



Eurasian Harm Reduction Network (EHRN)

Drug Policy Position Paper

I. Background

Drug policy should be aimed at “the attainment of a high level of health protection, well-being and social cohesion” and designed to maximize environmental, physical, psychological and social well-being worldwide (1). However, current approaches often prioritize criminalizing drugs and people who use them over protecting and promoting health. It is becoming increasingly clear that the existing drug-control system (with predominantly prohibitionist and punitive approaches to drug use) employed by many national governments, as well as at the international level, frequently leads to negative consequences, such as health emergencies (HIV and hepatitis epidemics, drug-related deaths), human rights abuses (including discrimination, denial of health care and of harm reduction services), and increased economic and social burdens on society (high cost of incarceration for non-violent drug-related offences) (2,3).

During the last twenty years, the region of Central and Eastern Europe and Central Asia (CEECA) has experienced an unprecedented growth in injection drug use — currently the region is home to 3.7 million people who

inject drugs. Among the most serious negative consequences is one of the world’s fastest-growing epidemics of HIV/AIDS and other blood-borne diseases: in Eastern Europe and Central Asia, one in four injectors is believed to be living with HIV (4). If the sharing of injecting equipment accounts for approximately 10% of HIV infections globally, in Eastern Europe and Central Asia in 2007, it accounted for 57% of infections for which the mode of transmission was known (4). In many respects this is due to harsh drug policies, which prohibit drug use and impose strict administrative and even criminal penalties for it. Several countries in the region employ a “zero tolerance” approach to drug use, which criminalizes drug use and institutes criminal liability for possession of very small amounts of any drug (5).¹

At the same time, the quality of health-related services and especially harm reduction for people who use drugs is often poor and service coverage inadequate. Harm reduction receives little or no funding from national governments in the region, demonstrating the lack of national commitment to the health of people who use

¹ However, member states of the European Union (Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovenia, Slovakia) tend to practise a more “balanced” approach.

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drugs. Not more than 10% of those in need have access to needle and syringe programs (NSP) in the CEECA region (6). Drug dependence treatment remains largely ineffective. In 2009, only 1% of all estimated people who inject drugs received opioid substitution therapy (OST) (6). Hepatitis C treatment and overdose management receive inadequate attention from national governments, despite being significant health risks for people who use drugs. Notwithstanding this alarming public health situation, there is a worldwide resource-allocation imbalance of 3:1 in favour of spending on security and law enforcement rather than on public health (7).

This lack of access to services for people who use drugs is prevalent despite the fact that during the last decade, international drug policy has undergone change, due in part to the acknowledgement that UN drug conventions allow governments some flexibility in their interpretation and do not prohibit needle exchanges, OST

and other harm reduction measures (8). The United Nations Office on Drugs and Crime (UNODC) recognized that there are negative consequences to a prohibitionist drug-policy approach, such as the existence of a huge criminal black market; the policy emphasis on enforcement over public health (policy displacement); the fact that tightening drug control in one region leads to an increase in drug production in another part of the world (geographical displacement); the production of new substances which are not yet tightly regulated (substance displacement); and significant negative human rights consequences (9). More and more, the international community underlines the need for a nuanced drug policy, in which countries are given the flexibility to implement a drug policy that best fits their needs, rather than be constrained by a 'one size fits all' approach (9). If in 1961–1988 — at the time of the adoption of three drug control conventions (11) — the two major principles of drug policy were supply reduction and demand reduction, today many regions acknowledge that drug policy includes harm reduction and treatment of drug dependence as equal pillar(s) (12). An understanding has emerged that public health including drug-dependence treatment is the first principle of drug policy, and that harm reduction is a part of drug policy (9).

Increasingly, the international community and national governments recognize that there are better ways to approach drug policy than to concentrate on criminal law enforcement (10). Examples of better drug interventions include decriminalization of drug use and possession of small amounts of drugs, as well as proportionality of sentences (13). Evidence suggests that legislation lessening criminalization, combined with shifting resources from law enforcement and incarceration to prevention, treatment and harm reduction, is a more effective technique in reducing drug-related problems. It also decreases stigmatization and discrimination, and increases access to prevention and treatment, including in prisons. There is additionally an understanding that harm reduction based on respect for human rights is a crucial part of universal access to HIV prevention, treatment and care (14).

