June 2004

A Comparative Look at International and National Drug Laws and Drug Policy and the Incidence of HI/AIDS and Related Diseases in Russia and the Scandinavian Countries of Finland and Norway

Daniel Sullivan

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Daniel Sullivan

M.S., Rutgers University, 1985

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2004

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2004
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I. Introduction

Worldwide drug use continues to increase despite international efforts to control demand and consumption. The United Nations (UN) estimates that over 3% of the world's population consumes drugs on an annual basis (UN CHRON 1998). The United Nations International Drug Control Programme (UNDCP) (1997) defines the term "drug" as all psychoactive substances that, when taken into a living organism, may modify its perception, mood, cognition, behavior or motor function. UN Secretary-General Kofi Annan (1998) has referred to the world's drug problem as the "contemporary plague".

The international treaties of the 1960's and 1970's relied primarily upon supply side measures to reduce drug use. Supply side measures mainly consist of punitive measures employed to reduce the production of drugs, stop the smuggling of drugs across international borders, police intervention to prevent the distribution of drugs and strategies designed to subvert underground business activities associated with drugs. Recently however, demand side (harm reduction) measures have been receiving more attention. Demand side (harm reduction) measures run the gamut from drug use prevention to treatment, rehabilitation and maintenance. Proponents of demand reduction point out drugs can be grown virtually anywhere, synthetic substitutes are readily available and there are many trade routes for drug smuggling (Weiner 1999). As long as there is a demand for illegal drugs and buyers willing to pay prices in excess of production costs, government intervention on the supply side cannot succeed (Tanner 1991). Still, most
countries devote more funds to reducing supply rather than demand (UNDCP 1997). The drug policies of most countries seek to conform to the international legal framework for the control of illegal drugs. Many governments fear that a shift in emphasis to demand reduction will be perceived by the public as “giving up” in the fight against drug abuse. With the prevailing view in many countries that drug abuse is a choice that should be punished, lawmakers are concerned with being seen as too liberal, or perhaps even promoting drug abuse.

However, the supply side approach has little to show for it. Despite stiffened penalties for drug use under the 1998 Russian Law on Narcotics and Psychotropic Substances, drug abuse has been rising at an alarming rate (Table 1). There was an estimated 91,000 drug users in treatment in Russia in 1994. At the beginning of 2001, there were 412,000 drug users registered with the Ministry of Health of the Russian Federation. Actual drug use is estimated to be ten times higher, upwards of 3 million, a 50% increase over 2000 estimates (INC 2002). An equally rapid rise in the number of HIV infections has mirrored the increase in drug use (Table 2). Some 50 – 60% of all reported HIV infections were transmitted through injection drug use (IDU) (EuroHIV 2003).

Table 1: Number of drug users registered with the Ministry of Health, Russian Federation, 1994 – 2001.

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<tbody>
<tr>
<td>Number</td>
<td>91,000</td>
<td>149,000</td>
<td>249,000</td>
<td>350,000</td>
<td>379,000</td>
<td>398,000</td>
<td>412,000</td>
<td>496,000</td>
<td>3,000,000*</td>
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</table>

* Estimate of actual drug users from the Russian Ministry of Interior (MVD)(2002)
Recent epidemiological data points to a dramatic increase in the incidence of HIV infections in the northwestern region of Russia. Murmansk, a northern county near the Barents Sea, has seen the number of newly diagnosed HIV infections increase seven-fold from 70 to 472 cases between 2000 and 2001. The HIV infection rate (51 per 100,000 population) is approaching that of metropolitan areas such as Saint Petersburg (241 per 100,000 population and Kaliningrad (0.41% infection rate). This recent outbreak has been fueled primarily by injection drug use (IDU), with 92% of cases transmitted through unsafe drug-injection practices (JAMA 2002). A high seroprevalence of both hepatitis B and C among injection drug users indicates that the sharing of needles and syringes is a common practice (Aavitsland 2001).

Table 2: HIV infections, newly diagnosed and rates per million in the Russian Federation, 1995 – 2002 (mid-year).

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</thead>
<tbody>
<tr>
<td>Number</td>
<td>197</td>
<td>1,524</td>
<td>4,377</td>
<td>4,062</td>
<td>19,851</td>
<td>59,281</td>
<td>87,177</td>
<td>28,746</td>
<td>207,711</td>
</tr>
<tr>
<td>Rate</td>
<td>1.3</td>
<td>10.3</td>
<td>29.7</td>
<td>27.7</td>
<td>135.8</td>
<td>407.5</td>
<td>602.6</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

European centre for the Epidemiological Monitoring of AIDS, 2003

This recent trend has led to concern that the unfolding epidemic will spread not only to surrounding areas of Russia, such as Arkhangelsk and the Republic of Karelia, but to the nearby countries of Finland and Norway. Although the rate of newly diagnosed HIV infections in Finland (2.5 per 100,000 population) and Norway (3.5 per 100,000 population) are relatively low, the fear is that these countries could see a major spike in new cases.
transmitted by injection drug users and sex workers coming across the border (JAMA 2002).

Investigators have noted that the Norwegian-Russian border [may be] the international border with the highest HIV rate gradient in the world. Researchers fear that, “In the future, the epidemic may spread by sex to the larger heterosexual population and vertically through newborns. Immediate preventive measures are needed to save young Russians from this grave infection” (JAMA 2002).

This paper will compare and contrast injection drug use, the legal approach to drug use, including demand and harm reduction strategies, and public health interventions in the Russian Federation versus the bordering Scandinavian countries of Finland and Norway. It will also examine the relationship between the legal and public health approach to drug use and the incidence of HIV/AIDS and related diseases in these countries and suggest possible policy changes which might help to quell the spread of these infectious diseases. This paper will find that the supply side measures utilized by the Russian Federation have done little to control drug abuse, and may even contribute to the harms associated with injection drug use. Conversely, the harm reduction strategies incorporated in the demand side approach favored by Finland and Norway have helped to maintain a relatively low prevalence of injection drug use and related harms.
II. International Law

A. A Historical Perspective

On July 28, 1958 the Economic and Social Council of the United Nations convened for the purpose of adopting a single convention of narcotic drugs which would replace the existing multilateral treaties in the field. This Council represented a single instrument which would function as a form of enforceable international law concerned with the control of narcotic drugs and make provision for the control of raw material production for narcotic drugs. It was the hope of the seventy-three member states represented at the original 1961 Convention to produce a multilateral treaty which would ultimately replace all existing multilateral agreements in the drug field. Subsequently, amendments made to the 1961 Convention in 1971, 1972 and 1988 have been signed by 71, 97 and 106 countries respectively.

Therefore, international treaties designed to control the supply and demand of psychoactive drugs fall primarily under the 1961 Single Convention on Narcotic Drugs (1961 Convention), the 1972 Protocol amendment to the 1961 Convention (1972 Protocol), the 1971 Convention on Psychotropic Substances (1971 Convention) and the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988 Convention). Since 1988, the UN General Assembly has issued many resolutions, declarations and plans of action regarding drug policy. However, while these resolutions and declarations establish standards, they do not contain the legal authority of international agreements (Weiner 1999).
i. **1961 Convention**: The provisions mentioned in the 1961 Convention focus primarily on supply side measures. Rexed et al. (1984) note that although the 1961 Convention contains provisions regarding drug demand reduction, details on the institutions, establishments and methodologies to be utilized are woefully neglected. The 1961 Convention (1961) established schedules of drugs it regulates and a mandate for treatment based on their classification (Tables 3-6).

For example, participants in the Convention were to establish legislative and administrative measures “to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs” in schedule I (Table 3), which includes, but is not limited to, cannabis, cocaine, LSD and opiates (1961 Convention). The Convention (1961) stipulates that offenses are to be punished, subject to a Party’s constitution, by a “deprivation of liberty” and are to be imposed for “serious offenses”.

**Table 3: Drugs classified as “Schedule I” under the 1961 Single Convention:**

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<th>Acetyl-alpha – methylfentanyl</th>
<th>Acetylmethadol</th>
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<td>Alphacetylmethadol</td>
<td>Alphameprodine</td>
<td>Alphamethadol</td>
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<tr>
<td>Alpha –methylfentanyl</td>
<td>Alpha – methylthiofentanyl</td>
<td>Alphaprodine</td>
<td>Anileridine</td>
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<td>Benzethidine</td>
<td>Benzylmorphine</td>
<td>Betacetylmethadol</td>
<td>Beta -hydroxyfentanyl</td>
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<tr>
<td>Beta - hydroxyl-3- methylfentanyl</td>
<td>Betamethadol</td>
<td>Betaprodine</td>
<td></td>
</tr>
<tr>
<td>Bezitramide</td>
<td>Cannabis and cannabis resin</td>
<td>Clonitazene</td>
<td>Coca leaf</td>
</tr>
<tr>
<td>Cocaine</td>
<td>Codoxime</td>
<td>Concentrate of poppy straw</td>
<td>Desomorphine</td>
</tr>
<tr>
<td>Dextromoramide</td>
<td>Diampromide</td>
<td>Diethylthiambutene</td>
<td>Difenoxin</td>
</tr>
<tr>
<td>Dihydromorphone</td>
<td>Dimenoxadol</td>
<td>Dimephentanol</td>
<td>Dimethylthiambutene</td>
</tr>
<tr>
<td>Dioxaphetyl butyrate</td>
<td>Diphenoxylate</td>
<td>Dipipanone</td>
<td>Drotebanol</td>
</tr>
</tbody>
</table>
Ecgonine
Etoxeridine
Hydrocodone
Isomethadone
Levophenacylmorphan
Methadone intermediate
Morphine-N-oxide
Noracymethadol
Norpipanone
Para-fluorofentanyl
Phenazocine
Racemoramide
Thebain

Ethylmethylthiambutene
Fentanyl
Hydromorphinol
Ketobemidone
Levoeomethorphan
Levomoramide
Levoerphanol
Morpheridine
Morphine
Morphine N-oxide
MPPP
Mormethadone
Opium
Pethidine
Pethidine Intermediate
Phenidine Intermediate
Phenidine Intermediate
Phenacemorphan
Pheneoperidine
Racemethorphan
Pheneoperidine
Pheneoperidine
Pheneoperidine
Thiofentanyl
Tildine
Tildine
Tildine

Etorphine
Furethidine
Hydromorphone
Leveomethorphan
Levoerorphine
Methadone
Metazocine
Morphine
Morphine methobromide
Myrpholine
Nicomorphine
Normorphine
Oxycodone
Oxymorphone
Pethidine
Pethidine Intermediate
Phenadoxone
Phenampromide
Norcodeine
Norcodeine
Norcodeine
Normorphine
Nicocodine
Nicocodine
Norcodeine
Nicocodine
Nicocodine
Nicocodine

Table 4: Drugs classified as “Schedule II” under the 1961 Convention:

<table>
<thead>
<tr>
<th>Acetylhydromorphone</th>
<th>Codeine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dextropropoxyphene</td>
<td>Dihydrocodeine</td>
</tr>
<tr>
<td>Ethylmorphine</td>
<td>Nicocodine</td>
</tr>
<tr>
<td>Nicocodine</td>
<td>Norcodeine</td>
</tr>
<tr>
<td>Pholcodine</td>
<td>Propiram</td>
</tr>
</tbody>
</table>

(1961 Single Convention on narcotic Drugs)

Table 5: Drugs classified as “Schedule III” under the 1961 Convention:

<table>
<thead>
<tr>
<th>Acetylhydromorphone</th>
<th>Codeine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dihydrocodeine</td>
<td>Ethylmorphine</td>
</tr>
<tr>
<td>Nicocodine</td>
<td>Norcodeine</td>
</tr>
<tr>
<td>Pholcodine</td>
<td></td>
</tr>
</tbody>
</table>

(1961 Single Convention on narcotic Drugs)
Table 6: Drugs classified as “Schedule 4” under the 1961 Convention:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha -methylthiofentanyl</td>
<td>Beta -hydroxy-3-methylfentanyl</td>
<td>Beta -hydroxyfentanyl</td>
<td></td>
</tr>
<tr>
<td>Cannabis and Cannabis resin</td>
<td>Desomorphine</td>
<td>Etorphine</td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td>Ketobemidone</td>
<td>3-methylfentanyl</td>
<td></td>
</tr>
<tr>
<td>3-methylthiofentanyl</td>
<td>MPPP</td>
<td>Para -fluorofentanyl</td>
<td></td>
</tr>
<tr>
<td>PEPAP</td>
<td>Thiofentanyl</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As Rexed et al. (1984) states, signatories to the 1961 Convention are required to “adopt appropriate legislation, introduce necessary administrative and enforcement measures and cooperate with the international drug control organs, as well as other countries” in order to comply with the established international legal framework. The 1961 Convention clearly delineated how governments were to control the supply of drugs based upon scheduling, how criminal laws should address drug-related offenses and the information signatories must supply to the International Narcotics Control Board (INCB). However, the treaty does not promote standards for demand reduction (Weiner 1999). The lone reference to demand reduction may be found in article 38, which states:

1. The parties shall give *special attention* to the provision of facilities for the medical treatment, care and rehabilitation of drug addicts.

2. If a party has a *serious problem of drug addiction* and its economic resources permit, it is desirable that it establish *adequate facilities* for the effective treatment of drug addicts (1961 Convention).

While the Convention (1961) addressed the desire to treat drug addicts, it failed to address prevention. Additionally, the Convention did not provide a policy which participants could easily implement nor did it define the role of international instruments in developing demand reduction initiatives. In
addition, any existing provisions relating to demand reduction would have been superceded by the 1961 Convention (Weiner 1999).

ii. **1971 Convention and the 1972 Protocol Amendment:** Rexed et al. (1984) points out that none of the international treaties specifically address demand reduction by UN member states. Article 38 of the 1961 Convention was amended by article 15 of the 1972 Protocol, changing its title to “Measures Against the Abuse of Drugs” and the text to:

1) *The Parties shall give special attention to and take all practical measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall coordinate their efforts to these ends.*

2) *The Parties shall as far as possible promote the training of personnel in the treatment, after-care, rehabilitation and social reintegration of abusers of drugs.*

3) *The Parties shall take all practical measures to assist persons whose work so requires to gain an understanding of the problems of abuse of drugs and of its prevention, and shall also promote such understanding among the general public if there is a risk that abuse of drugs will become widespread.*

(1972 Protocol)

The Protocol (1972) further modified article 38 of the 1961 Convention by adding a provision which encouraged member states to promote regional centers for scientific research and education and to allow parties to treat drug abuse offenders either in addition to or in place of punitive measures. Despite these modifications, neither the 1972 Protocol or the 1971 Convention identified exactly who would take an active role in developing these programs nor the methods to carry them out (WHO 1984).
iii. **WHO: Demand Reduction**: The lack of specifics found in the 1961 and 1971 Conventions and the 1972 Protocol led the WHO to identify goals for demand reduction programs. In 1980, the thirty-third World Health Assembly assigned the role of designing demand reduction models for preventing drug abuse, and treating and rehabilitating drug abusers to the World Health Organization (WHO) and various UN bodies (Rexed et al. 1984). The WHO promptly began a study on the implementation of the 1961 and 1972 Conventions in developing countries (Wiener 1999). Information obtained from host governments, health agencies, research facilities, areas of commerce and law enforcement was used to compile the WHO publication, *Guidelines for the Control of Narcotic and Psychotropic Substances: In the Context of International Treaties* (WHO 1984). The WHO approach was based on the concept that there are numerous reasons for drug use and it may be "unrealistic" to prevent all non-medical use. The WHO focused on prevention by way of harm reduction, the "limitation of the more individually and socially harmful effects of drug use" (WHO 1984). Harm reduction programs should consist of primary prevention (preventing nonusers from experimenting and occasional users from becoming chronic users), and secondary and tertiary measures (prevention or reduction of the number and severity of problems associated with non-medical use) and (preventing the worst effects of chronic drug abuse by means of treatment and rehabilitation) (WHO 1984).
The WHO approach supports dissemination of information about drugs but emphasizes accuracy in that it must be consistent with pharmaceutical knowledge and the experience of users. The WHO discourages the use of "scare" tactics, instead, supporting the integration of drug education into traditional disciplines of learning. WHO guidelines emphasize the local community as a mechanism to prevent the chronic use of drugs and to reduce the problems associated with non-medical use (Wiener 1999).


The inclusion of the CMO is noteworthy as two of its four sections contain demand side measures, a significant departure from the Conventions of the 60's and 70's. In addition, the CMO actually defined objectives, methods and key players as components of demand reduction programs (Wiener 1999).

The CMO was adopted in 1987 during the International Conference on Drug Abuse and Illicit Trafficking. It established measures for reducing the demand, supply and illegal trafficking in drugs along with mechanisms for providing treatment and rehabilitation to drug abusers. The CMO acknowledges the role of the WHO in providing policy guidance for treating addicts (Wiener 1999).
v. **1990 General Assembly:** The General Assembly (1990) continued to support demand reduction measures in its *Political Declaration and Global Programme of Action (1990 Program)*, citing 1991 – 2000 to be the United Nations “Decade Against Drug Abuse”. The Global Programme of Action (1990) acknowledges an increasing demand for narcotic drugs and psychotropic substances and that there are social causes “at the root of the [drug] problem”. The 1990 Program emphasizes the “treatment, rehabilitation and occupational reintegration of former drug addicts” to reduce the demand for illicit drugs rather than the prevention of initial use (1990 Program). This approach is in line with the WHO position that the prevention of initial use will not stop the non-medical use of drugs and that prevention programs should target the reduction of the harmful effects of drug abuse in current users (Wiener 1999).

vi. **Analysis of International Law from 1958 – 1990:** There are clear philosophical differences between the WHO and CMO approaches. The WHO acknowledges that there will always be some level of drug abuse and emphasizes harm reduction, the ultimate goal of the CMO appears to be the creation of a drug-free world (Rexed et al. 1984). In its discussion of demand reduction, the WHO includes measures aimed at nonusers, casual users and chronic users alike. By contrast, the CMO focuses primarily on the prevention of initial use and the rehabilitation of addicts. The CMO devotes scant attention to the levels between abstinence and addiction (Dennis 1991).
Additionally, the WHO approach is primarily concerned with the medical and social consequences of drug abuse while the CMO adopts a somewhat moralistic tone. The CMO advocates national drug testing and urges the media to refrain from glamorizing or advocating the legalization of drugs. It sees demand and supply reduction as “banishing an acknowledged evil” and “rescuing human beings from a precarious situation”. On the other hand, the WHO charges the media with simply providing accurate information so that users and nonusers alike may make informed decisions (Wiener 1999).

However, despite mounting data supporting the effectiveness of harm reduction in reducing drug-related harms and the prevention of the spread of HIV, it still faces significant opposition. Politicians call for punitive measures for drug users citing harm reduction measures as “too liberal”. Physicians often oppose methadone and other substitution therapy programs as not “real” drug treatment. Law enforcement agencies feel needle exchange programs undermine the social order. Anecdotal reports from drug users claim needle exchange programs, especially mobile services, interfere with police efforts to harass and arrest drug users. Negative media campaigns often focus on the provision of clean needles and syringes to “hopeless junkies”. Many neighborhood groups openly oppose needle exchange programs in their communities. All of these factors reinforce the general perception that HIV positive injection drug users are somehow “guilty” as in responsible for their own infections and as “dangerous carriers of disease” who should be avoided (OSI 1999).
Thus, over the course of thirty years, the international community has shifted, at least in theory, from a primarily supply side to a demand reduction approach to drug abuse. The UN member states have developed a framework for demand reduction policies and through a multidisciplinary network of UN bodies to implement drug abuse programs (Wiener 1999). However, this apparent paradigm shift has yet to be put into practice, as the majority of countries still overweight their drug control funding towards supply side measures. For example, in 1995, the countries of Pakistan and Columbia devoted 30% and less than 1% respectively of drug control funding to drug treatment and rehabilitation. In its 1993 and 1994 budgets, the United Kingdom earmarked 31% of funding towards demand side measures (UNDCP 2001). In its fiscal year 2002 budget, the United States appropriated 54.6% of its drug control monies towards supply side measures with 45.4% devoted to demand reduction (ONDCP 2003).

B. A Current Perspective

i. The Law: In June, 1998, the tenth anniversary of the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, the United Nations General Assembly held a special session devoted to dealing with the world drug problem (UN Chron 1998). At the close of the session, representatives from 150 countries adopted a Political Declaration, the Declaration on the Guiding Principles of Drug Demand Reduction and Measures to Enhance International Cooperation to Counter the World Drug Problem. UN member states, in recognizing that drug demand
reduction is “an indispensable pillar in the global approach to countering the world drug problem together”, established 2003 as the “target date for new or enhanced drug demand reduction strategies and programmes set up in close collaboration with public health, social welfare and law enforcement authorities” and committed “to achieving significant and measurable results in the field of demand reduction by the year 2008” (Wiener 1999).

ii. Analysis and Recommendations: While the United Nations claims to have made significant strides toward demand reduction, independent observers have questioned what exactly was achieved at the Drug Summit. Those outside of the UN characterize the Declarations of the Summit as simply a restatement of principles outlined in the CMO with continued priority given to supply side measures (Wiener 1999).

However, there are notable differences in the approach used in the Drug Summit from the declarations made at the CMO. The Drug Summit clearly outlines the preventive measures to be included in demand reduction programs and combines them with treatment and rehabilitation measures under the heading of harm reduction (UN Chron 1998).

In the wake of the 1998 Drug Summit, it is clear that the international community must formulate a drug policy short on rhetoric and long on workable solutions. Through its adoption of the Demand Reduction Declaration, the UN has identified supply and demand as the two-headed monster of drug abuse. The question is how best to allocate funds to facilitate both supply and demand reduction.
The Political Declaration of the Drug Summit would seem to reaffirm the member states unwavering determination and commitment to overcoming the world drug problem through domestic and international strategies to reduce both the illicit supply of and demand for drugs. The Demand Reduction Declaration calls for members “to intensify efforts in demand reduction and to provide resources towards that end” (CND 1998). However, this intensity is often attenuated when the participants arrive back on home soil. Many signatories stand to profit either directly from the multi-billion dollar drug industry or through the corruption of highly placed officials (Wiener 1999).

If supply and demand are truly addressed as equals they must receive equal funding, with governments encouraged to gradually increase the funding of demand side measures. This would allow for the evaluation of existing supply side measures while gradually increasing the funding for the establishment of demand side prevention and treatment programs (Wiener 1999).

