

# A Candle Lit from Both Sides: The Epidemic of HIV Infection In Central and Eastern Europe

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## INTRODUCTION

Until 1995 central and eastern Europe as well as the Asian republics of the former Soviet Union have been more-or-less devoid of epidemic outbreaks of HIV infection. In this region with more than 450 million inhabitants (United Nations 1997), the total number of HIV infections was estimated lower than 30,000 (WHO 1995; UNAIDS 1996). Most of these infections resulted from sexual and nosocomial transmission. In 1995 this epidemiologically soporific picture started changing drastically in two ways. Firstly, reports on rapid HIV outbreaks in various parts of the former Soviet Union started to surface, and, secondly, these new infections were almost exclusively associated with another major public health crisis that until then had gone largely unnoticed: the rapid diffusion of drug injecting. Indeed, the social networks of drug injectors have provided an almost custom-tailored infrastructure for the virus to spread through the former Soviet Union and most HIV cases are reportedly related to illicit drug injecting. Except for Poland and Yugoslavia, the countries in central and southeast Europe have not yet experienced epidemic HIV spread, although in many of these countries drug injecting has become a major public health concern as well.

At the end of the year 2000, there were an estimated 700,000 people living with HIV in this region; 250,000 of them acquired the virus in the new millennium. Most of these infections are among injecting drug users (UNAIDS/WHO 2000a). This chapter will provide an overview of the development of the epidemic in the region and discuss some of its epidemiological and social peculiarities. Subsequently, it will bring to the reader's attention some of the social and political impediments to developing appropriate responses, which are rooted in its recent totalitarian past and exacerbated by the "backdrop of social-economic

turmoil” (UNAIDS/WHO 2000b) that characterizes the post-communist transition process. Next, it will discuss the human rights aspects of the, for this epidemic so important, drugs-AIDS nexus, as well as its link to another historically unsettling feature of this region: its traditionally abysmal treatment of ethnic minorities, in particular the stateless Roma. To counter some of the pessimism these issues may have elicited in the reader, the chapter ends with a—given the immensity of the region, inevitably partial—description of interventions that nevertheless have developed.

## ISSUES RELATING TO HIV AND AIDS

### History of HIV/AIDS

It was in 1995 that the first reports appeared on outbreaks of HIV in different parts of the former Soviet Union, including the Black Sea ports Odessa and Nikolayev, the northwestern Russian enclave of Kaliningrad (a seaport as well), and Svetlogorsk in southern Belarus. Only separated by months, epidemics developed in these three countries with highly similar features.

In Ukraine less than 100 HIV infections were registered between 1988 and 1994, which concerned mainly foreigners. However, in March and April 1995 more than 1000 cases were detected among drug injectors in Odessa and Nikolayev, after the militia was instructed to round up registered drug users for testing. HIV prevalence among drug injectors arrested by the militia or in contact with narcology centers<sup>i</sup> grew rapidly from virtually zero to 31% Odessa and 57% in Nikolayev (Khodakevich 1997). Within a year HIV infections were reported among drug injectors from all 25 regional capitals and more recent reports suggest continued spread into rural areas and cities in the eastern and central parts of the

country (UNAIDS 2000a). Countrywide, the registered number of new HIV infections rose to 1490 in 1995, up from 31 in the year before. An additional 5400 new cases were registered in 1996, and this number peaked at 8913 in the following year. A total of 8575 new infections were registered in 1998 and 5827 in 1999, resulting in a cumulative total of 30,388 reported cases at the end of 1999 (WHO-EURO 2000). At the end of 1999, UNAIDS estimated the number of HIV-positive people in Ukraine at 240,000, and between 50 and 80% are associated with injecting drug use (UNAIDS 2000a).

Fewer than 1100 HIV cases were registered in the Russian Federation between the start of registration in 1987 and the end of 1995. Among these cases were very few injecting drug users (IDUs) (Pokrovskiy et al. 1997). Kaliningrad first reported a rapidly escalating number of infections among drug injectors, but the outbreak was not contained to this East Sea enclave. In 1996 and 1997 cities all over the Russian map, including Krasnodar, Nizhny Novgorod, Rostov Na Donu, Saratov, Tula, Tumen and Tver, reported epidemic spread among IDUs as well (Pokrovskiy et al. 1998; Burrows et al. 1998). In early 1999 the epidemic hit the federal capital. One year later (June 2000 data), Moscow has officially registered 6670 HIV infections and an additional 8904 infections in the surrounding Moscow oblast (administrative region). With 782 and 222 officially registered HIV cases, St. Petersburg and its surrounding oblast Leningrad still seem to lag behind (Ministry of Health of the Russian Federation 2000). However, a 1999 survey among IDUs in St. Petersburg found that HIV prevalence rates rose in six months from 12% to 19% (UNAIDS 2000b). To appreciate the epidemic's geographical dimension, the remote city of Irkutsk has already registered 5773 cases (Ministry of Health of the Russian Federation 2000). At the end of 2000 the epidemic has spread to over 30 cities across Russia and 82 out of 89 oblasts had reported HIV cases (UNAIDS/WHO 2000b).

Overall, the number of registered new cases in Russia increased from 196 in 1995, to 1546 in 1996 and 4399 in 1997. During 1998 new cases decreased to 3947, but the following year they jumped to 19,661. More than 90% of new cases in 1998 and 1999 were registered among injecting drug users. The average age of HIV infected individuals was 18 to 25 years. Nine HIV positive cases concerned 11 to 14 year-olds who became infected through injecting drug use. With 15,696 new cases in the first half year, the 2000 incidence is projected to supercede the total prevalence of 1999 (30,624 cases) (Ministry of Health of the Russian Federation 2000), and to climb to 50,000 by year's end (UNAIDS/WHO 2000a). At the start of 2000, UNAIDS estimated the number of HIV-positive people in the Russian Federation at 130,000 (UNAIDS 2000c). At the end of the year this figure will have climbed to 300,000 (UNAIDS/WHO 2000b). Close to 90% of cases are associated with injecting drug use.