... [P]unitive strategies have had little impact on the illicit drug markets or drug trafficking, which is their intended target. The only real result has been to criminalize the drug user populations, who are forced to lead marginalized and criminalized lives, ill health being their only companion. These policies not only increase deleterious health effects and premature death for drug users, they also threaten to increase the HIV sero-prevalance in the general population. This alone should persuade governments that harm reduction strategies are in the public interest and that it is necessary to adopt them.

– Anand Grover,
UN Special Rapporteur on the Right
to the Highest Attainable Standard of
Health (19).



II. EHRN Position

The EHRN position is based on an evidence-informed approach and promotes the respect, observance and protection of human rights. EHRN's overall goal as regards drug policy is to achieve a balanced and human rights-oriented drug policy that does not criminalize people who use drugs; that is conducive to providing them with adequate access to drug-dependence treatment, including OST and services for the prevention of blood-borne diseases and other health problems; and that protects human rights and reduces stigmatization and discrimination.

While drug conventions recognize two key pillars of drug policy — drug-supply reduction and drug-demand reduction, with harm reduction concepts embedded within the demand reduction pillar — EHRN supports a balanced drug policy, in which harm reduction (including drug treatment) is recognized as a separate pillar. EHRN recognizes that reducing drug demand does not always lead to a reduction of the harms associated with drugs and drug use. Similarly, efforts directed at reducing the harms associated with drugs by protecting the health and human rights of people who use drugs (the goals of harm reduction) do not necessarily reduce drug demand. Thus, the aims and goals of harm reduction (including drug treatment) overlap but do not always coincide with the aims and goals of demand and supply reduction. Treatment of drug dependence should be aimed at improving the quality of life of people who are dependent on drugs, rather than only reducing drug demand.

A balanced drug policy should have public health and human rights protection as its main goals, and be developed with the active participation of civil society, including people who use drugs. It should take into account the health, welfare and rights of people who use drugs and the communities they live in, and be based on evidence of efficacy and cost-effectiveness. At national and international levels, EHRN promotes an approach that minimizes the negative consequences of prohibitive drug policies, including from the criminalization of drug use and the incarceration of people who use drugs.

EHRN supports and advocates for the inclusion of harm reduction approaches in agendas relating to drug policy, HIV/AIDS, public health, and social inclusion. EHRN members share the principles of tolerance, partnership, and respect for human rights and freedoms.

Opioid substitution therapy is the safest and the most effective method of drug treatment worldwide, reducing mortality, transmission of infections, and criminality among drug users. Today, introduction of this type of treatment in Eastern Europe and Central Asia remains a political issue. The acceptance of opioid substitution therapy in a country is a sign of movement towards democracy and respect of human rights.

*– Daria Ocheret,
EHRN Chair at the Fifty-third session
of the Commission on Narcotic Drugs,
Vienna, March 11, 2010*

III. EHRN Key Principles and Priorities in the Area of Drug Policy

EHRN members agree to promote the following **Key Drug Policy Principles**.² Corresponding to the Key Principles, EHRN defines its **Priorities in Drug Policy**, based on the EHRN mission and formulated in order to provide the EHRN members and secretariat with general directions in their drug policy work.

Key Principle 1: Drug policy should maintain a balanced approach, where all elements of drug policy — demand reduction, supply reduction, harm reduction and drug-dependence treatment — are equally important and receive adequate funding.

The prohibitionist approach prioritizing supply reduction and law enforcement measures for demand reduction should give way to methods with equal emphasis on reducing the harms from drug use and on humane drug-dependence treatment. A balanced approach to drug policy supported by international law includes strengthening harm reduction and drug treatment interventions as part of national policies, including allocating funds proportionally between drug-supply and drug-demand reduction on the one hand, and harm reduction and treatment on the other.


