

# A Balancing Act

Polycymaking on Illicit Drugs  
in the Czech Republic





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## Policymaking on Illicit Drugs in the Czech Republic

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Cover and layout by Judit Kovács | Createch Ltd.

Cover photograph © 2012 Vojtěch Janouškovec | Progressive O.S. | A clean injection equipment dispenser in the Czech capital Prague. This machine drew political fire and is now used in a smaller city outside the capital. 2008.

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# Foreword

One hundred years after the first international drug control treaty was signed, the failures of the global drug control regime are becoming ever more apparent. The eradication of crops in producing countries, interception of trafficked substances, and punishment of drug users and dealers have done little to curb drug use or availability. Punitive sanctions for drug users have resulted in mass incarceration—harming families and communities, and violating human rights.

The arguments for drug policy reform, however, are gaining traction as the global drug reform movement becomes increasingly visible and influential. A number of governments are on the path toward drug decriminalization; high-profile advocates and new allies in the private sector publicly support the reform movement; and shifts in public opinion on illicit drug use are outpacing government policymaking.

Nevertheless, the appeal of waging a “war on drugs” endures, despite overwhelming evidence that war-like approaches have not reduced the supply of or demand for illicit drugs, and have caused enormous harm to individuals and societies. Too few countries have examined the evidence of the harms of the drug war and committed themselves to more effective and balanced policies.

For countries in the Soviet bloc, the fall of the Soviet Union meant both new possibilities and considerable challenges. With respect to illicit drugs, these countries generally inherited policies based on repression and moralistic denunciation of people who used drugs, even as much of Western Europe was moving toward less heavy-handed and more public health-oriented drug policies.

Many countries of the former Soviet empire continue to struggle with the legacy of drug policy based on harsh policing in pursuit of the unrealistic goal of a “drug-free society.” This report tells the story of how one former Eastern bloc country broke with old practices by using scientific research to inform drug policy and recognizing that people who use drugs should, above all else, have ready access to health and harm reduction services. Czech drug policymakers, often calling on their experience in civil society health and social service organizations, blazed a trail that led away from condemnation and criminal prosecution of drug use and addiction. In the process, they succeeded in controlling injection-linked HIV and have made inroads against hepatitis C.

The decisions faced by the leaders of the new Czech Republic continue to confront leaders across the globe. Politicians still find it easy to use harsh drug-control measures to prove that they are “tough on crime.” They can be confident that their constituents are unlikely to protest the arrest and incarceration of people who use drugs, no matter how minor the offense. At key moments in the history of the Czech Republic, however, courageous civil society and government leaders defied popular calls for more prosecution and instead crafted policies that respected the humanity of people who use drugs. They also have attempted to inform public debate by sustained and transparent monitoring of the impact of policies.

We believe the Czech drug policy experience serves as an exemplary precedent for transforming drug policy from repression-based to evidence-based approaches. This monograph is the third in a series of case studies that have also examined the Swiss and Portuguese drug policy experiences. We hope that these reports shed light on the policy challenge of bringing science to bear in the contentious and frequently misunderstood area of drug control.

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# Executive Summary

The “Velvet Revolution” of 1989 that ended 41 years of Soviet domination of Czechoslovakia caught the imagination of the world and still inspires people peacefully seeking freedom from autocratic rule. In the early post-Soviet period, Czech authorities, unlike their counterparts in some former Eastern Bloc countries, turned away from repressive drug policies and developed approaches to illicit drugs that balanced new freedoms with state authority.

The end of Soviet rule meant that drug markets and the use of a wide range of new drugs attained a magnitude and visibility not previously known to Czech society. From an early stage, some pioneering health professionals with expertise in drug addiction saw that the new drug situation would require greatly expanded services for drug users and collaboration between civil society and government to achieve this expansion. They were able to influence the new government and steer it toward drug policy that would define drug use as a multisectoral problem, not an issue for policing alone. Civil society organizations grew after 1989 and were at the forefront of advocating for and providing low-threshold health and social services for people who used drugs.

At the very moment that Czech authorities had to determine the direction of their drug policy, some marked drug policy trends were discernible in the European Union. Spurred partly by the threat of HIV, many EU countries adopted policies that explicitly supported harm reduction measures, including needle exchange and opiate substitution therapy. In addition, quite a few countries began to reject criminalization of drug use and harsh criminal penalties for possession of small amounts of drugs and other minor offenses as part of creating conditions conducive to providing health and social services to drug users. Envisioning eventual EU membership—the Czech Republic joined the EU in 2004—Czech

officials took decisions that aligned Czech policy with the “balanced” European drug policy models that were replacing “law enforcement only” approaches.

The first drug law and policy of the new Czech Republic in 1993 did not include criminal penalties for drug use or for possession of illegal drugs in a quantity judged to be for individual use. As drug markets and drug users became more visible, especially in the cities, there was greater political pressure domestically and from international bodies such as the International Narcotics Control Board in favor of harsher penalties for drug offenses. In 1998, the Czech Republic criminalized possession of “greater than small” amounts of drugs (and the question of defining “greater than small” became part of the policy discussion). Individual drug use itself remained a non-criminal act in the law.

This change was accompanied by the government’s remarkable decision to invest in a large-scale, rigorous research project to evaluate the impact of the 1998 law. The study concluded that the law, at least in its first two years of implementation, did not significantly curb problem drug use or result in less availability of drugs, as its proponents had posited. The 2009 law that eventually resulted from the study and subsequent deliberations defined “greater than small.” That is, it established quantities below which possession would not result in criminal penalties (but as a misdemeanor would be subject to imposition of fines). At the same time, the Czech Republic formally recognized a legal distinction between cannabis and other drugs by instituting somewhat more lenient penalties for some cannabis offenses than for analogous offenses involving other drugs. This measure also aligned the Czech Republic with a growing number of EU countries that effectively decriminalized some cannabis offenses.

To the degree that control of HIV is an indicator of drug policy effectiveness, the Czech experience merits very high marks. While some countries in Europe and the former Soviet bloc faced fast-growing HIV epidemics linked to drug use in the late 1980s and 1990s (and, in some cases, to this day), HIV prevalence among people who inject drugs was stabilized at a low level in the Czech Republic. Relatively high coverage of needle exchange programs and ready access to medication-assisted therapy for people with opiate dependence seem to have been central to this result. Low-threshold services have also come to include innovative harm reduction for people who use methamphetamines.

National drug coordinators in the Czech Republic have generally come from backgrounds of front-line service delivery for people who use drugs. This factor undoubtedly contributed both to the state’s relative willingness to invest in generating scientific evidence to inform policy and its formal inclusion of nongovernmental organization (NGO) practitioners in drug policy decision-making. The presence of a significant cadre of academic experts in addiction sciences has also been an asset.

The Czech drug policy experience contrasts that of the Slovak Republic, where minor drug offenses still often lead to incarceration and there is no official distinction among categories of drugs with respect to leniency of offenses. In addition, in the Slovak Republic the network of services for drug users is not as well developed as in the Czech Republic. This factor may contribute to higher seroprevalence of hepatitis C virus among people who use drugs in Slovakia than in the Czech Republic.

Despite the strong public health impact of the Czech Republic's approach to illicit drugs, rhetoric about drug use in the 2010 election campaign in the city of Prague illustrated that drug use is still highly stigmatized and that visible drug markets and drug user services can antagonize public sentiment. Czech authorities will also be challenged to sustain high-quality services, including low-threshold services run by NGOs, as fiscal austerity sharpens competition for public resources. A history of reliance on evidence-based practices, including measures that contain infectious diseases and other harms linked to drug use, and adherence to policies that limit criminal sanctions for minor offenses will be important as Czech drug policymakers face a future of inevitable fiscal constraints and political pressures.



# I. Emerging from Soviet Domination

The Czechoslovak Socialist Republic, which is now the separate Czech and Slovak republics was a “satellite” state of the Soviet Union from 1948 to 1989. The limits on possibilities for liberalization from Soviet policies were graphically demonstrated in the “Prague Spring” of 1968, when popular support for reforms announced by Communist Party leader Alexander Dubček provoked a Soviet invasion in August 1968. Two decades later, the “Velvet Revolution” of 1989 ushered in freedom from Soviet rule, caught the imagination of the world, and continues to inspire people to challenge autocracy peacefully. One of the leaders of the revolution was the late Václav Havel, a dissident playwright who was catapulted to the global stage as Czechoslovakia’s new president in 1989.

Before the period of Soviet domination, Czechoslovakia’s central location in Europe made it a frequent transit point for opium and other illicit drugs (National Monitoring Centre 2009). With the Communist takeover in 1948, the country was removed from principal trafficking routes as it was virtually closed to the West. Under Soviet occupation, the approach to drugs was a mixture of denial and repression. The official line was that the successes and prosperity of the Soviet system left the people too satisfied to need crutches like narcotics, which were also characterized as remnants of the decadence of the tsarist aristocracy (Conroy 1990). Even as the winds of *glasnost* stirred in the late 1980s, drug use and dependence were seen by the Soviet authorities as manifestations of Western degeneracy (Fleming et al. 2001).

Though the “iron curtain” limited the flow of illicit drugs, the manufacture of certain products with narcotic or psychotropic effect was possible in Czechoslovakia before the Velvet Revolution. In the 1960s codeine and other analgesics, ephedrine from legal medicines, and benzodiazepines and barbiturates were used on a large enough scale to constitute a drug scene in some cities (Zábranský 2007). By the 1970s, drug use had expanded with increasing popularity of a homemade hydrocodone-based opiate called “brown” and a homemade crystal methamphetamine (known locally as “Pervitin”) made from cough medicine and other ingredients. Pervitin has dominated the Czech drug scene since the 1980s.