In the beginning of 1996 the first case of HIV in an IDU since 1992 was established in Minsk, the capital of Belarus. This case concerned a resident of Svetlogorsk, a town of 72,000 in the southern Gomel oblast. Subsequent mass screening (targeting known drug users) revealed 1125 HIV infections, 88% among drug injectors (Bezruchenko-Novachuk and Romantsov 1998). In 1997 an HIV prevalence of 67% was found in blood samples drawn from the syringes of participants of the Svetlogorsk needle exchange (Bezruchenko-Novachuk and Romantsov 1998). That same year, HIV was detected among IDUs in all oblasts of Belarus. The number of registered new cases in Belarus increased from 8 in 1995, to 1021 in 1996, but fell to 653 in 1997 and continued to decrease to 554 and 411 in the subsequent two years (WHO-EURO 2000). At the end of 1999, there were 2752 cases of HIV infection registered in Belarus (WHO-EURO 2000), but UNAIDS estimated the number of HIV-positive people at 14,000 at the end of 1999 and more than 80% are associated with injecting drug use (UNAIDS 2000d).

Moldova experienced an outbreak of HIV soon after Ukraine, Belarus and Russia, but hitherto the number of cases remained lower. Registered new cases rose from 7 in 1995 to 48 in 1996 and further to 404 and 408 in the subsequent two years, but fell to 155 in 1999 (WHO-EURO 2000). A total of 1034 cases of HIV infection were registered in Moldova at the end of 1999 (WHO-EURO 2000), but according to UNAIDS the number of HIV-positive people was 4500. Most infections have been detected in the two major cities Chisinau and Baltsi, and more than 80% are associated with injecting drug use (UNAIDS 2000e).

More recently HIV has diffused into populations of IDUs in the Baltic states as well, most notably in Latvia where in 1998 the number of new cases jumped to 163, up from 25 in the previous year, while 241 new cases were registered in 1999. At the end of 1998, 122 cases were registered among IDUs (WHO-EURO 2000). These numbers may not seem dramatic, but they put Latvia among the three countries in the entire (WHO) European region with incidence rates (per million population) over 100 in 1999, the other two being Russia and Ukraine. After initial reports on outbreaks among IDUs in its port city Klaipeda, Lithuania seems to have been able to contain epidemic spread. At the end of 1998, 66 cases had been registered among IDUs (WHO-EURO 2000). But in 2000, a new epidemic emerged among drug injectors in Narva, Estonia, with the result that the country reported far more HIV cases than in any previous year (UNAIDS/WHO 2000a). In the three Caucasus republics Armenia, Azerbaijan and Georgia the number of infections is also on the rise. Although in a large number of registered HIV cases in this subregion the transmission category was unknown (e.g. prisoners or military personnel who may have injected drugs), most of these infections are associated with injecting drug use as well (WHO-EURO 2000). Central Asia has remained largely untouched by the global AIDS pandemic, but in 1999 HIV infections were reported among IDUs in four of the five countries. Furthermore, the detention-related

outbreak of HIV among IDUs in Temirtau, in the Karaganda oblast of Kazakhstan demonstrates that this subregion is not immune to rapid epidemic spread. Prior to the detection of HIV among drug users imprisoned in the local prison, there were just 69 registered cases of HIV in Kazakhstan. Since then, testing of drug users has been intensified. As a result, 736 new cases were reported between 1997 and 1998, 88% among injecting drug users (UNAIDS 2000f).

Most former communist countries in central Europe have thus far not reported epidemic spread of HIV, except for Poland. While homosexual and bisexual men in the region are the most affected population group, overall reported prevalence remained relatively low. Nonetheless, Poland was hit by an outbreak among drug injectors in the late 1980s. The numbers of reported infections among IDUs jumped from one in 1988 to 411 in 1989 and since 1995 between 539 and 638 new infections are registered yearly (WHO-EURO 2000). The majority of those are associated with injecting drug use (UNAIDS 2000g). At the end of 1999 the cumulative total reported cases in Poland was 6118 (WHO-EURO 2000), but UNAIDS estimates the total number of HIV positive people at 13,000 (UNAIDS 2000g). As in central Europe, HIV infections among injecting drug users in the Balkan countries have remained low, except in Yugoslavia (Serbia and Montenegro) which experienced an early IDU-driven epidemic similar to Poland. Most other countries in this sub-region primarily reported heterosexual transmission, but transmission between MSM is likely to be underreported because of strong stigmatization. Assessment of the levels of HIV and injecting drug use in southeastern Europe are severely hampered by the recent political events in the region.

All in all, both in central and southeastern Europe the preconditions exist for epidemic outbreaks of HIV infection among IDUs. While IDU populations are perhaps still smaller



than in several of the Newly Independent States (NIS), a growing number of authors have suggested that drug injecting is on the increase throughout both subregions (Grund and Nolimal 1995; Honti and Zelenai 1999; Khodakevich and Dehne 1998; Nolimal and Jerman 1996; Polanecky et al. 1996). Likewise, anecdotal reports suggest high prevalence of hepatitis C among IDUs in many parts of these two subregions.

### Data Collection Issues

In most countries in this large region—almost 30 countries between Germany's eastern border and the Pacific ocean, stretching 11 time zones—HIV reporting is based on mandatory mass screening and a two-stage registration process, introduced in 1987. Reporting of HIV/AIDS cases is required by law and MoH regulations. Screening targets include both low risk (e.g. pregnant women, blood donors, occupational groups) and vulnerable populations (drug users, prisoners, STD patients). For years millions of dollars have been invested in this costly but inefficient pursuit—in 1995 approximately 95% of the Ukrainian HIV/AIDS budget was spend on testing kits: that same year the epidemic struck the country's IDU networks.

Testing policies for low risk populations have become less stringent since the early 1990s. Officially, most HIV tests are now voluntary, except for blood donors and foreigners (e.g. in Russia). Yet, routine mandatory screening without informed consent and pre- and post-test counseling of high risk populations, including identified drug users, prisoners and STD patients remains a routine exercise throughout the region. Since 1999-2000, innovative methods of HIV surveillance (e.g. sentinel surveillance) are being slowly implemented in a few countries but officially these are not yet included in the national guidelines on HIV

monitoring (Y. Kobyshcha, personal communication). Voluntary, confidential, or anonymous testing accounts for only a fraction of both tests and positive results registered. This pattern is perhaps associated with the fact that the anonymity of people testing HIV positive is often not upheld.

Registration includes the recording of all test results and the referral of positive results to an AIDS center for confirmation, history taking, official registration, and treatment (when available). Classification (and reclassification of e.g., prisoners) into transmission category is based on the clinic interview. In most countries reporting is based on the registration of the AIDS centers. Because of intense stigmatization and potentially serious consequences (from losing one's employment or driver's license to imprisonment and ongoing police harassment, including unlawful entry of the home) many people are unwilling to disclose a history of drug use.