Priority 1: EHRN sees harm reduction as a separate approach — not simply as part of demand reduction — and promotes the development of a balanced drug policy in countries of EHRN operation, including by advocating for change in strategic documents, legislation and implementation; by initiating public debate on drug policy and raising public awareness; and by aiming at a reduction of the negative health and social consequences of drugs. EHRN initiates and participates in the promotion of balanced drug policies at both national and international levels.

Key Principle 2: Drug policy should be based on evidence-informed interventions entrenched in national strategies and legislation, which target key affected populations and are adapted to their specific needs, such as those related to gender, type of drug used and other relevant factors.

While the evidence for a positive impact of balanced drug policies including harm reduction programs is strong, in the CEECA region the introduction and scaling-up of such programs has been driven less by evidence and more by socio-cultural and political contexts (14). According to EHRN's position, drug policy should be based on the latest results of academic research and practical work related to drug-use prevention, drug-dependence treatment, harm reduction, rehabilitation and support, and on interventions shown to be effective and efficient, and not based on ideological considerations or moral values. EHRN holds that success in the development of evidence-based drug policies and in the scaling-up of harm reduction activities is shaped by several factors: political leadership, the legal environment, health system organization, the availability of domestic financing, and the engagement of civil society.

Evidence-informed interventions include the following: decriminalization of drug use and possession of small amounts of drugs not for the purpose of sale; depenalization of small-scale offences related to drugs; and

² The following principles concentrate on demand reduction and harm reduction, taking into account the focus of EHRN on prevention of blood-borne diseases and reduction of other harms associated with drug use and drug injecting. The principles outlined below are tightly interconnected.



alternatives to imprisonment for people who use drugs for non-violent drug-related offences, including non-custodial penalties for acquisition, possession and use of controlled substances in amounts for personal use, as well as for non-violent drug-related offences. EHRN does not support compulsory treatment and opposes those forms of voluntary treatment and prevention that are abusive or not based on scientific evidence. Evidence-informed drug policies include gender-specific interventions tailored to women, and other specific interventions designed for prisoners, young people, poly-drug users and amphetamine-type stimulant users.

Priority 2: EHRN works to promote evidence-based drug policy and create strong political leadership, in order to reform legal and regulatory norms and achieve a more enabling environment for the promotion and scale-up of harm reduction interventions. EHRN educates decision-makers and other stakeholders about the latest developments and lessons learned in the area of drug policy, and strives to translate widely available evidence into action.

Individuals who use drugs do not forfeit their human rights. These include the right to the highest attainable standard of physical and mental health (including access to treatment, services and care), the right not to be tortured or arbitrarily detained, and the right not to be arbitrarily deprived of their life. 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.

– Navenethem Pillay,
High Commissioner for Human Rights (17).



Key Principle 3: Drug policy should be based on a human rights approach.

It is increasingly acknowledged that drug control efforts should be guided first and foremost by human rights standards (16). All drug policies at the national and international level should be developed in full compliance with international human rights standards. Employing a human rights approach means keeping in mind the effects of drug policies on the human rights of people who use drugs, vulnerable groups and the population as a whole, since vulnerable groups do not “forfeit their human rights” because they might use drugs or belong to another criminalized group (17,3). The criminalization of drug use leads to violations of human rights and causes more harm than good. A human rights-based approach means promoting strategies aimed at eradicating the criminalization of people who use drugs and other vulnerable groups, such as sex workers, and promoting universal access to health, social and other services provided by the State.

Priority 3: Promoting human rights in developing and implementing drug policies, EHRN advocates for changes in national legislation and drug policies that would facilitate a reduction of the negative human rights consequences of drug control and contribute to a reduction of stigma and discrimination. EHRN works to prevent human rights abuses committed under the auspices of drug policy, such as (among others) a) the violation of the right to life (denial of life-saving treatment, especially in restricted environments, such as prisons); b) the violation of the right to be free from torture, and cruel and inhuman punishment (including forms of compulsory drug-dependence treatment); c) the violation of the right to health (restricted access to essential medicines and HIV prevention, such as OST); d) the violation of social and economic rights; and e) the violation of the right to be free from discrimination.