The penal code of the Czechoslovak Socialist Republic established criminal sanctions, including prison sentences, for drug production, procurement, and possession, while also mandating compulsory “treatment” for people deemed problematic drug users (Zeman 2007). Like other Eastern Bloc states, Czechoslovakia ratified the 1961 UN Single Convention on Narcotic Drugs, which occasioned changes in the national drug law. A 1962 drug law continued the previous penalization of drug offenses and added the possibility of punishment of up to eight years in prison when drug offenses were committed as part of an organized group or in a way that caused anyone serious harm or death (Ibid.).

Treatment services for drug dependence were limited in the Communist era. In 1948, Dr Jaroslav Skála, a pioneering psychiatrist, established a treatment center at the teaching hospital of Charles University in Prague inspired by the “therapeutic community” model developed in Great Britain (Kalina 2007). In the early 1960s, Skála met Dr Maxwell Jones, the British founder of the therapeutic community idea in the psychiatric hospital setting. Jones’s transformation of traditional hospital-based psychiatry into an approach in which patients and health professionals worked as a team and patients had something to say about their care influenced Skála and his colleagues (Kalina 2006). An American doctor who visited alcohol treatment facilities in Poland, Russia (then USSR), and Czechoslovakia in 1960 judged Skála’s services in Prague to be closest to Western standards of the three (Chafetz 1961). Kalina credits Skála’s work and charismatic influence with the development over time of treatment methods that were a humane alternative to the rigidity and impersonal approach of the Soviet-inspired polyclinic-based services. After 1989, many respected health professionals, including some who had studied or worked with Skála, entered the emerging NGO sector and built the foundation of a new era of evidence-based services (Kalina, interview).



## Liberalization Post-1989

After 1989, policies of the new Czechoslovak Federal Republic reflected the public's readiness for liberalization from repression in many spheres of life. A 1990 reform of the penal code (amendment no. 175/1990) made numerous changes to the Communist-era criminal laws, including the abolition of the death penalty. With respect to narcotic and psychotropic drugs, the penal code was changed in several ways (Zeman 2007):

- ▶ Possession of illicit drugs for one's own use was removed as a criminal offense and made an administrative or civil offense (misdemeanor). Possession of drugs for another person was still defined as a criminal offense.
- ▶ Smuggling drugs, offering them to another person, and sale of drugs were included as criminally prohibited forms of "illegal disposal" of drugs.
- ▶ A new crime of "propagation of drug use" was defined as inciting someone else to use drugs (not including alcohol).

Zeman (Ibid.) noted that in 1990 drug policy was not a burning public issue and these amendments passed without much debate. Decriminalization of the offense of drug possession put the Czech Republic in the vanguard of EU countries such as the Netherlands that had previously done the same (EMCDDA 2002). The measure was a clear statement that harsh criminalization of minor drug offenses was a thing of the past.

The period of drug use being a low-profile issue was, however, short-lived. Czechoslovakia's new openness to the world meant a fast-growing flow of illicit drugs and more substantial and visible drug markets than ever before. Consumption of home-cooked "brown" heroin was replaced by heroin from outside the country (Zábranský 2004). Prague became a transit point for cocaine, but cocaine use remained relatively minor, which Zábranský (2004) attributes to the established use of another stimulant, Pervitin, in all strata of society. Popular news media portrayed a growing drug scene as a social problem and an invitation to organized crime syndicates, and drugs became a polarizing political issue (Zeman 2007). The Czech people who had long yearned for greater freedoms were finding that government policies on drugs and crime were not what they had hoped for (Bullington 2007).

Health professionals, including those exposed to addiction medicine by Skála or his colleagues, were faced with growing health service needs associated with widening drug use. Supported by Dr Kamil Kalina (who was soon to become the first national drug coordinator), NGO-based practitioners found they could not be silent about the need for the state to support expansion of evidence-based health services for people with drug dependence and to provide a structure for a coherent response to drug use as a social problem. In a December

1992 open letter to the government—known as the “Christmas memorandum”—health care providers from a number of NGOs pled their case:

We must state that no law on addictive substances has been passed, there is no coordinated primary prevention, there is an acute lack of detoxification treatment and rehabilitation facilities for drug addicts, and the opportunities for foreign aid and cooperation have been missed....We acknowledge that the state authorities cannot resolve these issues on their own. This is why we declare that the nongovernmental sector is ready to participate in dealing with the problem of addictive substance abuse. However, this work is unthinkable without the underlying policymaking, technical, legislative and organizational involvement of the governmental sector, and particularly without drafting a fundamental framework drug policy.<sup>1</sup>

The reaction to the memorandum was swift. In early 1993, the government established a National Drug Commission (NDC) as an interministerial entity mandated to develop and coordinate national drug policy (National Monitoring Centre 2009). The NDC is known officially today as the Government Council for Drug Policy Coordination but will be referred to in this paper as the National Drug Commission. By August 1993, the NDC had proposed and approved a “Drug Policy Concept and Program for 1993–1996” (Ibid.). The Czechoslovak Federal Republic was dissolved in 1993 to become two new countries—the Czech Republic and the Slovak Republic. Thus the 1993–96 policy developed in Prague became the first drug policy of the Czech Republic. This policy rejected criminal sanctions for drug use itself and sought to provide firm grounding for health services for people who use drugs, including harm reduction services (National Monitoring Centre 2009). Under Skála’s aegis a needle exchange program began in 1987 and the opiate analgesic ethylmorphine was sometimes prescribed as a substitution therapy for people with opiate dependence (Kalina 2007), but harm reduction services were not widespread at the time.

The 1993–96 policy recognized the importance of NGOs as service providers for people who use drugs and acknowledged the need for low-threshold services. It also established district (provincial)-level drug coordinators who would work with intersectoral district drug commissions (National Monitoring Centre 2009), structures that continue in the Czech

1. Translation provided by the National Monitoring Centre (2009) based on a version of the Christmas memorandum found in the archives of the NGO SANANIM.

Republic today. Primary prevention of drug use was also established as a Ministry of Health function. In other words, while not explicitly labeled as such, the proposed new policy was similar to what the Swiss in the same period would call a “four-pillar” policy—including policing, prevention of drug use, treatment of drug dependence, and harm reduction.<sup>2</sup>

Czech authorities were cognizant of drug policy and program trends elsewhere in Europe, and the prospect of being part of the European Union was in the minds of at least some of those active in drug policy discussions (Kalina, Zábanský interviews). When Czech officials developed their strategy in 1993, there was some awareness in Europe of the experiences of the Netherlands, Germany, the United Kingdom, and Switzerland in developing drug policy not based exclusively on law enforcement (Chatwin 2003). In late 1990 for example, with some considerable publicity, the “Frankfurt resolution” was signed by local authorities in Hamburg, Frankfurt, Amsterdam, and Zurich, committing them to working toward “liberalization and harm reduction” as they sought to minimize HIV transmission linked to drug use (Ibid.). With a few exceptions, notably the repressive national policy in Sweden, there was a growing European consensus around removal of harsh penal sanctions for individual-level drug offenses, and a few countries even acknowledged that a “drug-free” society was not a realistic goal (EMCDDA 2002).

The National Drug Commission represented many governmental sectors and as of 1995 had a budget to support NGOs providing health and social services for people who use drugs (Kalina 2007). The NDC today includes: the ministries of interior; finance; education; youth and sport; defense; labor and social affairs; justice; and health; as well as the commissioner for human rights; representatives of the drug authorities in the 14 regions of the country and the city of Prague; and representatives of NGOs (Government of the Czech Republic 2011). The government appointed a civil servant to convene these entities and coordinate their work. The first national drug coordinator<sup>3</sup> was Dr Kamil Kalina, who had worked with the NGO SANANIM, which provides health services to people with addictions. In 1995, the Association of Nongovernmental Organizations (ANO) was formed as a coordinating body for the NGOs in this sector, and continues to play this role today. Representation of the NGO sector in the National Drug Commission was later formalized, and ANO is the most important focal point for ensuring participation of NGOs in drug policy discussions (Richter, interview).

2. See also J. Csete (2010), *From the Mountaintops: What the World Can Learn from Drug Policy Change in Switzerland*, Open Society Foundations Global Drug Policy Program: [http://www.soros.org/initiatives/drugpolicy/articles\\_publications/publications/csete-mountaintops-20101021](http://www.soros.org/initiatives/drugpolicy/articles_publications/publications/csete-mountaintops-20101021)

3. This position is also known as Head of the Secretariat of the Government Council for Drug Policy Coordination. The position will be referred to in this paper as “national drug coordinator.”



## II. The Politics of More Visible Drug Use

As drug use and drug markets became more visible in Czech society in the 1990s, especially in the cities, dissatisfaction with a “balanced” approach to drugs was brewing. This dissatisfaction was fed, in the view of some observers, by exaggerated reporting of the drug scene by the media, creating what Zábanský called a “moral panic” about drugs (Zábanský 2004; Radimecký 2007). Even without media hyperbole however, visible drug use on the order of what was already long known in Western Europe was likely to shock many in Czech society who had been raised to think that drug use was rare and decadent (Radimecký 2007). According to Bullington (2007), there was a combination of fear born of newness of the phenomenon and a certain naïveté in the Czech Republic on the matter of drugs. At the same time, the long period of repression from which the Czech people had recently emerged left many people without much appetite for harsh policing or trust in the police force (Ibid.).