In addition to funding, the UNDCP must develop specific strategies for demand reduction so as not to repeat ineffective policies. The UNDCP’s position holds that public information campaigns and school-based prevention programs do not work. The WHO Guidelines and the Demand Reduction Declaration of 1998 both point out the underlying socioeconomic conditions which trigger drug use (Rexed et al. 1984). Primary prevention measures banking on the spirit that potential users would not abuse drugs if they knew the potential harm caused will be ineffective “if they fall on the deaf ears of
people who believe that there is no opportunity cost for their drug abuse” (Wiener 1999).

A key component of the Demand Reduction Declaration was the inclusion of prevention, treatment and rehabilitation under the umbrella of demand reduction (CND 1998). However, this distinction will be meaningless unless policy includes users and nonusers alike (Wiener 1999). While the effectiveness of prevention programs aimed at nonusers remains controversial, the efficacy of treatment begins to mount (Elliot 1995). Additionally, a recent ONDCP study states that it is not only possible to reduce the harm associated with drugs but that it is also cost effective to do so. The study found “that $1 spent on treatment decreases drug use as much as $7 spent on domestic law enforcement, $11 on confiscating drugs at the border and $23 to stop drugs at their country of origin” (Shavelson 1998). If further studies support the cost effectiveness of demand reduction programs along with the success of treatment in reducing the harms of drug abuse it is clear the international focus must move from supply to the demand side of illicit drugs (Wiener 1999).

The following sections will cover drug-related laws and actual practice in the bordering countries of Russia (Table 7), Finland (Table 8) and Norway (Table 9), which have utilized distinctly different approaches to the control of drug abuse and related harms. Finland and Norway have embraced the concept of demand reduction within the framework of social welfare and health, while the Russian Federation has focused their limited resources on
supply side measures. Current laws related to drug possession, drug trafficking and the right to drug treatment will be addressed followed by an overview of the criminal justice system in each country.

III. National Strategies to Control Narcotics

A. Russian Federation

Russia is party to the 1988 UN Drug Convention, the 1961 UN Single Convention on Narcotic Drugs, the 1972 Protocol amending the Single Convention and the 1971 UN Convention on Psychotropic Substances. The Russian Border Service established an agreement in 1995 with Kyrgyzstan and Tajikistan which reinforces trilateral counter-narcotics cooperation on Russia’s borders with Afghanistan, Pakistan and Iran. Russia is also party to the 1992 Kiev Treaty on Cooperation in Interregional Drug Investigations and has signed the UN Convention against Transnational Organized Crime, the Protocol to Prevent, Suppress and Punish Trafficking in Persons and the Protocol against the Smuggling of Migrants (INC 2002).

The Russian Constitution of 1993 included an overhaul of the criminal code, which included laws pertaining to the possession, sale, production and trafficking of drugs. It also included the right of defendants to demand a jury trial along with other “Western-style” rights. However, many of these laws have yet to be put into practice as Russia struggles to convert to a system of trial by jury (Wines 2003). In addition, the day-to-day enforcement of law is open to the interpretation and discretion of the court and law enforcement officials (Table 7).
Table 7: Current Drug-Related Law Contrasted With Actual Practice in the Russian Federation

<table>
<thead>
<tr>
<th>Current Drug-Related Law</th>
<th>Current Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article 228 of the Russian Criminal Code prohibits the possession, sale, manufacture or</td>
<td>The current Russian Administration has placed a high priority on law enforcement. There were 59,000 heroin seizures over the first nine months of 2000, an increase of 134% over 1999 (INC 2001).</td>
</tr>
<tr>
<td>production of illicit drugs and imposes specific penalties.</td>
<td></td>
</tr>
<tr>
<td>Although the criminal code does not prohibit the non-medical use of drugs or psychotropic</td>
<td>There were 250,000 drug-related arrests in 1998, an increase from 185,000 in 1997 (INC 2001).</td>
</tr>
<tr>
<td>substances, it does not specify what substances are to be considered illicit drugs, nor</td>
<td></td>
</tr>
<tr>
<td>indicate what amounts of illicit drugs are to be interpreted as &quot;large&quot; for criminal</td>
<td></td>
</tr>
<tr>
<td>liability. However, these gaps have largely been filled by other legal provisions.</td>
<td></td>
</tr>
<tr>
<td>A draft law intended to change the criminal code would enable authorities to arrest and</td>
<td>Police feel that drug users undermine the social order and often harass and arrest suspected drug users. Low pay and difficult working conditions continue to foster corruption among law enforcement officials.</td>
</tr>
<tr>
<td>detain persons who were &quot;high&quot; at the time of arrest but were no longer in possession of</td>
<td></td>
</tr>
<tr>
<td>any illicit drug.</td>
<td></td>
</tr>
<tr>
<td>Possession of drug injection equipment is NOT illegal.</td>
<td>Needles and syringes may be purchased legally from pharmacies without a prescription.</td>
</tr>
<tr>
<td></td>
<td>Police often harass and arrest drug users outside of pharmacies resulting in reluctance by drug users to obtain clean needles and syringes.</td>
</tr>
<tr>
<td>Methadone is classified as an illegal drug</td>
<td>Methadone and other substitution therapies are precluded</td>
</tr>
<tr>
<td>Everyone shall be guaranteed the right to qualified counsel</td>
<td>Most accused persons lack the resources to secure legal counsel.</td>
</tr>
<tr>
<td>Imprisonment as a pre-trial detention measure should be invoked only when there are</td>
<td>State advocates are provided free of charge, but the quality of representation is poor. The bail minimum of $500 (US) is too high for the majority of the accused, thus there is an increase in pre-trial detainment.</td>
</tr>
<tr>
<td>reasonable grounds to believe that the suspect will hide from further investigation, put</td>
<td>A prosecutor has very broad powers, over which the courts exercise very little influence.</td>
</tr>
<tr>
<td>obstacles in the way of establishing justice or continue criminal activity.</td>
<td>A prosecutor may require pre-trial detention, a decision not automatically reviewed by the court.</td>
</tr>
</tbody>
</table>

i. **Current Trends in Drug Use Across the Russian Federation:** The Russian Ministry of Interior reported in October 2001 that the estimated number of drug addicts in Russia has increased by 50% since 2000 to over three million individuals. Drug addiction among Russians 14 years of age and under has risen 24-fold since 1991. The Russian Government now concedes that widespread drug use among its military has become a national security concern. The number of draftees using drugs has increased 7-fold since 1999. The government reports that 25% of officers, 40% of conscripts and 40% of soldiers of all ranks now serving in the Caucasus abuse drugs. It is also believed that members of the military have become increasingly involved in drug trafficking as well (INC 2002).

Officials now consider Russia to be a consumer country with heroin trafficking and use to be a threat to the national security and public health. Although almost half the heroin seized in 2001 was designated for export, it appears that Russia is facing a serious drug abuse problem. Dominating all other drug issues in Russia is the dramatic increase in the flow of heroin into the country from Afghanistan across the southern border. In 2001, 99% of the heroin seized in Russia came from Afghanistan, more than doubling the amount from 1999. The sharp increase in the supply of heroin has correlated with a sharp decrease in price, which has in turn stimulated demand to unprecedented levels. The Taliban increased the production and export of opium and heroin into Tajikistan, Kazakhstan and Russia in 1998 at the time of economic recession in those countries (Waller et al 2001). The economic
crisis resulted in a sharp drop in the standard of living in Russia, with high unemployment rates and a decline in the funding of technical resources available to law enforcement and treatment facilities. The widespread availability of cheap heroin has led to significant increases in the incidence of related infectious diseases such as HIV/AIDS, tuberculosis, hepatitis and sexually transmitted diseases (INC 2002). According to recent reports, the United States (US) war on Afghanistan has led the Taliban and al Qaeda to dump their stockpiles of opium on world markets. Heroin that cost $10 (US) per gram before the terrorist attacks on the U.S. sold for $35 (US) in subsequent weeks and currently trades for about $15 (US). However, even at these prices, the typical Russian heroin user cannot support a heroin addiction without some type of criminal activity. The government now recognizes that drugs are no longer simply an illicit product in transit (INC 2002).

While traditionally the drugs of choice in Russia have been opium poppy straw extract and cannabis products, abuse of other drugs including heroin, amphetamines and ephedrine are cause for concern. While the economy is currently experiencing some growth, Russia remains a depressed market for cocaine, which remains priced out of the Russian market. Demand for cocaine has fallen abruptly from its peak in the more prosperous 1990's, although the demand for cocaine never equaled that for heroin, which is much cheaper, more plentiful and more easily imported. LSD and methamphetamine abuse is increasing along with the manufacture and sale of "designer drugs" such as ecstasy (INC 2002).
ii. **Risk Behavior:** There is anecdotal evidence that opiate users in Moscow share needles and syringes more frequently than IDU's in other regions, primarily due to a lack of money. There is also anecdotal evidence that in several cities, human blood is added to the drug solution during preparation as a cleansing agent to precipitate solid particles and stabilize acidity levels. In most cases, the person who “boils” the drug solution uses his own blood. Assessments of HIV outbreaks in several Russian regions and cities suggest that drug “boilers”, either through negligence or ignorance of their HIV status, might have spread the virus in this way (INC 2001)

iii. **Drug Possession:** Article 228 of the Russian Criminal Code:

> “prohibits possession, sale, manufacture or production of illicit drugs and imposes specific penalties. Convictions under this code involve simple drug use as well as the sale of illicit drugs. Article 228 prohibits the possession of illicit drugs and makes the illegal acquisition or keeping without purpose to sell punishable by 3 years of imprisonment. More specific punishment is provided for (3 – 7 years) if possession is coupled with intent to sell. Repeat offenders face imprisonment for 5 – 10 years.”

Although Article 228 “does not prohibit the non-medical use of drugs psychotropic substances, does not specify what substances are considered to be illicit drugs, nor does it indicate what amounts of illicit drugs are to be interpreted as “large” for criminal liability purposes”, these gaps are filled by other sections of the criminal law.

The Permanent Commission on Drug Control has established a list of substances to be considered “drugs and psychotropic substances” within Article 228. There is currently a draft law that would enable authorities to arrest and detain persons who were “high” at the time of arrest but were no longer in possession of any illicit drug (RusCrCode 1997).
Possession of drug injection equipment is not illegal. Needles and syringes may be purchased legally from pharmacies without a prescription (RusCrCode 1997). Syringe exchanges operate, often with local resistance from the authorities, in cities across the Federation (IHRD 2001). However, possession of a syringe often exposes injection drug users to police harassment or intervention by indicating illegal drug possession (DET 1999). Syringe exchange programs run by NGO’s in cities such as Kazan, Moscow, Saint Petersburg and Kalingrad report that it is difficult to reach injection drug users. Many IDU’s are driven “underground” out of fear of police harassment. Law enforcement officials often place SEP’s under surveillance. IDU’s are confronted by police as they leave the facility and often have drugs placed on them unless they pay protection money, which they rarely have. The result is that IDU’s are more likely to share injecting equipment thus increasing risk factors for infection. The Russian public tolerates police corruption in this form as they have a generally unsympathetic view of drug users. Most feel that drug use is immoral and view drug users as criminals who belong in prison (IHRD 2003).

The criminalization of the purchase and possession of illegal drugs under the 1998 Drug Law has done little to discourage the growing substance abuse problem in Russia. Court sentences continue to be light despite the stiffening of penalties under the 1998 Law (INC 2001).

iv. Drug Treatment: Under the Russian Constitution of 1993, Article 41, everyone has the right to health care and medical assistance. Medical
assistance is made available by state and municipal health care institutions to citizens free of charge, with the money relevant to the budget, insurance payments and other revenues (RusCon 1993). The 1998 Russian Law on Narcotics and Psychotropic Substances provides for compulsory treatment of drug abusers who come to the attention of the authorities. The 1998 Drug Law restricts drug abuse treatment to government facilities (INC 2001). The permanent Committee on Drug Control established a list of substances considered to be “drugs and psychotropic substances” within the meaning of Article 228 and other relevant legislation. Methadone has been classified as an illegal drug (RusCRCode 1997). Since methadone is classified as an illegal drug, substitution therapy is precluded (RusCRCode 1997). Opposition to methadone maintenance and other substitution therapies on the basis that they are not “real” drug treatment comes from many drug treatment physicians (IHRD 1999).

v. Drug Trafficking: Up until 2000, neither Russian policy makers nor law enforcement officials considered making drug trafficking a high priority. Drug abuse was considered low and restricting the transit of narcotics through Russia was given a lower priority than other seemingly more critical illegal activities. However, with the dramatic rise in drug abuse, the Russian government now considers drug trafficking a serious threat to national security (INC 2002).

The 1998 Russian Law on Narcotics and Psychotropic Substances stiffened penalties for the distribution and large-scale trafficking of illicit drugs
(INC 2001). While this has done little to stem the growth in substance abuse in Russia, the 1998 Law has given law enforcement a somewhat increased ability to deal with serious drug traffickers. Afghan heroin flows across the southern Russian border and has increased three-fold over the past three years. The Taliban increased the production and export of opium and heroin into Russian in 1998 coinciding with the Russian economic crisis. The resulting sharp drop in the standard of living for many Russians, high unemployment rates and decreased financial and technical resources available to law enforcement coincided with the widespread availability of cheap heroin (INC 2002).

While Russian law enforcement budgets were increased 20% in 2001 and again in 2002, law enforcement morale is low and the temptation for corruption remains. Equipment has deteriorated and veteran officers have been lost to attrition. Little new funding is available for new equipment or procurement of new technology. Thus, inadequate budgets, low salaries and a lack of technical resources and support hamper performance and encourage corruption. Funds for training are also extremely limited (INC 2002).

vi. **Criminal Justice System in Principle and Practice:** The Russian Constitution of 1993 identified the basic human rights and liberties of its citizens under the law. These rights include, but are not limited to: the right to be considered innocent until proven guilty, constraints on pretrial detention, the right to a jury trial, the right to qualified legal counsel and parameters for the setting of bail.
Under the Russian Constitution of 1993, Section One, Chapter 2, Rights and Liberties of Man and Citizen, Article 17, the following rights exist:

“The basic rights and liberties in conformity with the commonly recognized principles and norms of international law shall be recognized and guaranteed in the Russian Federation and under this Constitution”.

Under Article 22:

“Everyone shall have the right to freedom and personal inviolability. Arrest, detention and keeping in custody shall be allowed only by an order of a court of law”.

Under Article 45:

“State protection for human rights and liberties in the Russian Federation shall be guaranteed”.

Under Article 46:

“Everyone shall be guaranteed protection of his or her rights and liberties in a court of law”.

Under Article 47:

“No one may be denied the right to having his or her case reviewed by the court and the judge under whose jurisdiction the case falls under by law. Anyone charged with a crime has the right to have his or her case reviewed by a court of law with the participation of jurors in cases stipulated by the federal law”.

Under Article 49:

“Everyone charged with a crime shall be considered not guilty until his or her guilt has been proven in conformity with the procedures stipulated by the federal law and established by the verdict of a court of law. The defendant shall not be obligated to prove his or her own innocence”. “The benefit of the doubt shall be interpreted in favor of the defendant”.

Under the Criminal Processing Code, Article 89:

“Imprisonment as a pretrial detention measure should be invoked only when there are reasonable grounds to believe that the suspect will hide
from further investigation or court; or will put obstacles in the way of establishing justice in the criminal case; or will continue his involvement into criminal activity. Otherwise, the prosecutor or judge may release the accused on bail.

Under Article 99:
“There is no amount set for bail, however, the minimum can’t be less than $500 (US), or two to three months of the average Russian salary”.

Under Article 97:
“pre-trial detainment cannot exceed two months, but a prosecutor may extend this term to three months. For crimes of a serious nature, the Deputy Prosecutor general may extend this term to 1 year”.

Under Article 48:
“Everyone shall be guaranteed the right to qualified legal counsel. Legal counsel shall be provided free of charge in cases stipulated by the federal law. Every person who has been detained, taken into custody or charged with a crime shall have the right to legal counsel (defense attorney) from the moment of, respectively, detention or indictment.

(Criminal Code of the Russian Federation 1997)

The former Soviet state outlawed juries in 1917. Since that time, the fate of accused Russians rested in the hands of a three-member panels which served as judge, jury and often, assistants to the prosecutor. This form of “justice” stood the test of time, producing 995 convictions for every 1,000 criminal cases as recently as 1996 (Wines 2003).

A new Code of Criminal procedure was approved by the Russian Parliament in July 2002. The new Code brings Russia in line with international standards of criminal justice and should facilitate integration into western legal institutions. The overhaul of the Russian Criminal Code gives defendants accused of capital crimes the right to demand a jury trial. Many of the judicial reforms had been written into the 1993 Russian Constitution. However, it
wasn’t until 1999 when Russia’s top court ordered the government to put these reforms into practice. Still, the Russian parliament failed to consider legislation until 2002. Even then, parliament voted to delay jury trials in 20 oblasts, including Moscow, because officials were unprepared to adopt the changes (Wines 2003).

Thus, while judicial reform was an early priority of post-Soviet Russia, reforms have stalled. The Judicial Reform Department was dissolved in 1995 followed by a judge’s strike. Currently, the Russian judiciary is in crisis as the 20,000 judges represent half the number required by the new system (Wines 2003). The strengthening of drug laws has led to a sharp increase in the workload of judges, but there has been no enlargement of staff to handle the increase. The courts are currently bankrupt, thus judges and court staff do not receive their salaries. An experimental trial in 2002 had to be halted because the $1.75 (US) per diem failed to attract potential jurors (Wines 2003).

Recent delays have raised the suspicions of civil liberties proponents who fear the rights of the accused will be “watered down” (Wines 2003). A prosecutor may require pre-trial detention in one of the countries many SIZO’s, or pre-trial detention centers, a decision that is not automatically reviewed by the court. The prosecutor has very broad powers, over which the courts exercise very little influence. The bail minimum of $500 (US) is too high for the majority of the accused. Since the minimum set for bail is so high, many Russians cannot afford to post bail, thus there is an increase in pre-trial detention (Schoofs 2002).
Most accused persons lack the resources to secure legal counsel. State advocates are provided free of charge, but the quality of this representation is poor (RusCrCode 1997).

The number of HIV-infected prisoners has increased dramatically in recent years. Approximately 16% of Russia's roughly 200,000 registered HIV positive individuals are in prison, while many others who are currently free having been recently incarcerated (Schoofs 2002). Although the data is incomplete, it is estimated that the prevalence rate of HIV among prisoners was 21.8 per 100,000 prisoners in 1996, rising to 106.5 per 100,000 prisoners in 1997. There were 1,636 HIV-infected persons in confinement institutions in 1997. During the nine years from 1987 to 1995, 46 HIV-infected prisoners had been identified, none of them injecting drug users. In 1996, 300 HIV-infected individuals arrived at Russian prisons, almost 90% of them injecting drug users. In 1997, 1,636 prison inmates were HIV-infected, 1,516 (93%) injecting drug users. In early 1998, 468 HIV-infected prisoners arrived, including 434 (93%) injecting drug users. As of May, 1998, approximately 20% (1,732) of all people registered as HIV-infected were in prison (DET 1999).

The highest number of HIV-infected people in prison was in Kaliningrad (370), followed by Krasnodarsky krai, Rostovskays region (274), Tverskaya region (201), Nizhegorodskaya region (105) and the Moscow Departments of Interior Affairs (100). Most HIV infections are detected at the time of entry into an investigative ward. However, in 1997, the proportion of first HIV diagnosis decreased to about 60% (DET 1999).
The draconian drug laws of the Russian Federation mean possession of even small amounts of heroin for personal consumption can bring long prison sentences. The fact that drug users are often jailed repeatedly has led to fears that the spread of HIV/AIDS will be fueled through IDU’s moving in and out of prison (Schoofs 2002).

Although sufficient evidence of HIV transmission in prisons is lacking, there are anecdotal reports of sex between men, rape and injecting drug use (DET 1999). Prison officials admit that HIV and related infectious diseases could spread throughout the prison system unnoticed. Inmates are supposed to receive mandatory HIV testing under the law upon entering prison. In practice, most inmates are tested only if they appear ill. The prisons main defense against the spread of infectious diseases appears to be segregation. Many keep infected and uninfected prisoners in separate cellblocks. The problem is that the HIV test measures antibodies, not the actual presence of HIV. Since it may take an immune system up to six months to generate antibodies against HIV, it is possible to place an infected prisoner in the “uninfected” cellblock. This method can also lead to a false sense of security among inmates as to who is and isn’t infected (Schoofs 2002).

Drug distribution and consumption appears to be taking place in prisons on some level. Overcrowding has made the control of drugs and syringes nearly impossible. Needle and syringe sharing appears to be common, and disposable and clean equipment is usually not available (DET 1999). Bleach is often restricted as it can be used to attempt suicide or harm other prisoners.
or guards. Condoms are rarely available as sex is not allowed (Schoofs 2002).

Despite the many problems facing the Russian criminal justice system, the significance of putting the recent judicial reforms into practice cannot be overstated. Drug abusers must be afforded due process, equality and human rights under the law. A legal system which continues to discriminate against and violate the human rights of drug users will only serve to fuel the epidemic of drug abuse and related infectious diseases in two ways. Fear of harassment and abuse often sends drug abusers underground and away from the few support systems that exist. Secondly, those who fall prey to the system will undoubtedly find themselves in a prison system which exposes them to drugs and infectious diseases such as HIV/AIDS, tuberculosis and hepatitis.

B. Finland

The responsibility of coordinating national drug policy in Finland is delegated to the Ministry of Social Affairs and Health. The Ministry also formulates narcotics legislation and regulations on the legal manufacture, sale and use of narcotics. The Ministry of Justice is responsible for the preparation of laws which regulate narcotics offenses and related issues (STAKES 2001).

The basis for drug control in Finland is the UN Drug Conventions. Finland is party to the 1988 UN Drug Convention, the 1961 UN Single Convention on Narcotic Drugs, the 1972 Protocol amending the Single Convention and the 1971 UN Convention on Psychotropic Substances.
Additionally, Finland has extradition treaties with several countries and ratified the European Union’s extradition treaty in 1999. Finland has signed the UN Convention against Transnational Crime, the Protocol to Prevent, Suppress and Punish Trafficking in Persons and the Protocol against the Smuggling of Migrants. Since regaining independence, Estonia has established bilateral narcotics agreements with Finland. The United States has a mutual assistance customs agreement with Finland and although a 1976 bilateral extradition is in place between Finland and the United States, Finland will only extradite non-Finnish citizens to the US. Membership in the UNDCP has provided the majority of financial assistance to drug production and transit and provides the basis for most of Finland’s cooperation with the United States (INC 2002).

