

# **DRUG POLICIES = DEATH: HIV/AIDS IN CENTRAL AND EASTERN EUROPE**

## **A Report by the Drug Law and Health Policy Network on the Current Impact of Law and Policy on Spread of HIV in Central and Eastern Europe and the Former Soviet Union**

A Preliminary Analysis of Twenty-One Countries  
July 8, 2002

### **EXECUTIVE SUMMARY:**

The HIV/AIDS epidemic in Central and Eastern Europe is largely man-made. The epidemic, which has reached crisis proportions in this region, is driven primarily and overwhelmingly by injection drug use.

Injection drug use is the leading mode of transmission of HIV in this region. The best available data suggests that injection drug use is responsible for more than 60% of all new HIV transmissions in Eastern Europe and is the single leading cause of new infections in Central Europe, responsible for more than 25% of new infections in Central European countries<sup>1</sup>. The damage, however, is not limited to drug users: HIV/AIDS is spread vertically far beyond injection drug users to the general population, including children. Nor is HIV/AIDS the only drug-related harm that threatens the people of Central and Eastern Europe: Hepatitis B and C, tuberculosis and overdose morbidity and mortality are among the several serious health consequences that flow from untreated substance abuse.

The transmission of HIV/AIDS and other drug-related harms can be stabilized and even reduced through the implementation of cost-effective public health interventions. Unfortunately, less than 5% - 10% of injection drug users (IDUs) in Central and Eastern Europe have access to such health interventions. In a majority of countries the only sources of care for IDUs or HIV/AIDS patients are international NGOs or local groups funded by international foundations. Although these international efforts are laudable, national policies and strategies need to be developed to expand prevention, treatment and health services to IDUs.

Various laws, policies and practices of the countries of Central and Eastern Europe, however, erect barriers to the creation or expansion of programs that have been repeatedly proven to reduce drug use, HIV/AIDS and other drug-related harms. These laws, policies and practices also tend to perpetuate harmful social stigmas that further

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<sup>1</sup> "National estimates for under reporting of AIDS cases are from 0% to 25% but no data is available for estimates for under reporting of HIV... In Western Europe its is estimated that about two thirds of the HIV population has been diagnosed; in Poland ...40% and in many countries of Eastern Europe, it is estimated to be lower." See, HIV/AIDS Surveillance in Europe, Mid-Year Report 2001, n 65, UNAIDS at 59-59.

marginalize persons with HIV/AIDS and drug users, thereby inhibiting access to health and social services that are a critical to prevention and treatment.

**If the tide is to be turned and the health crisis in this region is to be contained (much less abated), dramatic reforms in laws, policies and practices across the region are urgently needed. Specifically, governments can stem the HIV/AIDS epidemic by taking steps to:**

- **Ensure that drug users have access to sterile syringes free from police harassment**
- **Support Harm Reduction measures for drug users**
- **Establish and expand drug treatment, especially methadone treatment, for drug-dependent persons**
- **Stop prison overcrowding by not incarcerating non-violent drug users and other nonviolent persons at risk of HIV.**

## **INTRODUCTION:**

### Drug Law and Health Policy Network: Goals and Methods

This report was initiated by the Drug Law and Health Policy Network. It provides an overview of the current trends in health, law, policy and practice across 21 countries in Central and Eastern Europe.

Of paramount importance and deserving of singular attention is the following fact derived from available data about the course of the HIV/AIDS epidemic in this region: **injection drug use is the driving engine behind the majority of new infections.**

Much of this report explores the various and interconnected social, political, legal and cultural reasons why injection drug use is not only widespread in this region, but also is the primary vector for the spread of HIV/AIDS. The report also exposes and clarifies gaps in knowledge in each of these areas with respect to the various countries of this region. This report, in other words, is a work in progress. It marks the beginning of a potentially powerful collaboration between researchers and advocates, in public health, epidemiology and the law, that spans countries and continents. Hence the name *Drug Law and Health Policy Network*.

The report is meant to serve as a guidepost both for immediate policy making as well as for future research. It is hoped that this report – and future iterations of this report -- will prompt and inform discussion and debate about drug and health law/policy reforms in the countries addressed. The report analyzes, among other things, trends in the HIV/AIDS epidemic, drug use, drug trafficking, modes of transmission of infectious disease, risk behaviors and socioeconomic conditions that increase vulnerability to drug-related disease and harm, availability of drug treatment and public health interventions, and country-specific laws, policies and practices that can impact public health, positively and negatively. The sources for the data referenced in this report, when not cited in the

margins, can be found in the individual country reports that are linked to and form the basis for this report.

Although the law and policy data for many of the study countries is incomplete, the authors of the report nonetheless are able to recommend several important legal and policy reforms which, if implemented in a timely manner, could help stem the spread of the HIV/AIDS epidemic in this region. The recommended reforms are grounded in the practical experience of other countries and are endorsed by the leading governmental and non-governmental bodies devoted to combating HIV/AIDS, including UNAIDS, the National Institutes of Drug Abuse, and the World Health Organization. In addition, the recommended reforms have been proven to be highly cost effective methods for preventing new HIV infections.

The authors observe that the HIV/AIDS crisis in Central and Eastern Europe is largely man-made. That is to say that the epidemic stems predominantly from unsafe drug injecting practices, and these practices are the direct result of government policies and law enforcement tactics regarding the criminalization, arrest, incarceration and treatment of drug users. The HIV/AIDS epidemic in this region can be stopped and reversed by reforming drug laws, policies and practices that stand in the way of effective public health interventions. The vast majority of the countries of Central and Eastern Europe have drug laws and drug policies that *exacerbate* the spread of HIV/AIDS because they work at cross-purposes with public health and medical authorities in their attempts to contain the epidemic.

The four law and policy reforms urged by the authors are the following:

- Ensure that drug users have access to sterile syringes free from police harassment;
- Support Harm Reduction measures for drug users;
- Establish and expand drug treatment, especially methadone treatment, for drug-dependent persons;
- Stop prison overcrowding by not incarcerating non-violent drug users and other nonviolent persons at risk of HIV.

Each of these proposed reforms is consonant with public health principles forged and tested in the crucible of the AIDS crisis. None of these proposed reforms is at odds with the fundamental goal of protecting public safety and fighting crime that is the common mission of the countries' criminal justice systems. All of these proposed reforms are economically feasible despite the nascent or impoverished economies of many of the countries in this region. In short, these recommended reforms are, above all else, intensely practical. They also hold abundant promise of reduced disease, suffering and death for tens of thousands, perhaps hundreds of thousands of persons.

This report also underscores the need for a robust Law and Health Policy Network whose members can help create the conditions for a combating drug-related HIV/AIDS and other drug-related harms, in the short, medium and long-terms. Specifically, this report provides the basis for researchers and advocates to take immediate action on the three following fronts:

- Collecting additional country-specific data about drug use trends and the vectors of transmission of HIV/AIDS and other drug-related harms;
- Articulating the roles that laws, policies and practices play in shaping the response to drug use, HIV/AIDS and other drug related harms by law enforcement, public health workers, and the government officials in each of the focus countries; and
- Educating public health providers and policy makers at the local and national levels in these countries about drug use, drug-related harms and proven interventions to combat the spread of HIV/AIDS.

It must be emphasized that this report represents only a preliminary analysis of limited data available to the U.S. part of the research network. That is to say, it collects only data available in the English language about the countries of Central and Eastern Europe. To facilitate additional data collection and policy reform efforts, the Drug Law and Health Policy Network developed a Rapid Policy Assessment Tool (RPAT) for gathering epidemiological data and analyzing background law and policy. In June 2002, the Network trained researchers from six pilot countries on how to use the RPAT. The pilot countries include: Poland, Russia, Kazakhstan, Slovenia, Ukraine, and Hungary. This report will be updated with the data gathered by researchers using the RPAT.

### Structure of the Report

This report is divided into four sections with multiple subsections.

The first section, the HIV Pandemic and Related Diseases, offers a data-driven overview of the HIV/AIDS epidemic in Central and Eastern Europe as a whole, pinpointing injection drug use as a principal vector for the transmission of this disease. It also provides a country-by-country summary of Other Infectious Diseases (non-HIV/AIDS) that pose substantial risk to public health, as well as a snapshot of social stigmas and attitudes about HIV in the various countries. It then summarizes available data concerning HIV/AIDS -- Stigma and Social Attitudes for the countries in the region.

The second section covers the Prevalence and Use/Misuse of Drugs. It is composed of four subparts that analyze the following issues: Drug Use -- Social Attitudes; Drug Trafficking -- Data and Laws; Drug Use -- Summary and Trends; and Drug Use -- Risk Behaviors and Overdose.

The third section sets forth a description of PUBLIC HEALTH INTERVENTIONS – BEST PRACTICES. It contains the following subsections: NIDA’s Principles of HIV Prevention; UNAIDS “Best Practices” – 7 Recommendations from Asia’s Epidemic; and Essential Drug Law and Policy Reforms.

The fourth section addresses LAW, POLICIES AND PRACTICES CONCERNING DRUG USE, AND DRUG/DISEASE TREATMENT AND PREVENTION. It is divided into the following three parts.

Part 1, Laws and Practices Concerning Drug Use looks at the International Legal Framework for drug laws and policies comprised of international conventions; National Drug Strategies of the countries of this region; and surveys Drug Possession and Use – Country Law and Enforcement Practices in order to give a flavor of the manner and extent to which the countries’ drug laws and policies are enforced on the ground.