In the 1990s, the drug problem was a topic of sharp discussion in the Czech Parliament. After decades of Communist one-party rule, political parties emerged quickly after 1989. Strong support for harsher laws and policing came especially from the Christian People’s Democratic Party (KDU–CSL) sometimes in alliance with what was left of the Communist Party (Zábanský 2004). As Zábanský observed, the Christian Democrats were apparently motivated by a moralistic critique of drug use, while the Communist position reflected a certain lingering nostalgia for an era of state control of dangerous new behaviors—indeed, of any behaviors. The largest parties in the mid-1990s, the

Civic Democrats and the Social Democrats, were not unified internally on matters of drug policy (Ibid.).

Parliamentary debate was fueled by both continued sensational media reports and what Záborský (2004) characterizes as misinformation campaigns by pro-repression parties, including allegations that the Czech Republic was the new center for crime syndicates involved with drugs and that drug dealers frequented schoolyards. A rapid assessment of drugs in the Czech Republic was conducted under the auspices of the United Nations Drug Control Program (UNDCP) in 1995. The assessment highlighted the need for more treatment and harm reduction services in the face of a widespread and growing problem (Tyrlik et al. 1996). Though the report noted a marked increase in heroin consumption in the early 1990s, it found that Pervitin was still the dominant drug of choice (Ibid.). Following the release of the report, a UN staff member who appeared uninvited at a 1996 conference about drug policy in Prague told the conference that the Czech Republic would be in violation of its commitments to the UN drug conventions if it did not criminalize drug possession (Bullington 2007). This incident added fuel to the fire already raging in the parliament. In addition, in its annual reports for the years 1995 and 1996, the International Narcotics Control Board, which oversees adherence to the United Nations drug conventions, highlighted the rapid increase in heroin consumption in the Czech Republic and the continued illicit manufacture of large quantities of methamphetamines (INCB 1996 [para 365]; 1997 [paras 334, 343]).

The Christian Democrats brought a proposal to parliament in 1996 for criminalization of drug possession in the penal code (Záborský 2004). The national drug coordinator at the time, Dr Pavel Bém, and the executive branch of government opposed the measure, as did the parliament. In 1997, in an atmosphere of continuing media portrayal of drugs as a fundamental threat to Czech society, the Communist Party proposed to parliament a measure that would both criminalize possession of drugs in any amount and establish criminal penalties for anyone knowing of drug possession, production or sale who failed to report those acts to the police. Perhaps hoping to stave off these far-reaching provisions, the government put forward its own bill that would criminalize drug possession but only when the amounts possessed were “greater than small.” The parliament passed that bill, President Havel vetoed it, and the parliament finally overrode the veto. Penal code amendment no. 112/1998 came into force in 1999 (Zeman 2007).

“Greater than small” would become a continuing theme in Czech drug policy debates from this time on. The term was left undefined in amendment no. 112/1998, giving judges the task of interpreting it on a case-by-case basis, which the police found to be an objectionable degree of flexibility (Ibid.). The intent of introducing the term was to assert the need to distinguish between serious and less serious offenses and to preserve some possibility of avoiding criminal sanctions for people whose only crime is possession. In this regard,

the 1998 law also prohibited judges from using repeated offenses of possession, even in amounts “greater than small,” as an aggravating circumstance—that is, repeated possession offenses would not automatically entail harsher sentences (Ibid.).

Even with the criminalization of drug possession, Czech law did not criminalize drug use. In this regard, the Czech Republic aligned itself with a number of European countries that had moved toward defining drug use itself as exempt from criminal prosecution or had established lenient punishments for use (EMCDDA 2002).

## Calling on Research to Inform Policy

The 1998 law was a step backward for those who wished to see health and social services rather than policing dominate the response to minor drug offenses. For these persons, the pill of the new law may have been less bitter to swallow however, when the National Drug Commission made the extraordinary decision at the same time to commission a major scientific evaluation of the impact of the new law. Dr Bém, who spearheaded this decision as the drug policy coordinator at the time, was a psychiatrist with rich experience in treatment of drug dependence. For this scientific evaluation, he turned to a young researcher active in the field, Dr Tomáš Záborský, then of Palacky University in Olomouc (Moravia region) and now at Charles University in Prague. Dr Záborský formed an interdisciplinary team of mostly young scientists to take on this important work. The study they produced, *Impact Analysis Project of the New Drug Legislation* was known as PAD. The study was a sign that, at least at the level of the NDC, policymakers believed that careful research would help inform policy decisions.

PAD was designed to look at a number of questions that reflected issues that had embroiled drug policy discussions in the 1990s. Specifically, the questions studied by the PAD team were whether the criminalization of drug possession would have any of the following effects:

- ▶ Decrease availability of illicit drugs;
- ▶ Decrease the number of people who use drugs;
- ▶ Decrease the number of people who initiate drug use;
- ▶ Decrease (or otherwise affecting) the health consequences of drug use; and
- ▶ Affect the social costs of drug use (Záborský et al. 2001).

PAD was an ambitious undertaking. The five effects above were handled in five sub-studies marked by further sub-studies. Both qualitative and quantitative methods were used. An expert board oversaw the study; it included Dr Josef Radimecký, who replaced Bém as national drug coordinator, and NDC members. In addition, two professors from the United States were invited to provide technical support and review. After considerable preparatory activities, the main data collection activities took place in 2001, meaning that PAD could assess the impact of only about two years' worth of implementation of the law.

The main findings of the study were as follows (Zábranský et al. 2001):

- ▶ The availability of drugs did not decline, though the authors acknowledged that factors other than the 1998 law may have contributed to this result.
- ▶ The population of existing drug users did not decline; the PAD results suggested that the number of current drug users increased in the period investigated.
- ▶ The authors were unable to assess directly the question of how the number of new drug users changed, but they found higher initiation of drug use among younger persons than in the past and an increase in first-time demand for treatment. They concluded that the law did not reduce initiation of new drug use.
- ▶ Adverse health events related to drug use likely increased over the period investigated, but the authors were unable to attribute this result to the criminalization provision.
- ▶ Making a number of assumptions about the cost of law enforcement, incarceration, and other activities related to cases of drug possession, the authors conservatively estimated that the added "social" cost related to the 1998 amendment was on the order of 37 million Czech crowns (or about U.S. \$1 million at the time).

Thus, while PAD did not demonstrate the dire consequences of criminalizing possession that opponents of the law may have predicted, it provided strong evidence that the law was not effective in the ways that its supporters posited. According to the study, criminalizing drug possession did not have the desired deterrent effect, did not have a health benefit, and was economically costly to society.

The authors noted that two years was a relatively short period to judge the effect of the law and indeed some of the impacts they sought to measure may have been muted. Bruce Bullington, one of the U.S.-based experts who provided technical support to the study, had the opportunity to talk to a number of key informants about the results of the PAD after its release. The head of the national drug police told Bullington that virtually no arrests took place directly as a result of the new law in the study period because "the normal consumer who is not a dealer, with only a few doses...won't break the limit of 'greater than small'"



(Bullington 2007). It is possible, as Bullington suggests, that the police purposely acted cautiously during the PAD study period so as to soften any negative impacts.

Also noting that patterns of drug use differed between those involved with “hard” drugs and those persons consuming only cannabis, the PAD authors said in their conclusion that it would be wise to distinguish between types of drugs in law and policymaking.

The PAD results were extensively covered in the media and widely discussed in government. The authors’ comment about the usefulness of distinguishing types of drugs was not lost on policymakers. In late 2001, the government responded to PAD in Resolution no. 1177/01, which assigned a number of PAD follow-up tasks to various ministries (Zeman 2007). One of the most important of these was that the minister of health, working with the minister of justice, was asked to act on PAD’s suggestion of considering a distinction between types of drugs based on the degree of social and physical harm they pose (Zábranský 2004; National Monitoring Centre 2009).

The Ministry of Health convened an expert group to deal with this controversial question. According to Zábranský (2004), who worked with the group, the expert panel considered physical, psychological, social, and epidemiologic consequences of use of all of the available drugs, weighing such factors as addictive capacity, risk of lethal overdose, and capacity to engender harm to others. In the end, the panel proposed that drugs be classified into three categories: (1) cannabis and products containing THC (tetrahydrocannabinol), (2) LSD, MDMA (ecstasy) and psilocybin-containing mushrooms, and (3) all other illegal drugs (see also Zeman 2007). The National Drug Commission agreed with this classification. The Ministry of Justice however, objected to the three categories, asserting that the second and third categories proposed by the panel were not sufficiently distinct (Zábranský 2004; Zeman 2007). The Ministry of Justice thus proposed a two-category system with cannabis (and other plant drugs) treated differently in the law from all other illicit drugs.

The government moved forward with the Ministry of Justice proposal, but at a time when the Czech Republic was working on large-scale revisions of its criminal code and other laws linked to its accession to the European Union in 2004 (Zeman 2007; Jacoby 1999). It was partly for this reason that the provision on distinct penalties for cannabis was not formally established in law until 2009, to come into effect in January 2010. The new drug law was widely covered in the international press, including in some sensationalized stories that proclaimed Prague “the new Amsterdam” (Marchal 2010; Deutsche Welle 2010; Sevchenko 2010). In the end however, the changes in the law with respect to cannabis were relatively modest. Conviction for possession of a quantity of cannabis “greater than small” could draw a prison sentence of up to one year, whereas possession of relatively large quantities of other illicit drugs could result in imprisonment of up to two years (National Monitoring Centre et al. 2010). In addition, the law defined standards for cultivation of cannabis “for personal

use” that allowed small-scale cultivation to be treated as a misdemeanor, punishable with a fine. Possession of small amounts of all drugs remained a misdemeanor.