Based upon the 1997 memorandum of the Drug Policy Committee, Huumausainesstrategia 1997, 56-60 (STAKES 2001), the Finnish Government issued a resolution on drug policy in 1998 entitled the “Government decision-in-principle on Drug Policy”. The decision-in-principle outlines Finland’s basic approach to drug policy as:

*Finland’s drug policy is based on general socio-political measures, national legislation and international conventions. The aim is to intensify drug control based on a total prohibition on distribution and use of drugs, to prevent experimenting with drugs and their use, as well as to provide, and facilitate access to, adequate care and treatment for drug abusers. The goal of drug policy is to prevent drug use and the proliferation of drugs so as to make the detrimental effects on individuals, and the costs entailed by drug abuse, and related prevention, care and control measures, as small as possible. In its drug policy, Finland takes account of the European Union’s lines of action relating to drug policy and foreign and security policies.*

(STAKES 2001)
The national drug strategy proposal was completed in 1997 by the National Drug Policy Committee. The Government Decision-In-Principle on Drug Policy, based upon the Committee’s proposal, was published in 1998 (Table 8). The Decision outlines the Finnish approach to drug policy as:

The proliferation and use of drugs is prevented primarily by influencing the population’s living conditions on the basis of equality and fundamental rights, by implementing Nordic welfare policy. In this way, the factors that expose people to drug use and intoxicant problems are reduced. Education and information are the means to influence attitudes and to encourage young people to lead a drug-free way of life. Drug use and its related problems and damages can be prevented successfully by an early and efficient intervention in young persons’ drug problems and in symptoms preceding drug use. The educational system and social and health services can intervene at an early stage, if the problems and symptoms can be identified and if they can be tackled in the right way (STAKES 2001).

The Finnish Government has since set up a drug policy coordination group which is charged with coordinating national drug policy and to increase collaboration between relevant authorities in an effort to implement and monitor the drug program. The group, represented by individuals from relevant Ministries and agencies, has prepared an action plan which was approved by the Finnish Government on October 5, 2000 (Government Decision-In-Principle on Drugs Policy, 2000). The overall goal of the plan is to
reduce both the supply and demand of drugs and to retard the growth of narcotics use and related crime (STAKES 2001).

Current drug-related law and narcotics offences are outlined in the Finnish Penal Code. Examples of drug law found in the penal code and the practical realities of enforcement are contrasted in Table 8.

**Table 8: Current Drug-Related Law Contrasted with Actual Practice in Finland:**

<table>
<thead>
<tr>
<th>Current Drug-Related Law</th>
<th>Current Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narcotics offences are specified in the Finnish penal Code (1304/1993) whereby drug offences are classified as narcotics offences, preparation of narcotics offences and abetment of narcotics offences.</td>
<td>An amendment to the Penal Code (654/2001) in September 2001 implemented a system of fines rather than jail time for the illegal usage, possession or attempt to obtain small amounts of drugs for personal consumption</td>
</tr>
<tr>
<td>Sentences range from fines up to a maximum of two years imprisonment.</td>
<td>Penalties are often a fine or not more than six months imprisonment.</td>
</tr>
<tr>
<td>Narcotics crimes classified as aggravated may carry sentences of one up to ten years.</td>
<td>Amendment 654/2001 enables summary penal proceedings where the prosecutor may administer punishment outside of the court.</td>
</tr>
<tr>
<td></td>
<td>Prosecution or punishment may be waived if the offence is deemed insignificant in view of the amount and quality of narcotics.</td>
</tr>
<tr>
<td></td>
<td>Assignment to a drug treatment center may be applied in lieu of prison time.</td>
</tr>
<tr>
<td>Substitution treatment using buprenorphine, methadone or lavacetylmethadol is legal, as is maintenance therapy.</td>
<td>There are currently some 30 facilities offering substitution therapy in Finland.</td>
</tr>
<tr>
<td>Syringe exchange programs are legal.</td>
<td>There are currently 13 counseling centers in Finland who provide information on risk factors for infectious disease and where they may exchange their contaminated needles.</td>
</tr>
</tbody>
</table>

(STAKES 2001)

**i. Current Trends in Drug Use Across Finland:** Throughout the 1990’s, Finnish society experienced a steady increase in drug experimentation along with harms related to drug abuse (STAKES 2001). Officials attributed the increase in the experimentation with and use of drugs to societal changes such as economic recession, unemployment and weakened social networks.
In addition, more frequent international contact, increased availability and use of drugs in neighboring countries and a culture more accepting of illegal drug use are also cited (Drug Strategy 1997). Finish police attribute the increase in illegal drugs to the wider availability of drugs in post-cold war Europe, diminished police resources and greater experimentation by Finnish youth (INC 2002).

However, since the turn of the century, early indicators suggest the rapid increase of the 1990’s may be slowing down. This reversal of trend appears to be most marked among young adults, arguably the population most susceptible to drug abuse. While this apparent decline is supported by school health surveys taken from 1999 to 2001, it remains to be seen if this is an isolated cycle or the beginning of a new trend (STAKES 2001).

The most common form of drug abuse in Finland is polydrug use which involves the mixing of alcohol with such agents as sleeping pills, pain killers, tranquilizers and sedatives (Drug Strategy, 1997). The rate of cannabis use in Finland is the lowest in Europe and the use of cocaine is rare. However, Finland has seen a steady rise in the use of amphetamines, meth-amphetamines and heroin over the past decade, along with a significant rise in the use of ecstasy (INC 2002). Although the majority of the Finnish population maintain a negative attitude toward illegal drug use, the current culture is adopting a more tolerant viewpoint (Drug Strategy, 1997).

ii. Risk Behavior: Risk behaviors associated with the spread of infectious disease are relatively low throughout Finland. Reports of needle sharing or
the use of human blood during the preparation of injecting drugs are rare. The fact that drug policy is firmly imbedded in the welfare policy along with the efforts of non-governmental organizations (NGO's) has enabled it to become integrated into Finnish society as a whole. Drug treatment, including the use of methadone, along with needle-exchange programs are widely available throughout most of the country (Drug Strategy, 1997). The infection counseling center *Vinkki* is a location where used hypodermic needles may be exchanged for new ones. The impact of the Center is illustrated in Table 9, which shows a reduction in risk behaviors over time from 1997 to 1999. It has been in operation in Helsinki for over three years and ten other municipalities have opened similar centers since early 2001. Over 4500 of an estimated 10–15,000 injection drug users visited existing centers in 2000 alone (STAKES 2001). Finland's efforts to reduce the detrimental effects of drug use may have helped in maintaining its relatively low levels of related infectious diseases. Thus, a policy designed to reduce the detrimental effects of drug use has to be considered when assessing the lack of high risk behaviors and subsequent spread of related infectious disease in Finland.

**Table 9: Impact of the Vinkki Counseling Center as to decreased risk factors associated with injection drug use (STAKES 2001).**

<table>
<thead>
<tr>
<th>Behavior</th>
<th>1997</th>
<th>September 1, 1998 - June 9, 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has not borrowed syringes during the month</td>
<td>55%</td>
<td>67%</td>
</tr>
<tr>
<td>Has lent syringes to others</td>
<td>75%</td>
<td>44%</td>
</tr>
<tr>
<td>Reportedly cleaned syringes after use</td>
<td>46%</td>
<td>89%</td>
</tr>
<tr>
<td>Proportion of multi-risk users</td>
<td>21%</td>
<td>3%</td>
</tr>
</tbody>
</table>
iii. **Drug Possession**: The Finnish Government released a comprehensive policy statement on illegal drugs in 1998, which articulated a policy of complete prohibition. The document alerted citizens of Finland that all narcotics violations, however small, were punishable under Finnish law.

Narcotics offences are specified in the Finnish Penal Code (1304/1993) whereby drug offences are classified as narcotics offences, preparation of narcotics offences and abetment of narcotics offences. Sentences range from fines up to a maximum of two years imprisonment. Narcotics crimes classified as aggravated narcotics offences may carry sentences of one up to ten years of imprisonment. The criteria for aggravated drug offences includes:

- **The offence involves a highly dangerous substance or large quantities thereof.**
- **Considerable financial profit is sought.**
- **The offender acts as a member of a group organized for the extensive commission of such an offence.**
- **Serious danger is caused for the life or health of several people.**
- **Narcotics are distributed to minors or in an otherwise unscrupulous manner.**
- **The narcotics offence, when assessed as a whole, is to be deemed aggravated.**

(STAKES 2001)

According to the law, a highly dangerous drug refers to a narcotic substance which may cause death by overdose, serious damage to health even through short-term use or severe withdrawal symptoms (STAKES 2001).

Legislation that increased the ability of law enforcement to pursue violators with additional investigative tools, including undercover “buys” was

However, in September, 2001, Finland instituted a reduction in the penalty for simple possession. An amendment (654/2001) to the Penal Code implemented a system of fines rather than jail time for the illegal usage, possession or attempt to obtain small amounts of drugs for personal consumption (INC 2002). The penalty is a fine or not more than six months’ imprisonment. This amendment enables summary penal proceedings, where the prosecutor may administer punishment outside of the court. Preliminary investigation is often less extensive than in normal preliminary investigations (STAKES 2001).

This reform measure has helped to clarify regulations on waiving prosecution in drug related crimes. This amendment stipulates that prosecution or punishment may be waived if the offence is deemed insignificant in view of the amount and quality of narcotics, the situation and the circumstances. This may also be invoked when the suspect has sought treatment specified by the Ministry of Social Affairs and Health. Formally, the law stipulated that such persons had to commit themselves to treatment. In addition, other regulations pertaining to the waiving of proceedings are also applicable to drug offences (STAKES 2001). However, Finnish police fear this sends the wrong message to Finnish citizens and have an established a strategy for 2002-2003 placing increased emphasis on street-level drug trafficking (INC 2002).
iv. **Drug Treatment:** The government of Finland has taken the view that drug demand reduction is best reached through the implementation of an effective Nordic welfare policy. Such policy focuses on early intervention before drug use becomes a concern. Local government is given significant leeway in addressing demand reduction using federal monies. Drug education is required in all Finnish schools (INC 2002).

Drug treatment is available though limited in certain areas of the country. The goal of the social welfare policy is to guarantee equal access and treatment to all. The treatment of drug addicts takes place at the primary level and above. A-Clinics and short-term treatment centers specifically designed for younger drug abusers are found throughout Finland. Tertiary treatment is available in the detoxification unit at the Helsinki University hospital. Long-term treatment is available through community care, therapeutic communities and through individual and group therapy (Drug Strategy, 1997). All forms of drug treatment are strictly voluntary as the mandatory treatment of drug abusers is rarely practiced. Methadone replacement therapy is widely available although the use of buprenorphine for drug replacement and maintenance is a relatively new practice in Finland (INC 2002).

The Ministry of Social Affairs and Health issued an Order in 1997 (28/1997) on the detoxification and substitution treatment of opioid addicts with medicines containing buprenorphine, methadone or lavacetylmethadol. On November 2, 1998 a new order was issued (42/1998) and on July 1, 2000 the
Ministry of Social Affairs and Health issued a Decree on the Question (607/2000). Previous orders had limited the length of detoxification period preceding substitution treatment to 12 months and the number of facilities evaluating treatment need was limited to three university hospitals. The new decrees have limited the detoxification treatment period to one month, with substitution as well as maintenance treatment as a new method are intended for longer treatment. The evaluation of need for detoxification, substitution and maintenance treatment has been expanded to include all Finnish university and other central hospitals in addition to the Jarvenpaa Addiction Hospital (STAKES 2001).

According to the 2000 Decree on the question, opioid addiction is defined by the ICD-10 criteria (F11.2x). All treatment types require an individual treatment plan which specifies all medical, pharmaceutical and psychosocial care and follow-up required by the patient. Both detoxification and substitution treatment are defined by the Decree as rehabilitative care aiming at a drug-free lifestyle. New therapies are introduced in the form of maintenance treatment with harm reduction and enhancement of the patient’s quality of life as focal points of care. Additionally, maintenance treatment may be used to prepare the patient for rehabilitative substitution treatment. Commencement and follow-up of all forms of treatment are assigned initially to the aforementioned hospitals, but treatment may be continued at a public health care or substance abuse service unit. The Decree emphasizes the
importance of providing long-term treatment as close to the patient as possible (STAKES 2001).

v. **Drug Trafficking:** The production, cultivation and trafficking of narcotics is considered to be relatively modest in Finland, as is the production of precursor chemicals. Law enforcement has thus far been effective in controlling drug trafficking from abroad. The principal sources of illegal drugs in Finland are Russia, Estonia, Spain and the Netherlands. Finnish legislation makes the transport of narcotics illegal and provides for law enforcement, the extradition of traffickers, transit cooperation and the control of precursor chemicals (INC 2002).

Finland has established a significant international effort to control drug trafficking and related organized crime. Finnish police support four liaison officers in Russia and four in other European cities. Finland pools its resources and shares information with the other Nordic countries of Sweden, Norway, Denmark and Iceland. In addition, Finland participates in multilateral efforts through the European Union and the Council of Baltic Sea States’ organized Crime task Force (INC 2002).

vi. **Criminal Justice System in Principle and Practice:** The rise in drug use over the past decade has resulted in a consequent increase in the number of sentences for drug offenses. Approximately 15 – 20% of these sentences have been conditional, with 10 – 11% unconditional and 69 – 75% resulting in fines. The average length of a prison sentence for drug offenses was 27.4 months in 1994. Punishments imposed on drug traffickers have been most
severe with sentences exceeding 12 years being imposed on principals in such cases. The prosecution and court practice punishments have rarely been waived with regard to drug offences. As per the Narcotics Act of 1972 and the Penal Code of 1994, the waiving of punishment is to be used only in cases of drug use and related offences. In addition, grounds for waiving such cases are contingent on the individual seeking drug treatment approved through social and health authorities. The frequency of such cases being waived has declined from some 15 – 30% in the early seventies to less than 10% today (Drug Strategy, 1997).

The guiding principle behind the 1994 Narcotics Act was to address professional and organized crime. The goal of this act was to make drug use punishable as a means to convey a no tolerance message regarding drug use and to provide an effective deterrent against the growing illicit drug market in Finland (STAKES 2001).

Based upon changes made in the 1994 Penal Code, the prosecution and sentencing of drug use and related crimes may be waived if the crime does not undermine common obedience to the law or if the perpetrators commit themselves to a treatment regimen which has been approved by the Ministry of Social Affairs and Health. The provisions outlined in the 1994 Code address the personal use, import, possession or manufacture of drugs. Historically, it is believed that prosecutors have often waived prosecution inappropriately, viewing court proceedings as too cumbersome for the imposition of a simple fine. In an attempt to remedy this, the Prosecutor-
General issued clear guidelines in January 2000 for the waiving of prosecution in various types of drug and related crimes. According to the guidelines issued in (5/2000), the decision to prosecute an adult should be based on the amount and quality of the drugs in question and the duration of use. In addition, other related circumstances may be taken into account. The point of reference however, remains the vague concept of did the crime undermine common obedience to the law. In the case of long-term drug users, punitive action becomes less significant. The guidelines are applicable to both adults and juveniles, but the defendant's age may be taken into account, especially if the act is deemed to have resulted from thoughtlessness or imprudent judgment (experimental use) (STAKES 2001).

The ambiguity of drug laws in Finland was addressed by the Ministry of Justice in late 2000 through a proposal for amendment, which was subsequently passed in summer 2001, taking effect on September 1, 2001. The amendment defines a "user crime", making it possible to impose a fine in the form of summary penal judgment for the use, possession or attempt to obtain drugs for personal use. The goal of the amendment was to replace the abstract nature of the current law with a more precise expression of quantity, quality, situation and/or circumstances. The reform does not make the punishment more lenient, it simply expedites the imposition of a fine in such cases (STAKES 2001).

Court hearings in drug trials differ from other trials with respect to the burden of proof. It is often more difficult to establish proof in drug offences
since the evidence is generally based upon the story of the offender or an accomplice (STAKES 2001).

C. Norway

Norway is party to the 1988 UN Drug Convention, the 1971 UN Convention on Psychotropic Substances, the 1961 UN Single Convention on narcotic Drugs and the 1972 Protocol amending the Single Convention. Norway has in place bilateral customs agreements with the United States, Russia, select countries in Central and Eastern Europe and the European Union. Extradition of criminals to the United States and other countries is governed by 1975 extradition law. The UN Convention against Transnational Organized Crime, the Protocol to Prevent, Suppress and Punish Trafficking in Persons and the Protocol against the Smuggling of Migrants have all been signed but not yet ratified by the Norwegian government (INC 2002).

i. Current Trends in Drug Use Across Norway: Although illegal drug production was considered insignificant in 2001, consumption of illicit drugs appears to be increasing significantly (CIA 2002). Surveys among 15 – 20 year olds suggest a distinct increase in the number of different drugs being abused, beginning in the late 1990’s up to the present. Seventeen percent of young people aged 15 – 20 reported the use of cannabis in 2001 compare with less than ten percent up until the mid 90’s. Among other illegal drugs, 1 – 2% report the use of LSD, heroine, cocaine and ecstasy at least once. Additional surveys suggest a substantial increase in long-term drug abuse. The national Institute for Alcohol and Drug research shows that the number of
injection drug users has grown to 9 – 12,000 in a population of 4,459,000 (0.25%) during the late 1990's (1998) from 4,500 in a population of 4,230,000 (0.11%) at the end of the 1980's (1989). These surveys also show that the majority of injection drug users inject heroine (SIRUS 2001).

Once considered a problem associated only with youth, drug abuse is becoming a social problem increasingly among the middle-aged. The drug abuser population has grown older and evidence suggests that this trend will continue. Additionally, there appears to be more recruiting among older males, possibly due to traditional alcohol abusers moving to heroin. The overall increase in the use of heroin is a function of the increase in the number of users along with an increase in the dosage size per injection (SIRUS 2001).

Seizures of illegal drugs rose 16% in 2001, led by cannabis (38%), benzodiazepines (20%) and amphetamines (15%). Seizures of heroin arriving from Central Europe also increased in 2001. Norway continues to place tight controls on the sale, export and import of precursor chemicals (INC 2002).

ii. Risk Behavior: In 1997, a user survey was taken among clients of a needle-exchange bus in the capital city of Oslo, considered the primary base for injection drug use in Norway. According to the survey, 4% of injection drug users reported the use of a second hand needle during their last injection. The majority of these individuals reported that the previous user was a steady drug partner. However, given the context of the survey, a certain degree of underreporting may be assumed (SIRUS 2001).
iii. **Drug Possession:** Norway has no separate laws that deal with drugs only. Most illegal activities relating to drugs are covered under the Norwegian Penal Code of May 22, 1902, with the exception of the use and possession of minor quantities of drugs which fall under the Act on Medicinal Products of December 4, 1992 (Table 10) (SIRUS 2001).

The use and possession of small quantities of drugs was reclassified to a misdemeanor in 1984. The use and possession of small amounts of drugs do not fall under section 162 of the General Civil Penal Code, but under the more lenient Act on Medicinal Products of December 4, 1992, no. 132, section 31, paragraph 2. Punishment, which also applies to complicity, is fines or imprisonment not to exceed 6 months (SIRUS 2001).

In an effort to discourage the use of illegal narcotics, the Norwegian government increased the fines relating to narcotics crimes in 2000. The maximum penalty for possession of illegal narcotics is 21 years in prison, although penalties for the possession of small amounts are relatively mild (INC 2002).

Despite relatively strict laws pertaining to illegal drug use, punitive measures are often mild. The possession of small quantities of drugs for personal consumption is classified as a misdemeanor. Examples of current drug-related law in Norway and the realities of enforcement practices most often employed are contrasted in Table 10.
Table 10: Current Drug-Related Law Contrasted With Actual Practice in Norway

<table>
<thead>
<tr>
<th>Current Drug-Related Law</th>
<th>Current Practice</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>The Norwegian Government increased fines relating to narcotics crimes in 2000. The maximum penalty for possession of illegal narcotics is 21 years</td>
<td>Penalties for the possession of small amounts of drugs are relatively mild. The term of 21 years is meant to address aggravating circumstances such as large-scale international drug trafficking.</td>
</tr>
<tr>
<td>The penalty for intentionally manufacturing, acquiring, importing, exporting, storing, sending or conveying narcotic drugs includes fines and/or imprisonment not exceeding 2 years</td>
<td>Penalties for drug offenses primarily depend upon the substance and quantity involved. Personal consumption is shown greater leniency than cases which were motivated by profit.</td>
</tr>
<tr>
<td>The Prison Act of December 12, 1958 allows for drug treatment to be substituted for prison time.</td>
<td>Transfer to a treatment facility is voluntary</td>
</tr>
<tr>
<td>Substitution therapy is legal using methadone, Subutex, LAAM or high-dosage buprenorphin.</td>
<td>Substitution therapy is administered through a national treatment center in Oslo along with regional coordinating agencies covering four health regions</td>
</tr>
<tr>
<td>Syringe exchange programs are legal</td>
<td>Clean syringes and needles are available at supervised “needle-rooms&quot;.</td>
</tr>
</tbody>
</table>

(SIRUS 2001)

iv. Drug Treatment: Norway’s Ministry of Health and Social Affairs has continued to implement educational programs to reduce drug abuse through the Norwegian Directorate for the Prevention of Alcohol and Drug Problems. Released in 2000, the counter-narcotics program, “Narcotics Problems in Norway: Report and Anti-Drug Measures”, proposed the establishment of “needle-rooms” where supervised addicts could inject drugs. First implemented in 2001 on a limited basis to reduce drug-related crime and the spread of HIV, it is unknown whether this system will be maintained and expanded (INC 2002).
The Prison Act of December 12, 1958, No. 7, Section 12, allows for a prison sentence to be substituted for treatment. The decision to transfer a convicted individual to a treatment facility is made by the Governor of the Prison Service Institution, or in the case of serious crime, the Prison Service Administration. Special circumstances allow for the execution of a sentence to commence in a treatment facility. Transfer to a treatment facility is voluntary in accordance with section 12 of the Prison Act (SIRUS 2001).

v. Drug Trafficking: According to the Ministry of Health and Social Affairs and the police, illicit drug production, trafficking and the import and export of precursor chemicals remains insignificant in Norway due to tight legislation, enforcement and a harsh social climate. However, Norway remains a market for illegal drugs from Eastern and Central Europe, especially ecstasy from the Netherlands, although an increase in drug seizures appears to be making its mark (INC 2002).