Part 2, Laws and Practices Concerning Disease Prevention and Treatment, reviews Syringe Availability- Law and Practices, Availability of Drug Treatment; and Health Laws Governing the Rights and Treatment of Persons Infected with HIV and other Infectious Diseases.

Part 3, Criminal Justice System - Law and Practices re: Drugs, distills salient laws and practices concerning the functioning of the criminal justice systems in the region. The criminal justice issues highlighted are Right to Counsel, Pretrial Detention and Prison Conditions.

## **I. THE HIV PANDEMIC**

### **A) HIV/AIDS- Overall Country Data and Regional Distribution Data**

A review of the data published in English reveals that the HIV/AIDS epidemic in Central and Eastern Europe is largely driven by injection drug use. In the Central European Region of the World Health Organization the transmission of HIV is attributed by more than twenty-five percent (25%) to Injection drug use from 1997- mid year 2001. In the Eastern European Region injection drug use is attributable to more than sixty percent (60%) of all new HIV infections during the same time period.<sup>2</sup>

The following tables and charts depict this data:

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<sup>2</sup> HIV/AIDS Surveillance in Europe, Mid-Year Report 2001, n 65, UNAIDS.

**HIV/AIDS Surveillance in Europe, Mid-Year Report 2001, n 65, UNAIDS  
Collaborating Center on AIDS. Data for Central WHO European Region<sup>3</sup>**

Year	Reported AIDS cases		Reported New HIV infections		Homo/bi Contact #		Injection Drug Use #		Heterosexual Contact #		Perinatal Transmission #	
	#	Rate/ Million	#	Rate/ Million	HIV	AIDS	HIV	AIDS	HIV	AIDS	HIV	AIDS
1993	-	-			-	-	-	-	-	-	-	-
1994	799	4.4	1486	8.6	-	-	-	-	-	-	-	-
1995	1025	5.6	1753	10.0	-	-	-	-	-	-	-	-
1996	902	4.9	1624	9.2	-	-	-	-	-	-	-	-
1997	896	4.9	1665	9.2	116	91	334	97	216	110	34	27
1998	971	5.2	1689	9.3	128	82	375	106	238	173	24	21
1999	683	3.7	1283	7.0	109	86	273	107	250	158	26	21
2000	872	4.7	1381	7.5	107	74	344	73	279	334	13	14
2001 6 mos.	128		500		61	21	137	35	126	40	7	1
<b>Cum Total</b>	<b>10032</b>		<b>16781</b>		<b>1621</b>	<b>1005</b>	<b>4574</b>	<b>1010</b>	<b>2042</b>	<b>1459</b>	<b>220</b>	<b>329</b>

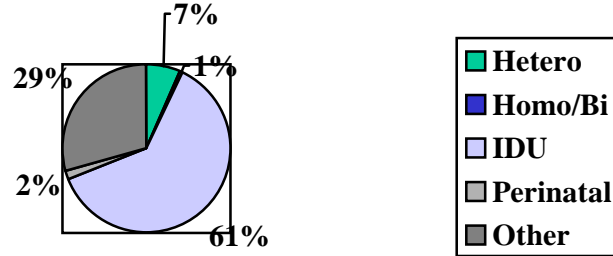
**HIV/AIDS Surveillance in Europe, Mid-Year Report 2001, n 65, UNAIDS  
Collaborating Center on AIDS. Data for Eastern WHO European Region.<sup>4</sup>**

Year	Reported AIDS cases		Reported New HIV infections		Homo/bi Contact #		Injection Drug Use #		Heterosexual Contact #		Perinatal Transmission #	
	#	Rate/ Million	#	Rate/ Million	HIV	AIDS	HIV	AIDS	HIV	AIDS	HIV	AIDS
1993	-	-			-	-	-	-	-	-	-	-
1994	64	0.2	230	0.9	-	-	-	-	-	-	-	-
1995	101	0.4	1751	6.9	-	-	-	-	-	-	-	-
1996	236	0.8	8132	32.0	-	-	-	-	-	-	-	-
1997	296	1.0	14948	53.1	75	31	11293	197	1402	110	238	5
1998	411	1.4	14115	50.2	102	43	9508	274	1793	173	449	16
1999	679	2.6	27236	96.9	96	15	15198	536	2192	158	708	10
2000	747	2.8	67904	241.7	104	13	41932	563	2993	334	1060	1
2001 6 mos.	397		49547		70	9	27425	303	1883	40	674	2
<b>Cum. Total</b>	<b>3122</b>		<b>185111</b>		<b>977</b>	<b>238</b>	<b>112810</b>	<b>1991</b>	<b>12048</b>	<b>1459</b>	<b>3271</b>	<b>52</b>

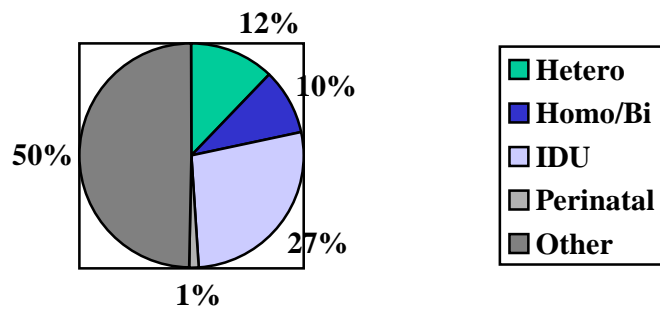
<sup>3</sup> Central European Region of WHO includes: Albania, Bosnia-Herzegovina, Bulgaria, Croatia, Czech Republic, Hungary, Macedonia, FYR, Poland, Romania, Slovakia, Slovenia, Turkey and Yugoslavia.

<sup>4</sup> Eastern European Region of Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

**HIV Cases By Mode of Transmission,  
Eastern WHO European Region  
1997-2000**



**HIV Cases By Mode of Transmission,  
Central WHO European Region  
1997-2000**



## **B. Other Infectious Diseases (non-HIV/AIDS)**

The incidence and prevalence of infectious diseases other than HIV/AIDS, such as tuberculosis, sexually transmitted diseases, and hepatitis are important health indicators. For health professionals treating HIV/AIDS, these other infectious diseases often lead to the further compromising of people's immune systems, causing increased sickness and death. For policy makers and officials, the spread of such diseases requires an examination of their root causes – which, in the case of Eastern and Central Europe, appear to lie in the high incarceration rates for injection drug users and other non-violent offenders, and the lack of access to (and social norms inveighing against the use of) sterile syringes and condoms.

The data, while incomplete, nonetheless paints a disturbing picture. As a general matter, tuberculosis, syphilis, gonorrhea and hepatitis are on the rise in the countries of Eastern and Central Europe. Particularly hard-hit are injection drug users, present and former inmates, and sex workers. For example, there is a rising TB epidemic in Kyrgyzstan, with an estimated 15% of inmates infected with the disease. Indeed, more than 50% of the 1,160 people who died from TB in Kyrgyzstan in 2000 were infected while in prison and there are on average one to two TB deaths per day in that country's prisons. In Tajikistan, TB is now considered a public health emergency and the number of TB cases is reportedly increasing at an annual rate of 13%, with an estimated incidence of TB of 100-300 per 100,000 population in 1999. In Poland, by the mid-1990's TB rates began to drop below the average of reference countries, yet still remained more than double the EU rate.

Romania and Uzbekistan appear to be in the midst of growing epidemics of both TB and syphilis. Russia and the Ukraine, too, are experiencing an epidemic of classic sexually transmitted diseases, especially syphilis. Syphilis in the Ukraine took on epidemic proportions in the period of 1993-1996; and although the rate has been falling since 1997, it remains one of the highest in the region.

Although the data concerning hepatitis is spotty, indications are that hepatitis C virus (HCV) is generally on the rise too. In Russia, the hepatitis epidemic has preceded the appearance of HIV. In Kazakhstan, it is believed that 85% of all drug users in the Karaganda Oblast are infected with HCV. In Lithuania, 44% of persons treated for HCV by the Vilnius health authority were IDUs and in the Ukraine, over 90% of IDUs in Odessa are reportedly infected with hepatitis B, HCV, or both.

For officials in this region, the rising rates of infection for TB, STD's and hepatitis, presents a compelling argument for scrutinizing and reforming the legal and governmental practices that often underlie and exacerbate the spread of these diseases. Specifically, the data suggest the need for urgent and dramatic reforms in the incarceration and detention practices, particularly of low-level drug users and other non-violent offenders, which is a major engine of the tuberculosis crisis that is sweeping several countries. As noted in the Best Practices section of this report, greater access to condoms and sterile syringes, combined with the elimination of penalties for the possession of syringes, are proven and effective means for counteracting these infectious diseases.

### **C. HIV/AIDS-Stigma and Social Attitudes**

Intense stigma surrounding HIV/AIDS and IDUs results in the erection of many barriers to the successful treatment of the epidemic. Where HIV/AIDS is a taboo, people are afraid to be tested for the virus and so are at heightened risk for infecting others. Lack of open discussion and education result in continuing risky behaviors, including unprotected sex and the sharing of drug injection equipment. Persons with HIV/AIDSs, and persons at increased risk for HIV/AIDS, particularly IDUS and gay men, have become the victims of intense discrimination and social approbation. The marginalization of these groups from health and social services and public life has had profound consequences for well-being of these populations – a chilling example being that suicide is reportedly the leading cause of death among HIV-infected people in Kazakhstan. Social disapproval of condoms increases the risk for STDs.