There were precedents elsewhere in Europe for the decision to distinguish cannabis (and other plant drugs, but cannabis was the most important) from other illegal drugs with respect to both its assessed potential for harm and the penalties associated with it. As early as 1976, the Netherlands changed its law to reflect a policy of decriminalization of cannabis possession up to a certain quantity (the cut-off quantity has changed over time) (Korf 2002). While the Netherlands case is most widely known because cannabis products are not only decriminalized but commercialized in “coffee shops,” by the early 1990s other European countries—including Spain, Ireland, Italy and to some degree the United Kingdom—distinguished cannabis from other drugs in law or law enforcement practices (Leroy 1992). By 2002, several additional countries made this distinction (EMCDDA 2002). Thus, formally recognizing distinct categories of drugs in this way aligned the Czech Republic with trends in much of the rest of Europe.

Perhaps more significant than the distinctions made in the new law between cannabis and other drugs was the publication of suggested cut-off points defining “greater than small” and “larger extent” quantities for purposes of prosecution of the law. As noted above, the absence of a clear definition of “greater than small” was seen by some as allowing too much judicial discretion in drug cases. Table 1 shows the quantities published with the 2009 law. The media noted that the Czech definition of a quantity associated with personal use of drugs was larger than those of some other countries in Europe where a “personal use” distinction was made (Sevchenko 2010; Deutsche Welle 2010). According to an EU summary however, for each drug in the table there are several European countries with equivalent or even greater cut-off quantities to define personal use (EMCDDA 2010c). The government hastened to note that “it is always an illegal act...to possess any amount of drugs” in the Czech Republic, only that small quantities would be treated as misdemeanors punishable with a fine rather than imprisonment (National Monitoring Centre et al. 2010).

**TABLE 1: Quantities “greater than small” defined by Czech penal code on drug possession, Government Decree no. 467/2009 Coll.**

<i>Drug type</i>	<i>Quantity “greater than small”</i>	<i>Smallest quantity of the active psychotropic substance that must be contained for a quantity under examination to be “greater than small”</i>
Pervitin (methamphetamine)	>2 g	0.6 g of base
Heroin (diacetylmorphine)	>1.5 g	0.2 g of base
Cocaine	>1 g	
Medicines containing buprenorphine		52 mg of base
Methadone		500 mg of base
Ecstasy (MDMA/MDA/MDEA)	>4 tablets of 0.4 g powder or crystals	0.34 g of base
LSD	5 paper tabs, tablets, capsules or “crystals”	0.000134 of base
Marijuana (delta-9-THC)	>15 g dry matter	1.5 g delta-9-THC
Hashish	>5 g	1 g delta-9-THC
Psilocybin mushrooms	>40 fruiting bodies	30.05 g of base (psilocin)

The specialized drug unit of the Czech national police had advocated that any changes in the law should preserve the central idea that drug possession is illegal, even if minor possession would not be penalized. The chief of the drug police, Jakub Frydrych, said however, that the police feel constrained by the “schizophrenia” of the law that makes possession but not drug use an offense (Frydrych interview). Asked if he would want the police to be spending their time hunting down people whose only offense is individual use, he said that indeed that would not be a sensible priority, but he would like there to be a way for young people who use drugs to feel some sense of sanction, perhaps by having to appear before a judge or having to report to a treatment program. In this regard, he found promising the drug treatment court model from the United States, Canada, and a few other countries, whereby minor offenders can be mandated by a court to attend treatment programs. He said the drug police continue to make stopping major drug traffickers the priority of their work.



### III. Providing Harm Reduction Services and Success against HIV

In 2009, the Czech government estimated that there were about 37,400 problem drug users (meaning people who inject drugs and those with long-term regular use of drugs other than cannabis) (National Monitoring Centre 2010). This figure represented a statistically significant increase over the previous year, mostly because of an estimated significant increase in Pervitin users (Ibid.). The estimated number of problem drug users in 2002 was 35,100, and the number hovered near 30,000 for most of the period 2003 to 2008. The National Monitoring Centre's most recent annual report notes that "as confidence intervals for the estimates from recent years overlap, the observed increase should be interpreted with caution" (Ibid.). Of problem drug users in 2009, an estimated 25,300 or two thirds used Pervitin (methamphetamine) and 12,100 or almost one third used opiates (Ibid.). This pattern is unusual for the European Union, as methamphetamine (Pervitin) use in the Czech Republic is much more dominant than elsewhere in the region (EMCDDA 2010a). In 2009, some 8,763 people sought treatment for drug dependence, according to the government, of which about 60 percent were people using Pervitin (methamphetamine), 23 percent opiates and 18 percent cannabis (National Monitoring Centre 2010). The Czech Republic ranks at or near the top of EU countries in prevalence of cannabis use in all age groups (EMCDDA, 2010). In 2009, an estimated 38.1 percent of

Czech young people aged 18 to 24 years reported cannabis use in the previous year (National Monitoring Centre 2010).

The drug policy environment in the Czech Republic has enabled the development of extensive low-threshold services for people who use drugs, in which NGOs play a key role. Needle exchange is provided in bigger cities through NGO drop-in centers (also called “contact centers”), of which there are three in Prague at this writing. Another seven needle exchanges in the city are street-based. The contact or drop-in centers also provide counseling, HIV testing, crisis management, and other health and social services. An estimated 70 percent of what the government characterizes as “problem” drug users in the country, and up to 80 percent in Prague, have contact with drop-in centers and/or street-based services (National Monitoring Centre 2010), which constitutes remarkable coverage. In 2009, about 95 needle exchange programs across the country distributed 4.9 million needles (Ibid.); in 2008, 10 programs in Prague alone distributed about 2.1 million needles for an estimated population of about 11,400 people who injected drugs regularly (Bém 2010). The Czech Republic is estimated to have one of the highest rates of coverage of needle exchange services in the European Union (EMCDDA 2010b). Needle exchange is complemented by peer outreach and education programs encouraging smoking or inhalation of drugs rather than injection (National Monitoring Centre 2010).

Any physician in the Czech Republic can prescribe buprenorphine to treat opiate dependence. In 2010, the government estimated that there were about 11,000 addicted opiate users of whom 5,000 were maintained in medical substitution treatment, mostly with buprenorphine, constituting a coverage rate of about 45 percent (Mravčík, personal communication). An overview of substitution therapy coverage in EU countries places this level of coverage among the highest within EU member states reporting coverage data (EMCDDA 2010a). According to the National Monitoring Centre, methadone patients never exceeded 700 in any year since monitoring began, and now buprenorphine far surpasses methadone in opiate dependence treatment. Dr Kamil Kalina, who served two separate terms as national drug coordinator, said that methadone use in the country was impeded by “a lot of prejudices” for a long time (Kalina, interview). As of early 2010, treatment with Suboxone (buprenorphine plus naloxone) is covered by health insurance in the country under certain conditions, including when patients strictly adhere to the schedule of doctor visits (National Monitoring Centre 2010).

The Czech Republic had 36 prisons and remand centers as of 2009. In that year, nine of these institutions offered methadone therapy to those in custody (National Monitoring Centre 2010). Persons awaiting trial may be included in methadone services at their request. In 2009, 15 NGOs provided health services including counseling and therapy for drug dependence in some 30 prisons and pretrial detention centers and helped link persons

awaiting release to community-based care (Ibid.). The national prison authorities have their own “Drug Policy Action Plan” that explicitly includes a harm reduction component (Ibid.).

Treatment for drug dependence other than medication-assisted opiate therapy is provided in psychiatric outpatient or inpatient services at government hospitals or private facilities. Some 15 to 20 therapeutic communities, most run by NGOs, have evolved from the early work by Skála and others (National Monitoring Center 2010). The EU’s Monitoring Centre for Drugs and Drug Addiction in Lisbon cited SANANIM’s therapeutic community in Karlov for young people (aged 15 to 25 years) as a “best practice” example (EMCDDA 2004). The Karlov site allows women to live with their children and includes parenting skills training. The program for young people includes work, life skills training and sports, and other leisure activities. The EMCDDA write-up of Karlov said that the six to eight month period envisioned for the young adult program might be too long, judging from the number of drop-outs the program has experienced (Ibid.).

Efforts have been made to develop and provide harm reduction services for people who use Pervitin (methamphetamine), the most widely used illicit drug in the country, which is often injected. Some low-threshold facilities provide empty gelatin capsules to Pervitin users who fill the capsules with the drug and ingest them orally (Mravčík et al. 2011). A less harmful alternative to injection, oral ingestion of encapsulated Pervitin, especially on an empty stomach, is reported at least for some people to have an effect comparable to that of injection (Ibid.). The method was inspired by the practice of some Pervitin injectors of swallowing a bolus of Pervitin wrapped in paper or plastic when they cannot find a vein or otherwise want to avoid injection at a given moment.

Unlike some of its counterparts in Europe and the former Soviet bloc, the Czech Republic has achieved low HIV prevalence among people who use drugs. HIV prevalence among people who inject drugs was reported in 2010 to be below 1 percent (National Monitoring Centre 2010), and it has been in that range for some time. Experts from outside the country have attributed this result to the relatively early availability and accessibility of low-threshold harm reduction services, especially needle exchange (Donoghoe 2006). Czech experts interviewed for this report generally concurred with that view (Kalina, Janyšková, interviews). Among EU member states, the Czech Republic also has one of the lowest seroprevalences of hepatitis C virus among people who inject drugs (EMCDDA 2011).

