineffective in reducing drug use and improving health, but are also extremely costly for little or no impact. Moreover, criminalization makes things worse from an economic, social and public health standpoint by increasing stigma, discrimination and social alienation as well as the risks of contracting HIV, hepatitis C among members of an already marginalized population. The consequences of violating their rights to health and life affect not just them but their families, friends and communities more broadly.

Most of these negative consequences can be minimized by implementation and scale-up of harm reduction interventions. Strong and farsighted political leadership are needed to reform punitive policies and, ideally, ensure that cost-savings associated with reform are used to increase services for people who use drugs, including evidence-based drug treatment.

Recommendations

- Governments should commission comprehensive drug policy cost assessments of benefits and costs related to implementation of policies aimed to combat drug use and drug trafficking, by:
  - evaluating whether measures implemented reach goals and targets stated in their national legislation and international human rights treaties;
  - providing detailed analysis of budgetary expenses directly and indirectly related to implementation of drug policies; and
  - analyzing economic and social effects of such policies, including but not limited to well-being, morbidity and mortality in affected communities and in the general population, as well as in respect to the human rights and social integration of people who use drugs.
- Governments should organize an open process of discussion of national drug policy reform, and take decisions guided by the following principles:
  - drug-related measures should be based on solid empirical and scientific evidence aimed at reducing harms to health and improving the welfare of individuals and society;
  - measures should be cost-effective, meaning that drug-related harms are prevented and managed with the highest impact at the lowest possible cost; and
  - measures should be implemented with respect for the human rights and dignity of all members of society including people who use drugs and/or are living with diseases.
- Governments should allocate national funding to ensure access to high-quality harm reduction programs, including NSPs and OST programs, as well as other programs to prevent and treat HIV, tuberculosis, viral hepatitis and drug overdose. National legislation should be adopted to provide supportive legal environments to implement such programs, including abolishing

unnecessary overregulation of methadone and buprenorphine, the medicines most commonly used in OST.

- Immediate measures should be undertaken to abolish the criminal liability for drug use and drug possession with no intent to supply by amendment of existing criminal laws. The administrative liability for drug offences should not foresee arrest and high fines.
- Drug-user community organizations, as frontline observers of the devastation caused by such policies, should play a key role in ensuring that drug policies do not impede access to prevention and care, as demanded in the United Nations Political Declaration on HIV/AIDS[109]. These organizations should therefore be involved in policy review and all political decisions related to drug users.

109 UN General Assembly 60th session (2006). Political Declaration on HIV/AIDS. Resolution adopted by the General Assembly 60/262.



www.harm-reduction.org