To be sure, some countries, notably Slovenia and the Czech Republic, have made significant advances in public education regarding HIV/AIDS and injection drug use in recent years. Unfortunately, however, the attitudes that pertain, for example, in the Ukraine are all too common throughout the region. There, a study reports that HIV-positive drug users experience rejection, accusation, abuse and contempt by the community, are refused or receive sub-standard medical care, are frequently estranged by relatives, and are either refused work or face immediate dismissal from work should their serostatus become known. Similarly, in Russia, the general public perception of HIV-positive IDUs is that they are "guilty" or responsible for the infection and are shunned. In Tajikistan, being infected with HIV is considered a criminal offense as it is linked with drug use and culturally inappropriate behavior. In Romania, people infected with HIV are often held responsible for the spread of the disease and many people believe that gay men should be punished in order to halt the epidemic. HIV/AIDS is a social taboo in Bulgaria, in Albania, condoms are not widely accepted, and in Romania, HIV and STD education and prevention, as well as discussion about sexual orientation is largely absent in school curricula.

Stigma is further fanned in countries where Islamic fundamentalism is taking root. For example, in parts of Uzbekistan government media campaigns about HIV/AIDSs and safe sexual practices have met with significant public resistance and considerable reluctance to address the threat of virus. Few of the estimated 5,000 sex workers in Tashkent have been tested for HIV even after being diagnosed with other STDs.

## **II. PREVALENCE AND USE/MISUSE OF DRUGS**

### **A. Drug Use- Social Attitudes**

In many of the countries of the region, drug use is highly stigmatized and met with increasingly punitive attitudes by governments and the public alike. In Poland, as a result in the spread of HIV through IDU, social attitudes toward drug dependant people have shifted from a climate of indifference to one of fear and repulsion. In Russia, politicians, clergy, the medical profession and the public at large believe that drug users

should face stiff criminal punishment. The dominant attitude in Kazakhstan is that drug use should be dealt with in a repressive manner by criminal justice authorities. In Bulgaria, the national television station has prohibited television programs from depicting drug dependent persons.

In several other countries in the region, drug use has received scant attention. In Albania and Romania drug use is officially considered to be a relatively new problem, the public is largely ignorant of the dangers of injection drug taking and little data is available as to the prevalence and forms of drug use. No public opinion data is presently available for several countries in this region.

A handful of countries, however, have established harm reduction programs and/or public education campaigns for drug users, with promising preliminary results in both the shifting of public attitudes away from drug use as criminal conduct to drug use as a medical and public health concern, as well as the reduction of risky drug taking practices by drug users. Slovenia, the Czech Republic, Slovakia, Belarus and Lithuania provide such examples.

## **B. Drug Trafficking—Data and Laws**

### Drug Trafficking.

Drug trafficking data is an important indicator of potential drug use in a society. As experience in other parts of the world (e.g., Latin America) suggest, the greater the flow of drugs across a country's borders, the greater the risk that drug use will increase within the country's borders, as illicit narcotics are bartered and siphoned during transit, and a growing black market economy that attends drug trafficking can destabilize economies, producing economic woes that often exacerbate drug misuse and unsafe drug-taking practices.

While most of the countries of Central and Eastern Europe generally are not considered to be major producers of illicit drugs, a majority of the countries in this region contain important trade routes for the transshipment of narcotics, particularly heroin from Afghanistan, across the continent into Western Europe.

Several countries claim to be major transshipment points for narcotics. Heroin originating in Afghanistan moves through the Balkan route of Turkey, Bulgaria, Macedonia, Romania, Albania into Europe, as well as through Kyrgyzstan (notably through the city of Osh), into Russia and Lithuania, and from there into Western Europe. Opiates originating in Iran tend to be smuggled through Armenia. Disruption of the Balkan Routes as a result of regional ethnic conflicts has led to increased trafficking through Azerbaijan. Because of its rugged and remote border with Afghanistan and Iran, Turkmenistan remains a crucial route for the trafficking of morphine base and heroin to Turkey and opium and heroin to Russian and European markets. Ukraine, with its numerous ports on the Black and Azov Seas, its porous borders, and poorly financed and under-equipped border and customs patrols, is also attractive for drug traffickers. Countries such as Belarus and Georgia are expected to experience an increase in drug trafficking activities.

Drug Trafficking Laws. Although further information must be obtained about the country laws in this region, the countries all appear to have legislation of varying vintages and scope that punish to differing degrees the trafficking and sale of drugs. Countries such as Hungary, Poland, Romania, Ukraine, Uzbekistan, and the Czech Republic have, in recent years, revised their drug laws to more directly address several facets of illicit drug production and distribution, and to better cohere with the frameworks set forth by international legal instruments and guidelines for dealing with drug trafficking. The United States, through the increasing international presence of the Drug Enforcement Administration, and the United Nations Drug Control Programs (UNDCP) have vigorously encouraged countries in this region to enact harsher drug laws. As a result, the countries' new drug laws tend to stiffen penalties for drug production and trafficking. Other countries, such as Lithuania and Armenia, are in the process of revising their drug laws.

A critical issue in assessing the impact of a country's drug laws on public health is the distinctions made between, and penalties assessed for, large-scale drug traffickers, small-scale drug sellers, and drug users. To the extent that drug laws conflate these categories and harshly sanction both low-level sellers and drug users, the likelihood increases that drug users will engage in more furtive and riskier drug-taking behavior in an attempt to avoid detection by authorities – for example, sharing and reusing injection equipment (syringes, swabs, cookers), injecting drugs in unsterile conditions, and avoiding medical treatment and testing for infectious diseases.

Punitive drug laws also can have a chilling effect on outreach efforts to drug users by medical and public health authorities. The more drug use is seen as a crime rather than a health issue, and the more that drug users are viewed as criminals instead of beneficiaries of and important partners in a broad public health campaign to combat HIV/AIDS, the less likely it is that a country's health and medical establishment will be motivated to address

A country's drug trafficking laws, however, tell only part of the story. The willingness and ability of government officials to enforce those laws are critical factors in assessing the laws' impact on public health. In many of the countries of Central and Eastern Europe, law enforcement agencies remain under-staffed, ill equipped, poorly paid. In some countries, for example, Georgia and Russia, the police force is fraught with corruption, especially with respect to drug interdiction efforts. In many countries, law enforcement has engaged in the brutal harassment of drug users. The efficacy with which law enforcement authorities can track and combat large-scale drug trafficking, and the manner with which they deal with low-level drug sellers and users, can dramatically shape the scope and course of the HIV/AIDS epidemic and other drug-related infectious diseases.

### **C. Drug Use-Summary and Trends**

Good data about rates of drug use, particularly injection drug use, is difficult to come by in most countries in this region, as governments have not focused on the collection of such data until very recently. A common theme emerges, however, from the

limited information that is available through government reports and official estimates of drug use: the countries of Central and Eastern Europe are experiencing a dramatic increase in opioid use, particularly the use of injectable heroin, by persons under 35 years of age.

Following are snapshots of drug use trends in several countries in the region:

**Albania** has an estimated 10,000 drug dependent persons, the majority of whom live in the capitol city, Tirana, and who are of high school or university age. Opiates and marijuana are the drugs of choice for this population. **Azerbaijan** has over 13,000 state-registered drug addicts, but estimates place the actual number of addicts several times higher. **Belarus** has registered 5,000 drug users, adding approximately 800 new registrants each year in recent years. These official figures, however, are considered to vastly under represent the actual number of drug addicts. In Belarus, the vast majority of HIV/AIDS cases have been found among IDUs. In 1997, 92 % of those surveyed said they had shared syringes; this number dropped by 1999 to 35%. **Bulgaria**, with a population of 8 million, is estimated to have approximately 50,000 heroin users, fewer than 10% of whom are currently receiving treatment. **Hungary** has recorded 10,000 heroin addicts. In **Latvia** and **Lithuania**, heroin use is becoming increasingly widespread, due in large part to the low price of the drug. In Latvia, for example, a single dose of heroin costs less than a McDonald's Big Mac hamburger. Roughly sixty-five percent of Latvia's drug dependant persons are believed to be IDUs; in Lithuania, over 90 percent of the country's drug dependency cases are IDUs.

Dominating all other drug issues in **Russia** is the dramatic increase in the flow of heroin into the country from Afghanistan's southern border. In early 2001, 412,000 drug users registered with the Ministry of Health of the Russian Federation. Nevertheless, the actual number of drug users is estimated to be 10 times higher, or over 4 million persons. WSJ ARTICLE. The **Ukraine** posts over 100,000 registered drug addicts, with the number of unregistered drug users estimated to be between 300,000 to 400,000.

In **Poland**, the Ministry of Health estimates that there are 30,000-40,000 drug dependent people and up to 400,000 casual users. Kompot, a homemade form of heroin, is the most common drug in Poland, used by approximately 75% of drug addicts. **Slovakia** experienced a rapid increase in drug use in the early 1990's. During the past decade, the drugs of choice shifted from solvents, hypnotics and sedatives to injectable heroin.