According to the National Monitoring Centre (2010), about 30 percent of problem drug users in the country are in Prague, and many health and social services are located there. Dr Pavel Bém, an addiction medicine specialist who held leading positions in clinical addiction services in the early 1990s and was national drug coordinator in 1994–98, was mayor of Prague from 2002 to 2010. In this period, low-threshold services for people who use drugs expanded significantly in the capital city. The city’s budget for health and social

services related to drug use expanded from 12.4 million Czech crowns (about U.S. \$206,000 at 2002 exchange rates) to 44.5 million Czech crowns (about U.S. \$2.6 million) (Bém 2010; Janyšková interview). At this writing, Bém is a member of the Czech parliament.

As noted above, NGOs provide many of the services described here and the majority of low-threshold services. Many NGOs receive funding for their services from the NDC and from the Ministry of Social Welfare. A licensing-type certification process run by the office of the national drug coordinator is meant to ensure quality of services provided outside government facilities. NGO facilities are periodically inspected by a certification team and facility managers provide a wide range of information on their activities. Until 2010, certification was granted for a maximum period of three years; since 2010, four-year certification is possible (National Monitoring Centre 2010). While they recognized the need for a rigorous certification system, NGO leaders interviewed for this report said that the government should match multiyear certification with multiyear funding (Richter, Janouškovec interviews). NGOs can generally get only one year of government funding at a time, and often the amount that will be received is not known in advance (Ibid.). These constraints limit the ability of NGOs to plan their activities and to have multiyear strategies in their work.



## IV. Politics and Stigma

As in many parts of the world, drug policy and services for drug users continue to be the subject of political debates in the Czech Republic. Many persons interviewed for this report said that people who use drugs were derided in campaigns during city elections in Prague in 2010 and used as scapegoats for social problems. The political posters from the election in Figures 1 and 2 below illustrate these practices. Some candidates made the closing of drop-in centers for drug users a central part of their platform or repeatedly promised taxpayers that none of their money would go to services for “junkies” (Janouškovec, Richter interviews). Others seemed to recognize the value of services but did not want them placed in their districts.

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**FIGURE 1: Poster of the Social Democratic Party, Prague city elections, 2010**



*Note:* The same slogan, “Down with addicts, the homeless, and gambling arcades,” appeared on billboards in the Prague’s fifth District.

*Source:* National Monitoring Centre 2010.

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**FIGURE 2: Poster of the Citizens Rights Party, Prague city elections, 2010**



*Note:* The headline reads “In our children’s interest—zero tolerance of junkies.”

*Source:* National Monitoring Centre 2010.

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Services that are visible to the public or are perceived to bring people who use drugs to a given neighborhood may test the limits of tolerance of some residents and local officials. The NGO Progressive, which operates a drop-in center in Prague, negotiated with local officials in one Prague neighborhood in 2008 to install a small needle and syringe vending machine on the street (Figure 3) that would enable access to injecting equipment around the clock. The experience was inspired by the use of numerous such machines in Germany. In the view of Vojtěch Janouškovec, the harm reduction director of Progressive, the machine filled an important need because the drop-in centers are not open at all hours and many pharmacies refuse to sell syringes to drug users and are not obliged to do so. The machine was heavily used. Officials in the Old Town neighborhood of Prague approved of and contributed financially to the machine, but then ordered its removal after neighborhood residents complained. The machine was moved to the town of Kolin about 100 km from Prague, where, according to Progressive, it is again heavily used.

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FIGURE 3: “Nonstop” vending machine for injection equipment, in Prague before its removal



Photos: Vojtěch Janouškovec (Progressive O.S.)

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Some persons interviewed for this report thought that politicization of drug issues was most pronounced in Prague compared to other parts of the country. Nina Janyšková, the drug policy coordinator for the city of Prague, said that her office regularly appeals to the public using evidence of the successes of drug policies and programs to counter unfounded allegations made in the heat of political campaigns. Her office conducts public campaigns that promote the importance of humane health and social services for people who use drugs. She recognized that some politicization of drug issues is inevitable but remained optimistic that the public understands that relying only on repressive policing is not the answer.

Still, stigma and social disdain surrounding drug use are continuing challenges for Czech policymakers. Michal Miovský (2009), the director of the Centre for Addictology of Charles University, put it this way:

There was a survey not too long ago asking “Who would you not want to have for neighbors?” and the so-called “junkies” won....On the other hand, our society has always been very tolerant towards alcohol, although the majority of drug-related problems are related to it. It is not considered out of the norm when your neighbor is a drunk who beats up his wife—at least he’s not a junkie.



## V. Established Principles and Systems: Successes and Challenges

The national drug strategy of the Czech Republic published in 2009 covers the period 2010 to 2018 and is to be accompanied by three three-year action plans (Secretariat of the GCDPC 2009). That the government can establish a nine-year strategy may indicate how well established the basic tenets of the drug policy are. Building on previous national plans and true to a multi-pillar approach, the objectives of the 2010–2018 strategy are: (1) to reduce the level of experimental and occasion drug use, especially among young people; (2) to reduce problematic and intensive drug use; (3) to reduce drug-related harms and risks to people and society; and (4) to reduce the available drug supply (Secretariat of the Government Council for Drug Policy Coordination 2009). In view of the continuing challenge of stigma, it is significant that the drug strategy aspires explicitly to be based on both scientifically sound approaches and “respect for human dignity, freedom, democracy, equality, solidarity, the rule of law, and human rights” (Ibid.).

The national response to illicit drugs includes a network of regional drug coordinators and multisectoral drug committees in each of the Czech Republic’s 14 regions. Some of the regional drug coordinators are full-time coordinators; others have government responsibilities in addition to drug coordination. Marek Nerud, the full-time drug coordinator of the Southern Bohemia region based in České Budějovice, said that the regional drug commit-

tee there provided a platform for the representatives of the concerned sectors to think in a multisectoral way and see drug issues not as just a police matter or just a health matter. The regional drug coordinators meet together and with the national drug coordinator at regular intervals. NGOs are important service-providers and participate in regional drug bodies in most regions.

The annual reports on the drug situation produced by the National Monitoring Centre for Drugs and Drug Addiction in Prague follow a template issued by the European Union and inform EU summary reports on drug issues. The Czech annual reports are thorough and thoughtful in their interpretations of the vast amount of evidence presented. The reports build helpfully on information in previous reports, providing a historically coherent analysis of many topics. They often include results of special surveys or other studies on topics of current policy interest. The director of the National Monitoring Centre, Dr Viktor Mravčík, was one of the PAD researchers and credits the PAD experience with having contributed to technical capacities and approaches on which the center still relies.

The Czech Republic has played a leadership role in the European Union on drug issues, notably in the lead-up to and during the important meeting of the UN Commission on Narcotic Drugs (CND) in March 2009. The special 2009 CND session was to produce a political declaration reflecting on 10 years of the global response to drug problems and setting strategies for the next 10 years. At the time, the Czech Republic held the EU presidency. The statement by the European Union, prepared and delivered by the Czech Republic (Radimecký interview), was an important indictment of the prohibitionist strategy of the previous global declaration. It said that the goals of reducing drug supply and demand had not been achieved because of “a lack of implementation of a balanced and comprehensive approach” (European Union 2009). Citing success in the European region in containing HIV among people who inject drugs, the statement further asserted the importance of harm reduction as a policy pillar that “cannot replace prevention, treatment and rehabilitation—and cannot be replaced by them” (Ibid.). While the political declaration of the high-level CND meeting did not, in the end, reflect these values, the EU statement was a powerful endorsement of evidence-based drug policy principles and a remarkable achievement of a unified consensus among EU countries.

The Czech experience also includes university-based development of a formal science of addiction medicine and related social services. The Centre for Addictology of Charles University in Prague, though founded only in 2005, is an internationally-respected institution in the field. Its concept of the addiction discipline includes not only clinical and public health aspects but also the social and legal context of drug addiction, and its faculty include experts in all of these areas. It trains undergraduates and master’s level students and carries out an ambitious program of research (Miovský 2009; Centre for Addictology 2009).

In a time of economic downturns and fiscal constraints, Czech drug policymakers face the challenge of sustaining comprehensive services that are part of a multipillar strategy. According to the National Monitoring Centre (2010), there was a steady increase in budget allocations from the ministries of education, defense, labor and social affairs, health and justice and the customs authorities for the national drug response from €6.3 million annually in 2002 to €14.9 million in 2008. In 2009, the total fell to €14.2 million. The contribution of the 14 regions (including the city of Prague) rose from €952,000 to €6.5 million from 2002 to 2008 and similarly fell in most regions in 2009, though the overall total remained at about €6.5 million. NGOs are particularly worried about cutbacks in support for essential services. The NGO SANANIM, which is the oldest of the organizations providing services to people who use drugs, runs a café and a charity store in Prague that generate some revenue for the organization, and it has benefited from a few private-sector donors (SANANIM 2010). But SANANIM and other organizations are concerned by the difficulty of finding private-sector donors for their essential services in the face of potential government cutbacks.

It is often challenging to sustain the functioning of interministerial bodies such as the drug commission in the Czech Republic. Representatives of line ministries inevitably come to the table with their own sectoral concerns and finding common positions across sectors can be difficult. Interministerial entities are frequently not given the budget or decision-making authority that would enable them to make significant strides in developing and implementing policy. Radimecký (2007), a former national drug coordinator, bemoaned the National Drug Commission's lack of authority to ensure that the decisions it makes are implemented by line ministries, a common problem in interministerial bodies. In June 2011, NGO leaders told the author of this report that some of the government members of the commission were attempting to eliminate NGO representation on the commission, which in the end did not occur. Nonetheless, most experts interviewed for this report found that the National Drug Commission, while not perfect, plays an important role in a challenging area of intersectoral policymaking.