Furthermore, incomplete referrals between the initial test site and the health institution responsible for registration have resulted both in underreporting and biased distributions over transmission categories. For example in Ukraine, each person with a confirmed HIV positive test result is obliged to attend an AIDS Center or other specialized infectious diseases clinic for extensive clinical and biological examinations, which must be completed before official registration. But in practice a large number of people found HIV positive after laboratory testing (mainly drug users) do not show up for further examination at these clinics, resulting in delays in reporting and considerable under-reporting. Thus, during the first years of the epidemic (1996-1997) only 50% of people with HIV positive test results were officially registered (Y. Kobyshcha, personal communication). Likewise, Russian data for 1996 and 1997 included more than 2000 cases for which the transmission mode was unknown. The

HIV data presented in this section are therefore in all likelihood an underestimate of the true dimensions of the HIV epidemic in this region.

### Colliding Epidemics: HIV and Injecting Drug Use

Research in diverse regions of the world has established rapid HIV spread associated with transmission among IDUs (Angarano et al. 1985; Ball et al. 1998; Hamers et al. 1997; Ismail 1998; Rebagliato et al. 1995; Stimson 1994; Zheng et al. 1994), sometimes resulting in increases of HIV prevalence among drug injectors from less than 5% to 30 to 50% in one to three years (Burns et al. 1996; Crofts et al. 1998; Des Jarlais et al. 1994; Htoon et al. 1994; Stimson 1994; Weniger et al. 1991). Khodakevich (1997) reported equally rapid HIV spread in Svetlogorsk, Belarus, and Odessa and Nikolayev in Ukraine. By mid-1999 HIV transmission among IDUs was reported from 114 countries and in many countries injecting drug use has been the main mode of transmission (UNAIDS 2000h). However, in no other region the overall proportion of reported cases associated with drug injecting is as high as in eastern Europe, in particular in the NIS. In this section we will discuss some of the factors that may be associated with this issue. This discussion will concentrate on the countries of the former Soviet Union as those are hit hardest by the HIV epidemic.

While certainly not unknown before the breakdown of communism, drug use seems to have rapidly increased in the 1990s. Officially registered injecting drug users in Ukraine rose from around 20,000 in the early 1990 to 80,000 in 1997 (Dehne et al. 1999). According to the Russian ministry of internal affairs the number of people undergoing drug treatment was 249,000 in 1996, up from 91,000 two years earlier (Khodakevich and Dehne 1998). The country's ministry of health reported a more modest increase: from 25,000 in 1990 to 85,000

in 1996 (Khodakevich and Dehne 1998). Such a discrepancy illustrates the unreliability of these statistics. Before the political changes in the Soviet Union drug use was officially non-existent and consequently not enumerated. In reality drug users were persecuted indiscriminately by militia, sentenced to many years in prison, committed to inhumane mandatory treatment and other repressive measures. Nowadays these practices still prevail in many parts of the region with the result that people who use drugs avoid contact with drug treatment and other health institutions as much as possible. As a consequence, the official number of registered drug users is only a small proportion of the real size of the drug user population.

In 1997 the Ukrainian ministry of internal affairs estimated the total number of drug users between 600,000 and 700,000 and IDUs represented 75% to 80% of these cases (Khodakevich and Dehne 1998). Estimates in Russia range from 600,000 to one or two and a half million (Brunet 1996; USAID and Centers for Disease Control and Prevention 1998). While their reliability is difficult to assess, these estimates suggest that in both countries more than 1% of the population is involved in drug use. "Rapid Situation Assessments" (WHO 1998) in a number of Russian cities estimate the number of IDUs at 35,000 for Nizhniy Novgorod, 9,500 to 10,000 in Rostov Na Donu, 70,000 in St. Petersburg and 18,000 in Volgograd. The author's fieldwork in these cities during 1999 suggests that the use of injectable opiates in particular has become a regular feature of the social ecology of many neighborhoods in these cities. As one outreach worker in Volgograd explained, "*People drink or inject in this place.*" Likewise, an epidemiologist in Rostov Na Donu thought that "*it [was] difficult to find a building in this town that is not affected by drug use.*"

While more recently the use of (imported) heroin has increased drastically in many cities, drug use patterns throughout the NIS are characterized by two rather specific observations, which add dramatically to the potential for drug related harm. First, the tradition of kitchen production of alcoholic beverages seems to have been extended to a number of other psychoactive substances. Simple ‘bathtub chemistry’ is used to process opium poppies into a strong injectable opioid cocktail, and ephedrine-based medications into methamphetamine and methcathinone, both powerful psychostimulants. Second, there seems to be a prevailing perception among a majority of drug users that, perhaps apart from cannabis, drugs are to be injected. Thus, while in the USA snorting Ketamine (a dissociative anesthetic primarily used in veterinary medicine) has gained considerable popularity in gay dance clubs, in Russia this drug is primarily injected among straight middle class youth. The self-produced opioids and amphetamines are generally prepared for injection as well.

Many risk behaviors identified in drug injecting-related HIV epidemics elsewhere are relevant to the reported rapid spread. For example, sequential use (sharing) of syringes and needles has been reported from many cities throughout the region, including Moscow, St. Petersburg, Kaliningrad, Nizhniy Novgorod, Rostov Na Donu, Volgograd and Pskov in Russia, Poltava and Odessa in Ukraine, Svetlogorsk in Belarus, Almaty and other cities in Kazakhstan, and Tblisi in Georgia. In a recent study of syringe exchange participants in five Russian cities, 38% (N=1076) of the participants admitted that in the 30 days before they joined the program they had injected with a syringe that was previously used by someone else (Grund et al. 2001).

However, a number of region-specific risk factors can be identified, associated to the home preparation of injectable drugs, in particular opiates. Using water and common household chemicals, including ethyl acetate, soda vinegar and acetic anhydride, IDUs boil

opium poppies or opium gum into a strong injectable cocktail of opioid alkaloids (containing, codeine, morphine and heroin in varying proportions). The resulting cocktail is known under a number of different names in the region, including Cheornaya (black), Chemia or Himya (chemistry), Mak, Shirka and Hanka.