**Tajikistan**, the number of suspected drug users known to authorities is roughly 3,000, but the estimated number of actual drug users is believed to be 15 to 20 times higher. Heroin accounts for roughly 40-45% of drug use in Tajikistan, where a dose of heroin is said to be cheaper than vodka. **Uzbekistan** has witnessed a dramatic increase in the use of heroin, opium and hashish, with heroin and opium use largely attributed to increased production of these drugs in nearby Afghanistan.

**Armenia** and **Slovenia** are among the few countries in the region that do not report significant drug problems. Armenian officials, however, note growing drug use

among teenagers. In Slovenia, it is estimated that there are between 3.6 to 7.1 heroin users per 1,000 persons aged 15 to 64 years.

#### **D. Drug Use --Risk Behaviors and Overdose**

Unsafe drug taking behavior can result in the rapid spread of infectious disease as well as increased morbidity and mortality related to drug overdose. As noted throughout this report, national drug laws and drug enforcement policies appear to significantly shape drug taking behaviors by creating (or not creating) an atmosphere of fear, wherein drug users use drugs quickly and furtively, are marginalized from health resources, and do not have easy access to sterile injecting equipment. Drug users who also belong to ethnic or religious minorities that are subject to widespread and intense discrimination, such as the Roma, face even further alienation and are at heightened risk for contracting drug-related illnesses.

A number of risk behaviors related to drug use are prevalent across the region. Singly and collectively, such risk behaviors increase the opportunity for the transmission of HIV/AIDS and other infectious diseases like Hepatitis. Where studies have been performed, from 23% to 80% of IDUs share syringes. Other risk behaviors include, but are not limited to:

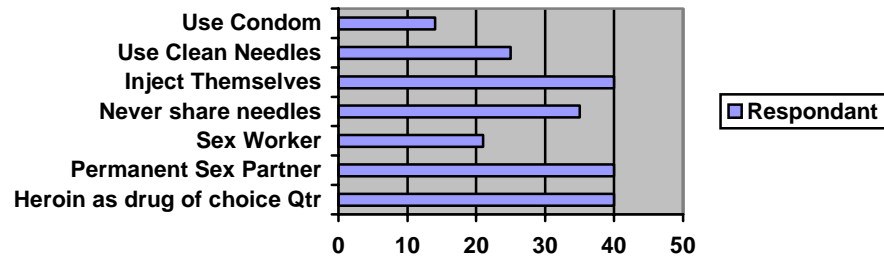
- Cleaning drug preparation with human blood to reduce debris prior to injection (sometimes referred to as “blood boiling”);
- Collecting cotton balls used in filtering to achieve a satisfactory dose for one “hit”;
- Scavenging disposed syringes from waste containers and hospital refuse;
- Drawing and injecting a test batch of the drug solution directly from the mixing container and returning the remaining unused portion to the container after testing (which risks introducing the tester’s blood into the solution).

Other risk behaviors not directly related to drug taking further contribute to the spread of disease. Such behaviors include having unprotected sex and multiple sexual partners. Sex workers, not surprisingly, are at increased risk for contracting HIV/AIDS; the risks are magnified for sex workers who are IDUs and have IDU clientele.

Below are two graphs depicting risk behavior data from the Czech Republic and Poland.

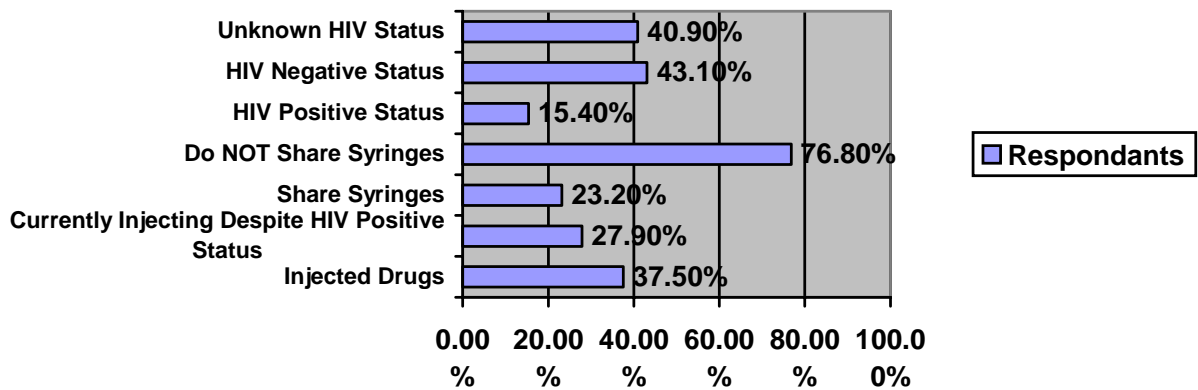
## Czech Republic --

Risk Behavior in Addicts who have not Sought Treatment



## Poland

Risk Behavior & HIV Status



As with drug use data, much more needs to be learned about risk behaviors in each of countries of the region. Following is a snapshot of several countries in the region with respect to what is known about risk behaviors and drug overdose:

**Bulgaria:** The prevalence among IDUs of Hepatitis B is 20 % and is above 50% for Hepatitis C. As one report notes: “Bulgaria has the potential for a rapid spread of HIV/AIDS. Profound social changes over the past ten years have increased the presence of vulnerable groups-youth. In addition, there are a considerable number of ethnic minorities who continue to be marginalized from society (the Roma community).”

Data collected in the mid-1990’s from the **Czech Republic** indicates that drug use and injection usually take place in the company of others, and that needle sharing is common. Only 35% of IDUs claimed to never share syringes. IDUs obtained sterile syringes from pharmacies, syringe exchange programs, and most commonly from friends. IDUs who injected with used syringes typically scavenged them from hospital dumps and other “high-risk sources”. Unprotected sexual intercourse among IDUs was high, with

only 14% of IDUs surveyed consistently using condoms. Roughly 21% of IDUs surveyed were sex workers.

**Kazakhstan's** IDUs are reportedly engaging in high-risk injection behavior. A major reason for this risky behavior is the lack of basic information about infectious diseases: at least 30% of IDUs know nothing about HIV/AIDS and how to prevent it. A 2000 report for the UN observes that in the country's two largest cities, Almaty and Shymkent, 80 % of the IDUs, irrespective of gender, studied shared syringes or injecting solution. Moreover, IDUs often use blood to prepare drugs. The behavior of the men and women in this case was identical. A significant percentage of female IDUs supported their drug habits through prostitution, which risks spreading HIV/AIDS far beyond the IDU population, and 30% of the estimated commercial sex workers use illicit drugs. With respect to drug overdose, an estimated 4,000 overdose patients are seen annually in the country's four largest cities. Antidotes for opioid overdose, such as naloxone, are not sufficiently available to address the problem.

**Poland:** A 1995 study of Poland by UNDCP provides a sample of risk behaviors among IDUs. Information on risk behavior and HIV status suggests that 37.5% of respondents to a survey conducted by the National Institute of Hygiene were at one point injecting narcotics, 27.9% of whom were injecting despite their HIV status. 23.2% of those currently injecting admit to sharing needles and syringes. 15.4% of respondents with a history of injection drug use were seropositive; 43.1% claimed to be HIV negative; and 40.9% of respondents either were never tested or had been tested, but were unaware of their HIV status. From 1988 to 1997, there was a dramatic increase in drug overdoses, from 106/per 100,000 total population to 143/per 100,000 population.

**Russia:** There is anecdotal evidence that opiate users in Moscow share needles and syringes more frequently than IDUs in other regions of the country, primarily due to a lack of money. There is also anecdotal evidence that in several cities, human blood is added to the drug solution during preparation as a cleansing agent to precipitate solid particles and stabilize acidity levels. In most cases, the person who "boils" the drug solution uses his own blood. Assessments of HIV outbreaks in several Russian regions and cities suggest that drug "boilers", either through negligence or ignorance of their HIV status, might have spread the virus. There are no available data on the incidence of drug overdoses or trends over time or by region. Since the number of IDUs has grown significantly and the cost of pure heroin has gone down, it is likely that drug overdoses are a significant problem in several communities.

**Slovakia:** In 1997, almost 80% of drug dependant people who sought treatment were addicted to opioids, particularly heroin, and the majority were IDUs. Approximately 60% of drug users in Banska Bystrica are thought to be infected with Hepatitis C.

**Slovenia:** In 1996, two sentinel surveys estimated the prevalence of HIV infection among IDUs in major urban areas as 0.565%. The Ministry of Health reported that ". . . [T]he sharing of needles, syringes (58%) and other equipment (67 %), as well as unsafe sexual behavior, are common among drug users in Slovenia and dangerously increase the potential for the spread of HIV in the community."

In **Tajikistan**, the purity of heroin is purportedly much higher than in other countries, so much so that users need not cook it. Instead, it is popular to mix heroin with water and inject the mixture. Heroin may also be mixed with tobacco and smoked or snorted straight from the packet. Syringes are too expensive for most drug users to afford. As a result, many IDUs share syringes. IDUs generally lack information about whether or where syringes can be lawfully purchased. Most IDUs inject in groups of three or four, sharing one another's needles. IDUs who are unable to afford to purchase heroin sometimes collect the cotton balls used in filtering the mixture to aggregate a single dose. It is reported that heroin users sometimes attempt to detoxify themselves with alcohol, which has led to increased drug overdoses.