An example of the usefulness and limits of the national drug coordination mechanisms was the challenge the government faced in 2010 as new synthetic drugs manufactured in China entered the country via Poland and were sold in shops legally because Czech drug law did not explicitly prohibit them (Buehrer 2011). The national drug coordinator Jindřich Vobořil called on parliament to amend the drug law to expressly prohibit these new substances. The government became aware of the new drugs in September 2010, a draft amendment was prepared by November and delivered to the parliament in December, but legislators did not vote on the amendment until April 2011. At that time, the parliament added to the drug law criminal prohibitions against 33 new drug formulations (National Monitoring Centre 2011). Both Vobořil and the director of the National Monitoring Centre

for Drugs and Drug Addiction, Dr Viktor Mravčík, urged that there be a procedure that would give the executive branch of government the authority to act quickly without the need for parliamentary action in cases such as this, particularly given the likelihood that many new synthetic drugs would follow the ones covered in the amendment (Velinger 2011). In this case, as Vobořil noted, the government also needed to confront China directly, not something that the office of drug coordination could easily do on its own.



## VI. The Czech Republic and Slovakia: Neighbors Pursuing Different Drug Policy Paths

On the eve of the 2004 EU expansion, the European Centre for Monitoring of Drugs and Drug Abuse (EMCDDA) raised a cautionary flag about the range of drug policies represented by the EU candidate countries, especially those of the Eastern Bloc, and emphasized the need for coherence in European drug policy (EMCDDA 2003). In particular, EMCDDA noted that EU policies were converging in the direction of more harm reduction activities and depenalization of drug use, and of possession of minor amounts of illicit drugs (Ibid.). “Such initiatives are almost non-existent in the candidate countries, and the limited funding available is often more oriented to law enforcement,” the center asserted, noting that it was “imperative” for the EU not to lose momentum in its efforts toward multipillar drug policy.

As already noted, the Czech Republic took many drug policy decisions before its 2004 accession to the European Union that aligned it with EU trends. The Slovak Republic, however, took a direction closer to what the EMCDDA feared on the eve of the 2004 accessions. Remarkably, given the shared history of the Czech and Slovak republics, Slovak drug policy has been markedly different from that of the Czech Republic, both on paper and in its application.

Until 2005, the Slovak Republic’s strong prohibitionist law included little room for any deviation from harsh criminal prosecution of all levels of drug offenses. When Czecho-

slovakia was dissolved with the formation of the Czech and Slovak republics, the Slovak authorities moved quickly to penalize drug possession for personal use, thus deviating from the liberalizing policies of early post-Soviet Czechoslovakia (Hičárová et al. 2010). In 1999, Slovak drug law was modified to distinguish those convicted of selling drugs from those convicted only with possession for personal use with much harsher penalties for the former, though possession for personal use remained a crime.

Like other countries that became EU members in 2004, the Slovak Republic undertook a major revision of its criminal code to reframe its law in light of EU standards. The new Slovak criminal code (Act 300/2005) and the new code of criminal procedure (Act 301/2005) were meant to reflect positions more in line with the EU trends. In particular, the new criminal code allowed for removal of criminal penalties for possession of drugs in the amount of up to 10 times the amount of a single dose as opposed to the previous law that criminalized possession of more than a single dose (Hičárová et al. 2010). However, the law does not specify the quantity that corresponds to a single dose, leaving room for interpretation by judges of this key fact of drug cases. The government's Forensic Institute may study the possessed quantity and suggest how many doses could be derived from it, sometimes giving a numerical range that might span the under-ten and the over-ten categories, again requiring an interpretation from the courts (Hičárová interview). The explanatory note to the law emphasizes that the intent of the change is to distinguish traffickers from those possessing drugs for personal use, enabling law enforcement mechanisms to focus on traffickers, and to enable more use of "diversion" from criminal proceedings for minor offenders, including diversion to treatment.

A 2010 study of Slovak drug policy (Hičárová et al. 2010), undertaken by NGOs in collaboration with government officials and with technical support from experts from the Centre for Addictology of Charles University, investigated the impact of the 2005 drug law reforms in Slovakia. The study concluded that irregularities in determining how many doses are really at issue in a given case has undermined the goal of the legal reform and enabled the continued harsh prosecution of persons who are not drug dealers. It also found that while some cases were disposed of through assessing fines rather than prison sentences, little use was being made of diversion to treatment. In addition, the study uncovered instances of police interference with the operations of needle exchange programs, inhumane treatment of people in custody for drug offenses, and other violations of detainees' rights, which the authors said undermined the spirit of "balanced" drug policy that was ostensibly behind the criminal code reform. The Slovak Government has not responded to this study as of this writing.

The Slovak police retain a system of arrest quotas for drug dealers. Jaroslav Spišiak, the president of the Slovak National Police, said the quota for 2011 was 2,874 dealers. He

said however, that in reality the line between drug use and dealing was often blurred, and that sometimes the police “just know” that someone not found with large quantities of drugs in his or her possession may still be a dealer. Marek Para, a lawyer in Bratislava who handles many drug cases, said that the police are forced by quotas to arrest whoever is easiest to get to, and that is most often the minor drug offender. He disputed the police’s assertion that the arrest quotas help them target dealers and traffickers only. When each police officer is paid depending on how many drug offenders he brings in, Para said, then minor offenders will be apprehended in large numbers. Jozef Čentéš, the chief prosecutor for corruption and money-laundering in the Slovak Republic, whose office handles drug-related offenses, said that prosecutors have attempted to encourage the police to focus on trafficking and larger-scale offenders, but without great success. He was interested in expanding alternatives to incarceration for minor drug offenders, but that would require a different approach by the police. Para also urged that the Slovak Republic define “small” amounts for possession as the Czech Republic has done and use that definition to institute noncriminal penalties for minor offenses.

The reasons drug policy in the Czech and Slovak republics went in such different directions are many and complex. Slovak drug policy in the 1990s reflected larger policy tendencies of the government of Vladimír Mečiar, who became prime minister in 1994, shortly after the dissolution of Czechoslovakia. The Mečiar government was widely seen as undemocratic and corrupt—what some experts called a “thugocracy” (Kopstein and Reilly 2000). As Western critiques of Slovakia’s “deficit of democracy” mounted, Slovakia turned eastward and made Russia a key economic and political ally. This political climate was conducive to harsh drug laws. Mečiar’s party suffered a defeat in 1998, after which a more vocal civil society and a desire for EU membership contributed to more democratic policies in some spheres (Pridham 2002).

Some observers also noted that before the Velvet Revolution, Slovakia did not have the equivalent of a Skála and his cadre of colleagues and students trained over many years, whose leadership in civil society and government helped steer Czech drug policy in a multipillar direction with health professionals in key policy positions (Kalina, Hičárová interviews). The general weakness of the NGO sector in Slovakia, especially in the health area, may also be at the root of some differences (Potůček 1993; Zábanský interview). Low-threshold services for people who use drugs are less developed in Slovakia than in the Czech Republic in spite of the efforts of NGOs in the field; indeed there is at this writing only one low-threshold harm reduction service in Slovakia as opposed to scores of them in the Czech Republic (Zábanský, Hičárová interview). The rate of hepatitis C virus seroprevalence in Slovakia is about twice that of the Czech Republic (EMCDDA 2011, p. 85). Observers have also cited the more secular and perhaps less moralistic quality of Czech society (Musil 1993; Zábanský

interview). In addition, Musil (1993) noted that in what is now the Czech Republic a great degree of industrialization and development of urban communities took place before the Soviet occupation, whereas urbanization was most intense in Slovakia during Soviet rule. In light of this fact, Musil suggests that the historical roots of democratic governance structures may not be as deep in Slovakia as they are in Czech cities.

## VII. Conclusion

To the degree that control of HIV is an indicator of drug policy effectiveness, the Czech experience merits very high marks. While some other European countries such as Switzerland, Spain in the 1980s, and countries of the former Soviet bloc, including Russia, in the 1990s and beyond, faced fast-growing HIV epidemics linked to drug use, the Czech authorities and civil society were able to avert significant HIV transmission in a highly vulnerable population. Relatively high coverage of needle exchange programs and ready access to medication-assisted therapy for people with opiate dependence seem to have been central to this result. Innovative harm reduction with respect to methamphetamine use attests to a commitment to reduce HIV and other harms as an important element of drug policy. Policies that have encouraged the police to prioritize large-scale trafficking and other major crimes are a central element of a conducive environment for harm reduction and health services.

National drug coordinators in the Czech Republic have generally brought front-line NGO experience to the job of providing health and social services for people who use drugs. National and regional governments in the Czech Republic provide financial support to NGO services—especially low-threshold services—and outreach that NGOs are likely to perform more effectively than government institutions. Formal NGO representation on the National Drug Commission demonstrates the importance of civil society to the country's drug response.

There is probably no country in the world where drug policy relies exclusively on scientific evidence; it is only too easy for drug policymaking to be driven by politics, sectoral agendas, and ideology. But the experience of the Czech Republic illustrates a demonstrable

commitment to rigorous monitoring of the consequences of policymaking and learning from the results. In the face of political challenges to balanced drug policy, which are likely only to intensify in times of fiscal restraint, this reliance on evidence-based approaches will be of great importance.