A number of authors have wondered whether HIV might be introduced into the mixture during the production process through the use of contaminated mixing containers. Others hypothesized that the (nowadays rare) practice of using blood to filter solid particles from the solution might have caused rapid outbreaks of HIV in several Russian and Ukrainian cities (Bolekham and Zmushko 1998; Liitsola et al. 1998; Lukashov et al. 1998). However, recent ethnographic observations of the production process in Russia (Grund et al. 2001; Dehne et al 1999) and laboratory simulations of the process (Heimer, personal communication) show that contamination of the drug solution during the production process is extremely unlikely. Even when contaminated blood is used, the solution is subsequently repeatedly boiled for extended periods and at the end of the process acetic anhydride (a highly caustic chemical) is added. (For a description of the process and its potential for HIV transmission, see Dehne et al. 1999.)

A perhaps more plausible hypothesis is related to how the practice of self-production has shaped the drug culture (Grund 1998a) in this region. A typical feature of the self-production and use of opiates is that it is mostly conducted within groups of two or more people and when the drugs are ready for consumption they are divided by squirting them from one (large) syringe into those of the group members. This technique—termed “Frontloading” or “Syringe-Mediated-Drug-Sharing” (SMDS)—has been described in many other parts of the world and is associated with HIV seroconversion (Grund et al. 1991; Grund et al. 1996; Jose et al. 1993). The regular practice of preparing and using in groups is also

likely to result in higher frequencies of needle sharing, than in more individualistic cultures of drug injecting. Nevertheless, a recent study of syringe exchange participants in five Russian cities indicated that while syringe sharing decreased substantially (from 38 to 11%) after respondents joined the exchange program, several behaviors associated with the context of group drug use decreased to a much lesser degree. The practice of injecting with friends itself was hardly affected by participation in the needle exchange program, going from 91% before, to only 86% after joining the program. Likewise, sharing drug paraphernalia other than needles and syringes only went down from 82% to 73%, while SMDS decreased only from 58% to 48% (Grund et al. 2001).

Thus, the social context of drug injecting, especially the seemingly ubiquitous practice of preparing and using drugs in groups may well be responsible to a large extent for the rapid diffusion of HIV among the IDU populations in the region. Many questions arise from this hypothesis—for example, concerning the density and connectivity of IDU networks. Nevertheless, home production and its communal aspects in particular may well produce considerably higher rates of established risk behaviors than in more individualistic drug injecting cultures where (imported) powder drugs are used.

In summary, the circumstances under which HIV is transmitted among IDUs in the region is at present insufficiently understood. This situation is in urgent need of thorough ethnographic and epidemiological study. Not only is it essential to gain a better understanding of transmission among IDUs themselves, but research should also address the questions of the potential and mechanisms of secondary spread into non-IDU populations. At the presentation of the December 2000 AIDS epidemic update, WHO's director general, Dr. Gro Harlem Brundtland, warned that "in just three to four years, Russia may well have a

generalized epidemic” (UNAIDS/WHO 2000b). Elsewhere Dehne and colleagues (1999) reviewed this hazard and hypothesized that the overlap between drug injecting and sex work could well become the critical link in the epidemiological chain between the current HIV epidemics among IDUs and a generalized epidemic. Another scenario might be based on the sheer magnitude of the fast-paced, post-communist epidemic of drug injecting in central and eastern Europe and the FSU and its apparent normalcy in many communities.

Although reliable statistics are lacking, injecting drug use appears to have touched a significant proportion of the population in the region. Drug injectors may be subject to intense state repression, but they appear to remain fairly well integrated in family structures and social networks that are not necessarily built around drug-related activities (Grund unpublished data). Likewise, self-injection does not always seem to invoke the same level of stigmatization known in western Europe or the USA, and is, reportedly a commonly accepted method of taking both medical and recreational drugs in parts of the region (de Jong et al. 1999). When the stigma against drug injecting is limited, and when IDUs spend relatively more time in “non-drug” networks, they are likely to meet more sexual partners who do not inject drugs, than when they only socialize with other drug users. Ergo, the widespread practice of drug injecting may provide for many links in the epidemiological chain towards a generalized epidemic, that will be unprecedented in the northern hemisphere.

#### Obstacles to controlling the HIV/AIDS epidemics in the region

The common denominator of this region is that all countries are undergoing a transition process from closed societies with state-controlled economies towards more democratic, open societies with free market economies—until now, with various results. For



most people the transition includes a significant drop in the quality of life, set against a background of profound social and political change. For many citizens, unemployment and decreased access to housing, health care and social services have been the price for economic and political liberalization. Where formal economies stagnate, informal economies have mushroomed and organized crime is growing rapidly. Increasingly, illicit drugs are becoming a prime commodity within this “shadow economy.” The region’s transition process, its communist legacy, and the associated economic crises in many parts of the region can be seen to hamper the response to the HIV epidemic in many ways.

In most, if not all, of the NIS countries that experienced significant HIV outbreaks among IDUs, appropriate governmental responses only developed after these outbreaks were firmly established, despite the writings on the wall. Instead of timely introducing public health-based HIV prevention programs targeting IDUs, governments relied on outmoded and ineffective mass screening procedures and police repression of drug users. What's more, most of the (central European) countries that have been spared epidemic HIV spread so far seem bound to repeat this mistake, as funding levels for needle exchange and other HIV prevention activities targeting IDUs are, generally speaking, grossly inadequate. In fact, most needle exchange programs in the region exist on foreign funding.

One of the most important lessons in this epidemic is that successful responses require “multisectoral and multilevel” approaches (UNAIDS 2000h). However, such thinking does not tie in well with the bureaucratic legacy of the communist era we find in many, if not most countries in the region. The Soviet approach to management was strictly hierarchical and multi-layered, and in many places few structural changes have taken place in the bureaucracy. Governmental health structures are extremely complex and frequently the number of local, state and federal institutions involved in HIV prevention planning runs into

the double digits. Furthermore, in establishing a training program to assist Russian health professionals and others involved in HIV prevention among IDUs, Burrows and colleagues (1999) observed a highly competitive atmosphere among (government) health agencies involved in this area. Absence of inter-agency collaborations and of information sharing within and between agencies seemed to be the usual *modus operandi*. They linked this situation to the scarcity of funds, but such a *culture of secrecy and competition* is of course a remnant of the communist past as well. As one Lithuanian narcologist explained: “*Why would you share information or your ideas about a certain matter? It could only be used against you.*”

Absence of sufficient funding is nonetheless a genuine issue. Salaries of health and other government workers (e.g., militia) are often months behind, buildings are in poor shape and funds for equipment, medications and professional literature are often lacking. In one regional AIDS center in the south of Russia the library was filled with the dust-covered complete works of Lenin and Stalin. Russian or international professional literature was nearly absent.