Norway’s Customs and Excise Directorate has continued to implement its own counter-narcotics plan which focuses on slowing drug imports and the seizure of drug money and precursor chemicals used in drug production. A mobile narcotics control unit has been established and surveillance and coordination with both the police and Coast Guard has been maintained (INC 2002).

vi. Criminal Justice System in Principle and Practice: The Norwegian General Civil Penal Code and the Act on Medicinal Products fail to define the term “drug”. Section 22 of the Act on Medicinal Products empowers the King
to determine exactly which substances shall be regarded as drugs. As of January 1, 2001, the King delegated this responsibility to the Norwegian medicines Agency, who has since detailed a list of narcotics (The Narcotics List of 30, June 1978, No.8). The national drug list includes all psychotropic substances and narcotic drugs under international control and in addition, several substances and plants which fall under national control only. Also included in the list are the chemical derivatives of the substances listed in the national narcotics list plus any variation of the substance which are also considered narcotic drugs. On December 19, 1997, regulations issued concerning certain substances that may be used in the illicit manufacture of narcotic drugs and psychotropic substances and precursors, implements the European Community Directive n° 92/109 issued December 14, 1992 (SIRUS 2001).

The Norwegian Civil Penal Code, section 162, first paragraph, supplies the main provisions with regard to drug related felonies. It applies to anyone who intentionally manufactures, acquires, imports, exports, stores, sends or conveys narcotic drugs. The penalty for drug offenses pursuant to section 162 include fines and/or imprisonment not exceeding 2 years. Aggravated drug felonies, addressed in paragraph 2, may be punished by imprisonment of not more than 10 years. The criteria for a drug offense to be considered an aggravated felony include the type of substance, significant quantities and the sale to vulnerable groups, such as students, prison inmates and residents of social institutions (SIRUS 2001).
Drug cases in which a very considerable quantity is involved in the offense is noted in paragraph 3 where the penalty is increased to a term of imprisonment “of no less than 3 years and a maximum of 15”. In an effort to address large international drug trafficking, the second paragraph, item 2, imposes a term of imprisonment not to exceed 21 years (maximum penalty under Norwegian penal laws) for very aggravating circumstances (SIRUS 2001).

Actual practice in Norway has demonstrated that penalties for drug offenses primarily depend upon the substance and quantity involved. In addition, the nature of involvement with the substance, e.g., personal consumption, is shown greater leniency than in cases which were motivated by profit. Three recent Supreme Court rulings, (Rt. 1999, p.33 and p. 1504 and the Supreme Court Ruling of September 6, 2000) strongly express the need to establish a distinct line between the purchase and storing of drugs intended for private consumption and those intended for sale. The Ministry for Social Affairs has appointed a committee, which was to submit a report by July 1, 2002, to summarize the existing knowledge in the field of substance abuse, evaluate the need for further research and indicate policy dilemmas and options in the upcoming years (SIRUS 2001).

D. Contrast in Drug-Related Law and Practice in Russia, Finland and Norway:

Clearly, the national drug policies of Finland and Norway contrast with that of the Russian Federation. Russia has chosen to implement draconian
measures which rely almost exclusively on supply side measures and leave little room for treatment and rehabilitation. To make matters worse, the current state of the Russian criminal justice system has fostered a high level of corruption among law enforcement officials. The implementation of a jury trial system has been slowed by inadequate resources and political opposition. Although their drug laws are relatively strict, Finland and Norway have chosen to put into practice a demand side approach emphasizing prevention, treatment, rehabilitation and maintenance. Examples of drug-related law contrasted with the common practices of law enforcement in each country are summarized in Table 11.

Table 11: Contrasting Drug-Related Law and Practice in Russia, Finland and Norway

<table>
<thead>
<tr>
<th>Drug-Related Law</th>
<th>Practice in the Russian Federation</th>
<th>Practice in Finland</th>
<th>Practice in Norway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use and Possession of Small Quantities of Drugs</td>
<td>Possession of up to 1/1,000 of a gram can draw as much as three years imprisonment</td>
<td>Possession of small quantities of drugs brings a fine or imprisonment not to exceed 6 months</td>
<td>Possession of small quantities of drugs brings a fine or imprisonment not to exceed 6 months</td>
</tr>
<tr>
<td>Criminal Justice System</td>
<td>Russia began jury trials in 2002. prosecutor has broad powers and may require pre-trial detention in “SIZO’s”</td>
<td>Prosecutor may administer punishment (fines) outside of court, and frequently waive punishment entirely</td>
<td>Prosecutor may administer punishment (fines) outside of court, and frequently waive punishment entirely</td>
</tr>
<tr>
<td>Transfer to a Treatment Facility in Lieu of Prison Time</td>
<td>Not Available</td>
<td>Available on a Voluntary Basis</td>
<td>Available on a Voluntary Basis</td>
</tr>
<tr>
<td>Substitution Therapy</td>
<td>Substitution therapy is currently illegal</td>
<td>Substitution therapy is legal and available in over 30 facilities using buprenorphine, methadone or lavacetylmethadol</td>
<td>Substitution therapy is legal and widely available using LAAM, methadone, Subutex or high-dosage buprenorphine,</td>
</tr>
</tbody>
</table>
Possession of Needles and Syringes

Needles and syringes may be purchased legally from pharmacies. Police often harass and arrest drug users outside of pharmacies, resulting in a reluctance by drug users to obtain clean needles and syringes.

Possession of needles and syringes is legal. They may be purchased at pharmacies or available for free at 13 counseling centers.

Possession of needles and syringes is legal. They may be purchased at pharmacies or through vending machines or for free at supervised "needle-rooms".

Syringe Exchange Programs

A small number of NEP/SEP operates throughout the country run by various NGOs. Police often harass and arrest drug users in the area of NEP/SEP, resulting in a reluctance by drug users to obtain clean needles and syringes.

There are currently 13 counseling centers that provide information on risk factors for infectious disease and where IDUs may exchange their contaminated injection equipment.

Clean needles and syringes are available at supervised "needle-rooms".

IV. Epidemiology of HIV/AIDS and Related Diseases

A. Russian Federation

i. HIV/AIDS: The transition of the Soviet Union into independent republics has led to an alarming increase in drug abuse accompanied by dramatic increases in the incidence of infectious diseases such as HIV/AIDS, Hepatitis A, B and C and Tuberculosis. President Vladimir V. Putin has attributed the increase in drug abuse in part to the social and economic stresses associated with a transition to democracy and a free market economy (INC 2002). In addition, the increase in prostitution as an outgrowth of substance abuse and economic dislocation has led to significant jumps in sexually transmitted infections (STI's) such as gonorrhea, syphilis and chlamydia.
According to a report released in March, 2001 by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), the prevalence of HIV infection is rapidly increasing. Approximately 700,000 people in Eastern Europe tested positive for HIV in 2000, compared to 420,000 in 1999. Russia and Estonia reported many more cases in 2000 than in any previous year and most (54%) new infections were a result of injection drug abuse (IDU) (UNAIDS 2000). From 1999 to 2000, the regions of Eastern Europe and Central Asia saw the largest jump (55%) in the number of HIV/AIDS cases worldwide as compared to Sub-Saharan Africa (17.7%), North Africa and the Middle East (25%), East Asia (25.5%), South-East Asia (16%), Latin America (12%), North America (5.1%) and the Caribbean (18.2%) (NY Times 2001).

In much of the former Soviet Union (FSU), poverty, unemployment and a crumbling public health system have led to a sharp rise in drug abuse and prostitution causing epidemics of STD's including HIV. Among the hardest hit is Russia, where the number of people living with HIV has risen from 30,000 in 1999 to over 200,000 in 2002 (Table 12). The rate of HIV infection has increased from 10.3 per million population in 1996, to 594 per million population in 2000, a 58 fold increase (Table 12).
**TABLE 12: Total reported AIDS and HIV cases and by mechanism of transmission and incidence rates per million population during year of diagnosis and adjusted for reporting delays (WHO European Region 2002)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Reported AIDS Cases</th>
<th>Reported New HIV Infections</th>
<th>Homo/Bi Sexual Contact (N)</th>
<th>Injection Drug Use (N)</th>
<th>Heterosexual Contact (N)</th>
<th>Perinatal Transmission (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Rate/ Million</td>
<td>N</td>
<td>Rate/ Million</td>
<td>HIV</td>
<td>AIDS</td>
</tr>
<tr>
<td>1994</td>
<td>34</td>
<td>0.2</td>
<td>162</td>
<td>1.1</td>
<td>u/a</td>
<td>u/a</td>
</tr>
<tr>
<td>1995</td>
<td>39</td>
<td>0.3</td>
<td>197</td>
<td>1.3</td>
<td>u/a</td>
<td>u/a</td>
</tr>
<tr>
<td>1996</td>
<td>50</td>
<td>0.3</td>
<td>1,524</td>
<td>10.3</td>
<td>91</td>
<td>17</td>
</tr>
<tr>
<td>1997</td>
<td>71</td>
<td>0.5</td>
<td>4,377</td>
<td>29.6</td>
<td>55</td>
<td>19</td>
</tr>
<tr>
<td>1998</td>
<td>66</td>
<td>0.4</td>
<td>4,062</td>
<td>27.6</td>
<td>70</td>
<td>23</td>
</tr>
<tr>
<td>1999</td>
<td>40</td>
<td>0.3</td>
<td>19,851</td>
<td>134.9</td>
<td>77</td>
<td>4</td>
</tr>
<tr>
<td>2000</td>
<td>22</td>
<td>0.1</td>
<td>59,281</td>
<td>403.5</td>
<td>71</td>
<td>0</td>
</tr>
<tr>
<td>2001</td>
<td>u/a</td>
<td>u/a</td>
<td>87,177</td>
<td>594.4</td>
<td>78</td>
<td>u/a</td>
</tr>
<tr>
<td>2002*</td>
<td>u/a</td>
<td>u/a</td>
<td>28,746</td>
<td>u/a</td>
<td>u/a</td>
<td>11,121</td>
</tr>
<tr>
<td>Total</td>
<td>451</td>
<td>207,711</td>
<td>776</td>
<td>119</td>
<td>111,310</td>
<td>29</td>
</tr>
</tbody>
</table>

* January – June 2002

Technical note: Accurate and complete data on HIV in Russia are not available. The data presented here are from a variety of sources and may not entirely agree. These data generally do not represent HIV incidence, and depend heavily upon patterns of HIV testing and reporting that remain very incomplete in the most severely affected countries. HIV infection is defined as an individual with HIV infection confirmed by a laboratory according to country definitions and requirements. AIDS cases are reported according to a uniform AIDS case definition originally published in 1982 and revised in 1985, 1987 and for adults and adolescents (>age 13) in 1993. The 1993 European AIDS surveillance cases definition differs from that used in the United States in that it does not include CD4 lymphocyte criteria (European Centre for the Epidemiological Monitoring of AIDS, 2002)

Data from the Ministry of Health and the Federal AIDS Center for the Russian Federation are equally discouraging. According to the Russian Government, the prevalence of HIV has increased from 0.7 in 1995 to 199.5 per 100,000 population in 2001 (Table 13).

**Table 13: Data on new and cumulative HIV infections reported along with the incidence rate per year and cumulative rate of infection for the years 1987 – 2002 as compiled by the Ministry of Health and the Federal AIDS Center of the Russian Federation.**

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>New Infections</td>
<td>23</td>
<td>47</td>
<td>265</td>
<td>103</td>
<td>84</td>
<td>88</td>
<td>107</td>
<td>161</td>
</tr>
<tr>
<td>Total Infections</td>
<td>23</td>
<td>70</td>
<td>335</td>
<td>438</td>
<td>522</td>
<td>610</td>
<td>717</td>
<td>878</td>
</tr>
<tr>
<td>Prevalence/100,000</td>
<td>0.3</td>
<td>0.4</td>
<td>0.4</td>
<td>0.5</td>
<td>0.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incidence/Year/100,000</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Infections</td>
<td>196</td>
<td>1,526</td>
<td>4,375</td>
<td>4,055</td>
<td>19,846</td>
<td>59,340</td>
<td>82,852</td>
<td>28,746</td>
</tr>
<tr>
<td>Total Infections</td>
<td>1,074</td>
<td>2,000</td>
<td>6,975</td>
<td>11,030</td>
<td>30,876</td>
<td>90,216</td>
<td>173,068</td>
<td>207,711</td>
</tr>
</tbody>
</table>
Prevalence/100,000 | 0.7 | 1.8 | 4.7 | 7.5 | 21.1 | 62.1 | 199.5 | u/a
Incidences/Year/100,000 | 0.1 | 0.1 | 3 | 2.8 | 13.6 | 40.9 | 57.2 | u/a

* 2002 numbers are for January 1 – June 30
Source: Ministry of Health and Federal AIDS Center of the Russian Federation

Since the emergence of the HIV epidemic among IDU’s in 1996, 82 of Russia’s 89 regions report HIV cases. The majority of these cases (54%) are injection drug users (Figures 1 & 2). Surveys taken in Saint Petersburg in 1999 indicate the prevalence of HIV among IDU’s rose from 12% to 19% in six months (UNAIDS 2000). Russia’s Maritime province totals 70% of AIDS cases in the Far East, 84% of which transmitted through IDU. Additionally, most of these individuals are infected with hepatitis and sexually transmitted infections (Shatilova 2000).


Recent epidemiological data points to a dramatic increase in the incidence of HIV infections in the northwestern region of Russia. Murmansk, a northern county near the Barents Sea, has seen the number of newly diagnosed HIV infections increase seven-fold from 70 to 472 cases between 2000 and 2001.
Located near the border with Finland and Norway, the Murmansk territory contains 1,080,000 inhabitants, of which 375,000 live in the city of Murmansk itself. Current demographic trends show a movement towards the city from rural areas. Up until 1996, the prevalence of reported HIV cases was 28. Incident cases for 1996 through 2000 were 6, 10, 20, 39 and 70 respectively, resulting in a cumulative total of 173 reported cases of HIV infection at the start of 2001. The 472 incident cases of HIV reported in 2001 exceed the cumulative cases of HIV reported during the previous 14 years, despite the fact that the number of HIV tests performed leveled off in 2000 at approximately 20,000. Reported cases approximate 40% from the cities of Murmansk and Kandalaksha with the remaining 20% spread among 17 surrounding smaller municipalities (Aavitsland 2001).

Alarming as these numbers may be, many experts feel they fall well short of expressing the true severity of the problem. The national registration system found in Russia likely captures a fraction of HIV infections understating the real growth of the epidemic. While approximately 208,000 Russians are registered as HIV positive, Dr. Vadim Pokrovsky, Director of the Russian Federation AIDS Center estimates the actual number of cases closer to one million. This number is expected to grow to five million by 2005 (Rodriguez 2002).

In addition, health officials are concerned about the spread of HIV from IDU’s to their partners and possibly others. Officials fear a second wave of HIV spread by sexual contact in 3 to 4 years following the current IDU
epidemic (Stephenson 2001). Dr. Pokrovsky has stated that the proportion of Russia’s incident cases of HIV linked to heterosexual transmission increased from 4% in 2001 to 8.4% during the first 3 months of 2002 (Figure 3) (Rodriguez 2002).

Epidemiological studies have indicated that HIV is spread primarily through the sharing of contaminated needles and other drug injection equipment and through unprotected sexual intercourse with infected individuals. Many fear that HIV may spread to neighboring Finland and Norway in this manner (Needle, R.H., Coyle, S.L., Normand, J., Lambert, E. & Cesari, H. 1998).


![Graph showing trends in HIV cases](image)

**ii. Hepatitis:** Although attention tends to focus on HIV/AIDS, the Hepatitis viruses are spreading across the Former Soviet Union faster than any class of infectious viruses fueled by the region’s exploding narcotics epidemic (Garrett 1997). While the incidence rates of hepatitis A decreased during the 1990s, the rates of hepatitis B and C climbed steadily (Table 14) (CDC 2002). It is
currently estimated that hepatitis C is the most common bloodborne infection and has the greatest potential for long term morbidity. Most of those chronically infected with hepatitis C lack any clinical signs of infection. These individuals serve as sources of transmission to others and are themselves at great risk of chronic liver disease or other HCV-related chronic illnesses over the two decades following initial infection (MMWR 1998). While vaccines exist for Hepatitis A and B, they are basically unavailable for mass distribution by the cash strapped governments of the FSU, including the Russian Federation (Garrett 1997). There is currently no effective vaccine against hepatitis C (MMWR 1998).

Table 14: Incidence rates per 100,000 population for hepatitis A, B & C in the Russian Federation, 1990 – 2000.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td>204.3</td>
<td>165.5</td>
<td>117.9</td>
<td>109.3</td>
<td>111.2</td>
<td>122.6</td>
<td>86.9</td>
<td>50.1</td>
<td>33.8</td>
<td>30.6</td>
<td>15.9</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>21.9</td>
<td>17.9</td>
<td>18.2</td>
<td>22.2</td>
<td>27.0</td>
<td>35.2</td>
<td>35.8</td>
<td>36.5</td>
<td>35.8</td>
<td>43.3</td>
<td>21.7</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>u/a</td>
<td>u/a</td>
<td>u/a</td>
<td>u/a</td>
<td>3.2</td>
<td>6.8</td>
<td>8.4</td>
<td>9.1</td>
<td>11.6</td>
<td>19.3</td>
<td>10.9</td>
</tr>
</tbody>
</table>

Additionally, the Hepatitis epidemic has followed a pattern not seen in other areas. Since the appearance of HIV in 1981, Hepatitis epidemics have tended to follow HIV, especially in IDU's. However, in the Russian Federation, Hepatitis B infection has preceded the appearance of HIV. Experts fear this course may lead to taxed immune systems capable of only token resistance to HIV. An immune system already compromised by fighting hepatitis infection will likely be less able to control HIV and the progression to AIDS. In addition,
Hepatitis A, not known as a needle-borne virus, appears to be spreading rapidly among drug user’s in the region (Garrett 1997).

iii. **Tuberculosis:** The deterioration of the tuberculosis (TB) situation began around 1992, when social and economic conditions worsened dramatically (WHO 2003). Following a gradual decline in cases reported up until 1990, estimated TB rates more than tripled in a trend reversal from 34 per 100,000 population in 1990 to 134 per 100,000 population in 2001 (Table 15). The rate of reported cases of TB has increased from 33.9 per 100,000 population in 1991 to 92 per 100,000 population in 2001 (Table 16 & Figure 4). The number of reported cases of TB has increased from 50,407 in 1991 to 137,597 in 2000 (Table 16 & Figure 5). TB incidence rates increased 70% between 1990 and 1995 (CDC 2001), with incident cases doubling between 1990 and 2001 (WHO 2003). The rate of TB was 4.5% higher in 1999 than in 1998 (CDC 2001). Cases of Tuberculosis (TB) in Russia continue to rise climbing 12% in 2000 along with a 30% increase in mortality. The Russian Federation saw more than 137,000 incident cases in 2000. In addition, the TB mortality rate has nearly tripled since 1990, reaching 20 per 100,000 population in 2000, resulting in the highest TB mortality rate in Europe. Tuberculosis ranks first in mortality among infectious diseases within the Russian Federation (WHO 2003).

While the main cause of susceptibility to TB used to be alcohol abuse, the current rise is being blamed on concomitant illnesses such as HIV/AIDS, which itself has increased as a result of rising drug abuse (ITAR-TASS 2000).
The deterioration of living conditions in Russia over the past 10 years is also associated with the increase in TB rates. Susceptibility to infection by the TB bacterium and active disease are exacerbated by factors which increase exposure and/or decrease resistance. Food shortages, poverty, severe overcrowding and poor ventilation as seen in Russian prisons along with large numbers of undetected active TB and other immunosuppressive disorders increase susceptibility to TB. These factors, coupled with a shrinking health budget resulted in an erratic supply of anti-TB medications and laboratory supplies, reduced quality control in TB dispensaries and labs and inadequate treatment led quickly to multi-drug resistant strains of TB (CDC 2001).

According to the World Health Organization, a case of tuberculosis is recorded if the presence of Mycobacterium tuberculosis is identified directly using Ziehl-Neelson microscopy. If the Mycobacterium is identified through culture, polymerase chain reaction or other diagnostic methods, the cumulative case number some 15-fold (CDC 2001). Although the Russian surveillance system identifies the majority of cases, detection rates as defined by WHO remain low (31%) (Table 15). This is because many cases are not confirmed through bacteriologic testing and smear microscopy is not routinely performed. The heavy reliance on x-rays for diagnosis likely means that some reported cases do not have TB (WHO 2003).

The situation is even more devastating in Russia’s prison system where TB incidence and mortality among prisoners are ten times higher than in the civilian population. In 2000, the case notification rate was 3,118 per 100,000
including the convicted and persons under criminal investigation. These factors may further burden TB control among the civilian population as TB infected prisoners are released into the community. The compulsory imprisonment of drug offenders, many of whom carry HIV, has provided an excellent mechanism for transmission of TB including several antibiotic resistant strains. TB case rates are some 30 times higher in prisons than in the general population (WHO 2003). Although several government programs throughout the FSU, including the implementation of Directly Observed Therapy Supervised (DOTS), have demonstrated some success in controlling the spread of TB among prisoners, health officials face an uphill battle against an infection which in some prisons affects 50% of the population (Garrett, 2000).

DOTS stands for “Directly Observed Treatment, Short-Course, and is an internationally recognized health care management system” (SA Health 2003). The DOTS system utilizes a patient-based approach which provides support through direct observation of patients while they take their TB drugs. This helps to provide effective drug treatment while monitoring the patient’s progress toward a cure. The DOTS program also assists in identifying individuals in the infectious stage of TB through the monitoring of sputum samples under microscopy (SA Health 2003).

A special network of facilities, which have not been integrated into the general health care system, provides TB control in the Russian Federation. The care and treatment of individuals with TB is provided by a network of TB
specialized dispensaries and hospitals. TB patients are also treated in prisons under the auspices of the Ministry of Justice. The Ministry of Health is currently attempting to reorganize these services to link TB control with the primary health care network (WHO 2003).

By the end of 2001, Directly Observed Therapy (DOTS) had been implemented in nineteen pilot projects among both civilian and prison populations and DOTS-Plus was implemented in one prison. This represented a population coverage of 16% (Table 15). Beginning in January 2002, 20 additional pilot projects were scheduled to begin. Data reported from ten Russian territories covering the first half of 2000 indicated a 68% treatment success rate (Table 15). This less than optimal success rate was attributed to late diagnosis (6%), treatment failures often linked to drug resistance (13%) and treatment interruption (9%), especially among the homeless, drug abusers and alcoholics (WHO 2003).