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4 Key Principle 4: Drug policy should be conceived with public health considerations.

Governments should tackle drug use as a social and public health issue. All drug policy interventions should be checked against their possible impact on public health. This includes demand reduction and supply reduction efforts, which should shift focus from law enforcement measures and the punishment of people who use drugs to drug-dependence treatment and education, including in prisons. Harm reduction interventions should be accessible to all people who use drugs; governments should ensure that a legal and policy framework serves prevention efforts aimed at HIV and other blood-borne diseases (including hepatitis C), as well as overdose management.

Priority 4: Promote a public health approach in drug policy and a balanced allocation of funds between public health and law enforcement measures. Despite the acknowledgement of its importance, both international and national funding for reduction of drug-related harms is inadequate (18). (In many countries, no government money at all goes to harm reduction interventions.) Additionally, spending on drug-dependence treatment is often directed at outdated and non-evidence-based interventions, rendering treatment ineffective (treatment success rates in the CEECA region are notoriously low).

EHRN advocates for availability, quality and accessibility of voluntary drug treatment services. EHRN supports the inclusion of needle and syringe programs, naloxone distribution, OST and other voluntary, humane drug treatment methods in national legislation, policies, strategies and programs, as well as the allocation of domestic funding for the initiation and maintenance of these programs in both the community and in prisons.

5 Key Principle 5: Drug policy should be transparent and participatory.

Civil society involvement and the engagement of key stakeholders including affected communities is paramount in developing a responsive and balanced drug policy, and in its implementation, assessment, monitoring and evaluation. Transparent drug policy requires public debate and public disclosure about the effectiveness of existing national drug policy as well as policies in other countries. Drug policy and related activities should seek to promote the social inclusion of at-risk and marginalized groups.

Priority 5: Promote a transparent and participatory approach to drug policy and strengthen the capacity of civil society. EHRN's work aims at further consolidating civil society organizations, activist groups including groups of people who use drugs, public health specialists and other stakeholders to achieve their common goal of protecting the rights of those who do not have a voice in today's policy-making — people who use drugs. EHRN recognizes the important contribution to the development of drug policy by organizations of people affected by drugs and promotes their inclusion, participatory partnership and cooperation.