Another serious problem is the absence of a positive NGO climate, in particular in the NIS, but for example in Slovakia as well. Not only are NGO legislation and regulation often unnecessary complicated, but many state health workers consider NGOs with Argus’ eyes, that is, as a new set of competitors in a shrinking market. To make matters more complex, while “real NGOs” certainly exist in the HIV/AIDS field, many are closely linked to government institutions. In the previously mentioned evaluation study of Russian needle exchange programs, three out of five of the programs were administered by NGOs that were run by the head physician and core staff of the AIDS center, and all three were located at the premises of the AIDS center. The primary function of this type of NGO seems to be

attracting and channeling non-governmental and foreign funding. It also provides AIDS center staff a chance to be innovative and operate outside the rigid structures that determine their usual work (Burrows et al. 1999). And, last but not least, it offers a possibility to boost their regular (devaluated ruble) salaries with hard currencies, such as US dollars. Some of these initiatives have built impressive (peer/outreach-based) needle exchange projects, but elsewhere middle-aged epidemiologists and laboratory workers in white coats have taken up the outreach profession.

A problem of a different order is that in most countries in the region, policy makers and professionals alike seem to believe that the situation in their country is not comparable to any other place in the world. “My country is different,” is a mantra that many foreign consultants have heard over and over again, where “my country” can be substituted by “our mindset,” “our drug users’ mentality” and other variants. Burrows and colleagues (1999) refer to this phenomenon as “Russianness,” but this author has been exposed to it in at least ten countries in the region, and elsewhere as well. The upshot of such remarks is generally that pragmatic interventions for IDUs tried successfully elsewhere will not work in the country. Perhaps associated to the cold war, such beliefs go hand in hand with a mistrust of “western” research and approaches, and with this comes a moral dismissal of many aspects of what UNAIDS terms “Best Practice” (UNAIDS 1999). The explicit ban on the use of methadone in the new Russian drug law serves as an apt example.

Particularly strong are misconceptions of drug users and their ability to adjust their behaviors, which are embedded in obsolete and unscientific ideas on the dynamics of drug use, addiction and the careers of drug users. Many narcologists and psychiatrists were trained to believe that, after their first injection, IDUs have on average three to four years to live, and that drug users are “hopeless” cases, who do not care whether they live or die (Burrows et al.

1999). When the prevailing sense is that drug users are not interested in protecting themselves and their family and friends against HIV, pragmatic, unmoralistic prevention becomes a hard sell. Along with these ideas comes an unwarranted belief in repressive approaches and mandatory treatment—hence the emphasis on mass screening, contact tracing and regular mandatory reporting.

In areas such as drugs, prostitution and infectious diseases the health and law enforcement structures (Internal Affairs) have traditionally maintained fairly cooperative relationships in the Soviet Union and its successor states. As the director of the AIDS center in a large city east of Moscow explained, “*The police have some same points of interest and same directions of work.*” In particular “Narcology” maintained close ties with law enforcement—according to Burrows and colleagues (1999), Narcology in Russia was until the 1990s largely an instrument of Internal Affairs. A psychologist of a narcological center in the south of Russia put it in plain terms: “*The relations with the police are good, they do a lot of mutual work.*” Indeed, in the early stages of the epidemics in many cities in Russia, Ukraine, Belarus and other countries in the region drug users (and prostitutes) have been rounded up by militia and mandatory tested at the nearest AIDS center.

One can certainly find “enlightened” police officials in the region, who have more thoughtful ideas on drug use and HIV, especially outside of the capitals (and political spotlight)—in Ukraine, one of the first needle exchanges was initiated by (among others) a militia major. But, overall the position of Internal Affairs towards innovative HIV prevention programs, such as needle exchange has been highly censorious (Medecins Sans Frontieres-Holland 1999). The first two needle exchange programs in Russia (St. Petersburg and Yaroslavl) were closely monitored and frequently hassled by Internal Affairs (Medecins Sans

Frontieres-Holland 1999; Sergeyev et al. 1999). Sergeyev and colleagues (1999) quoted a Russian national newspaper to illustrate the activities of Internal Affairs in the city of Yaroslavl:

*“For two weeks Drug Enforcement Officers have been watching closely the gray van running around Yaroslavl and attracting local drug users. The attention of police officers is focused on the needle exchange facility inside the van. The police are taking notice of every client attending the needle exchange so that their officers can report about the victories in the fight against drugs later on.”*

Perhaps because the St. Petersburg and Yaroslavl programs took a lot of the political heat, most of the more recently initiated needle exchange programs in Russia have some sort of agreement in place with the locally active branches of Internal Affairs. Outside of the political spotlight, at the oblast and city levels, the authorities have more autonomy and they seem simply less dogmatic and sensitive to pragmatic considerations. However, while police officials in the region are politically less dependent on Moscow and have some room for creative interpretation, they cannot totally ignore the federal (drug) laws or the views of the Ministry of Internal Affairs. As the head physician of an AIDS center which started needle exchange in the south of Russia explained:

*“The city and oblast police departments ... approve of the program activities. But the drug legislation is repressive. It is necessary to change it. Now the attitude of the Ministry of Internal Affairs toward such programs is negative. That’s why it is difficult to work with police at the exchange sites.”*

Thus, agreements with one (of the several) police department(s) do not preclude the negative influence of Internal Affairs on IDUs’ participation in needle exchange and other HIV prevention programs.

Furthermore, street militia is not always aware of these agreements and continues to hassle drug users around needle exchange programs. In the previously mentioned multi-city evaluation of needle exchange, 44% of respondents mentioned being harassed by the police or militia because they were suspected of carrying needles. Of those, 74% mentioned that they were verbally abused or threatened, while 59% said they were physically abused or pushed and shoved around. Another 59% said they were detained and 67% mentioned that the police had confiscated their injecting equipment, while 44% was forced to destroy or dispose of injecting equipment in front of the officer. That such treatment negatively influences program participation seems self-evident, as 40% of the respondents said that they normally do not carry injection equipment at all. Of those 58% explained that they feared discovery by the police as the reason for not doing so.

Thus, IDUs may run serious immediate risks (police hassling and brutality, arrest and subsequent withdrawal) by participating in an intervention, which helps them avert risks, which only matter in the long term. Under such conditions, visiting the needle exchange may score higher on the IDUs' "Hierarchy of Risk" (Connors 1992) than averting some unclear infection (note that at present only few infected drug users in central and eastern Europe have developed clinical manifestations).