**Table 15: Overview of tuberculosis control in the Russian Federation at the end of 2001.**

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Population:</td>
<td>144,664,291</td>
<td>DOTS population Coverage (%)</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Estimated Incidence (all cases/100,000 population)</td>
<td>134</td>
<td>Notification rate (all cases/100,000 population)</td>
<td>81</td>
<td>76</td>
<td>92</td>
<td>95</td>
<td>92</td>
</tr>
<tr>
<td>Global rank (by estimated number of cases)</td>
<td>9</td>
<td>Detection (new ss+ cases, %)</td>
<td>60</td>
<td>57</td>
<td>28</td>
<td>32</td>
<td>31</td>
</tr>
<tr>
<td>Regional rank</td>
<td>1</td>
<td>DOTS detection (new ss+, %)</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Est. adult (15-49y) TB cases That are HIV positive (%)</td>
<td>1</td>
<td>Treatment success</td>
<td>67</td>
<td>68</td>
<td>65</td>
<td>68</td>
<td>--</td>
</tr>
<tr>
<td>Countrywide (new ss+,%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Est. multi-drug resistance (new cases, %)</td>
<td>6</td>
<td>Treatment success under DOTS (%)</td>
<td>67</td>
<td>68</td>
<td>65</td>
<td>68</td>
<td>--</td>
</tr>
<tr>
<td>DOTS status (year adopted)</td>
<td>1996</td>
<td>Est. new ss+ success under DOTS (%)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>--</td>
</tr>
<tr>
<td>WHO Control Category:</td>
<td>2*</td>
<td></td>
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</tr>
</tbody>
</table>
(SS+) = smear positive cases, which are bacteriologically confirmed via smear microscopy. WHO control category 2 refers to countries implementing the DOTS strategy in less than 10% of the total population (pilot phase).

(WHO 2002)

Table 16: Reported incidence and incidence rates per 100,000 population of TB in the Russian Federation for the years 1991 – 2001.

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases Reported</td>
<td>50,407</td>
<td>53,148</td>
<td>63,591</td>
<td>70,822</td>
<td>96,828</td>
<td>111,075</td>
<td>121,491</td>
<td>121,434</td>
<td>134,360</td>
<td>137,597</td>
<td>132,477</td>
</tr>
<tr>
<td>Reported TB Case Rate per 100,000 population</td>
<td>33.9</td>
<td>35.7</td>
<td>42.7</td>
<td>47.6</td>
<td>65.2</td>
<td>75</td>
<td>82.3</td>
<td>82.5</td>
<td>91.3</td>
<td>94.6</td>
<td>92.0</td>
</tr>
</tbody>
</table>

Figure 4: Reported TB case rate per 100,000 population in the Russian Federation, 1990 – 2001.

Reported TB case rate, per 100,000 population in the Russian Federation, 1990 - 2001

Figure 5: Number of reported cases of TB in the Russian Federation, 1990 – 2001.

Number of TB cases reported, Russian Federation, 1990 - 2001
iv. **Sexually Transmitted Infections:** While the struggling economies of the FSU have fostered a dramatic rise in substance abuse, the very same economic difficulties have led to an increase in prostitution to support daily living and possibly drug habits. While providing an excellent vehicle for the spread of HIV it has also led to epidemics of other sexually transmitted infections (STI) particularly syphilis. The number of incident cases of syphilis registered annually has risen from 8,000 in 1990 to 388,000 in 1996 and 405,000 in 1997 (Table 17). Virtually all parts of the FSU report rapid increases in the incidence of syphilis since 1991. Although data is scarce and of somewhat dubious reliability, the prevalence of many STI’s including chlamydia, gonorrhea, herpes and trichomoniasis all appear to be rising dramatically throughout the region (DET 1999). For example, despite the apparent decline in the incidence of syphilis beginning in 1998, experts do not believe this decline is real. The official numbers released by the government are based upon a system of state registration left over from the days of the Soviet Union. Recently, commercial medical services have expanded, offering anonymous treatment without registration. This eliminates an increasing number of cases from the records (Johnson, 2002).

While the actual determinants are variable, a recent rise in prostitution at least somewhat attributable to the rise in drug abuse appears to be somewhat responsible (DET 1999). The potential overlap between the still uncontrolled epidemic of syphilis and HIV remains to be seen. The spread of STI’s is closely linked to prostitution and drug addiction, as prostitution helps
to cover the cost of drugs (Johnson 2002). However, rapid changes in sexual norms and behaviors and the growing commercial sex industry coupled with the huge economic and socio-political crisis have created a fertile environment for the spread of HIV (Atlani et al 2000).

Table 17: Number of new cases and Incidence rates per 100,000 population for syphilis, gonorrhea and chlamydia in the Russian Federation, 1991 – 2001.

<table>
<thead>
<tr>
<th>Year</th>
<th>Syphilis Number</th>
<th>Rate</th>
<th>Gonorrhea Number</th>
<th>Rate</th>
<th>Chlamydia Number</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>10,704</td>
<td>7.20</td>
<td>190,693</td>
<td>128.26</td>
<td>u/a</td>
<td>u/a</td>
</tr>
<tr>
<td>1992</td>
<td>19,890</td>
<td>13.37</td>
<td>251,538</td>
<td>169.05</td>
<td>29,754</td>
<td>20.00</td>
</tr>
<tr>
<td>1993</td>
<td>50,074</td>
<td>33.68</td>
<td>340,957</td>
<td>229.31</td>
<td>54,813</td>
<td>36.86</td>
</tr>
<tr>
<td>1994</td>
<td>126,551</td>
<td>85.25</td>
<td>301,695</td>
<td>203.23</td>
<td>90,839</td>
<td>61.19</td>
</tr>
<tr>
<td>1995</td>
<td>261,908</td>
<td>176.80</td>
<td>256,611</td>
<td>173.22</td>
<td>133,446</td>
<td>90.08</td>
</tr>
<tr>
<td>1996</td>
<td>388,247</td>
<td>262.73</td>
<td>203,920</td>
<td>137.99</td>
<td>155,802</td>
<td>105.43</td>
</tr>
<tr>
<td>1997</td>
<td>405,746</td>
<td>275.38</td>
<td>167,046</td>
<td>113.38</td>
<td>169,834</td>
<td>115.27</td>
</tr>
<tr>
<td>1998</td>
<td>342,657</td>
<td>233.38</td>
<td>150,386</td>
<td>102.43</td>
<td>166,111</td>
<td>113.14</td>
</tr>
<tr>
<td>1999</td>
<td>271,699</td>
<td>185.83</td>
<td>174,444</td>
<td>119.31</td>
<td>181,609</td>
<td>124.21</td>
</tr>
<tr>
<td>2000</td>
<td>239,391</td>
<td>164.54</td>
<td>175,954</td>
<td>120.94</td>
<td>182,672</td>
<td>125.56</td>
</tr>
<tr>
<td>2001</td>
<td>207,157</td>
<td>143.20</td>
<td>156,721</td>
<td>108.33</td>
<td>175,255</td>
<td>121.15</td>
</tr>
</tbody>
</table>

(WHO 2002)

B. Finland

i. HIV/AIDS: As of June 30, 2002, Finland has reported a cumulative total of 1,430 cases of HIV (Table 18). Of the 1,430 cases, 34% were transmitted through heterosexual contact, 31% through homo or bisexual contact, 18% through injection drug use and 1% through perinatal transmission (Figure 6).
As of June 30, 2002, a cumulative total of 339 cases of AIDS have been reported (Table 18). Of the 339 cases, 26% were attributable to heterosexual contact, 63% to homo/bisexual contact, 4% to injection drug use, 3% to blood products and 1% to perinatal transmission (Figure 7) (WHO 2001).

By the end of 1997, 864 cases of HIV had been reported, 28 of which (3%) had been transmitted through injection drug use (only two were transmitted in Finland, 26 transmitted elsewhere). In 1998, 19 of the 80 (24%) incident cases of HIV cases were transmitted through injection drug use, mostly in the area of Helsinki. In 1999, 86 of 142 (61%), in 2000, 57 of 146 (39%) and in 2001, 48 of 128 (38%) new cases of HIV were transmitted through injection drug use. During the first six months of 2002, 15 of the 69 (22%) new cases of HIV were transmitted through injection drug use, suggesting a decline and possible leveling off of HIV transmission through IDU since the high of 1999 (Table 18/Figure 6). The cumulative number of reported HIV infections transmitted through injection drug use is 252 out of the 1,430 total (18%) (Figure 7). The cumulative number of reported AIDS cases transmitted through injection drug use is 13 out of 339 total cases (4%) (Figure 8). A seroepidemiologic study conducted in 1998 determined that 3% of injection drug users in Finland were infected with HIV. In 2000, voluntary HIV tests carried out in prisons and at needle exchange centers indicated that 2.5% of those tested were positive for HIV (STAKES 2001).
Table 18: Total reported AIDS and HIV cases and by mechanism of transmission and incidence rates per million population in Finland during year of diagnosis and adjusted for reporting delays (WHO European Region 2002)

<table>
<thead>
<tr>
<th>Year</th>
<th>Reported AIDS Cases</th>
<th>Reported New HIV Infections</th>
<th>Homosexual/ Bisexual Contact (N)</th>
<th>Injection Drug Use (N)</th>
<th>Heterosexual Contact (N)</th>
<th>Perinatal Transmission (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Rate/ Million</td>
<td>N</td>
<td>Rate/ Million</td>
<td>HIV</td>
<td>AIDS</td>
</tr>
<tr>
<td>1994</td>
<td>43</td>
<td>8.5</td>
<td>69</td>
<td>13.6</td>
<td>u/a</td>
<td>u/a</td>
</tr>
<tr>
<td>1995</td>
<td>41</td>
<td>8.0</td>
<td>72</td>
<td>14.1</td>
<td>u/a</td>
<td>u/a</td>
</tr>
<tr>
<td>1996</td>
<td>24</td>
<td>4.7</td>
<td>69</td>
<td>13.5</td>
<td>u/a</td>
<td>u/a</td>
</tr>
<tr>
<td>1997</td>
<td>19</td>
<td>3.7</td>
<td>71</td>
<td>13.8</td>
<td>19</td>
<td>11</td>
</tr>
<tr>
<td>1998</td>
<td>15</td>
<td>2.9</td>
<td>80</td>
<td>15.5</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>1999</td>
<td>10</td>
<td>1.9</td>
<td>142</td>
<td>27.5</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>2000</td>
<td>16</td>
<td>3.1</td>
<td>146</td>
<td>28.2</td>
<td>24</td>
<td>4</td>
</tr>
<tr>
<td>2001</td>
<td>17</td>
<td>3.3</td>
<td>128</td>
<td>24.7</td>
<td>27</td>
<td>8</td>
</tr>
<tr>
<td>2002*</td>
<td>7</td>
<td>u/a</td>
<td>69</td>
<td>u/a</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>339</td>
<td>1.430</td>
<td>441</td>
<td>209</td>
<td>252</td>
<td>13</td>
</tr>
</tbody>
</table>

*2002 figures are from January 1 – June 30, 2002

Technical note: Accurate and complete data on HIV in Finland are not available. The data presented here are from a variety of sources and may not entirely agree. These data generally do not represent HIV incidence, and depend heavily upon patterns of HIV testing and reporting that remain very incomplete in the most severely affected countries. HIV infection is defined as an individual with HIV infection confirmed by a laboratory according to country definitions and requirements. AIDS cases are reported according to a uniform AIDS case definition originally published in 1982 and revised in 1985, 1987 and for adults and adolescents (>age 13) in 1993. The 1993 European AIDS surveillance cases definition differs from that used in the United States in that it does not include CD4 lymphocyte criteria (European Centre for the Epidemiological Monitoring of AIDS, 2002)

Figures 7 & 8: Cumulative reported HIV and AIDS cases and by mechanism of transmission and incidence rates per million population during year of diagnosis and adjusted for reporting delays, 1994 - mid-year 2002 (WHO European Region 2002)

Reported Cases of HIV by Transmission Category 2001

Reported Cases of AIDS by Transmission Category, 2001

(WHO European Region 2002)

HIV testing is mandatory for blood donors but voluntary for all others. Diagnosed HIV infections are recorded in a national HIV case reporting system using an identifying code. Data on HIV also comes from screening programs. Surveys on pregnant women have been conducted nationally since 1993 (WHO 2001).

ii. Hepatitis: The prevalence rate for hepatitis C was 0.02 in Finland in 1999. However, recent studies have shown that 60% of injection drug users in Finland have hepatitis C. Of those individuals tested at counseling centers, 30-60% tested positive for hepatitis C. It is estimated that 90% of all cases of
hepatitis C in Finland are attributable to injection drug use. The strong correlation between injection drug use and hepatitis C has brought some in Finland to call for the use of hepatitis C prevalence as an indicator of drug use trends. In 2000, there were 1,739 reported incident cases of hepatitis C, over half of which involved persons under the age of 30, most among 20-24 year olds. The incidence of hepatitis C is believed to have remained fairly constant, between 1,500-1,700 cases in 2001 (STAKES 2001).

Follow up on injection drug users at the Vinkki counseling center in 1997 revealed that 25% of clients exchanged contaminated needles, 50% tested positive for hepatitis C, 33% tested positive for hepatitis B, but no one tested positive for HIV. It was not until 1998 when the first client tested positive for HIV. Follow up in 1998-1999 revealed 25% of clients testing positive for hepatitis B, likely owing to an increase in hepatitis B vaccinations (STAKES 2001).

In 2002, 385 microbiologically confirmed cases of hepatitis A were reported in Finland resulting in an incidence rate of 7.4 per 100,000 population. This was significantly higher than the period 1999 – 2001, when between 48 and 51 cases were reported for an incidence of 1.0 per 100,000 population for each of the three years. Of the reported cases of hepatitis A in 2002, 260 (68%) took place in the Helsinki and Uusimaa Health District (HUS), which is the most highly populated district in Finland. By year end, residents of Helsinki accounted for 178 (46%) of cases; an incidence of 31.8 per 100,000 population (Eurosurveillance 2003).
Interviews during early 2002 indicated that nearly all cases were injection drug users or could be linked to IDU's. Later in the year, a growing number of cases (33%) were identified in individuals with no history of drug abuse. Several smaller outbreaks were also detected in other health districts throughout Finland, most of which were tied to injection drug use (Eurosurveillance 2003).

Although both hepatitis A and B vaccinations are recommended for IDU's in Finland, hepatitis A vaccination is not included in the national vaccination program. Individuals must pay out of pocket for hepatitis A vaccination (Eurosurveillance 2003).

The extent of the hepatitis A outbreak was likely buffeted by the administration of hepatitis A vaccine to close contacts of cases during the first three months of 2002. This was followed in April by a campaign to vaccinate IDU's against hepatitis A in Helsinki at needle exchange sites, which were utilized to reach the IDU population (Eurosurveillance 2003).

iii. Tuberculosis: The number of TB cases reported has declined from a high of 2,247 cases in 1980 to a low of 460 cases in 2001 (Table 19/Figure 9). The rate of reported cases of TB has declined from a high of 47 per 100,000 population in 1980 to a low of 9 per 100,000 in 2001 (Table 19/Figure10) (WHO 2002). This decline is credited primarily to the efforts of the National Public Health system (Table 20).
Table 19: Reported incidence and incidence rates per 100,000 population of TB in Finland for the years 1991 – 2001.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TB Cases Reported</td>
<td>771</td>
<td>700</td>
<td>542</td>
<td>553</td>
<td>662</td>
<td>644</td>
<td>573</td>
<td>508</td>
<td>565</td>
<td>527</td>
<td>460</td>
</tr>
<tr>
<td>Reported TB Case Rate per 100,000 population</td>
<td>15.4</td>
<td>13.9</td>
<td>10.7</td>
<td>10.9</td>
<td>13.0</td>
<td>12.6</td>
<td>11.1</td>
<td>9.9</td>
<td>10.9</td>
<td>10.2</td>
<td>9.0</td>
</tr>
</tbody>
</table>

Table 20: Overview of TB control in Finland at the end of 2000.

<table>
<thead>
<tr>
<th>Information</th>
<th>2000</th>
<th>Number of smear positive (ss+) cases of TB: 201</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>5,172,000</td>
<td>Estimated number of smear positive (ss+) cases of TB: 254</td>
</tr>
<tr>
<td>Number of reported cases of TB in 2000</td>
<td>527</td>
<td>Detection rate: 0.8%</td>
</tr>
<tr>
<td>Number of estimated cases of TB in 2000</td>
<td>574</td>
<td>Proportion of pulmonary cases of TB which are smear positive (ss+): 62.8%</td>
</tr>
<tr>
<td>Estimated rate of TB cases who are HIV positive/100,000 population</td>
<td>6.0</td>
<td>Reported cases rate of TB Per 100,000 population: 10.2</td>
</tr>
<tr>
<td>WHO Control Category: 1*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(SS+) = smear positive cases, which are bacteriologically confirmed via smear microscopy.

* WHO Control Category 1 refers to countries not implementing the DOTS strategy and having a reported case rate of over 10 cases per 100,000 population. (WHO 2002)

Figure 9: Number of reported cases of TB in Finland for the years 1990 – 2001 (WHO 2002).

Number of TB cases reported,
Finland, 1990 - 2001

![Graph showing the number of TB cases reported in Finland from 1990 to 2001.](image-url)
iv. Sexually Transmitted Infection's:

Between 1990 and 1992, only 30 to 40 serologically confirmed cases of syphilis were reported annually in Finland. The typical cases were heterosexual men who acquired the infection abroad. Beginning in 1993, the incidence of syphilis has been increasing (Figure 11). In 1995, a total of 118 new cases were reported, nearly twice as many cases as in 1994 (63 cases). Of the 118 cases in 1995, 65% were males infected abroad, 51% of which were infected in Russia. The majority of cases were isolated along the southern Finnish border with Russia (Eurosurveillance 1996).
C. Norway

i. HIV/AIDS: By mid-year 2002, 2,417 cases of HIV have been reported (Table 21). Among cases reported in 1994 – June 30, 2000, 42% were attributed to heterosexual contact, 33% to homo/bisexual contact, 19% to injection drug use and 1% to perinatal transmission (Figure 12). A total of 750 cases of AIDS have been reported by June 30, 2002, 26% through heterosexual contact, 50% through homo/bisexual contact, 17% through injection drug use, 4% through blood and 1% through perinatal transmission (Figure 13). The number of reported cases of HIV transmitted through injection drug use has remained relatively stable from 1996 through 2001 (Figure 14).
TABLE 21: Total reported AIDS and HIV cases and by mechanism of transmission and incidence rates per million population in Norway during year of diagnosis and adjusted for reporting delays (WHO European Region 2002)

<table>
<thead>
<tr>
<th>Year</th>
<th>Reported AIDS Cases</th>
<th>Reported New HIV Infections</th>
<th>Homo/Bi sexual Contact (N)</th>
<th>Injection Drug Use (N)</th>
<th>Heterosexual Contact (N)</th>
<th>Perinatal Transmission (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Rate/ Million</td>
<td>HIV</td>
<td>AIDS</td>
<td>HIV</td>
<td>AIDS</td>
</tr>
<tr>
<td>1994</td>
<td>74</td>
<td>17.1</td>
<td>u/a</td>
<td>u/a</td>
<td>u/a</td>
<td>u/a</td>
</tr>
<tr>
<td>1995</td>
<td>67</td>
<td>15.4</td>
<td>u/a</td>
<td>u/a</td>
<td>u/a</td>
<td>u/a</td>
</tr>
<tr>
<td>1996</td>
<td>56</td>
<td>12.8</td>
<td>u/a</td>
<td>u/a</td>
<td>u/a</td>
<td>u/a</td>
</tr>
<tr>
<td>1997</td>
<td>34</td>
<td>7.7</td>
<td>117</td>
<td>26.6</td>
<td>34</td>
<td>11</td>
</tr>
<tr>
<td>1998</td>
<td>39</td>
<td>8.8</td>
<td>101</td>
<td>22.8</td>
<td>29</td>
<td>13</td>
</tr>
<tr>
<td>1999</td>
<td>28</td>
<td>6.3</td>
<td>136</td>
<td>30.6</td>
<td>33</td>
<td>12</td>
</tr>
<tr>
<td>2000</td>
<td>38</td>
<td>8.5</td>
<td>169</td>
<td>37.8</td>
<td>32</td>
<td>9</td>
</tr>
<tr>
<td>2001</td>
<td>27</td>
<td>6.0</td>
<td>163</td>
<td>36.3</td>
<td>37</td>
<td>8</td>
</tr>
<tr>
<td>2002*</td>
<td>11</td>
<td>u/a</td>
<td>96</td>
<td>u/a</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>750</td>
<td>2,417</td>
<td>804</td>
<td>375</td>
<td>462</td>
<td>130</td>
</tr>
</tbody>
</table>

2002 figures are from January 1 – June 30, 2002

Technical note: Accurate and complete data on HIV in Norway are not available. The data presented here are from a variety of sources and may not entirely agree. These data generally do not represent HIV incidence, and depend heavily upon patterns of HIV testing and reporting that remain very incomplete in the most severely affected countries. HIV infection is defined as an individual with HIV infection confirmed by a laboratory according to country definitions and requirements. AIDS cases are reported according to a uniform AIDS case definition originally published in 1982 and revised in 1985, 1987 and for adults and adolescents (>age 13) IN 1993. The 1993 European AIDS surveillance cases definition differs from that used in the United States in that it does not include CD4 lymphocyte criteria (European Centre for the Epidemiological Monitoring of AIDS, 2002)

As of December 31, 2000, figures from the Norwegian Institute for Public Health show 448 individuals diagnosed with HIV having a risk factor for injection drug use (Table 22). Among those who had developed AIDS, 119 or 17% of the total number of AIDS cases were injection drug users. However, the number of incident cases of both HIV and AIDS among injection drug users is considered low. A significant number of injection drug users who developed AIDS are now deceased. In addition, a large proportion of HIV positive injection drug users have died of other causes. According to recent studies, over 90% of injection drug users report being tested, thus the number of undetected infections is considered to be low (WHO 2002).
Table 22: Number and percentage of individuals diagnosed as HIV positive and diagnosed with AIDS in Norway who are injection drug users for the years 1984 - 2000.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total HIV</th>
<th>HIV + Injection Drug user</th>
<th>Percentage of HIV + Injection Drug User</th>
<th>Total AIDS</th>
<th>AIDS Injection Drug User</th>
<th>Percentage of AIDS Injection drug User</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984-89</td>
<td>894</td>
<td>315</td>
<td>35%</td>
<td>144</td>
<td>8</td>
<td>6%</td>
</tr>
<tr>
<td>1990</td>
<td>90</td>
<td>22</td>
<td>24</td>
<td>59</td>
<td>13</td>
<td>22</td>
</tr>
<tr>
<td>1991</td>
<td>142</td>
<td>16</td>
<td>11</td>
<td>59</td>
<td>16</td>
<td>27</td>
</tr>
<tr>
<td>1992</td>
<td>105</td>
<td>12</td>
<td>11</td>
<td>50</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>1993</td>
<td>113</td>
<td>13</td>
<td>12</td>
<td>64</td>
<td>13</td>
<td>20</td>
</tr>
<tr>
<td>1994</td>
<td>94</td>
<td>12</td>
<td>13</td>
<td>74</td>
<td>19</td>
<td>26</td>
</tr>
<tr>
<td>1995</td>
<td>105</td>
<td>11</td>
<td>10</td>
<td>67</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>1996</td>
<td>116</td>
<td>9</td>
<td>8</td>
<td>56</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>1997</td>
<td>112</td>
<td>11</td>
<td>10</td>
<td>34</td>
<td>8</td>
<td>24</td>
</tr>
<tr>
<td>1998</td>
<td>98</td>
<td>8</td>
<td>8</td>
<td>36</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>1999</td>
<td>147</td>
<td>12</td>
<td>7</td>
<td>21</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>2000</td>
<td>177</td>
<td>7</td>
<td>4</td>
<td>38</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Totals</td>
<td>2,194</td>
<td>448</td>
<td>20%</td>
<td>703</td>
<td>119</td>
<td>17%</td>
</tr>
</tbody>
</table>

(National Institute for Public Health 2001)
Figures 12 & 13: Cumulative reported HIV and AIDS cases and by mechanism of transmission and incidence rates per million population in Norway during year of diagnosis and adjusted for reporting delays (WHO European Region 2002)

Reported Cases of HIV by Transmission Category, 2001

Reported Cases of AIDS by Transmission Category, 2001

In Norway, HIV testing is systematic for blood donors, pregnant women and patients with sexually transmitted infections (STI). Diagnosed HIV cases are reported in a national HIV database which utilizes an identifying code (WHO ntroduction of hepatitis B immunization programs in 1984 aimed at high risk groups, the incidence of hepatitis B has gradually declined. Hepatitis B vaccines have been offered to all drug users at no charge since 1985 (EpiNorth 2000). 2002).

ii. Hepatitis: The incidence rate of hepatitis A averaged approximately 100 cases reported annually through the 1970’s, 1980’s and early 1990’s with almost half of the cases acquired abroad. Hepatitis A vaccines have been offered to drug users at no charge since 1997. Prior to this, vaccines were offered at no charge only in cases of local outbreaks of hepatitis A. With the introduction of immunization programs in 1984 aimed at high risk groups, the incidence of hepatitis B has gradually declined. Hepatitis B vaccines have been offered to all drug users at no charge since 1985 (EpiNorth 2000).