IDUs in the **Ukraine** engage in a variety of high-risk injection behaviors, mainly stemming from the lack of basic information about HIV/AIDS. In 1998, the rate of injecting drug use in the major urban areas was about 8.6% of the population. 60-80% of IDUs in three Ukrainian cities reported sharing syringes, with only 15 to 20% of IDUs reported using a new syringe for each injection. The inadvertent mixing of tester's blood in homemade opium solutions posed a significant risk for the transmission of HIV. In addition, there were anecdotal reports from several cities regarding the unsafe practice of adding human blood to act as a cleansing agent to precipitate solid particles, to stabilize acid levels in drug mixtures. 80% of IDUs in Odessa purchase their drugs from dealers in containers; and it is estimated that 60% of IDUs share the same container. Moreover, between 38 and 50% of IDUs bought ready-to-use drugs in contaminated syringes from dealers. Among IDUs who rinse their syringes as a risk reduction measure, two-thirds shared rinsing containers.

In **Uzbekistan**, ignorance about HIV and STDs is relatively high. Commercial sex workers, who are at increased risk as a result of drug use and unprotected sex, are not necessarily better informed than the general public.

### **III. PUBLIC HEALTH INTERVENTIONS – BEST PRACTICES**

There are several components to an effective public health intervention for injection drug users that is proven to reduce the risk of transmission of HIV and other blood borne diseases. There has been extensive long-term research on these methods and a general consensus on the efficacy and cost effectiveness of these programs that are designed to address the underlying social problems associated with drug use. A number of agencies and aid organizations promote, support and operate public health intervention programs in Central and Eastern Europe. This report limits discussion of "best practices" to the UNAIDS program and the National Institute on Drug Abuse.

UNAIDS has produced a Best Practices series<sup>5</sup> and the National Institute on Drug Abuse (NIDA) has produced the "Principles of HIV Prevention in Drug-Using Populations."<sup>6</sup>

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<sup>5</sup> See. [www.unaids.org](http://www.unaids.org).

<sup>6</sup> See. [www.nida.nih.gov/POHP](http://www.nida.nih.gov/POHP).

There are two general findings and recommendations for the effective deployment of public health interventions; (1) Develop a comprehensive community based services, (2) Drug laws and HIV policies need to be compatible -- there should be no drug law, policy or practice that impedes the implementation of proven public health programs that prevent the spread of HIV among IDUs.

#### A. NIDA's Principles of HIV Prevention

NIDA's "Principles of HIV Prevention" are the product of fifteen years of research. The resulting seventeen (17) principles for HIV/AIDS intervention among drug users in the community are reproduced here in part:

- Reducing the risk of HIV/AIDS in drug users is an achievable goal...
- Community programs should start as soon as possible...
- Effective prevention programs require a comprehensive range of coordinated services...that adapt to the changing needs and circumstances is the most effective approach...should include such services as community outreach, HIV testing and counseling, drug abuse treatment, access to sterile syringes and service providers through community health and social service providers. Services must be carefully coordinated.
- Prevention programs should work with the community to plan and implement interventions and services...
- ...Prevention and treatment efforts should target drug users who already have HIV infection, as well as their partners...
- ...Drug users and their sex partners must be treated with dignity and respect and with sensitivity to cultural/racial/ethnic, age, and gender-based characteristics...
- ...In a comprehensive program, interventions that target injection risk must address sharing other injection equipment in addition to syringes...
- ...HIV/AIDS risk-reduction interventions must be sustained over time...
- Community-based intervention is cost-effective.<sup>7</sup>

#### UNAIDS "Best Practices" – 7 Recommendations from Asia's Epidemic

UNAIDS, in its "Best Practice Digest" for Drug Use and HIV vulnerability, reports on the results of a study commissioned by the UNAIDS Asia Pacific Intercountry team to the Asian Harm Reduction Network. The studies "main purpose...is to establish

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<sup>7</sup> [www.nida.nih.gov/pohp](http://www.nida.nih.gov/pohp) Principles of HIV Prevention in Drug-Using Population.

a basis for effectiveness assistance to governments in the development and implementation of policies and programmes for the prevention of the transmission of HIV among drug users”<sup>8</sup> This seven-country study encompassed a region with a mean HIV transmission rate of sixty-two percent (62%).

The study produced seven recommendations. Those recommendations, reproduced here in their entirety, are as follows:

- Countries should examine their drug and HIV policies and attempt to achieve greater congruence and compatibility between the two, ensuring that there are no legislative impediments that constrain the implementation of necessary measures to prevent HIV transmission between IDUs and their sexual partner.
- Countries should adopt a comprehensive approach to treatment and prevention of drug use and HIV transmission. A wide range of services is needed to meet the multiple needs of drug users.
- Policy makers should be urged to consider employing prevention and treatment approaches that are in line with the principles of ‘public health’ and ‘health promotion’ in preference to law enforcement approaches that emphasize punishment as the principal means of promoting behavior change.
- Countries should adopt inter-sectoral training programs to broaden knowledge, understanding and skills of drug and HIV/AIDS workers, opinion leaders and decision-makers working in key areas impacting on drug use in the drug field.
- Special attention should be paid to enhancing the quality of training for direct service providers in the drug field.
- Countries should consider promoting and facilitating the establishment of self-help organizations for drug users that could initiate advocacy and enable users and ex-users to create mutually supportive environments.
- Countries should give special attention to the provision of drugs and HIV/AIDS preventive services among drug users presently incarcerated in prisons and other long-term labour rehabilitation facilities.<sup>9</sup>

#### D. Essential Drug Law and Policy Reforms.

As noted, when it comes to combating the HIV/AIDS epidemic, it is accepted wisdom that prevention and treatment approaches that are consistent with principles of public health and health promotion must take precedence over law enforcement

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<sup>8</sup> See. [www.unaids.org](http://www.unaids.org), Best Practice Digest, Drug use and HIV Vulnerability.

<sup>9</sup> See. [www.unaids.org](http://www.unaids.org), Best Practice Digest, Drug use and HIV Vulnerability. (Recommendations)

approaches that emphasize punishment as the principal means of promoting behavior change. Put differently, national drug laws, drug policies and drug enforcement practices must be made harmonious with the proven goals and methods of disease prevention, treatment and harm reduction. For many countries in Central and Eastern Europe, this means that dramatic changes must take place, particularly with respect to insuring safe and ready access to sterile injecting equipment both in the general community and behind prison walls.

The following chart illustrates many of the key components of an effective prevention and treatment program, and the national and international organizations that officially endorse (or, in the case of USAID, oppose) these interventions. When considered against the backdrop of specific country laws and practices, discussed in the next section of this report, this chart provides a roadmap for future law and policy reform efforts in Central and Eastern Europe.

<b>IDU Best Practice</b>	<b>World Bank</b>	<b>UNAIDS</b>	<b>UNGASS</b>	<b>SOROS</b>	<b>US CDC</b>	<b>USAID</b>	<b>GHC</b>	<b>ABA</b>
Counseling	X	X	X	X	X	G		
a. Voluntary Counseling	G	X	X	X				
Drug Abuse Treatment	X	X	X	X	X			
Outreach Program	G	X	G	X	X	G		
Testing		X	G	X	G	G	G	
Needle Exchange Program		X	X	X	G	N	G	G
a. in prisons		X		X	X	N		
b. Machines		X		X		N		
c. Pharmacies		X		X		N		
d. Clean Injecting Equipment	X	X	X	X		N		X
e. Free Needles	X			X		N		
Laws and Gov Policy Change	G	X	X	G		G	G	G
Education	X	X	X	X		G		
a. Peer Education	G	X	G	X				

Reduce Poverty	X	X						
Condoms	X		X	X				
Overdose Prevention				X		N		
Methadone				X		N		
Reduce Stigma	G	G	X	X				
Reduce Demand for Drugs		X						

Legend X = Lists as a Best Practice, G = Supports as Best Practice, N= Does not support  
A blank space indicates that item was not addressed.<sup>10</sup>

#### IV. LAW, POLICIES AND PRACTICES CONCERNING DRUG USE, AND DRUG/DISEASE TREATMENT AND PREVENTION.

If the HIV/AIDS epidemic is to be slowed, much less halted or reversed, drug laws and policies must dovetail with prevention and treatment efforts, such that there is a concerted and collaborative effort between public health and public safety agencies and officials. Such collaboration, however, is largely absent across Central and Eastern Europe. In fact, law enforcement often works at cross-purposes to public health authorities, undermining both the ability of health officials to undertake effective interventions, and the efficacy of the relatively few interventions that are underway in the region.

The evaluation of laws, policies and practices in this region was based on limited access to written law and various reports from various reports and statements made by government, international, NGO and news organizations that were available to researchers. Although the information available to researchers was limited and incomplete, we are nevertheless able to reach the following conclusion: **the criminal justice system, police practices, drug laws and treatment programs of the countries of Central and Eastern Europe are poorly designed, under funded, and *frequently interfere* with public health interventions necessary to prevent HIV among IDUs.**

The remainder of this section sets forth in greater detail the shortcomings and tensions that exist in country laws and practices with respect to drug use, disease prevention, and treatment.

##### A. Laws and Practices Concerning Drug Use

###### i. International Legal Framework:

<sup>10</sup> Review of materials from the World Bank, UNAIDS, UN General Assembly, Open Society Institute, United States Centers for Disease Control, United States Agency for International Development, Global Health Council, and the American Bar Association.