A related matter seriously troubling the development of adequate responses to the HIV epidemic in the region is the recent passing of increasingly repressive drug legislation. In April 1998 the Russian Duma passed a new, very repressive drug law, under which substitution treatment of opiate addiction with methadone is forbidden, while syringe exchange and other HIV prevention activities might be interpreted as abetting to drug use. Soon after president Yeltsin signed the law, police harassment of the St. Petersburg and Yaroslavl needle exchange programs increased. In Yaroslavl the needle exchange operation

closed its doors for two months for fear it was in violation of the new law, and in June 1998 the police tried to close down the St. Petersburg project. In the following excerpt from an email, the program's co-director from Medecins Du Monde described the situation:

*“News from the front. The bus has trouble with the police again. They are trying to stop it and for a while the bus is staying day and night in Pravoberejniy Rynok. The threat is that if the bus moves the police will take away all the driver's licenses. For several days now, the bus has stayed put and the staff is sleeping in it to avoid problems.”* (B. Stambul, e-mail June 29, 1998)

Several other countries in the region have recently introduced more repressive drug legislation as well, among them the Czech Republic (1998), Poland (1997) and Hungary (1999). The Slovak Republic stiffened up drug laws as early as 1993. The most important difference with previous legislation is that all these new laws make possession of drugs a criminal act, although both the Polish and Czech laws made exceptions for possession of small quantities, treating those as a misdemeanor (Grund 1998b).

While human rights concerns—the proposed legislation punishes the victims rather than the perpetrator—prompted Czech president Vaclav Havel to veto these legislative proposals, this veto was overturned by an ad-hoc majority in parliament, which included Communists and Christian Democrats (Jakl 1998). What's more, on November 17, 2000 Polish President Aleksander Kwasniewski approved an even tougher anti-narcotics bill, which banned the possession of even small amounts of drugs and introduced compulsory treatment. Two days later, a senior official from the Country Planning and Programme Development section of UNAIDS sent the following reaction to the e-mail listserver of the CEE Harm Reduction Network:

*“If [this new law] is properly reinforced it may isolate drug users from the service providers, with the well known consequences. We had such an example in one city of the region in 1996. At the end of that year the police made intensive raids on the apartments where traditionally built small groups of drug users/friends met to prepare and inject drugs. Following these raids, the groups reshuffled, mixing the members of different groups and the demand for ready solution prepared elsewhere grew up. This was considered at least one of the reasons that at the beginning of the next year the HIV epidemic blew up among IDUs in that city.”* (L. Khodakevich, e-mail, November 19, 2000)

UNAIDS has played an important role in developing a response to the HIV epidemics in this region. However, it has had great difficulties convincing another—for this effort crucial—UN agency, the United Nations Drug Control Program (UNDCP) of the necessity of harm reduction approaches to HIV prevention among IDUs, and, until very recently, this UN agency has not been involved in the “Joint United Nations Program.” For years UNDCP has been promoting repressive drug legislation in the region, opposing methadone, needle exchange and other harm reduction interventions. ” With the recent establishment of a new UNAIDS office in Vienna, next to the UNDCP headquarters, this will hopefully change. Nevertheless, this contradiction within the UN system illustrates perhaps the most essential problem in policy making for HIV prevention among IDUs: the fundamentally different goals and interests of the international struggle against HIV/AIDS and the globalized war on drugs.



### Colliding International Concerns: Drugs, AIDS and Human Rights

Because such measures counter marginalization, and thus vulnerability to HIV, UNAIDS stresses that “[p]romoting human rights and tolerance is ... important in fighting AIDS as well as in its own right” (UNAIDS 2000h). Its June 2000 Report on the Global HIV/AIDS Epidemic reads that “[m]any factors in vulnerability—the root causes of the epidemic—can best be understood within the universal principles of human rights.” The report continues with pointing towards a number of factors that engender vulnerability to HIV/AIDS. These include lack of respect for “freedom of expression and association,” “the rights to liberty and security,” “freedom from inhuman or degrading treatment,” and “the right to privacy and confidentiality” (UNAIDS 2000h). When it comes to drug users just about all of these rights are severely compromised in most countries in this region. Participants of focus groups of drug users in the previously mentioned multi-site needle exchange evaluation in Russia told many stories of police abuse. They maintained that the police persecute drug users with HIV/AIDS. They thought that the police still have the idea that the only way to stop the epidemic is by isolation of all infected people. One of the respondents told his story:

*“On April 30 I came out of the prison for HIV positives and was stopped 3 times by the police in the following 9 days. I have to report 2 times a month to the police. Three different police departments can come into my home whenever they want. I think the police hounds us because we are HIV positive.”*

Historically, this region does not have a good reputation for championing human rights, and focus group participants were well aware of their marginalized situation. They felt that civil rights are meaningless to them: “*What human rights?*” said one of them, while rubbing his fingers, “*No money; no human rights! Ta ta!*”

UNAIDS insists that successful interventions can only develop when partnerships are created, and communities—including the drug user community—are taken into trust and not confronted (UNAIDS 1999). Nonetheless, the dominant approach towards the community hit hardest by the HIV epidemic in this region (and elsewhere) is rooted in a mixture of repression and grave disrespect for human rights.

The combustible properties of this mixture are likely to be exacerbated by yet another volatile ingredient: the treatment of ethnic minority communities. For example, the recent HIV outbreak (and drug injecting in general) in Narva Estonia mainly concerns IDUs from the Russian minority in the city. However, in particular the stateless Roma, which are present in almost every corner of the region may be hit hard by the epidemic in the near future. A recent study reported a number of unsettling findings. In many cities across the region a substantial proportion of the Roma community is involved in drug injecting. The overall prevalence of injection drug use in these cities equals or greatly exceeds those known in Western Europe and other established market economies. However, proportionally, injection drug use seems to have touched the Roma community in these cities to a much greater (2 to 20 times) extent. Thus, in Vilnius, the capital of Lithuania, reportedly 0.3 to 0.5% of the overall population are drug injectors, while the prevalence of drug injecting in the local Roma community is estimated at 6 to 10% (Grund et al. 2000). The problems seem to concentrate in one Roma tabor (settlement) on the edge of town, where some 50 out of approximately 250 residents are drug injectors (Subata and Tsukanov 1999), while Roma living in the city—who are more “integrated” and economically better off—seem less affected. Likewise, in Szeged in southern Hungary, the overall prevalence is reportedly slightly less than one percent, but among the local Roma it is 5 to 7%. In all, 80 out of 200 participants of the local peer-outreach-based syringe exchange are Roma IDUs (Grund et al 2000).