However, during the five-year period of 1995 – 1999, 1,343 cases of hepatitis A (Table 23) and 998 cases of hepatitis B (Table 24) were identified in injecting drug users by the Norwegian Surveillance System for Communicable Disease (MSIS). Many of these cases had serological indicators of possible double infection with both hepatitis A and B. In addition, the prevalence of hepatitis C is thought to be high among IDU’s. These numbers are believed to be on the low side as many drug users remain asymptomatic and do not seek medical care (EpiNorth 2000).
The hepatitis A outbreak was characterized by local outbreaks in different parts of the country, in particular, major cities with large IDU populations. The virus was believed to be transmitted among IDU's primarily through contaminated syringes and needles and sustained through the fecal-oral route. The outbreak peaked in 1999 with 998 reported cases, representing an incidence rate of 22.4 cases per 100,000 population, the highest incidence of hepatitis A in Norway since 1959 (EpiNorth 2000).

In contrast, the outbreak of hepatitis B was reported from all areas of the country. The reason for this is unknown but possibly due to the presence of chronic hepatitis B carriers. Most cases of hepatitis B are thought to be associated with intramuscular and subcutaneous injections by so-called “skin poppers” (Eurosurveillance 2001). The incidence of hepatitis B peaked in 1999 with 472 reported cases representing an incidence rate of 10.6 per 100,000 population, the highest incidence of hepatitis B in Norway since 1975 (Epinorth 2000).

The outbreak of hepatitis A appeared to be in decline at the end of 2000 but large numbers of hepatitis B cases are still being reported among IDU’s. During the period 1995 – 2000, a total of 1,353 cases of hepatitis A and 1,136 cases of hepatitis B were reported. In addition, a number of cases had serological indicators of hepatitis C in addition to both hepatitis A and B (Eurosurveillance 2001).
Table 23: Reported cases of hepatitis A in Norway by transmission category, 1995 – 1999.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Injecting Drug Use</td>
<td>110</td>
<td>273</td>
<td>150</td>
<td>278</td>
<td>532</td>
</tr>
<tr>
<td>Contacts of Drug Users</td>
<td>10</td>
<td>82</td>
<td>25</td>
<td>19</td>
<td>60</td>
</tr>
<tr>
<td>Travel Abroad</td>
<td>68</td>
<td>73</td>
<td>86</td>
<td>56</td>
<td>84</td>
</tr>
<tr>
<td>Others/Unknown</td>
<td>62</td>
<td>93</td>
<td>73</td>
<td>154</td>
<td>322</td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
<td>521</td>
<td>334</td>
<td>507</td>
<td>998</td>
</tr>
</tbody>
</table>

Table 24: Reported cases of hepatitis B in Norway by transmission category, 1995 – 1999.

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection Drug Use</td>
<td>39</td>
<td>55</td>
<td>135</td>
<td>385</td>
<td>374</td>
</tr>
<tr>
<td>Sex</td>
<td>37</td>
<td>27</td>
<td>29</td>
<td>69</td>
<td>74</td>
</tr>
<tr>
<td>Others</td>
<td>6</td>
<td>3</td>
<td>7</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Unknown</td>
<td>17</td>
<td>11</td>
<td>14</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>99</td>
<td>96</td>
<td>185</td>
<td>469</td>
<td>472</td>
</tr>
</tbody>
</table>

The number of reported cases of hepatitis C does not reflect a true prevalence rate as reporting is only required in the case of acute infection. Acute cases of hepatitis C were reported in the years 1997, 1998, 1999 and 2000 to be 13, 17, 15 and 11 respectively. The prevalence rate of hepatitis C was 0.1 in 1999 (WHO 1999). The majority of newly infected individuals does not experience symptoms and therefore do not seek medical attention. In addition, once hepatitis C is diagnosed it is rarely possible to identify the time of infection. These two factors make it nearly impossible to define the
incidence of hepatitis C in Norway with any degree of accuracy. Thus, these figures represent an unreliable incidence rate for disease. However, it is believed that a significant number of injection drug users have been infected with hepatitis C. Numerous prevalence studies indicate that 50-80% of drug addicts in Norway tested positive for anti-HCV (SIRUS 2001).

iii. Tuberculosis: The number of TB cases reported in Norway has gradually declined over the period of 1980 to 2000 (Table 25/Figure 15). During that period, the highest level of reported TB cases was 499 in 1980, and the lowest was 205 recorded in 1997. After a small spike in 1998 of 244 cases, the level again declined to 221 in 2000, before increasing to 276 in 2001. The reported TB case rate has also steadily declined from a high of 12 per 100,000 population in 1980 to a low of 6 per 100,000 population which has been maintained since 1995 (Table 25/Figure 16) (WHO 2002).

Table 25: Reported incidence and incidence rates per 100,000 population of TB in Norway for the years 1991 - 2001

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TB Cases</td>
<td>290</td>
<td>288</td>
<td>256</td>
<td>242</td>
<td>236</td>
<td>217</td>
<td>205</td>
<td>244</td>
<td>213</td>
<td>221</td>
<td>276</td>
</tr>
<tr>
<td>Reported</td>
<td>6.8</td>
<td>6.7</td>
<td>6.0</td>
<td>5.6</td>
<td>5.4</td>
<td>5.0</td>
<td>4.7</td>
<td>5.6</td>
<td>4.8</td>
<td>4.9</td>
<td>6.0</td>
</tr>
<tr>
<td>TB Case Rate per 100,000 population</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Control of TB in Norway has been credited primarily to the routine implementation of Directly Observed Therapy, Supervised (DOTS) in over 90% of the total Norwegian population (Table 26). The treatment success rate with DOTS is over 77% and the re-treatment success rate is 100% (Table 24).
Table 26: Overview of TB control in Norway.

<table>
<thead>
<tr>
<th>Latest information:</th>
<th>Estimated number of smear positive (ss+) cases of TB: 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>Detection rate of new smear positive (ss+) cases of TB: 0.4%</td>
</tr>
<tr>
<td>Population:</td>
<td>Proportion of pulmonary cases which are smear positive (ss+) with DOTS: 26.4%</td>
</tr>
<tr>
<td>4,488,000</td>
<td>Estimated cases of TB: 264</td>
</tr>
<tr>
<td>Reported cases of TB:</td>
<td>Treatment success rate of new smear positive cases with DOTS: 77.4%</td>
</tr>
<tr>
<td>221</td>
<td>Estimated rate of TB cases which are HIV positive/100,000 population: 3.0</td>
</tr>
<tr>
<td>Estimated cases of TB:</td>
<td>Treatment success rate of re-treatment smear positive cases with DOTS: 100%</td>
</tr>
<tr>
<td>264</td>
<td>New smear positive (ss+) cases of TB: 37</td>
</tr>
<tr>
<td>WHO Control Category:</td>
<td>WHO Control Category: 4</td>
</tr>
</tbody>
</table>

(SS+) = smear positive cases, which are bacteriologically confirmed via smear microscopy.

* WHO control category 4 refers to countries implementing the DOTS strategy in over 90% of the total population (routine implementation). (WHO 2002)

Figure 15: Reported cases of TB in Norway for the years 1990 – 2001.

Number of TB cases reported,
Norway, 1999 - 2001
Figure 16: Incidence rate of reported cases of TB per 100,000 population in Norway for the years 1990 – 2001

Reported TB case rate, Norway,
1990 - 2001

iv. Sexually Transmitted Infection’s: The incidence of syphilis has declined steadily in Norway since a high of 328 cases in 1975. Since 1993, when Norway instituted a system of independent and anonymous testing, the country has averaged 10 cases of syphilis annually. During the seven year period of 1993 – 1999, 1506 cases of gonorrhea and 111 cases of primary syphilis were reported. The majority of these cases were transmitted abroad. The declining incidence of syphilis as well as gonorrhea has been credited to widespread diagnosis and treatment offered through the public health system (EpiNorth 2000).

There are concerns that the epidemics of syphilis and gonorrhea seen in Russia may spread to Norway, in particular the bordering county of Finnmark. Of the 1,506 cases of gonorrhea reported in Norway from 1993 – 1999, 29 cases (2%) were linked to Russia. Of the 111 cases of syphilis reported over the same period, 12 cases (11%) were linked to Russia (EpiNorth 2000).
Less than ten cases of gonorrhea and syphilis are linked to Russia implying the epidemiological situation is stable (Table 27). Reasons for this include: Russians and Norwegians may not engage in sexual relations with each other, sexual relations are protected through condom use or that Russians who engage in sex with Norwegians are not infected (EpiNorth 2000).

Table 27: Distribution of cases of gonorrhea and syphilis reported in Norway with links to Russia, 1993 – 1999.

<table>
<thead>
<tr>
<th></th>
<th>Norwegians Infected In Russia</th>
<th>Norwegians Infected By Russians in Norway</th>
<th>Russians Diagnosed In Norway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhea</td>
<td>15</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Syphilis</td>
<td>6</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>9</td>
<td>11</td>
</tr>
</tbody>
</table>

(EpiNorth 2000)

Epidemics of syphilis and gonorrhea may be used as markers of behavior which increase the spread of HIV. In addition, the presence of syphilis and gonorrhea increase the infectiousness of HIV. Thus, it is critical that close surveillance of these diseases is maintained. The successful eradication campaigns for syphilis and gonorrhea in Norway should prove instructive for Russia. It would seem beneficial to the region for public health officials from both countries to combine efforts to control the spread of sexually transmitted infections (EpiNorth 2000).

D. Comparison of the Epidemiological Situations in Finland, Norway and the Russian Federation

i. **HIV/AIDS:** According to the Russian Government, the prevalence of HIV in Russia at the end of 2001 was 199.5 per 100,000 population. The incidence of HIV was almost 603 cases per 100,000 population in the year 2001. The
total number of reported HIV infected individuals in the Russian Federation numbered 207,711 as of June 30, 2002 (Figure 17). Of the 207,711 cumulative reported HIV infections, 54% were transmitted through injection drug use, which represents the primary mechanism of transmission. (Figure 18) (Russian Gov't 2002). As dismal as these numbers are, many among the Russian public health community fear the actual numbers may be ten times higher.

As of June 30, 2002, the total reported cases of HIV and AIDS in Finland number 1,430 and 339 respectively. The incidence of HIV was 24.7 per 100,000 population in 2001, and the incidence of AIDS was 3.3 per 100,000 population in 2001 (Figure 17). Of the 1,430 cumulative cases of HIV, 18% were transmitted through injection drug use. The primary mechanisms of transmission of HIV in Finland are heterosexual contact (34%) and homosexual/bisexual contact (31%) (Figure 18) (Euro 2003).

As of June 30, 2002, there were 2,417 reported cases of HIV and 750 reported cases of AIDS in Norway. The incidence of HIV in 2001 was 36.3 per 100,000 population. The incidence of AIDS over the same period was 3.3 per 100,000 population Figure 17. Of the 2,417 cumulative reported cases of HIV, 19% were transmitted through injection drug use. The primary mechanisms of transmission of HIV in Norway are heterosexual contact (42%) and homosexual/bisexual contact (33%) (Figure 18) (Euro 2003).
Figure 17: Comparison of the trend in annual incidence rates of HIV in Russia, Finland and Norway for the years 1994 through June 30, 2002.

Figure 18: Comparison among four (4) mechanisms of transmission for cumulative reported cases of HIV in Russia, Finland and Norway, 1994 – June 30, 2002.
ii. **Hepatitis:** Hepatitis B & C rates in the Russian federation climbed steadily throughout the 1990s. Hepatitis B rates doubled between 1990 and 2000 and hepatitis C rates more than tripled (x3.4) between 1994 and 2000. The epidemic of hepatitis B was unusual in that it preceded the outbreak of HIV, leaving compromised immune systems in its wake capable of only token resistance against HIV. Hepatitis C has become the most common blood-borne infection in Russia and presents the greatest potential for long-term morbidity from chronic liver disease. Most individuals infected with hepatitis C lack clinical signs of infection and serve as a source of transmission to others. Vaccines against hepatitis A & B are not widely available due to cost factors, especially in areas with large concentrations of high-risk populations where it is needed most (MMWR 1998).

Prevalence rates of hepatitis C in Finland remain low (0.02 in 1999). However, 60% of injection drug users tested positive for hepatitis C infection in 1999. It is estimated that 90% of hepatitis C infections in Finland are attributable to injection drug use. Localized outbreaks of hepatitis A among IDUs in 2002 appears to be under control due to an aggressive, national free vaccination program (STAKES 2001).

Norway has averaged 100 cases each of hepatitis A and hepatitis B throughout the 1970s, 1980s and 1990s. Approximately one half of these cases were acquired abroad. However, the period between 1995 and 1999 was characterized by localized outbreaks among injection drug users. The
epidemic of hepatitis A peaked in 1999 with 22.4 cases per 100,000 population, but has been in decline ever since due to widespread vaccination. The hepatitis B outbreak also peaked in 1999 at 10.6 cases per 100,000 population, but remains high among IDUs. Infection rates for hepatitis C are considered unreliable primarily due to the fact that many infected with hepatitis C remain asymptomatic and do not seek treatment. However, public health estimates that some 50 – 80% of the IDU population is infected with hepatitis C (EpiNorth 2000)

iii. Tuberculosis: The rise in the incidence of tuberculosis correlated with the decline of the socioeconomic situation in Russia beginning in 1992. The rate of reported cases of TB more than doubled (x2.7) from 33.9 per 100,000 population in 1991 to 92 per 100,000 population in 2001 (Table 28). The number of reported cases of TB also more than doubled (x2.7) from 50,407 in 1991 to 137,597 in 2000 (Table 28/Figure 19). The incidence of TB increased 70% between 1990 and 1995. The number of reported cases of TB continued to climb, rising 12% in 2000 coupled with a 30% rise in mortality. Tuberculosis is currently first in mortality among infectious diseases in Russia and the mortality rate of 20 per 100,000 cases in 2000 was the highest in Europe. DOTS population coverage was 16% in 2001 with additional pilot programs in the planning stage (WHO 2003).

The number of reported cases of TB in Finland declined from a high of 2,247 in 1980 to 460 in 2001 (Table 28/Figure 19). The TB case rate declined from 47 per 100,000 population in 1980 to 9 per 100,000 population in 2001
The decline is credited mostly to aggressive diagnosis and treatment by the Finnish public health system (WHO 2002).

The number of reported cases of TB in Norway declined between 1980 and 2000 reaching a low of 205 cases per 100,000 population in 1997 (Table 28/Figure 19). Norway has implemented the DOTS program in over 90% of the country. The treatment success rate for DOTS is 77% with a 100% retreatment success rate (WHO 2002).

Table 28: Comparison of reported cases of TB, case rate per 100,000 population, new smear positive (ss+) cases, smear positive rate per 100,000 population, new confirmed cases of TB, new confirmed TB case rate per 100,000 population, estimated cases of TB and estimated case rate per 100,000 population, estimated smear positive (ss+) and estimated smear positive (ss+) case rate, and TB detection rate and new smear positive cases of TB detected in Finland, Norway and the Russian Federation, 2001.

<table>
<thead>
<tr>
<th>2001</th>
<th>Finland</th>
<th>Norway</th>
<th>Russian Federation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>5,178,000</td>
<td>4,488,000</td>
<td>144,664,000</td>
</tr>
<tr>
<td>Total reported cases of TB</td>
<td>460</td>
<td>276</td>
<td>132,477</td>
</tr>
<tr>
<td>Case rate per 100,000 population</td>
<td>9</td>
<td>6</td>
<td>92</td>
</tr>
<tr>
<td>New ss+ cases reported</td>
<td>150</td>
<td>59</td>
<td>26,605</td>
</tr>
<tr>
<td>New ss+ cases reported rate per 100,000 population</td>
<td>3</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>New confirmed cases of TB</td>
<td>280</td>
<td>147</td>
<td>4,446</td>
</tr>
<tr>
<td>New confirmed cases of TB per 100,000 population</td>
<td>5</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Estimated cases of TB</td>
<td>568</td>
<td>265</td>
<td>193,363</td>
</tr>
<tr>
<td>Estimated cases of TB per 100,000 population</td>
<td>11</td>
<td>6</td>
<td>134</td>
</tr>
<tr>
<td>Estimated ss+ cases of TB</td>
<td>251</td>
<td>119</td>
<td>86,917</td>
</tr>
<tr>
<td>Estimated ss+ cases of TB per</td>
<td>5</td>
<td>3</td>
<td>60</td>
</tr>
<tr>
<td>100,000 population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Detection rate of TB</td>
<td>81</td>
<td>104</td>
<td>69</td>
</tr>
<tr>
<td>Detection rate of ss+ cases of TB</td>
<td>60</td>
<td>50</td>
<td>31</td>
</tr>
</tbody>
</table>

(SS+) = smear positive cases, which are bacteriologically confirmed via smear microscopy.

**Figure 19:** Comparison of reported cases of TB in Finland, Norway and the Russian Federation over the years 1991 – 2001.

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**iv. Sexually Transmitted Infections:** The number of registered incident cases of syphilis reported annually rose from 8,000 in 1990 to 405,000 in 1997. Data is incomplete on the incidence rates of gonorrhea, herpes, trichomoniasis and Chlamydia, but government estimates have these diseases on the rise as well. The dramatic rise in sexually transmitted infections is blamed on the increase in prostitution brought about by economic instability as a result of the break up of the former Soviet Union in 1991 (DET 1999). Also of note is the link between and concomitant rise of drug abuse, HIV and sexually transmitted infections (Johnson 2002).
The prevalence of sexually transmitted infections is relatively low in Finland. The primary mechanism of transmission has been through heterosexual contact abroad. There has been an increase in cases of syphilis since 1993, with cases nearly doubling (x1.9) between 1994 and 1995. More than half of the 1995 cases were acquired in Russia along the southern Finnish border (Eurosurveillance 1996).

The incidence of syphilis in Norway has decreased from 328 cases in 1975 to an average of 10 annually since 1993 due to rigorous diagnosis and treatment standards. The majority of cases are transmitted abroad, with growing concerns along the border with Russia (EpiNorth 2000).

V. Public Health Interventions to Reduce Disease and Other Injuries Associated with Drug Use

A. Russia

This section will cover public health strategies in both law and practice which may potentially decrease the spread of HIV and related infectious diseases among drug users. These strategies include primary harm reduction interventions such as education and increasing public awareness, treatment and its availability and maintenance therapy to prevent relapse.

The Government of Russia has limited resources devoted to public health. Health care funding, as a percentage of Gross Domestic product (GDP) has changed little over recent years and remains woefully inadequate at 2.6% (1990), 4.5% (1995) and 4.6% (2000) respectively (World Bank 2003). The result is an almost complete lack of primary prevention interventions and
the absence of acceptable services targeted at vulnerable population groups (DET 1999).

While Russian authorities have expressed an interest in developing a comprehensive counter-drug strategy which would incorporate education, healthcare and law enforcement, little in the way of harm reduction has been put into practice. Supply side law enforcement still commands the majority of the little monies available. In the 2003 budget, the government identified five target areas for increased funding, none of which include healthcare, drug abuse prevention or treatment (World Bank 2003).

The prevalence of HIV and related infections is much higher in the prison system than in the general public. The stiffening of Russian drug laws has led to overcrowding in prisons which has facilitated the spread of infectious disease. While the Ministry of Justice, which runs the countries prisons, has pushed to reduce overcrowding, change is often haphazard and slow. Access to condoms is restricted as sex is not allowed. Bleach, which can be used to sterilize injection and tattooing equipment, is also restricted for fear it could be used to attempt suicide or to injure prison guards or fellow inmates (Schoofs 2002).

Under Russian law, mandatory testing is required for all new prisoners upon arrival. However, in practice, only those individuals who “appear sick” are actually tested. Often, prisons run out of money and cannot afford to but testing equipment. In addition, the HIV test works by detecting the presence of antibodies to HIV, not the virus itself. Since it may take an immune system
up to six months to produce antibodies to HIV, false negatives may occur. Any one suspected of carrying HIV or other infections such as TB and hepatitis are supposed to be segregated by different cellblocks. However, due to inconsistencies in testing, HIV infected prisoners are often placed among HIV negative inmates. Under a false sense of security, these prisoners often share injecting equipment thinking it is safe and ultimately spread the infection (Schoofs 2002).