International drug control conventions, protocols, and agreements provide the legal structure for an international system of drug control by defining control measures to be maintained within each state party to these instruments and prescribing rules to be obeyed by these Parties in their relations with each other. The rules set forth by these instruments can be categorized according to two principal methods of achieving drug control: (a) commodity control – the definition and regulation of the licit production, supply and consumption of drugs; and (b) penal control – the suppression through criminal law of illicit production, supply and consumption.

As a general matter, the international drug control conventions do not recognize, and so do not advance, public health responses to the rapid spread of infectious diseases that result from injection drug use. Rather, the conventions are focused primarily on efforts of drug interdiction. Indeed, two of the three UN Conventions on drugs pre-date the HIV/AIDS epidemic. Nevertheless, while these conventions do not expressly recognize the role of drug laws in perpetuating or ameliorating the spread of infectious diseases, *nothing in these conventions prohibits signatory countries from modifying national drug laws, policies and practices, to make them consonant with a public health approach that adopts the best practices set forth by UNAIDS and NIDA.*

The following chart illustrates which countries are signatory to which international drug control instruments.

#### International Drug Conventions -- Signatory Status Chart

Albania	Albania is not a party to any UN Drug Conventions
Armenia	<ul style="list-style-type: none"> <li>• 1988 UN Drug Control Convention</li> <li>• 1972 Protocol</li> <li>• 1971 UN Convention on Psychotropic Drugs</li> <li>• 1961 UN Single Convention</li> <li>• 1992 Kiev and 1996 Dushanbe Narcotics Control Assistance Agreements of the NIS countries</li> <li>• 1999 Trilateral Agreement on Cooperation to Combat Drug Trafficking with Iran and Georgia</li> <li>• Bilateral Agreements on Cooperation Against Illegal Traffic in Narcotics and Psychotropic Substances with the Customs Service of Turkmenistan, Customs Committee of Georgia and the Customs Committee of Tajikistan</li> <li>• OPG expected Armenia to sign an Agreement on Collaboration of Member States of the Commonwealth of Independent States in Combating Illegal Trafficking of Narcotic, Psychotropic and Precursor Substances in January/February 2001.</li> </ul>
Azerbaijan	<ul style="list-style-type: none"> <li>• 1988 UN Drug Control Convention</li> <li>• 1972 Protocols</li> <li>• 1971 UN Convention on Psychotropic Drugs</li> </ul>

	<ul style="list-style-type: none"> <li>• 1961 Single Convention</li> <li>• UN Convention Against Transnational Organized Crime and Accompanying Protocols, December 2000</li> <li>• No narcotics-related treaties with the United States</li> <li>• No extradition treaties with the United States</li> <li>• Section 907 of the Freedom Support Act precludes the funding of US counternarcotics assistance</li> </ul>
Belarus	<ul style="list-style-type: none"> <li>• 1988 UN Drug Convention</li> <li>• 1971 Convention on Psychotropic Substances</li> <li>• 1961 Single Convention</li> <li>• Party to CIS Convention on Legal Assistance</li> <li>• Legal assistance treaties with Lithuania and China</li> </ul>
Bulgaria	<ul style="list-style-type: none"> <li>• 1988 UN Drug Convention</li> <li>• 1972 Protocols</li> <li>• 1971 Convention on Psychotropic Substances</li> <li>• 1961 Single Convention</li> <li>• 1990 Convention on Laundering, Search, seizure and Confiscation of Proceeds from Crime</li> <li>• UN Convention Against Transnational Organized Crime and its Protocols, December, 2000</li> <li>• 1924 US/Bulgarian Extradition Treaty and its 1934 Supplemental treaty still in effect</li> <li>• 1957 Council of Europe Convention on Extradition</li> <li>• 1959 European Mutual Legal Assistance Treaty in Penal measures</li> <li>• 1983 Council of Europe Convention on Transfer of Sentenced Persons</li> <li>• Bilateral treaty with Turkey for Transfer of Convicted Persons</li> <li>• Bulgarian Customs Agency has memoranda on understanding of mutual assistance and cooperation with several European counterparts</li> <li>• Cooperation Agreement with the United States, 2000</li> </ul>
Czech Republic	<ul style="list-style-type: none"> <li>• Party to the 1988 UN Drug Convention</li> <li>• The United States –Czech Mutual Legal Assistance Treaty (MLAT)</li> <li>• Czech concluded a Customs Mutual Legal Assistance Agreement (CMAA) (2000)</li> <li>• Party to the World Customs Organizations International Convention on Mutual Administrative Assistance for the Prevention, Investigation, and Repression of Customs Offenses (Nairobi Convention), Annex X on Assistance in Narcotics Cases. (4)</li> </ul>
Georgia	<ul style="list-style-type: none"> <li>• 1988 UN Drug Control Convention</li> </ul>

	<ul style="list-style-type: none"> <li>• UN Drug Control Program</li> <li>• Party to the Council of Europe Prisoner Transfer Treaty</li> </ul> <p>UN Convention Against Transnational Organized Crime and its Protocols, December 1999 (4)</p>
Hungary	<ul style="list-style-type: none"> <li>• 1961 UN Convention as amended by the 1972 Protocol</li> <li>• 1971 UN Convention on Psychotropic Drugs</li> <li>• <a href="#">1988 UN Drug Control Convention</a></li> <li>• <a href="#">Extradition Treaty and Mutual Legal Assistance Treaty</a> are in <u>force between Hungary and the United States</u></li> <li>• <a href="#">Bilateral Data-Sharing Agreement with the United States</a> was signed in January, 2000</li> <li>• UN Convention Against Transnational Organized Crime and its accompanying Protocols was signed in December, 2000</li> </ul> <p>(4)</p>
Kazakhstan	<ul style="list-style-type: none"> <li>• 1988 UN Drug Control Convention (1998)</li> <li>• 1972 Protocol (1998)</li> <li>• 1971 UN Convention on Psychotropic Drugs (1998)</li> <li>• 1961 Single Convention (1998)</li> <li>• Bilateral Agreements with South Korea, Russia and Pakistan on counter narcotics cooperation.</li> <li>• Renewed cooperation agreements with neighboring Central Asian Countries.</li> <li>• UN Convention Against Transnational Organized Crime (2000)</li> <li>• Bilateral Assistance Agreement with the United States (pending)</li> </ul>
Kyrgyzstan	<ul style="list-style-type: none"> <li>• 1988 UN Drug Control Convention</li> <li>• 1972 Protocol</li> <li>• 1971 UN Convention on Psychotropic Drugs</li> <li>• 1961 Single Convention</li> <li>• UN Central Asian Counternarcotics Protocol</li> <li>• UN Convention Against Transnational Organized Crime and its Protocols, December, 2000</li> <li>• Currently, no bilateral extradition or mutual legal assistance treaties with the United States</li> </ul>
Latvia	<ul style="list-style-type: none"> <li>• 1988 UN Drug Convention</li> <li>• 1971 Convention on Psychotropic Substances</li> <li>• 1961 Single Convention</li> <li>• 1923 Extradition Treaty supplemented in 1934 with the United States</li> <li>• 2000 UN Convention Against Transnational Organized Crime</li> </ul> <p>(1)</p>
Lithuania	<ul style="list-style-type: none"> <li>• 1988 UN Drug Convention</li> <li>• 1971 Convention on Psychotropic Substances</li> <li>• 1961 Single Convention</li> <li>• 1972 Protocol</li> </ul>

	<ul style="list-style-type: none"> <li>• 1924 Extradition Treaty supplemented in 1934 with the United States</li> <li>• 1999 Bilateral Mutual Assistance Treaty with the United States</li> <li>• 2000 UN Convention Against Transnational Organized Crime (1)</li> </ul>
Poland	<ul style="list-style-type: none"> <li>• Party to the 1988 UN Drug Convention</li> <li>• The United States and Poland have an extradition and mutual legal assistance treaty</li> <li>• Poland is cooperating with the European Union to bring its legal code into line with that of other EU members</li> <li>• Signed the UN Convention Against Transnational Organized Crime in 2000 (4)</li> </ul>
Romania	<ul style="list-style-type: none"> <li>• 1988 UN Drug Convention</li> <li>• Extradition treaty with the United States</li> <li>• Mutual Legal Assistance Treaty with the United States</li> <li>• UN Convention on the Trafficking of Illicit Narcotics and Psychotropic Substances</li> <li>• UN Convention Against Transnational Organized Crime and its Protocols (December 2000) (1)</li> </ul>
Russia	<ul style="list-style-type: none"> <li>• 1961 UN Single Convention</li> <li>• 1971 UN Convention on Psychotropic Drugs</li> <li>• 1972 Protocol</li> <li>• 1988 UN Drug Control Convention</li> <li>• 1992 Kiev Treaty on Cooperation in Inter-regional Drug Investigations</li> <li>• 1995 Trilateral Counter Narcotics Cooperation with Kyrgyzstan and Tajikistan</li> <li>• Mutual Legal Assistance Treaty with the United States, Fall, 2000</li> <li>• UN Convention Against Transnational Organized Crime and its Protocols, December, 2000 (1)</li> </ul>
Slovakia	<ul style="list-style-type: none"> <li>• 1988 UN Drug Convention</li> <li>• Bilateral extradition treaty between Czechoslovakia and the United States has been updated to encompass drug-related offenses by virtue of the Slovakian ratification of the UN Narcotics Conventions (1)</li> </ul>
Slovenia	<ul style="list-style-type: none"> <li>• 1902 Extradition treaty between the United States and Yugoslavia remains in force between the U.S. and Slovenia.</li> <li>• 1961 Single Convention</li> <li>• 1971 UN Convention on Psychotropic Drugs</li> <li>• 1972 Protocol</li> <li>• 1988 UN Drug Control Convention</li> <li>• SECI Transborder Organized Crime Center Agreement (2000).</li> <li>• UN Convention Against Transnational Organized Crime (12/2000)</li> <li>• European Union PHARE Multi-Beneficiary Drug Program</li> </ul>