Heroin use is rapidly gaining popularity among Roma youth and reportedly they start injecting at a very early age. The study points towards many factors that suggest an increased vulnerability of the Roma for HIV infection. These include increased levels of HIV risk behaviors among Roma IDUs, barriers to clean needles and other HIV prevention services (HIV testing and education; drug treatment), as well as social-economic matters, such as the community's structural exclusion from the mainstream economy. HIV prevention or drug treatment projects targeting drug users in this minority community are virtually absent.

Throughout the region, Roma are considered to be an undesirable underclass and they are still heavily discriminated on the labor market, in the educational system, in health care and in many other services. Given their structural exclusion from the mainstream economy and historical reliance on the "shadow economy" for their sustenance, it should not come as a surprise that Roma communities in many parts of the region are reportedly involved in supplying heroin and other drugs. Thus, Subata and Tsukanov (1999) reported that about 70% of the production of opiates from poppy straw in the region takes place in the mentioned Roma labor. In all five cities in the Russian needle exchange evaluation study, the local Roma population was reportedly the main source of opiates and other drugs, while in Bratislava consumption level heroin dealing is dominated by Roma as well.

Against the background of a mounting drug war atmosphere in the region, their involvement in drugs is likely to pose a genuine threat to both their already compromised health status and the historically delicate human rights situation of the Roma communities in the region at large. It is not undue to expect that the police will increasingly target the Roma community under the pretext of the fight against drug dealers, in particular under the new repressive drug legislation. Furthermore, law enforcement targeting Roma drug users and dealers may implicitly or explicitly, and perhaps even deliberately, foster the impression that

the drug problem and Roma are synonymous and that Roma are to blame as perpetrators rather than to commiserate with as victims. Both the World Bank and UNAIDS have warned that the more marginalized and oppressed minority populations are, the more vulnerable they become to HIV epidemics. Hopefully, the sketched scenario will not become a case study of this important observation.

### Glimmers of Hope?

The picture sketched in this chapter does not evoke a lot of confidence in the possibilities of developing appropriate and timely responses to HIV in the region. Reading the December 2000 AIDS epidemic update, jointly issued by UNAIDS and WHO and providing a global summary of the HIV/AIDS epidemic up to that moment (UNAIDS/WHO 2000b), one gets the impression that the epidemiologists at UNAIDS and WHO share much of this pessimism (UNAIDS/WHO 2000b).

Despite this grim picture, there are signs that a response is developing in the region. Because of the large number of countries in this region it is nearly impossible to outline country-specific responses in this chapter. Therefore, the following section does not pretend to provide a comprehensive overview of policy and project development in central and eastern Europe, but merely discusses some interesting developments.

At the level of policy development, UNAIDS, WHO and other UN agencies, as well as international organizations, such as Medecins Sans Frontieres (MSF), Medecins Du Monde (MDM) and the Lindesmith Center, a project of financier George Soros' Open Society Institute (TLC/OSI) have played a leading role in developing the initial response.

UNAIDS, WHO and other UN agencies have invested much time and energy in supporting national governments develop integrated “multisectoral and multilevel” approaches (UNAIDS 2000h). It seems that this onerous exercise is starting to yield rewards in some countries. For example, despite its Soviet bureaucratic tradition, in Belarus practically all ministries and state committees are involved in the response to HIV, which includes harm reduction interventions for IDUs and awareness-raising campaigns conducted by the national railways (UNAIDS/WHO 2000a). Reliance on obsolete mass screening techniques is reportedly decreasing in many countries and substituted by more intelligent HIV sentinel surveillance and education of the population. In 1998, Ukraine passed legislation, embracing a modern public health-based philosophy towards controlling its HIV epidemic. Among other positive changes, the country stopped compulsory screening of inmates and isolating those found HIV-positive, and, instead, started prevention programs in the prisons. Voluntary drug treatment is also developing in the country, and steps have been taken toward the introduction of methadone maintenance treatment for opiate addicts.

In Russia, Medecins Sans Frontieres-Holland has developed an intensive training project on HIV prevention among IDUs for health care providers and others working on HIV prevention. Between January 1998 and February 1999, the project trained 200 people from 61 Russian cities (U. Weber, personal communication, Burrows et al. 1999). The program is developed in consultation with the ministry of health and part of a strategic alliance with Medecins Du Monde and the International Harm Reduction Development program (IHRD) of the Lindesmith Center/Open Society Institute. This alliance, the Russian AIDS Prevention Initiative-Drugs (RAPID) is unique in the world in the sense that following the training, successful trainees are supported in applying for funding at a grants program funded by IHRD and OSI Russia. Thus, it includes intensive initial training, support with project

formulation and budget development—which are new concepts—and project funding, including further technical assistance. Until today, IHRD has funded more than 150 harm reduction programs, including needle exchanges and methadone maintenance programs. These projects are not only in Russia, but throughout the region, in both areas that reported significant outbreaks of HIV in IDUs and in low prevalence areas.

With its growing magnitude, a realization grows that drastic, unconventional and innovative measures are required to counter and control the HIV epidemic. Research from around the world has built strong scientific case for harm reduction approaches (Des Jarlais 1995; Drucker 1995) and after initial—largely ideological—resistance support for this comprehensive approach is rapidly in central and eastern Europe, as well as in the central Asian countries. Strengthened by the support of fortunately an increasing number of other international (donor) organizations, researchers, activists and professionals in the region have started to develop a wide range of harm reduction projects. An equally important development is the development of networks in the region, such as the Central Eastern European Harm Reduction Network, the South East European Harm Reduction Coalition and the recently established Central Asian Harm Reduction Network. These, often internet-based, networks are a definitive departure with the old culture of secrecy and competition and they connect scientists, professionals and activists not only within the region, but also to the international drugs and AIDS community.

While the HIV epidemic is getting out of control in Russia, the overall number of new infections in Ukraine and Belarus seems to have decreased. While these results received both UNAIDS praise and extensive media coverage, another, possibly more significant, result just across the border in Lithuania caught less attention. Perhaps because until now a large outbreak has not yet occurred in the country. According to the Lithuanian AIDS Center, early

prevention programs have helped Lithuania—which shares borders with HIV epicenters Poland, Belarus and Russia's Kaliningrad region—keep its HIV infection rate the lowest in central Europe, at 6.8 cases per 100,000 people. A total of 257 HIV cases have been recorded in Lithuania, including 56 new infections reported so far this year (Anonymous 2000). Lithuania belongs to the few countries where before rapid HIV spread among IDUs was reported, concerned clinicians, activists (e.g., parents of drug users) and policy makers worked together in implementing “best practice” or proven harm reduction interventions. The country largely abandoned the soviet narcology system, and has developed perhaps the most pragmatic government guidelines on methadone (maintenance) treatment in the region. Likewise, needle exchange, outreach and peer strategies were timely introduced, giving the country, compared to its neighbors, a headstart in contacting and educating out-of-treatment drug users about HIV.