References

- (1) Preamble of the 1961 UN *Single Convention on Narcotic Drugs*: “The Parties [are] concerned with the health and welfare of mankind”; EU Drugs Strategy, Council of the European Union, 2004, p.5; Transform, *Towards Effective Drug Policy: Time for an Impact Assessment*, 14 July 2009.
- (2) International Drug Policy Consortium, *Drug Policy Guide*, Edition 1, March 2010.
- (3) *Recalibrating the Regime: The Need for a Human Rights-Based Approach to International Drug Policy*, The Beckley Foundation Report, Report Thirteen, March 2008; United Nations General Assembly. (1998) S-20/3, *Declaration on the Guiding Principles of Drug Demand Reduction*. UNAIDS, *2008 Report on the Global AIDS epidemic* (Geneva, 2008), Annex 1.
- (4) UNAIDS, WHO, *Fact Sheet: Eastern Europe and Central Asia*, 2009.
- (5) To give several examples (non-exhaustive): Georgia establishes criminal liability for simple drug use, punishable with high fines and imprisonment. Russia and countries of Central Asia establish administrative penalties for drug use and criminal liability for possession of the smallest amounts of any drugs not for sale (including residual amounts in used syringes).
- (6) B. Mathers, L. Degenhardt et al., “HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage”, *The Lancet*, Vol. 375, Issue 971, p.1014–1028, 20 March 2010.
- (7) UNODC, *Responding to the prevalence of HIV/AIDS and other blood-borne diseases among drug users*, Report to the Executive Director to the Commission on Narcotic Drugs (53rd session, March 2010), 21 December 2009.
- (8) UNDCP (Legal Affairs Section) *Flexibility of Treaty provisions as regards harm reduction approaches*, Decision 74/10, UN Doc. E/INCB/2002/w.13/SS.5 (30 September 2002).
- (9) UNODC, “*Making drug control ‘fit for purpose’: Building on the UNGASS Decade*”, Report by the Executive Director as a contribution to the review of the 20th special session of the General Assembly, March 7, 2008. UNODC, *Health: The First Principle of Drug Policy*, Costa’s corner, 18 March 2008.
- (10) Martin Jelsma, *Legislative Innovation in Drug Policy: Latin American Initiative on Drugs and Democracy*, Transnational Institute, October 2009.
- (11) *Single Convention on Narcotic Drugs* (1961), 520 UNTS 331, as amended by the 1972 Protocol; *Convention on Psychotropic Substances* (1971), 1019 UNTS 175; *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988), UN Doc. E/CONF.82/15.
- (12) See, for example, drug policies in several Canadian cities (Toronto, Regina, Edmonton, London, Vancouver). These strategies usually include four pillars: a) prevention; b) treatment; c) harm reduction, d) enforcement. See at: <http://vancouver.ca/fourpillars/acrossCanada.htm>.
- (13) Examples include Portugal, Mexico, Brazil and Argentina. In the European Union countries, drug interventions are based on a) a more powerful focus on treatment rather than on criminal punishment; b) a sense of disproportion between custodial sentences and illicit use of drugs; and c) the perception that cannabis is less dangerous to the health compared to other drugs (European Monitoring Centre for Drugs and Drug Addiction, *Illicit drug use in the EU: legislative approaches*, EMCDDA thematic papers, Lisbon 2005).
- (14) The UN system in 2009 developed a comprehensive package of HIV-related services for people who inject drugs, which include nine interventions: a) needle and syringe programs, b) opioid substitution therapy and other kinds of drug dependence treatment; c) HIV testing and counselling; d) antiretroviral therapy; e) prevention and treatment of sexually transmitted infections; f) condom programs for people who inject drugs and their sexual partners; g) targeted information, education and communication for people who inject drugs and their sexual partners; h) vaccination, diagnosis and treatment of viral hepatitis; i) prevention, diagnosis and treatment of tuberculosis. These should be complemented by other health services, such as overdose prevention and management (WHO/UNODC and UNAIDS *Technical Guide*, 2009).
- (15) Rifat Atun and Michel Kazatchkine, “Translating evidence into action — challenges to scaling up harm reduction in Europe and Central Asia”, in Tim Rhodes and Dagmar Hedrich, *Harm reduction: evidence, impacts and challenges*, European Monitoring Centre for Drugs and Drug Addiction, (EMCDDA), 2010, pp. 94–101.
- (16) UNODC Executive Director A.M. Costa (10 March 2008), speech at the 51st Session of the Commission on Narcotic Drugs, Vienna.
- (17) United Nations Press Release (10 March 2009), “High Commissioner calls for focus on human rights and harm reduction in international drug policy”.
- (18) International Harm Reduction Association, *Three cents a day is not enough: Resourcing HIV-related Harm Reduction on a Global Basis*, 2010.
- (19) Anand Grover, UN Special Rapporteur on the Right to the Highest Attainable Standard of Health, Foreword to *Harm Reduction and Human Rights: The Global Response to Drug-Related HIV Epidemics*, International Harm Reduction Association, 2009.

The Eurasian Harm Reduction Network (EHRN) is a regional network 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.

Founded in 1997, EHRN today brings together over 270 organizations and individuals from the Central and Eastern Europe and Central Asia (CEECA) from 6 sub-regions: Balkans, the Baltics, Central Europe, European Countries of the Commonwealth of Independent States, Caucasus and Central Asia. The organization is governed by the Steering Committee elected by members with Secretariat based in Vilnius, Lithuania.

EHRN is signatory of the Code of Good Practice for NGOs Responding to HIV/AIDS. It is granted a Special Consultative NGO Status by the Economic and Social Council of the United Nations (ECOSOC).



www.harm-reduction.org