Tajikistan	<ul style="list-style-type: none"> <li>• 1988 UN Drug Control Convention</li> <li>• Central Asian Counternarcotics Protocol with the UNODCCP and neighboring Central Asian countries</li> <li>• Party to the World Customs Organization's International Convention on Mutual Administrative Assistance for Prevention, Investigation and Repression of Customs Offense (the Nairobi Convention, Annex X on narcotics cases)</li> <li>• Signed the UN Convention Against Transnational Organized Crime, December, 2000 (4)</li> </ul>
Turkmenistan	<ul style="list-style-type: none"> <li>• 1988 UN Drug Control Convention (1996)</li> <li>• 1972 Protocol (1996)</li> <li>• 1971 UN Convention on Psychotropic Substances (1996)</li> <li>• 1961 Single Convention on Drug Abuse (1996)</li> <li>• Participant in the UN Six Plus Two Narcotics Initiative</li> <li>• Signed agreements on counter-narcotics cooperation with its Central Asian neighbors</li> <li>• <i>Has not</i> signed the Regional Action Plan it helped to draft. (4)</li> </ul>
Ukraine	<ul style="list-style-type: none"> <li>• Party to the 1988 UN Drug Convention</li> <li>• Party to the Agreement of the Police Forces of the Members of the Commonwealth of Independent States</li> <li>• Bilateral Anti-narcotics Agreements with Belarus and Russia</li> <li>• International Agreements for Joint Enforcement Efforts Against Drug Trafficking have been signed with the Czech Republic, Austria, Hungary, Poland, Bulgaria, Romania, Slovakia and the United Kingdom.</li> <li>• Ratified the U.S-Ukraine Mutual Legal Assistance Treaty in Criminal Matters (September 2000)</li> <li>• UN Convention Against Transnational Organized Crime (December 2000) (4)</li> </ul>
Uzbekistan	<ul style="list-style-type: none"> <li>• 1988 UN Drug Convention</li> <li>• Commonwealth of Independent States Multilateral Extradition and Mutual Legal Assistance Agreements</li> <li>• UN Six Plus Two Counternarcotics Initiative Regional Action Plan</li> <li>• UN Convention Against Transnational Organized Crime (December 2000) (7)</li> </ul>

## ii. National Drug Strategies

National drug laws provide the framework within which lie the opportunities as well as obstacles to the implementation of effective HIV/AIDS prevention strategies. An analysis of the information available to researchers regarding country-specific laws and policies yields the ineluctable conclusion that the drug laws and policies in the vast majority of study-countries pay scant attention to HIV/AIDS prevention or the effective treatment of drug users.

Few countries in the region report a national drug strategy. What passes for a national drug strategy in most countries are the remnants of the Soviet era characterized by the arrest and incarceration of drug users. The impact of law and police activity is a generalized fear among IDUs of arrest, prolonged pretrial detention, compulsory detoxification, abuse, imprisonment and registration with both treatment and police resulting in continued harassment, and at time, extortion of bribes. This regional approach results in few safe guards for basic civil rights and little recognition of serious public health consequences. Indeed, the large-scale detention of IDUs in many countries of Central and Eastern Europe, most notably Russia and the Ukraine, greatly exacerbates the risk of HIV infection, tuberculosis and syphilis. Prisons are generally overcrowded, poorly funded, and criminal justice officials often deny there is a drug use or HIV problem in state institutions.

In short, the governments in the region have responded slowly and inadequately to the dramatic increase in drug use. Countries such as Albania, Belarus, Kazakhstan, and Romania have yet to promulgate a national drug strategy. In Russia, the government along with the leading medical establishment opposes methadone maintenance treatment, which remains illegal in that country, despite methadone's proven efficacy at treating heroin addiction and helping prevent the spread of injection drug-related diseases.

Only a handful of countries, for example Poland, Lithuania, and Slovenia have formulated (often incomplete) drug policies at least partially rooted in public health and harm reduction principles to address the problem of escalating drug use. Several other countries have quietly allowed international NGOs to establish and fund public health and harm reduction programs aimed at drug users. But without strong government support, many of these programs are fledgling.

## iii. Drug Possession and Use – Country Law and Enforcement Practices

Most countries in the region have enacted strict laws prohibiting both drug use and possession of drugs for personal use. Such laws, when aggressively enforced, have the affect of driving drug users further under ground and beyond the reach of standard medical and public health services. They also prevent law enforcement authorities from collaborating with public health authorities to expand access to prevention and treatment programs. In addition, the enforcement of such laws leads to increasing numbers of active IDUs incarcerated in often overcrowded prisons, a situation which can spawn the

rapid transmission of HIV, HCV, tuberculosis and STDs when prisoners share illicit, unsterile injection equipment and engage in unprotected sex.

**Albania, Azerbaijan, Hungary** (which has an exemption for certified drug addicts), **Lithuania, Poland** and **Russia**, are among the countries with laws prohibiting possession and use. In 2000, **Poland** enacted three amendments to its National program for Counteracting Narcotics, including one amendment that criminalizes possession of narcotics. Under the new legislation, police are now authorized to arrest and prosecute persons found possessing any quantity of illicit drugs. **Russia's** new drug laws enacted in 1998 prohibit simple possession, sale, manufacture or production of illicit drugs and imposes specific penalties. Convictions for personal possession without intent to sell are punishable by up to three years imprisonment. Repeat offenders face sentences of 5 –10 years imprisonment. A draft law under consideration would enable authorities to arrest and detain persons who were “high” at the time of arrest but were no longer in possession of any illicit drug.

**Uzbekistan** has recently enacted a new comprehensive drug control law that sets out a legal framework for the regulation of production, use and transport of narcotics and precursors. According to the U.S. State Department, “licensing is now required for all legitimate activities, including medical use, of these substances. In addition, import and export activities require explicit permission of the State Commission on Drug Control. The law also contains a section on combating illegal trafficking in narcotics, directing the State Commission on Drug Control to coordinate counternarcotics efforts and authorizing law enforcement agencies to take such measures as conducting searches, confiscating contraband and compelling blood testing for suspected criminal drug use. The law's final section guarantees medical treatment for addicts.”

In **Slovakia**, drug use cannot be punished, but penalties for drug possession – even small amounts -- can be quite severe. Currently, drug users constitute about 2% of the inmates in Slovakia's, up from 0% in recent years past. From 1993 to 1998, the **Czech Republic** legalized possession for personal use and use of drugs, but outlawed production and distribution. The law was changed in 1998, criminalizing possession of even a small quantity of narcotics. **Tajikistan** criminalizes possession but not use. Bulgaria and Kazakhstan do not criminalize possession or use.

## **B. Laws and Practices Concerning Disease Prevention and Treatment**

An analysis of preliminary country data concerning disease prevention and treatment practices makes clear that drug users have not been accorded a high priority in the national HIV prevention plans in this region. Such is evident by the lack of attention given to syringe availability and drug treatment (especially methadone maintenance) – two highly effective and cost efficient ways to stem the spread of HIV/AIDS among drug users.

### **(i) Syringe Availability- Law and Practice**

As observed in the best practices section {LINK TO Essential Drug Law and Policy Reforms} of this report, safe access to sterile syringes is an essential component of

an effective public health approach to an HIV/AIDS epidemic that is primarily drug use driven.

Data regarding the legal status of syringe purchasing and possession is not available for roughly half the countries in the region. In nine countries, however, the purchase of syringes does not appear to be legally prohibited -- **Belarus, Bulgaria, Hungary** (by prescription), **Kazakhstan, Latvia, Poland, Russia, Ukraine** and **Uzbekistan**. In eight countries, the possession of syringes does not appear to be prohibited -- **Bulgaria, Kazakhstan, Latvia, Lithuania, Poland, Russia Ukraine** and **Uzbekistan**. It is entirely another question whether and to what extent IDUs in these countries are aware of their legal right to purchase or possess syringes, whether syringes are readily available on the market, and whether the majority of IDUs can afford to purchase the necessary amount of sterile injection equipment that would allow them to avoid sharing with other drug users.

A review of syringe exchange programs operating in the region reveals an enormous shortage of supply in the face of overwhelming demand. What follows is a description of some of the leading programs in various countries in the region. While these programs provide critical services under trying conditions with minimal resources, they are able to reach only a small minority of IDUs in need of sterile syringes, HIV/AIDS information, testing, and related assistance.

In **Albania**, the Open Society funds two such programs, both in Tirana. In Belarus, where syringe exchange programs are legal, local authorities actively support such programs by assisting with recruitment and providing facilities. Needle exchange and harm reduction programs exist in Svetlogorsk, Pinsk, Soligorsk, Minsk, Mogilev and Vitebsk, funded by the World Health Organization, the Joint UN Program on HIV/AIDS, and the Open Society Institute.