The Russian medical establishment is largely resistant to reforming the penal system and drug treatment. Many influential Russian physicians were educated under the old authoritarian Soviet public health system. They strongly oppose the employment of harm reduction strategies in the treatment of injection drug use and control of HIV. Many physicians, including Alexei Mazus, Director of the Moscow AIDS Center, resist needle exchange programs for fear that they “lure youths into drug addiction” (Schoofs 2002). Additional opposition comes from the police, clergy and politicians. The general public’s perception is often based on negative media portrayals of harm reduction programs (WHO 2001). Since 1997, small-scale needle exchange programs have been operating in several cities. However, law enforcement officials hinder their operations by frequently harassing or even arresting those who attempt to utilize these programs. (WHO 2001). There is strong opposition from city administrators and neighborhood groups (businesses, residents, etc.) to needle exchange programs (DET 1999).
Most harm reduction programs depend on funding through NGO’s and the international community. The Russian Federation has received approximately 37 grants for needle exchange and methadone projects from 1996 through 2000 (WHO 2001).

While vaccines are available to prevent hepatitis A & B, they are costly and generally unavailable in Russia. While hepatitis A is controlled mostly through careful monitoring of food and water, this is not occurring in Russia (OSI 1999).

i. **Drug Treatment Programs/Availability:** The 1998 Russian Law on Narcotics and Psychotropic Substances provides for compulsory treatment of drug abusers who come to the attention of authorities. The 1998 Law restricts drug abuse treatment to government facilities. Russian counter-narcotics efforts rely heavily on law enforcement, but authorities have recently displayed an increased interest in initiating cooperation and accepting assistance in the areas of drug abuse prevention and treatment (INC 2001). However, since funding is limited and methadone is illegal, drug treatment usually consists of detoxification and a daily routine of vitamins and painkillers (Rodriguez 2002).

Substitution therapies are generally unavailable due to the illegality of methadone and opposition to this form of therapy from physicians, politicians, clergy, police and the general public (DET 1999), (INC 2001). Russian prisoners suffering from heroin withdrawal often resort to used needles and syringes and whatever drug(s) may be available (including homemade drugs) to relieve the stress of withdrawal (Schoofs 2002).
ii. **Sociopolitical Environment in the Russian Federation:** Social attitudes toward drug use and IDUs are mostly negative. The general perception of HIV-infected injection drug users is that they are "guilty" or responsible for their own infection. Therefore, as carriers of a dangerous disease they must be avoided. The media helps to fuel this negative public perception by referring to injection drug users as "hopeless junkies". The general attitude from politicians, clergy and the medical profession to the general public is that drug users should face criminal punishment. The police often harass and arrest drug users sending them underground (OSI 1999).

Russia has taken some measures to effectively prevent HIV transmission in the most affected regions. Risky drug preparation practices have been reduced following the dissemination of targeted information and education among drug users in the most highly affected areas such as Moscow, St. Petersburg and Kalingrad. However, other regional and national policies have further increased the risks associated with injection drug use by driving many drug users underground, effectively rendering them unreachable. Arkadiusz Majszyk, the Russian Federation’s representative to the United Nations program on HIV/AIDS estimates that needle-exchange programs reach approximately 5% of the injecting population. Majszyk believes 60% coverage is necessary to slow the spread of HIV among IDU’s (Rodriguez 2002).

The traditional approach to prevention in prisons remains testing, with the goal of segregating HIV infected prisoners from those which are HIV
negative. Small gay groups have emerged but generally only target other gay inmates with prevention messages (OSI 1999).

Official approaches to sex work and HIV prevention among sex workers have so far been characterized by either negligence or repression. Lacking legislation against sex work, prostitutes are frequently detained with no legal basis or because they do not have the required residence documents. Reportedly, the police in Moscow occasionally become involved in pimping (OSI 1999).

iii. Programmatic Details: HIV testing is widely available. According to Russian law, anyone who wants an HIV test can obtain one anonymously. As of December 31, 2000, the rate of testing per 1,000 population was 27.3 (Euro 2002) The number of tests performed decreased 43% between 1994 and 1996, due in large part to the change in testing policies and decreased funding. However, the number of tests decreased 33% in blood donors and 54% in prisoners for whom testing policies remain the same for lack of funding (DET 1999). The total number of HIV tests performed, excluding unlinked anonymous testing and the testing of blood donations by year (1997 – 2001) and rate of testing per 1,000 population were:

1997: 16,480,739
1998: 16,337,404
1999: 18,205,730
2000: 20,387,206
2001: 19,810,751

Tests per 1,000 population/habitants in 2001: 135.1

(European Centre for the Epidemiological Monitoring of AIDS 2002)
B.芬兰

The HIV epidemic in Finland began in 1998 among injection drug users. The relationship between injection drug use and HIV and related infectious disease has served to underscore the importance of reducing the health hazards associated with drug abuse. Despite public awareness, few Finnish treatment facilities engage in needle exchange programs. Although most pharmacies formerly sold syringes to addicts, nearly one quarter have stopped doing so, citing reasons of security. Additionally, most pharmacies report that they do not sell syringes to minors. In response, the Ministry of Social Affairs and health, the National Agency for Medicines, the National Public health Institute, the Association of Finnish Pharmacies and the University Pharmacy have all sent recommendations encouraging pharmacies to sell syringes to drug users (STAKES 2001).

Currently, Health (infection risk) counseling services for injection drug users are operating in thirteen municipalities in Finland. This number includes one syringe exchange program. The goal of the counseling service is to encourage drug users to reduce behaviors associated with the risk of infectious disease. Clients receive information regarding the risks of using contaminated needles, syringes and other drug paraphernalia and are able to exchange their contaminated needles. The longest running health counseling center in Finland is Vinkki which has operated in Helsinki since 1997. The Vinkki Center reports that the average client participates in their needle exchange program six times per year. Condoms are made available and
visitors receive information regarding sexually transmitted diseases. The primary goal of counseling is to motivate drug addicts to seek help and treatment so they may eventually abandon their drug habit (STAKES 2001).

The national Public Health Institute launched a project in 1999 in an effort to lower the technical requirements to perform HIV testing. The project included both theoretical and hands-on training in the use of HIV tests and aspects of associated counseling and was intended primarily for use in prisons and needle exchange program sites. In addition, a project that included both counseling and support for HIV-infected drug abusers was sponsored in late 1999 by the Ministry of Social Affairs and Health. Another project, coordinated by the A-Clinic Foundation in collaboration with infection risk counseling centers, the National Public Health Institute, the National Research and Development Center for Welfare and Health (STAKES) and the Ministry of Social Affairs and Health was launched in 2000 to follow up risk behavior among injection drug users. The Deaconess Institute in Helsinki opened the Kluuvi service center in 2000 to provide specialized services for HIV infected drug users. The center provides both daytime activities and short-term accommodations and hopes to soon provide long-term support housing services. The center currently serves about 50 clients per day (STAKES 2001).

The use of harm reduction practices in Finland, while generating much debate, have assumed a more widely acknowledged position as a component of drug treatment. One such example would be the development of infection
risk counseling in addition to the substitution therapy and maintenance treatment system. An ongoing three year experiment in Finnish prisons, though in its' early stages, has produced several well-designed instruments for prison drug treatment and the after-care of released prisoners in conjunction with field organizers (STAKES 2001).

Drug demand reduction in Finland involves a broad range of activities and authorities, organizations, citizens and the private sector. Their work is carried out on the local, regional and national level within the framework of international cooperation. Drug demand reduction, in particular prevention, legislation and relevant social and health services falls under the jurisdiction of the Ministry of Social Affairs and Health. The state provides individual municipalities with program resources from a central base which allows the government the opportunity to exercise a degree of control over the planning of drug abuse services. However, Finnish municipalities are given extensive autonomy and are responsible for providing intoxicant abuser services and temperance work by law. Civic groups have a long-standing tradition in Finland of complementing the public systems. Drug use prevention work is done by several non-profit and public health organizations specializing in substance abuse services (STAKES 2001).

Issued at the end of 1998, the Government Decision-in-Principle on Drug Policy contained a draft proposal for a drug research program. The conclusions of the Decision were that in order to combat the distribution and use of drugs, general sociopolitical measures were necessary in addition to
specific drug demand and supply reduction activities. Demand reduction was divided into prevention, treatment and support for both abusers and their families. The Decision was clarified on October 5, 2000 by a second Government Decision to enhance drug policy (STAKES 2001).

According to the 1998 Government Decision-in-Principle, drug demand reduction can best be promoted by influencing the population's living conditions through the pursuit of the Nordic welfare policy and through early and effective intervention in emerging intoxicant problems. This goal may be achieved through programs that:

- Develop new approaches in drug education
- Promote early intervention and encourage staff members to intervene through experience and adequate knowledge of useful working methods.
- Establish a committee which will develop proposals for preventing drug use among young people and reduce the detrimental effects of abuse.
- Launch local projects which will support early intervention in young people's problems. (STAKES 2001)

The goal of this strategy is the prevention of substance abuse problems through a national information and prevention campaign carried out by regional municipalities. A second goal is to provide Finnish citizens with the services they need, including the care and treatment of drug abusers. Thus, the strategy utilizes a two pronged approach of preventing and reducing substance abuse while minimizing the related social and health harms associated with drug abuse. However, the protean nature of drug abusers often makes treatment difficult, thus access to care needs to be flexible. In order to maximize the effectiveness of drug treatment, the Government
Decision-in-Principle on drug policy in 1998 has outlined the following approaches:

- Referral to treatment will be provided on a 24 hour basis.
- The quality of care must be assured throughout the country on an equal basis.
- Detoxification and substitute therapy will be provided to meet present needs.
- The Ministry of Social Affairs and Health will examine provisions of care for pregnant women who use drugs.
- Drug prevention in prisons will be developed to minimize the recruitment of new users and continued drug use.
- Models of action will be developed to prevent the spread of communicable diseases.
- Those subject to police measures will be offered expert help in order to assess their situation and treatment.
- The special needs of drug abusers will be considered in the development of existing services by intensifying personal training.

(STAKES 2001)

i. **Drug Treatment Programs/Availability:** The care and treatment of drug abusers functions on the general principle of Finnish social welfare and health care which provides all citizens with the services they require. Drug abuse and its related problems increase insecurity and cause harm to other citizens. Therefore, positive outcomes of care and drug treatment have a favorable impact on drug and related crimes. Ultimately, continued drug abuse will result in greater costs to society than provision of care and treatment. Thus, the effective care and treatment of drug abusers is in the best interests of society as a whole. Additionally, families of drug abusers are also in need of support guidance and services (STAKES 2001).

In the Finnish drug treatment system, the development of services for youth and low-threshold services in addition to related training has been
emphasized. These services are available at a number of low-threshold day centers throughout the country. Following an assessment of the client’s physical, psychological and social condition, these day centers offer temporary accommodations including meals, a shower, and in some cases, health services. The immediate needs of the client are met while more permanent solutions are sought within other social and health services. One of the major goals is to involve potential clients in the treatment system as early as possible (STAKES 2001).

In the summer of 2001, a working group appointed by the Ministry of Social Affairs and Health developed a proposal after evaluating the current systems ability to meet the needs of drug abusers. In their assessment, the working group concluded that the existing treatment provisions were not being met due to an incoherent service system. The seeking of treatment is often made difficult by the fact that different bodies assess treatment need and provide related services. They cited many cases where social service organizations alter the original assessment resulting in denial of treatment due to a shortage of municipal funds. They established that when treating severe drug addiction, the primary goal is not freedom from drugs, but a reduction in substance abuse and the prevention, elimination and treatment of related health, social and other issues. The group determined that successful treatment requires individual, sustained, many-sided and systematic service chains, including outpatient clinics, short-term institutional care, rehabilitation units, support services and self-help groups committed to by both client and
Personal service counselors should be appointed in municipalities to assist those with severe drug problems and to ensure appropriate implementation and coordination of treatment. The working groups proposal called for significant changes in the methods, skills, attitudes, resources and legislation (STAKES 2001).

In 1986, it was established in the Act on Welfare for Substance Abusers (41/1986) that individual municipalities are responsible for organizing services for intoxicant abusers in a way that meets their needs. The service system in Finland is composed of outpatient clinics, short-term institutional care, rehabilitation units and support services and self-help groups. In addition, many primary health care social service units address drug problems. However, the number of these specialized services available to drug addicts is limited primarily to the area of Helsinki and other major cities. Since 1996, Finland has had an ombudsman based in non-governmental organizations (NGOs) working with treatment clients throughout the country (STAKES 2001).

Primary health care providers in Finland offer specialized services for substance abusers primarily in the treatment of poisonings, illnesses and injuries associated with drug use along with short-tem detoxification. Both general and psychiatric hospitals treat severe withdrawal symptoms and cases requiring hospitalization. Mental health clinics provide outpatient care for psychiatric illnesses which may include substance abuse problems. In 2000, the Ministry of Social Welfare and Health designated a special role to
university and central hospitals in the assessment of medical detoxification, substitution and maintenance treatment of opiate addicts (STAKES 2001).

There are specialized local outpatient clinics in over 100 municipalities in Finland and several have contracted services for residents from public or private service providers. Approximately 46,000 people visited outpatient clinics for substance abusers while 11,000 used residential treatment services in 2000. Twenty percent of outpatients and sixteen percent of residential treatment patients were under age 30. The majority of treatment lasted one week or less while 20% lasted longer than two weeks and 1.4% lasted three months or longer. A one day census in 1999 revealed that drug clients accounted for 20% of patients using outpatient services and 30% of those in residential treatment (STAKES 2001).

Finland has approximately 30 units with special drug treatment programs, of which, 13 provide residential detoxification, 18 provide withdrawal treatment and 18 rehabilitation. Drug treatment periods for detoxification and withdrawal typically last 2-3 weeks while rehabilitation lasts 2-3 months or longer (STAKES 2001).

The Ministry of Social Welfare and Health issued regulations addressing the use of substitution and maintenance therapies in 1997, which were subsequently revised in 1998 and 2000. According to the Orders of the Ministry (28/1997; 42/1998) and a Decree passed in 2000 (607/2000), substitution treatment using medicines containing buprenorphine, methadone or levacetylmethadol may only be provided to patients for whom generally
accepted means of detoxification have failed. The Decree of 2000 also allows for maintenance therapy but stipulates that treatment may start only when it is imperative to reduce the negative effects of drug abuse on the patient. This includes those who are unlikely to stop using drugs but may benefit from maintenance treatment and avoid contracting communicable diseases or other negative health effects. Those whose quality of life can be improved and can be trained for a more demanding rehabilitative substitution treatment may also qualify. Levacetylmethadol has yet to be employed as its sales authorization was cancelled in 2001 (STAKES 2001)

Criteria for medical detoxification treatment was established in 1999 at the Drug Detoxification Unit of Helsinki University Central Hospital and included the patients age (18 and over), diagnosed opiate dependence (ICD-10 or DSM-IV) and drug screening to detect recent drug use (naloxone test). Disqualification from detoxification included uncontrolled polydrug use, acute alcoholism, psychological or somatic illnesses which preclude treatment and pregnancy. Criteria for methadone substitution treatment in the Greater Helsinki area has historically been age (20 and over), compulsive use of opiates (minimum of 4 years), and a history of institutional or long-term care. Disqualification from treatment has been brought about by uncontrolled polydrug use, severe psychological or somatic illnesses which preclude treatment and acute alcoholism (STAKES 2001).

The working group charged with developing a treatment system for drug abusers has stated the need for additional resources in order to provide
treatment for some 1,000 opioid-dependent clients on an annual basis. Additional monies will also be needed to provide treatment for users of other drugs (STAKES 2001).

On October 2, 2001, another working group proposed actions to increase the availability of medicinal treatment of opioid-dependent clients. The report included methods for increasing treatment options based upon existing regulations and new regulations that will help meet current requirements. The present system in Finland does allow for the expansion of medical treatment services such that all central hospitals provide treatment or be in a position to do so. Under the present system, treatment begins on a low-threshold basis whereby the patient is transferred as soon as possible for follow-up care in a different unit (STAKES 2001).

The working group has also suggested that the Ministry of Social Affairs and Health could issue a Decree on the organization and implementation of substance abusers treatment with medicines under the Act on Welfare for Substance Abusers. This would provide greater flexibility in the implementation of treatment for opioid-dependent clients than is currently provided in the existing Governmental Decree. The group feels that a revised Decree should authorize hospitals, health centers, A-Clinics and other substance abuse outpatient or in-patient units as well as health care units in prisons to start detoxification with buprenorphine provided they have received sufficient training. All substitution and maintenance treatments would be reported anonymously to a central board, which would provide nationwide
supervision. The transfer of buprenorphine treatment to primary health care facilities should allow for more comprehensive implementation of methadone therapies. In addition, the group suggests a pilot project to assess the efficacy of treatment provided through private physicians with medicines supplied by local pharmacies (STAKES 2001).

It is hoped that the proposals of the working group will increase the availability of treatment without an adverse effect on quality. Recent information on the effectiveness of buprenorphine should justify a revision in the regulations that currently limit its use and put Finnish regulations more in line with those of other nations such as the United States, Australia and France (STAKES 2001). The Federal Drug Administration (FDA) of the United States approved the use of both buprenorphine and buprenorphine-naloxone for heroin addicts in October 2002 (NY Times 2002). Currently, it is not uncommon for opiate addicts in Finland to travel abroad, especially to Paris to acquire buprenorphine. The National Agency for Medicines has issued regulations (3/2000) which limit the import of buprenorphine to 14 days personal use (STAKES 2001).

ii. Sociopolitical Environment in Finland: The increasing number of written correspondences to the Finnish government in 2000 and 2001 reflect a growing national concern over the drug problem. The most common themes addressed to Parliament include drug treatment, drug-related crime and resources devoted to anti-crime activities, the spread of infectious diseases
associated with drug use, drug testing, drug use prevention (especially directed at young people) and mothers with drug problems (STAKES 2001).

These themes have generated much public debate along with legislative reforms. In 2000, a Decree was passed concerning substitution and maintenance treatment and during the summer of 2001, a working group appointed by the Ministry of Social Affairs and Health addressed the issue of resources for drug treatment. The group submitted a memorandum expressing a desire to amend legislation and augment resources for drug treatment activities (STAKES 2001).

Throughout 2001, there has been much ongoing debate over the inadequate resources of the police, customs and the frontier guard and the repercussions on the prevention of international drug trafficking. Infectious diseases associated with injection drug use have been widely discussed in light of the HIV epidemics in nearby Russia and Estonia. An effort has been made to develop legal reform concerning mandatory drug testing in conjunction with the Act on the protection of privacy in working life, but it has been forwarded to a special working group which was expected to tackle the issue by the end of 2001 (STAKES 2001).

iii. **Programmatic Details:** HIV testing is mandatory for blood donors but voluntary for all others. Diagnosed HIV infections are recorded in a national HIV case reporting system using an identifying code. Data on HIV also comes from screening programs. Surveys on pregnant women have been conducted nationally since 1993 (WHO 2001).
The total number of HIV tests performed, excluding unlinked anonymous testing and testing of blood donations, (1997-2001), and rate of testing per 1000 population (2001):

1997: 88,181  
1998: 149,939  
1999: 130,505  
2000: 143,490  
2001: 145,000

Tests per 1,000 population/habitants in 2001: 28.0

(European Centre for the Epidemiological Monitoring of AIDS 2002)

C. Norway

The Norwegian strategy for combating drug abuse was outlined in documents developed by the Ministry of Health and Social Affairs in 1991-92. The documents, entitled Measures Directed at Drug Addicts provides for the development of a rehabilitation sector and a framework for the organization of treatment. It also provides for intervention measures, a division of responsibility and the establishment of regional centers of competency which focus on the field of drug abuse (SIRUS 2001).

A later report entitled The Drug Policy which was put forth in 1996-97, describes the development of the drug situation and presented goals and measures. The need to strengthen prevention work, collective assistance and rehabilitation, along with an expansion of the restrictive legal drug policy already in place were emphasized. The goal of a drug-free society was to be upheld as a necessary expression of the government’s attitude towards drugs (SIRUS 2001).
The Ministry of Health and Social Affairs presented an action plan in 1998, which was initiated under a backdrop of increased alcohol abuse along with research showing illegal substances were gradually gaining a foothold with Norwegian youth. The plan defined areas for intervention and contained strategies that would ultimately strengthen measures directed at prevention and public opinion. The primary goals of the plan which address drug abuse are as follows:

- **Reduction of the abuse of illegal substances among youth and young adults.**
- **Increase awareness of the links between the use and abuse of various substances.**
- **Strengthen negative opinions regarding drug use.**
- **Better and more effective treatment, low threshold health service and treatment alternatives for drug addicts, including pregnant women and those with children.**

(SIRUS 2001)

To achieve these goals, the state must establish:

- **Cooperation with homes, schools and leisure time activities within the framework of building public opinion.**
- **A broad mobilization of volunteers, organizations and youth groups.**
- **Allow municipalities, local police and local communities to play a meaningful role in prevention.**
- **A long-term perspective on prevention.**
- **Directed measures towards entire populations and high-risk groups.**
- **That rehabilitation and treatment measures operate in cooperation with voluntary organizations, groups and individuals.**
- **Strong after-care services.**

(SIRUS 2001)

Out of this action plan came the establishment of a drug policy panel that was to act as a reference group for the Minister of Social Affairs until January 1, 2001. The panel provided a bridge between authorities and labor
groups, the business community, the insurance industry and organizations working on drug policy. During 2000, a reorganization of the state intervention in prevention was conducted aimed at strengthening local and regional work and prevention measures. The reorganization was expected to produce and spread knowledge and information within the drug abuse field and the creation of more effective administrative practices (SIRUS 2001).

The primary result of this reorganization was the creation of the National Institute for Alcohol and Drug Research (SIRUS) on January 1, 2001. SIRUS has the responsibility of conducting research and disseminating results and documentation on drug issues, with particular attention to aspects of social science. Research has been divided into five principle areas: drug markets, drugs and drug culture, prevention, consequences, rehabilitation and care (SIRUS 2001).

The reorganization of 2000 has given birth to Norway-Net, a collective of seven regional centers for drug competence. These regional centers are responsible for increasing competency levels and spreading knowledge within the drug abuse field among health care and social workers. In addition, the centers are charged with up grading the drug education levels of key employees of municipalities and to further develop specialized services for drug users and to provide schools with prevention assistance. The centers are to provide the Ministry of Health and Social Affairs with advice concerning the expansion of national drug policy (SIRUS 2001).
Recently, the Norwegian government has earmarked funds for low-threshold services to 14 of the country's municipalities where the largest number of drug-related deaths have been recorded. These services target drug abusers, who for various reasons do not seek help from established health care centers. Drug addicts are provided with access to doctors and nurses who provide general health check-ups, treatment for abscesses, hepatitis vaccinations, x-rays to confirm TB, assistance with hospital admittance, referrals and accompaniment to both municipal and private health care centers (SIRUS 2001).