## Lessons from the Czech Experience

The Czech drug policy experience offers many lessons for countries emerging from autocratic regimes and for governments more broadly. Among these are the following:

**Profile of drug policy coordinators and other key players:** The position of general secretary or coordinator of the National Drug Commission is an important one in the Czech drug policy structure. When so many interministerial drug control bodies in the world are chaired or dominated by police, military or criminal justice officials, it is striking that the Czech drug policy coordinators have generally been persons with extensive experience in providing front-line health or social services to people who use drugs. These include Dr Kamil Kalina, the first drug coordinator whose expertise in the field of addiction medicine helped establish a health perspective in decision-making that would follow, and Jindrich Vobořil, the coordinator as of this writing, whose experience includes having been the cofounder of an NGO serving drug users in Brno. In between, Dr Pavel Bém (drug coordinator 1994–98) established a sustainable funding system for NGOs and commissioned the PAD study. Dr Josef Radimecký, who had founded one of the country's first therapeutic communities for drug users, further strengthened reliance on scientific evidence in drug policymaking and authored the first drug strategy that defined harm reduction as a pillar of national policy. He was also the main proponent of using the PAD results to inform legal changes after 2002. That a health professional who espouses evidence-based programs and policy such as Dr Bém was mayor of Prague for eight years and then in the national parliament also undoubtedly helped balance political debates and priority-setting. While many factors led Czech drug policy in the direction it took, the presence of these health and social service professionals in key policy positions was a major factor in getting a national commitment to policy based on more than just policing.

**Scientific evidence and policymaking:** The influence of the Impact Analysis Project of the New Drug Legislation (PAD) and the continued investment of the government in generating high-quality research on the impact of drug policies indicate that the Czech Republic, at least at certain moments, has managed to produce rigorous evidence to inform drug policy

debates and decisions. Coming at an important turning point in Czech drug policy history, the PAD established a high standard for the kind of evidence that policymakers should expect from scientists and contributed to the building of technical capacity in this area. Drug policy decision-making processes are widely supported by the drug information system coordinated by the National Monitoring Centre for Drugs and Drug Addiction. The profile of the national drug coordinators already mentioned has also given the Czech Republic the asset of policymakers whose academic training and professional experience predispose them to respect scientific evidence. The existence of a high-quality, multidisciplinary academic Centre for Addictology that also contributes research evidence relevant to policymaking is an important additional asset. It is of note that both the National Monitoring Centre and the Centre for Addictology at Charles University are headed by experts who were members of the PAD team.

**Role of civil society:** Because of the stigma of drug use and the tendency for official structures to be unable to reach the most marginalized people who use drugs, effective responses to drug use are difficult without the active involvement of civil society. The Czech experience attests to this fact. The role of civil society was crucial for the establishment and maintenance of a multipillar policy at many stages from the beginning of the post-Velvet Revolution period. The Christmas memorandum of 1992 perceptively articulated that the state and civil society would have to work together to scale up urgently needed services. NGOs have sustained crucial low-threshold health and harm reduction services in the country. NGOs suffer because of the delays and restrictions associated with financial support from government and struggle to find private-sector support for their activities. They nonetheless have official standing as part of drug policy decision-making, a status that their counterparts in many countries have not achieved. The voice of NGOs in the National Drug Commission will be crucial to face the fiscal and political challenges of Czech drug policy in the future.

**Prospect of EU membership:** Virtually all the Czech experts interviewed for this report thought that the prospect of EU accession was an important influence at key moments in the shaping of Czech drug policy. In exactly the period that the Czech Republic had to decide the direction of its policies, trends in EU member countries, especially toward more lenient penalties for minor drug offenses, were becoming more evident. The direction of Czech drug policy and its alignment with EU trends set the stage for Czech leadership in the important articulation of EU ideas at the 2009 high-level session of the UN Commission on Narcotic Drugs. Alignment with EU standards was also apparently an important factor in the 2005 change in the drug law of the Slovak Republic, though the spirit of that change has been difficult to discern in law enforcement practices. At this writing, there are five can-

didate countries for EU membership, including Croatia, Macedonia, and Montenegro. The Czech experience of policy informed by EU trends, paving the way to a leadership position in Europe-wide drug policy, may provide helpful lessons for these countries.



## References

- Bém, P. 2010. Presentation to conference, “Urban drug policies in the globalised world,” September 30, Prague. (Slides given to the author in hard copy.)
- Buehrer, J. 2011. Government urged to ban new designer drugs: market flooded with Chinese synthetics, trafficked via Poland. *Prague Post*, February 2. [<http://www.praguepost.com/print.php?url=7334-govt-urged-to-ban-new-designer-drugs.html>]
- Bullington, B. 2007. The velvet hangover: reflections on Czech drug policy. *Journal of Drug Issues* 37(1):205–228.
- Centre for Addictology, Department of Psychiatry of the First Faculty of Medicine, Charles University, 2009. *2009 report on activities*. Prague. [<http://www.adiktologie.cz/en/articles/418/Activity-reports>]
- Chafetz, ME. 1961. Alcoholism problems and programs in Czechoslovakia, Poland and the Soviet Union. *New England Journal of Medicine* 265(2):68–74.
- Chatwin, C. 2003. Drug policy development within the European Union. *British Journal of Criminology* 43:567–582.
- Conroy, MS. 1990. Abuse of drugs other than alcohol and tobacco in the Soviet Union. *Soviet Studies* 42(3):447–480.
- Deutsche Welle. 2010. New Czech drug guidelines are Europe's most liberal, January 7. [[www.dw-world/de](http://www.dw-world.de)]

- Donoghoe, M.C. 2006. Injecting drug use, harm reduction and HIV/AIDS. In S. Matic, J.V. Lazarus, and M.C. Donoghoe, eds. *HIV/AIDS in Europe: Moving from death sentence to chronic disease management*. Copenhagen, WHO-Europe. [[http://www.who.int/hiv/pub/idu/hiv\\_europe.pdf#page=58](http://www.who.int/hiv/pub/idu/hiv_europe.pdf#page=58)]
- European Monitoring Centre for Drugs and Drug Addiction. 2002. *Drugs in focus: drug users and the law in the EU—a balance between punishment and treatment*. Lisbon: European Union.
- European Monitoring Centre for Drugs and Drug Addiction. 2004. *Overview: Karlov therapeutic community (Best Practice Portal)*. Lisbon: European Union. [[http://www.emcdda.europa.eu/modules/wbs/dsp\\_print\\_project\\_description.cfm?project\\_id=6197](http://www.emcdda.europa.eu/modules/wbs/dsp_print_project_description.cfm?project_id=6197)]
- European Monitoring Centre for Drugs and Drug Addiction. 2010a. *The state of the drugs problem in Europe: Annual report 2010*. Lisbon: European Union.
- European Monitoring Centre for Drugs and Drug Addiction. 2010b. *Harm reduction: evidence, impacts and challenges*. Lisbon: European Union.
- European Monitoring Centre for Drugs and Drug Addiction. 2010c. *Threshold quantities for drug offenses (web summary)*. Lisbon: European Union. [<http://www.emcdda.europa.eu/html.cfm/index99321EN.html>]
- European Monitoring Centre for Drugs and Drug Addiction. 2011. *The state of the drugs problem in Europe: Annual report 2011*. Lisbon: European Union. [[http://www.emcdda.europa.eu/attachements.cfm/att\\_143743\\_EN\\_EMCDAR2011\\_EN.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_143743_EN_EMCDAR2011_EN.pdf)]
- European Union. 2009. Statement by Ivan Langer, Minister of the Interior of the Czech Republic on behalf of the European Union to the High-Level Segment of the 52nd Session of the Commission on Narcotic Drugs, Vienna, March 11.
- Fleming, P., Bradbeer, T., and Green, A. 2001. Substance misuse problems in Russia: a perspective from Saint Petersburg. *Psychiatric Bulletin* 25:27–28.
- Government of the Czech Republic, 2011. *Statute of the Government Council for Drug Policy Coordination*. [<http://www.vlada.cz/assets/ppov/protidrogova-politika/Statute-rvpkppx.pdf>]
- Hičárová, T., Kiššová, L., Očenášová, A., et al. *Project to evaluate selected drug-possession provisions of Act no. 300/2005—Criminal Code of the Slovak Republic: Summary final report*. Bratislava: Open Society Foundations, 2010. [[http://www.soros.org/initiatives/drugpolicy/articles\\_publications/publications/slovak-drug-possession-report-20110301/evaluation-drug-paragraphs-20110308.pdf](http://www.soros.org/initiatives/drugpolicy/articles_publications/publications/slovak-drug-possession-report-20110301/evaluation-drug-paragraphs-20110308.pdf)]
- International Narcotics Control Board (INCB). 1996. *Annual report for 1995*. Vienna, United Nations. [[http://www.incb.org/incb/en/annual\\_report\\_1995.html](http://www.incb.org/incb/en/annual_report_1995.html)]