It remains to be seen whether the country can maintain its low infection rate, as harm reduction services for IDUs are not present in all cities and such services must compete for scarce funds with primary drug prevention programs and low-volume, high-threshold drug treatment programs. As the director of the Vilnius Substance Abuse Treatment Center contended:

*“Definitely, the low HIV prevalence is not due to primary drug prevention or the twelve treatment slots in [the country’s] therapeutic community. On the other hand I am not sure that there is no potential “Narva” in one of the industrial cities in Lithuania, which have no methadone maintenance treatment and needle exchange programs for IDUs. No services, no IDUs reached, no HIV positives. Just as three months ago in the Estonian city of Narva”* (E. Subata, Personal Communication).

## CONCLUSION

This chapter described the HIV epidemic in central and eastern Europe. Based on a review of the epidemiological evidence, we can conclude that, more than anywhere else, the rapid pace of HIV spread is fueled by illicit drug injection. The examination of the injecting drug use patterns prevalent in the region suggested that the characteristic social setting of drug injecting (group use) might have facilitated rapid spread within this population. Likewise, the widespread nature and relatively high level of community tolerance of drug injecting may set the stage for a rapid secondary diffusion into the general population by way of sexual transmission.

In some parts of the region the responsiveness of politicians and bureaucrats to the epidemic seems to have improved and a number of innovative HIV prevention projects have been established. Nevertheless, the overall conclusion must be that the response to the epidemic has developed at a pace too slow to control further spread. The chapter described several (socio-cultural and political) obstacles from which this slow development resulted. Many of these are associated with the slow transition away from totalitarianism.

How the response to HIV in the region further progresses may depend very much on the developments in Russia. Having been educated within the soviet system, policy makers and professionals in leading positions throughout the region are confused about how to address the drug injecting-driven HIV epidemic, and many, in particular in the central Asian successor states of the FSU, are looking towards Moscow for guidance and leadership. Russia's emphasis on the allegedly unique features of its culture and the resulting dismissal



of “best practice” is in this context an important impediment to controlling the epidemic in the whole region. Of course, the design of appropriate interventions must include a cultural sensitivity to the particularities of each culture facing the epidemic. However, the international experience teaches that certain best practice interventions can transcend such cultural specificity. A lackluster response of archaic bureaucratic structures can therefore not be hidden behind a front of “Russianness” or its regional variations.

In particular, the vulnerable position of drug users is of great concern: intense repression of drug users has alienated them from the public health system to a great extent. This outcome is associated with the dominant influence of Internal Affairs in matters of public health. Not only are ministries of internal affairs vocal opponents of needle exchange, methadone treatment and other examples of “best practice,” their repressive approach to drug users is a main obstacle to the region’s struggle against HIV/AIDS, and brings about serious human rights concerns. While the experience elsewhere shows that good collaborative relationships between public health and law enforcement structures are important for developing successful interventions, such collaborations ought not to be determined by a law enforcement agenda, but by the requirements of an efficient public health-based response to the virus.

An additional worry is the influx of highly stigmatized ethnic minorities into the drug injecting population, such as the Roma. This trend is expected to result in rapid HIV spread in these communities and further complicate the human rights aspects of the epidemic, as they may easily become scapegoats for the failures of the authorities in controlling the twin epidemics of drug injecting and HIV.

The recent introduction of more repressive drug laws in several countries suggests that joining the international war on drugs may seem attractive to governments of countries

where the legacy of communist bureaucracy is still tangible in many areas of public policy making. Referring to its negative consequences, including HIV/AIDS, George Soros wrote that US drug policy “offers a prime example of adverse, unintended consequences.” He argued that “there is perhaps no other field where our public policies have produces an outcome so profoundly at odds with what was intended” (Soros 1997). The US drug war has facilitated the spread of disease (Grund et al. 1992), and its opposition to harm reduction measures, such as needle exchange has resulted in extensive human and economic loss (Lurie and Drucker 1997). Embarking on an US-style drug war would further compromise the region’s response to HIV. One should not forget that, from a biological viewpoint, the struggle against HIV/AIDS is an inter-species battle, while the drug war has become an intra-species conflict.

It may perhaps nowhere else become more obvious than in central and eastern Europe, and in particular in the FSU, how from a public health perspective, the HIV epidemic among drug injectors has become a sentinel measurement for assessing the success of our drug policies. With up to 90% injecting drug users among the region’s registered HIV cases, the region can simply not afford for its leaders to jump on the bandwagon of the drug war.

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<sup>i</sup> Narcology is a medical specialization, usually held by psychiatrists, though narcology staff also tends to include psychologists. Prior to 1991, when drug use was decriminalized in Russia (which was undone again in 1998), (alcohol and) drug treatment was punitive and draconian, involving prison sentences, labor camps and specialized correctional centers, based on medical, moral and Pavlovian treatment models. Confidential treatment was non-existent. Nowadays, narcology staff performs many of the functions of drug and alcohol workers in western countries including efforts to prevent drug use, assessment for treatment and detoxification. Detoxification is provided at narcological hospitals, and is normally supported by medication, but this seems to depend on whether the patient can afford those. Medications appear to be mainly Russian-made variations of minor tranquilizers and analgesics. Present detoxification treatment models vary widely, and include Western-style (psychological) individual and group counseling, but also neural surgery, hyperthermic heating of the blood, aromatherapy, coma therapy, and music therapy. The exact methodology seems to depend on the ideas and beliefs of the most senior local narcologist). While more patient/client-centered treatment approaches are being introduced, in many places treatment assessment continues to be an involuntary practice in many cases, as clients are often brought to the clinic by police or parents. Detoxification is often undergone under pressure from families and, once a detoxification center is entered, clients are usually locked in and cannot leave. Only limited post-detoxification treatment is available, usually involving counseling. Residential rehabilitation is still rare and usually run by NGOs, which contract narcologists as consultants (Burrows, Personal Communication; Green et al. 2000).