In 1999, **Bulgaria** enacted a law giving official support to needle exchange programs. Registration requirements of the law, however, have encumbered the establishment of programs. The Sophia Needle Exchange Program begun in 1999 has expanded to include the training of university students and former IDUs as volunteers and three teams operate at six centers and engage in mobile outreach work. OSI currently funds four programs in Bulgaria, two of which focus on commercial sex workers and under-served Roma population.

Although the **Czech Republic** has been able to establish several harm reduction programs, workers in those programs report that the country's recent, increasingly prohibitionist drug laws "and more repressive police actions are pushing drug users further underground, hampering the project's outreach efforts..." "There is concern that the new, harsh national criminal law regarding drugs may deter drug users from establishing contact with the center and other organizations that work with drug users."

In **Kazakhstan**, where syringe purchase and possession is legal, a number of programs, referred to as "trust points," provide services, including syringe exchange, to IDUs. Temirtau has six trust points that provide such services; Karaganda has two such trust points plus an NGO called Mother to Child for mothers of drug users. Harm

reduction workers note, however, that outreach is difficult because the country's drug users still remember that under the Soviet regime their names were taken by health professionals and given to public security officials.

In **Latvia**, syringe exchange programs are legal and operating in Riga. The Open Society Institutes funds one such exchange that caters to IDUs and sex workers near Riga, and a prison project that distributes bleach and condoms to prisoners, educates them about HIV, and seeks to promote understanding about harm reduction among prison workers.

**Lithuania** is a relative success story with respect to the establishment of syringe exchange programs. Since 1997, anonymous consultation and needle exchange services have operated in all major cities, with substantial assistance from local authorities. In Klaipeda, local police have allowed outreach workers to distribute needles in all parts of the city including where illegal drugs are prepared and sold. The slow rate of spread of HIV in Lithuania's IDU community as compared to the rest of Europe is largely credited to the targeted response of the Lithuanian AIDS Centre and other institutions.

**Poland** has needle exchange programs operating in Warsaw, Kamienna Gora, Lublin, Pulawy, Gdansk, Krakow, Szczecin, and Zielona Gora. A number of these programs receive support from the Open Society Institute and many of the programs coordinate with other agencies providing drug treatment, replacement therapy, medical care and counseling.

In **Romania**, OSI funds four harm reduction programs all in Bucharest. In **Russia**, syringe exchanges operate in cities across the Federation, but often encounter local resistance from the authorities. In **Slovakia** needle exchange was instituted in 1997 in Bratislava. OSI funds three harm reduction programs in the country. Because drug possession is illegal, IDUs are afraid to possess or carry syringes, making outreach difficult. **Slovenia's** Minister of Health has issued strong statements in support of syringe exchange and harm reduction measures. And while such programs have been operating in the country since 1992, funded in part by WHO, OSI and government ministries, it is estimated that such services reach only about 10% of the country's estimated 10,000 heroin users.

In 2000, OSI provided support for the opening of the first two sites for Harm Reduction programs in Dushanbe, **Tajikistan**, where it is estimated that up to 75% of IDUs share syringes. In the **Ukraine**, where syringe exchange programs are legal and where syringes are available in pharmacies and in commercial shops, the government has been "relatively ineffective in directly supporting HIV/AIDS prevention efforts." Nevertheless, the Ukrainian government "has not hampered certain prevention measures funded by international donors and local groups. The government has allowed needle exchanges to function, under the management of small NGOs." A number of NGO's operate harm reduction programs for IDUs in Ukraine.

## (ii) Methadone Availability – Law and Practice

A touchstone of a country's commitment to addressing the interdependent issues of opioid dependence, injection drug use, and HIV/AIDS prevention is whether the country makes methadone treatment available to its opioid users. Methadone is the most effective treatment for heroin-dependence and costs only pennies per day to administer. For more information about methadone treatment, see [http://www.lindesmith.org/cites\\_sources/brief4.html](http://www.lindesmith.org/cites_sources/brief4.html)

Although the country data is incomplete, a dismal picture emerges from the information presently available. Of the 21 countries surveyed for this report, methadone treatment is known to be available in only three: **Bulgaria, Lithuania and Poland.**

Notwithstanding their large numbers of heroin users, **Russia, Tajikistan and Turkmenistan** *prohibit* methadone treatment. Although methadone treatment is permitted in **Albania, Kazakhstan, and Kyrgyzstan** it is unavailable in those countries.

Against this backdrop, the authors conclude that a crucial and urgent part of HIV/AIDS prevention in Central and Eastern Europe address the legal and policy obstacles that prevent tens of thousands of persons in need of methadone treatment from getting it.

### C. Criminal Justice System -- Law and Practice

The treatment of drug users at the hands of law enforcement and the criminal justice system is a powerful determinant in whether and how drug users access HIV/AIDS prevention and treatment services, including drug treatment programs. Reports of police abuse and harassment of drug users are widespread in many of the countries of the region. Such abuse and harassment at the hands of law enforcement, including the shaking down of drug users for drugs and money, tends to drive drug users further underground and away from badly needed social and public health services. Lack of legal protections for persons accused of drug crimes worsens the marginalization of drug users. Finally, the circumstances and conditions under which accused and convicted drug users are confined by the state fuel the spread of HIV/AIDS within and beyond the drug using population.

#### **Right to an Attorney**

The right to an attorney, guaranteed by the laws of most countries of Central and Eastern Europe, is honored more in the breach than in practice. For example, in **Belarus** where the criminally detained are theoretically granted unlimited contact with legal counsel, and an attorney is appointed for the indigent accused, both inmates and lawyers report sentences being levied on defendants who never met with counsel, and of serious restrictions on the ability of counsel to communicate with their clients. Similar reports emanate from **Latvia**, and legal informants in **Hungary and Lithuania** note that there is a shortage of trained advocates, and that those appointed to indigent clients often are poorly paid and provide meager services.

## Pre Trial Detention

The circumstances, duration and conditions of detention of the criminally accused are often illustrative of a host of human rights that are honored – or, as is often the case, breached – by government. Pretrial detention practices also shape the ways in which drug users relate to the state, since even if they are eventually acquitted of a crime, drug users who are incarcerated pretrial nonetheless regard themselves as having been punished and exposed to myriad physical dangers and health risks behind bars, including unsafe injecting practices in prison, unprotected sex, and tuberculosis.

While pretrial detention practices vary widely across the region, and many holes in pretrial detention data remain, several examples are notable. In **Belarus**, the accused may be kept in pre-trial detention for a period of 3-18 months, without judicial oversight. **Kazakhstan**'s criminal code permits continued pretrial detention for up to 12 months with the approval of the General Prosecutor of the Republic. Prolonged detention in Kazakhstan is a serious problem, with the General Prosecutor's office acknowledging that law enforcement authorities kept more than 7,000 persons in custody longer than legally allowed in 1998. **Hungary**, which lacks a bail system, posted an average length of pretrial detention of 3-6 months in 1996, with nearly 10% of detainees held for 8-12 months. In **Latvia** and **Lithuania**, pretrial detention can span up to 18 months. In **Russia**, where pretrial detention can be extended by several months at a prosecutor's will, bail schedules are out of reach for most accused, resulting in increased numbers of incarcerated.

## Prison Conditions

Generally speaking, the prisons of Central and Eastern Europe are prime locations for the spread of HIV/AIDS and other infectious diseases such as tuberculosis, hepatitis B and C, and syphilis. Unsanitary conditions, lack of basic health care and drug treatment, the unavailability of harm reduction programs and HIV testing, and the widespread corruption of prison officials create an environment where incarcerated drug addicts, many ignorant of their HIV status or that of their fellow injectors, have access to (often poor quality) narcotics, and must fashion, share and reuse unsterile injection equipment, cookers and drug mixtures with up to dozens of other inmates. Accordingly, seroconversion rates in prison are extraordinarily high. When inmates are released, the pump is primed for the spread of HIV and other infectious diseases into the larger community. In addition, recently released inmates who have untreated drug problems are at heightened risk for drug overdose.

Again, incomplete data of prison conditions in this region prevent a thorough analysis of the problem. What follows is a snapshot of the issue in some of the countries studied. In **Belarus**, prison conditions are poor and many are detained without trial for long periods of time. Diseases such as syphilis and tuberculosis are reportedly widespread. In **Kazakhstan**, two thirds of the roughly ninety thousand people in prison are there on drug charges. Prison officials deny that HIV is problem in the prisons and oppose the creation of syringe exchange programs for prisoners. Inmates are regularly tested for HIV but not for Hepatitis B or C. Many drug users are former prisoners who contracted tuberculosis while in prison. **Latvian** prison conditions are poor and drug

abuse is a common way for prisoners to deal with boredom, anxiety and despair. In **Uzbekistan**, prisoners known to be HIV-infected are isolated from other inmates. Drugs are widely available and needle sharing is common in prison. The prisons are overcrowded

In **Russia**, the number of HIV-infected prisoners has increased dramatically in recent years. In 1997, 1,636 prison inmates were HIV-infected, 1,516 (93%) injecting drug users. It is estimated that up to one-half of all HIV-infected registered drug users were in contact with the Russian prison system in 1997. The highest number of HIV-infected people in prison was in Kaliningrad (370), followed by Krasnodarsky krai, Rostovskays region (274), Tverskaya region (201), Nizhegorodskaya region (105) and the Moscow Departments of Interior Affairs (100).