- International Narcotics Control Board (INCB). 1997. *Annual report for 1996*. Vienna, United Nations. [[http://www.incb.org/incb/en/annual\\_report\\_1996.html](http://www.incb.org/incb/en/annual_report_1996.html)]
- Jacoby, W. 1999. Priest and penitent: the European Union as a force in the domestic politics of Eastern Europe. *East European Constitutional Review* 8:62–67.
- Kalina, K. 2006. Therapeutic communities for addicts in the Czech Republic—roots, recent development and current profiles. *International Journal of Therapeutic Communities* 27(1):31–44.
- Kalina, K. 2007. Developing the system of drug services in the Czech Republic. *Journal of Drug Issues* 37(1):181–204.
- Kopstein, J.S., and Reilly, D.A. 2000. Geographic diffusion and the transformation of the postcommunist world. *World Politics* 53:1–37.
- Korf, DJ. 2002. Dutch coffee shops and trends in cannabis use. *Addictive Behaviors* 27:851–866.
- Leroy, B. 1992. The European Community of twelve and the drug demand: excerpt of a comparative study of legislations and judicial practice. *Drug and Alcohol Dependence* 29:269–281.
- Marchal, J. 2010. Czech pot smokers exhale with relief over new drug law. *Agence France Presse*. March 17. [<http://www.ccguide.org/news/shownewsarticle.php?articleid=15441>]
- Miovský, M. 2009. 1st Medical Faculty's Addictology Center introduces its master's programme (online interview). [<http://iforum.cuni.cz/IFORUM-9878.html>]
- Mravčík, V., Škařupová, K., Orlíková, B., et al., 2011. Use of gelatin capsules for application of methamphetamine: a new harm reduction approach. *International Journal of Drug Policy* 22:172–173.
- Musil, J. 1993. Czech and Slovak society. *Government and Opposition* 28(4):479–494.
- National Monitoring Centre for Drugs and Drug Addiction of the Czech Republic, 2009. Czech drug policy and its coordination: History and the present. Prague. [[http://www.vlada.cz/assets/ppov/protidrogova-politika/dokumenty/publikace/Zaostreno\\_coordination\\_2009\\_www.pdf](http://www.vlada.cz/assets/ppov/protidrogova-politika/dokumenty/publikace/Zaostreno_coordination_2009_www.pdf)]
- National Monitoring Centre for Drugs and Drug Addiction of the Czech Republic, 2010. *Annual report: the Czech Republic 2009 drug situation*. Prague. [[http://www.drogy-info.cz/index.php/english/annual\\_report\\_the\\_czech\\_republic\\_2009\\_drug\\_situation](http://www.drogy-info.cz/index.php/english/annual_report_the_czech_republic_2009_drug_situation)]
- National Monitoring Centre for Drugs and Drug Addiction of the Czech Republic, 2011. New 33 substances under control in the Czech Republic (web announcement). [[http://www.drogy-info.cz/index.php/english/new\\_33\\_substances\\_under\\_control\\_in\\_the\\_czech\\_republic](http://www.drogy-info.cz/index.php/english/new_33_substances_under_control_in_the_czech_republic)]
- National Monitoring Centre for Drugs and Drug Addiction of the Czech Republic, National Drug Squad of the Czech Police, and Centre for Addictology of the Psychiatric Clinic of the

- First Faculty of Medicine of Charles University, 2010. Changes in the Czech drug-related legislation. [[http://www.drogy-info.cz/index.php/english/changes\\_in\\_the\\_czech\\_drug\\_related\\_legislation\\_2010](http://www.drogy-info.cz/index.php/english/changes_in_the_czech_drug_related_legislation_2010)]
- Potůček, M. 1993. Current social policy developments in the Czech and Slovak Republics. *Journal of European Social Policy* 3(3):209–226.
- Pridham, G. 2002. The European Union's democratic conditionality and domestic politics in Slovakia: the Mečiar and Dzurinda governments compared. *Europe-Asia Studies* 54(2):203-227.
- Radimecký, J. 2007. Rhetoric versus practice in Czech drug policy. *Journal of Drug Issues* 37(1):11–44.
- SANANIM, 2010. *Annual report 2010*. Prague. [<http://www.sananim.cz/sananim/about-us.html>]
- Secretariat of the Government Council for Drug Policy Coordination, 2009. National drug policy strategy for the period 2010–2018. Prague: Government of the Czech Republic.
- Sevchenko, M. 2010. Prague: the new Amsterdam? *Global Post*. November 28. [[www.global-post.com/print/5602284](http://www.global-post.com/print/5602284)]
- Trávníčková, I. and Zeman, P. 2009. Criminal justice opportunities in drug-prevention policy —I. Developmental aspects; II. Empirical part. In Schienost, M., ed. *Selected results of research activities in ICSP in the years 2004–2007*. Prague: Institute of Criminology and Social Prevention.
- Velinger, J. 2011. Synthetic drugs a threat again. *Český Rozhlas*. June 7. [<http://www.radio.cz/en/section/curraffrs/synthetic-drugs-a-threat-again>]
- Tyrlik, M., Zuda, T., Bém, P., Power, R. 1996. The drug-use situation in the Czech Republic. *Bulletin on Narcotics* 1:89–98.
- Zábranský, T. 2004. Czech drug laws as an arena of the drug policy battle. *Journal of Drug Issues* 34(3):661–686.
- Zábranský, T. 2007. Methamphetamine in the Czech Republic. *Journal of Drug Issues* 37(1): 155–180.
- Zábranský, T., Mravčík, V., Gajdosikova, H., Miovský, M. 2001. PAD: Impact analysis project of new drugs legislation (summary final report). Prague: Office of the Czech Government, Secretariat of the National Drug Commission.
- Zeman, P. 2007. Legislation and practice concerning prosecution of drug offenses in the Czech Republic. *Journal of Drug Issues* 37(1):45–72.

# Annex: Persons Interviewed

## Czech Republic

### **Persons based in Prague:**

- ▶ Aleš Borovička, international cooperation coordinator, National Drug Headquarters, Criminal Police and Investigation Service
- ▶ Hana Fidesová, attorney, Centre for Addictology, Charles University
- ▶ Col Jakub Frydrych, director, National Drug Headquarters, Criminal Police and Investigation Service
- ▶ Vojtěch Janouškovec, harm reduction services expert, Progressive (NGO)
- ▶ Nina Janyšková, drug coordinator for the City of Prague
- ▶ Dr Kamil Kalina, Centre for Addictology, Charles University; former National Drug Coordinator
- ▶ Lucia Kiššová, former director, National Monitoring Centre for Drugs and Drug Addiction of the Slovak Republic
- ▶ Dr Viktor Mravčík, head of the National Monitoring Centre for Drugs and Drug Addiction

- ▶ Dr Josef Radimecký, former national drug coordinator, Centre for Addictology, Charles University
- ▶ Jiří Richter, director, SANANIM (NGO)
- ▶ Jindřich Vobořil, national drug coordinator, Office of the Government of the Czech Republic
- ▶ Dr Tomáš Zábranský, director of Research and Development, Centre for Addictology, Charles University (interviewed by telephone)
- ▶ Dr Petr Zeman, law specialist, Institute of Criminology and Social Prevention

### **Outside Prague:**

- ▶ Marek Nerud, regional drug coordinator, Southern Bohemia, České Budějovice

## **Slovak Republic**

- ▶ Dr Jozef Čentéš, head prosecutor, money laundering and organized crime, General Prosecutor's Office, Bratislava
- ▶ Tatiana Hičárová, executive director, Plan B, Bratislava
- ▶ Marek Para, attorney at law, Bratislava
- ▶ Col Jaroslav Spišiak, president of the National Police Force, Bratislava

## About the Author

Joanne Csete is associate professor of Clinical Population and Family Health at Columbia University's Mailman School of Public Health. The objective of her teaching and research is to find ways to overcome human rights-related barriers to health services for marginalized and criminalized populations, especially people who use illicit drugs, sex workers, prisoners and detainees, and people living with HIV. As the founding director of the HIV and Human Rights Program at Human Rights Watch, she oversaw the building of a body of research on human rights abuses as barriers to access to HIV services and conducted advocacy with many governments on removing those barriers. She was executive director of the Canadian HIV/AIDS Legal Network in Toronto, one of the world's leading health and human rights research and advocacy organizations. She previously was a senior technical advisor at UNICEF and taught at the University of Wisconsin–Madison.

# Global Drug Policy Program

Launched in 2008, the Global Drug Policy Program aims to shift the paradigm away from today's punitive approach to international drug policy, to one which is rooted in public health and human rights. The program strives to broaden, diversify, and consolidate the network of like-minded organizations that are actively challenging the current state of international drug policy. The program's two main activities consist of grant-giving and, to a lesser extent, direct advocacy work.

At present, global drug policy is characterized by heavy-handed law enforcement strategies which not only fail to attain their targets of reducing drug use, production, and trafficking, but also result in a documented escalation of drug-related violence, public health crises, and human rights abuses.

# Open Society Foundations

Active in more than 80 countries, the Open Society Foundations work to build vibrant and tolerant democracies whose governments are accountable to their citizens. Working with local communities, the Open Society Foundations support justice and human rights, freedom of expression, and access to public health and education.









Drug policies that are based on human rights and promote public health are a priority for the Open Society Foundations. Our efforts focus on developing new drug policy organizations, promoting collaboration and expanding the range of stakeholders committed to drug policy reform, empowering drug users to advocate for their rights at the national and international level, and supporting research into the economic and social costs of current drug policies.

*A Balancing Act: Policymaking on Illicit Drugs in The Czech Republic* is the third in a series of publications by the Open Society Foundation's Global Drug Policy Program. The series seeks to document positive examples of drug policy reform around the world. We believe the Czech drug policy experience serves as an exemplary precedent for transforming drug policy from repression-based to evidence-based approaches. *A Balancing Act* provides a revealing example of what is required to bring science to bear in the contentious and frequently misunderstood area of drug control.

In addition to drug policy reform, the Open Society Foundations work in over 70 countries to advance health, rights and equality, education and youth, governance and accountability, and media and arts. We seek to build vibrant and tolerant democracies whose governments are accountable to their citizens.