The "Pro Center" in Oslo provides outreach work in known areas of prostitution with the goal of health education and prevention. Non-governmental organizations (NGO's) such as the Salvation Army and the Church City Mission run low-threshold services for drug abusers, including shelters, soup kitchens, food and clothing distribution, etc. Strax-house in Bergen offers services to women over 18 with a history of heavy drug abuse. They provide shelter for acute cases, a day center, evening and night-time services and follow-up care. The Socio-Medical Center in Tromso is a cooperative project with services provided by municipal, county and university agencies (SIRUS 2001).

In response to the high risk of HIV/AIDS from needle sharing, the city of Oslo established the AIDS information bus in 1988. The bus provides access to clean needles, condoms and information about risk factors associated with injection drug use and HIV/AIDS in an effort to reduce the high-risk behaviors
seen in this population. Recently, several municipalities have begun to
distribute needles from vending machines and through pharmacies (SIRUS
2001).

In 1995, an epidemic of Hepatitis A and B broke out among drug
abusers in Norway. However, the National Institute of Public Health in Oslo
closely monitored the situation and took immediate action. Local health
authorities were advised to initiate preventive measures which included:

- **Cooperation between primary health care, social
  services, prisons and drug rehabilitation centers**
- **Information to the drug abuse community regarding
  outbreaks, symptoms, modes of transmission, personal
  protection and immunization.**
- **Access to clean syringes and other disposable
  equipment.**
- **Immunization against hepatitis A and B.**
  
  (EpiNorth 2000)

Vaccines against hepatitis A and B were provided free of charge to all
drug users. The cost of vaccination was covered by the National health
Scheme. The cost of clean syringes and information campaigns was covered
by local health authorities. Thus, the national and local surveillance and
prevention programs, which remain in place, successfully controlled the
outbreak of hepatitis A and B (EpiNorth 2000). This is an empirical example of
successful harm reduction.

i. **Drug Treatment Programs/Availability:** According to section 3-1 of the
Social Services Act of Norway, municipal social services have an obligation to
sustain efforts to prevent and combat substance abuse. In addition, according
to section 6-1, municipalities have a comprehensive responsibility for the care and treatment of substance abusers.

Section 6-1 states:

"By means of advice, guidance and practical assistance, cf. Sections 4-1 and 4-2, the social services shall help individuals to stop abusing alcohol and drugs. Advice, guidance and help shall likewise be given to families of the persons in question."

"When necessary and when the client so wishes, the social services shall provide for a course of treatment. Such a course of treatment may among other things comprise the appointment of a support contact, the establishment of a support network at work, and contact with the primary health services or specialist services."

"Should such assistance outside institutions prove insufficient, the social services shall provide a place in a suitable institution for care and treatment. If the need for such a place at an institution cannot be met, the social services shall if necessary see that temporary measures are adopted."

"The social services shall follow up the client through the course of treatment in conversations and if necessary on home visits, and by making arrangements for the measures required on the termination of a stay, if any, at an institution." (SIRUS 2001)

According to section 7-1 of the Social Services Act, the counties of Norway are responsible for establishing and running institutions with specialist services associated with them for the care and treatment of alcohol and drug
abusers. These institutions may be county-owned facilities or they may enter into an agreement with private institutions, psychiatric hospitals, departments of social medicine and child protection services. Ultimately, the responsibility for specialized services will fall under the new Act on Specialized Health Services (SIRUS 2001).

Norway has developed a wide array of treatment and rehabilitation services using various professional and ideological approaches. Treatment alternatives range from professional psychotherapeutic approaches to more simplistic methods based upon a central Christian message. Open psychiatric alternatives consist of child and youth psychiatric clinics, open social medicine clinics and a youth psychiatry team. The approximately 70 child and youth psychiatric clinics offer youths under the age of 18 treatment alternatives for all types of mental illness. Some of the approximately 100 adult clinics found across the country employ personnel dedicated to working with drug abuse and mental disorders. The 28 nationwide youth psychiatric teams concentrate on working with individuals between 15 and 30 with both drug abuse problems and psychiatric disorders (SIRUS 2001).

The Social Services Act sets forth the legal provisions for the compulsory treatment of drug addicts in Norway. These provisions have also included pregnant drug abusers since 1996. Section 6-2a provides that a pregnant drug or alcohol abuser can, without her consent, be admitted to an institution and be detained there throughout the pregnancy, provided the abuse is of such a nature that it will in all probability have a harmful effect on
the child, and provided that voluntary assistance is not sufficient. The goal of this practice is to prevent or limit the likelihood of harm coming to a child, by offering the pregnant woman satisfactory help for her drug or alcohol abuse while enabling her to care for her child during her stay in treatment (SIRUS 2001).

Drug treatment in Norway is mostly voluntary, but the law allows for the holding of an addict in an institution for up to 3 months upon the recommendation of the County Council for Social Cases. Those who submit to treatment voluntarily may enter into agreement which allows them to be held in treatment for a maximum of three weeks. Compulsory treatment is employed with the intention of encouraging the client to continue further treatment (SIRUS 2001).

Institutes with 24 hour services, of which two-thirds are in private hands, consist of minimal intervention facilities up to large institutions. Organizations such as Kirkens bymison, Stiftelsen Pinsevennenes Evangelisenter, Blue Cross, the Salvation Army and others help supplement the public institutions. These facilities are generally open to anyone with alcohol, medication or drug problems. Emergency and detoxification institutions provide drug detoxification and referrals to other rehabilitation services. In addition, there are a number of purely care-related measures which accept chronic drug abusers who demonstrate little potential for rehabilitation. They offer these individuals general care and a drug-free environment (SIRUS 2001).
Up until the mid 1980s, the broad consensus among politicians and
drug treatment workers was that methadone therapy should not be used to
rehabilitate drug abusers. However, with continuing reports on the
deteriorating state of chronic users and the rise in drug-related deaths, officials
have reconsidered methadone treatment. A maintenance trial using
methadone conducted in Oslo in 1991 on HIV-positive clients with long-term
immunodeficiency generated little negative criticism. Ultimately, debate
centered on whether methadone therapy should be made available
independent of HIV status. Opponents feared that methadone therapy would
be interpreted as a sign that drug abusers are considered hopeless victims of
their own abuse (SIRUS 2001). Proponents countered that methadone could
save drug abusers from humiliation and an early death while improving their
quality of life (Skretting 2001).

A three-year methadone-assisted trial project was initiated on 50 opiate
addicted drug users in Oslo in 1994. The program was based upon the
Swedish model which carries strict admission criteria, including opiate
addiction for a minimum of ten years and being over 30 years of age. In June
1997, the Norwegian Government established the development of a national
methadone program. The target group consisted of drug abusers for whom
progress had remained elusive with other forms of treatment. The primary
emphasis of the program was rehabilitation combining efforts to improve the
clients’ standard of living along with medical treatment. Criteria were re-
evaluated in 2000 and are currently less restrictive. Potential clients must be a
minimum of 25 years of age and heavily addicted to opiates for several years despite a reasonable amount of treatment (SIRUS 2001).

A national treatment center has been established in Oslo with regional coordinating agencies spread over four health regions. The treatment plan is based on cooperation between social centers and physicians. The potential client applies for admission through local social centers. Application must include an action plan outlining individual goals and necessary measures. In addition to methadone, Subutex, or high-dosage buprenorphin has also been approved for use. Trials using LAAM, a methadone-like medication with a longer half-life were performed in 2001 (SIRUS 2001). The program has expanded rapidly and was expected to service 1,600 clients by the end of 2001 (Waal et al. 2001).

The proportion of prison inmates serving time for drug use has been growing, but is thought to reflect only a microcosm of the drug problem in the general population. Prison authorities report some 40 – 60% of inmates use drugs at least once while in prison. Despite strict controls, there are large numbers of injection drug users in the prison system. Thus, drug use, along with the associated problem of HIV/AIDS presents a major problem for the Norwegian prison system. A major goal of the prison system is to provide both prison staff and inmates the greatest degree of protection with respect to HIV exposure. In an attempt to prevent the spread of HIV and related diseases, the State Health Authority has required prisons to make bleach available for the cleaning of used needles. However, there are no clean needle distribution
programs in the Norwegian prison system. Substitution therapy is made available to inmates who have already begun treatment so they may continue therapy while serving out their sentence. Substitution therapy may also be made available at the beginning of a sentence should the inmate satisfy program requirements (SIRUS 2001).

ii. Sociopolitical Environment in Norway: Currently, the “general consensus” among drug abuse experts, politicians and the general public is that any measures leading to the liberalization of drug laws should be rejected. Despite the sharp increase in the use of cannabis and amphetamine type stimulants, the vast majority of young people under the age of 21 oppose the use of illicit drugs (SIRUS 2001).

Although there has been minimal debate within the legislature, criticism has been raised against the existing drug policies of Norway. In recent years, the media in particular has focused in on the dramatic rise in the number of drug-related deaths and has called for more effective measures to limit drug associated mortalities. Critics often point to what they see as an uneven balance between the legal framework and the seriousness of the crime. Sentencing for non-drug related criminal behavior in Norway is considered mild, while the level of punishment for drug-related crimes is considered harsh. Additionally, citizens and attorneys have raised doubts regarding the effectiveness of the current penal system with respect to preventing drug abuse. Some in Norway have questioned whether the current restrictive drug
laws are counter-productive, in that they may lead to prison overcrowding and associated problems, such as the spread of infectious disease (SIRUS 2001).

It is generally viewed in Norway that harm-reduction measures directed at reducing the negative effects of drug abuse towards the abuser, their families and society as a whole are compatible with the general goal of treatment as full rehabilitation. However, the need for additional harm-reduction measures is seen as somewhat controversial, in particular, the establishment of public injecting rooms in protected environments. Before its' resignation in October 2001, the former Government concluded that public injecting rooms could be legally established in a limited number of municipalities on a trial basis. The new Government is awaiting commentary on the proposal before it acts (SIRUS 2001).

The issue of substitution therapy also remains controversial among both those seeking treatment and the drug rehabilitation community. Since the conclusion of a pilot study in 1997 involving 50 clients, the number receiving substitution therapy has risen significantly and was estimated to reach 1,600 by the end of 2001. Government investment in substitution therapy in Norway is based on the moral duty to improve the lives of those suffering as a result of chronic drug abuse. The viewpoint is that substitution therapy does not ignore the ethical dilemmas associated with replacing a lifelong addiction to one narcotic drug with another. Norway has been funneling increasing resources into substitution treatments primarily due to the fact that other rehabilitation programs have generated limited results (SIRUS 2001).
iii. Programmatic Details: In Norway, HIV testing is systematic for blood donors, pregnant women and patients with sexually transmitted infections (STI). Diagnosed HIV cases are reported in a national HIV database which utilizes an identifying code (WHO 2002).

The total number of HIV tests performed, excluding anonymous testing and testing of blood donations, (1997-2001), and rate of testing per 1,000 population (2001):

1997: 189,369
1998: 194,771
1999: 196,395
2000: 175,002
2001: 172,960

Tests per 1,000 population/habitants in 2001: 38.6

(European Centre for the Epidemiological Monitoring of AIDS 2002)

VI. Discussion

A. A Contrast in Policy and a Growing Problem

This section will contrast the drug policies of Finland and Norway with those of the Russian Federation. The overall approach to supply and demand reduction on both a national and local level will be addressed in each country.

The increase in drug experimentation along with related harms seen throughout the decade of the 1990's led to increasing concerns over the question of drug abuse in Finland. In response, an inter-administrative committee was launched in 1996, charged with creating a national drug strategy. A proposal was developed in early 1997 which ultimately led to the Government's Decision-in-Principle on Drug Policy in late 1998. Both
documents followed the recommendations of the United Nations by completely endorsing a well-balanced approach to drug policy. The drug strategy proposal initiated regional training in local municipalities that led to the planning of drug strategies assigning equal weight to both supply and demand reduction (STAKES 2001).

On a national level, the Decision-in-Principle resulted in a proposal for a drug research programme for the Academy of Finland in 1999. Additionally, local drug research programs composed of working groups charted new drug cultures among young people. Data compiled by these groups was used to plan preventive measures and proposals for developing drug treatment systems. Concerned Ministries included drug topics in their financial and action plans (STAKES 2001).

A joint meeting between the Academy of Finland and the Finnish Medical Society Duodecin convened in late 1999 to further develop a drug treatment plan. The outcome of the conference centered on a need to promote drug treatment and research. Similar approaches arose from working groups on young people’s drug prevention (2000) and drug treatment (2001) under the auspices of the Ministry of Social Affairs and Health. In addition, both the police and prison officials have produced their own drug strategies in line with the 1998 Decision-in-Principle, with demand reduction receiving equal consideration to supply-side measures (STAKES 2001).

The government of Finland has determined that drug use and related harms warrant a broad, multi-administrative national plan based upon the
1998 and 2000 Government Decision-in-Principle on drug Policy. The 2000 Decision enhanced the efforts of the 1998 Decision while providing for a supplementary budget for drug work. The primary objective of the 2000 Decision was to reduce both the supply and demand for drugs and to slow the growth of drug related crime. It proposed an action plan to integrate the anti-drug focal points of various agencies (Justice, Interior, Finance, Education and Social Affairs and Health) and allotted an additional 5.5 million (EURO), increasing the 2001 budget to 10 million (EURO) for drug control (STAKES 2001). The main components of the 2000 Decision included:

- *Anti-drug attitudes in society will be reinforced by targeting preventive drug information at the entire population*
- *Drug addicts will be given better possibilities for treatment and rehabilitation*
- *Drug offenders’ risk of getting caught will be increased; an effort will be made to ensure criminal liability in drug crime; and anti-drug work in prison will be promoted.*

(STAKES 2001)

In conjunction with the long-term plans outlined above, actions have been undertaken to solve current drug problems on both regional and local levels as well. Prevention has been focused on the life management skills of young people through the use of the media in combating drug use and early intervention in drug experimentation. A network of municipal coordinators provide drug training for prevention workers and plans exist for a nationwide drug information campaign subject to broad-scale evaluation (STAKES 2001).

On a national level, emphasis has been placed on enhancing the flow of information between components and increasing the availability of existing
data. Services have been developed to disseminate information among drug workers regarding research results, working methods, municipal drug strategies and anti-drug projects advanced by municipalities and other organizations. Telematics services in drug work, including drug information services, discussion forums and anonymous self-testing through the use of text messaging on mobile phones have also been developed. However, proposals involving mass screening for drugs have generated much public debate (STAKES 2001).

The development of treatment services for Finnish youth and low-threshold services in the treatment sector have been emphasized with the aim of involving clients in the treatment system as soon as possible. In addition, the position of harm reduction in treatment has gained wider acceptance, including the development of infection risk counseling as well as substitution and maintenance therapy systems (STAKES 2001).

Rehabilitation for substance abuse has been ongoing in Finnish prisons for approximately ten years. A three-year experiment begun in 1996 and ended in 1999 has resulted in effective drug treatment in prison and after-care for prisoners upon their release. The project produced a total of ten rehabilitation and training programs for use in prisons. Currently, rehabilitation for substance abuse is based upon structured handbook programs produced from a cooperative effort between the prison Administration and organizations in the field of drug abuse. The majority of these programs are based on several theoretical models, including cognitive behavior therapy, solution-
oriented approaches, community treatment or the twelve-step program. Generally, these programs involve a period of rehabilitation two to three times per week, life management skills, work and/or work training and learning to develop hobbies all of which support a drug-free lifestyle. Being multidisciplinary, prisons provide an excellent environment for the teamwork approach necessary to prevent relapse (STAKES 2001).

As in Finland, drug policy in Norway is based on a comprehensive, multidisciplinary approach. Demand reduction efforts such as prevention, treatment and rehabilitation are equally balanced with, and designed to reinforce, supply side measures. Throughout the decade of the nineties, the Norwegian government has increasingly emphasized the importance of developing a comprehensive “substance abuse policy”, with regard to prevention, care and treatment. The pragmatic implementation of the national drug policy is focused equally on demand and supply reduction, primarily through prevention (SIRUS 2001).

There has been a significant increase in the quality and extent of research results concerning substance abuse in Norway over the previous two decades. Thus, the Government of Norway has lent increasing support to efforts that seek to obtain knowledge in the substance abuse field and in turn, raise the level of competence among drug abuse professionals. With the challenge of increased access to and availability of illicit drugs, the government of Norway has made substance abuse policy a major priority (SIRUS 2001).
Since illicit drug abuse became a social problem in the 1960's, Norway has pursued a restrictive drug policy. The increase in drug possession and trafficking has led to discussions concerning the value of a restrictive approach. However, a government report released in 1996-97 clearly stated that liberalization would imply that society no longer considers drug abuse a serious problem. This would lead to an increase in the availability of drugs and consequent increase in abuse. The "Government declared that the ambitious goal of a drug-free society would be firmly upheld, as a necessary expression of attitude towards drugs (Innst.S.nr40 1998-99)." The Government also stressed that greater emphasis must be placed on prevention, not the least of which to be carried out within the framework of NGO's. The goal is to reinforce negative attitudes towards drugs through prevention (SIRUS 2001).

The primary responsibility of drug policy, that being prevention, care and treatment, lies with the Ministry of health and Social Affairs. The multidisciplinary nature of drug abuse has led the Ministry to appoint a drug policy panel to analyze the drug problem and coordinate specific aspects of drug policy. The national drug prevention field has recently undergone reorganization. This was done primarily to increase support to local communities, strengthen after-care programs and ensure broad and current access to knowledge and experience as a basis for strategic planning and policy development. Additionally, the reorganization was intended to strengthen research and education within the drug field. Beginning January 1,
2001, three central components of drug abuse prevention; research and documentation, education and competence and administrative tasks under went the following reorganization:

- The National Institute for Alcohol and Drug research (SIRUS)
- The Norway-Net consisting of seven regional centres of competence
- The remaining Norwegian Directorate for the prevention of alcohol and drug problems.

(SIRUS 2001)

Based on guidelines supplied on a national level, municipalities are responsible for both prevention and rehabilitation of substance abusers. The belief is that services should be anchored in the local communities where problems exist. Treatment is based primarily on the basis of voluntary, drug-free rehabilitation. Additionally, measures should be designed to meet the special needs of clients, such as pregnant drug abusers and those with children. Low threshold services are also given added priority (SIRUS 2001).

Substitution treatment for IDU’s has been available on a national level since 1998. Therapy is provided in specialized regional centers, but municipal health and social services are responsible for follow-up. A major effort has been made to clarify issues of organization, responsibility and financing in order to alleviate confusion among local doctors and social services. A revised model integrating substitution therapy into municipal health and social services was implemented in July 2001 (SIRUS 2001).

Substitution therapy using methadone and/or buprenorphin has become well established in Norway using a well functioning, regionally based
professional model with municipal and county cooperation. Opposition to substitution therapy is gradually being replaced with a consensus on the positive and negative aspects of treatment (SIRUS 2001).

Criminal care facilities in Norway work diligently to direct inmates to correctional programs addressing their problems with drugs. Both during and after serving sentence, prisoners are provided with opportunities to participate in various programs dealing with dependency. These programs include, but are not limited to:

- Contract sentences
- An alternative sentence in accordance with paragraph 12* of the prison law
- Drug dependency programs
- Life mastery programs
- The establishment of networks
- Probation groups
- Work experience within an institution
- Education
- Leisure activities
- Participation in the prison system’s work-furlough program

(*Prison law 12 provides that inmates with a drug problem may elect to be transferred to a treatment facility that meets the specific needs of the inmate. The law specifies that mitigating circumstances be present if the convicted person is to serve their entire sentence in a treatment facility.)

(SIRUS 2001)

Criminal care services also cooperate with a number of humanitarian, religious, sports, cultural and drug prevention organizations. These groups promote improved self-esteem and integration into leisure activities through outreach work and measures that promote various skills. Attention is given to
building and maintaining networks that help individuals establish themselves in drug-free environments before release (SIRUS 2001).

The development of HIV/AIDS has presented a major challenge for the prison system. It has been critical to ensure the greatest degree of protection with respect to HIV exposure for both inmates and prison staff. Intravenous drug use is relatively common in Norwegian prisons (it is estimated that 40-60% of inmates use drugs) despite strict controls. In an effort to prevent the spread of disease, the State Health Authority has required prisons to make chlorine bleach available for the cleaning of needles. However, there are no needle distribution programs in Norwegian prisons (SIRUS 2001).

Access to substitution therapy is provided to inmates that have already begun such treatment. In addition, inmates that fulfill admission criteria may begin substitution therapy while in prison (SIRUS 2001).

Since the breaking up of the Soviet Union in 1991, the Government of Russia has focused increasing attention on the expanding illegal drug trade in the country. Numerous measures have been taken both internationally and domestically to slow the rapid increase in illegal drug use. However, Russia has neglected the balanced approach to illicit drug abuse recommended by the United Nations. Current drug policy focuses primarily on supply side measures with little in the way of provisions or finances for demand side measures such as prevention, treatment and rehabilitation (MPI 2000).

Dr. Vadim Pokrovsky, Director of the Russian Federation AIDS Center estimates that as much as $65 million (US) is needed immediately to slow the
spread of HIV and to treat those already infected with HIV. However, the Russian Government budgeted only $5.1 million (US) for 2002 to combat HIV/AIDS. The Russian Government failed to submit a proposal to a new global AIDS fund which could have supplied as much as $27 million (US). Alexander Goliusov, Head of the Russian Health Ministry's HIV Infection and Treatment Department said that "while Russia contributed to the fund, we chose not to request aid like Ukraine, which like a beggar, has stretched out a hand for help" (Rodriguez 2002).

The fight against illegal drug use has been guided primarily by the Russian Criminal Code put into effect in 1997 and the Federal Law on Narcotic Drugs and Psychotropic Substances of 1998. The restrictive policies of these documents make it extremely difficult to grant exemption from criminal responsibility even for the possession of small quantities of drugs. This, in turn, makes it difficult to assign drug treatment in lieu of time in prison (MPI 2000).

The efforts of Russian law enforcement under these policies has led to a staggering increase in the number of reported drug offenses to 216,364 in 1999 from 16,255 in 1990. However, most of the recorded offenses (82.5% from 1990-1999) concerned drug users with no intent to distribute. Analysis of judicial sentencing shows that most of the individuals arrested and prosecuted for drug offences in Russia on a yearly basis are drug users, not dealers. According to Galinsky and Zobnev, 1998,
“the police prefer to arrest drug users rather than drug distributors because it is easier to do so. For the same reason, they prefer to detain and transfer to the courts mostly cases of addiction to narcotics, not the distributors of narcotics”.

(MPI 2000)

Many drug users are arrested and convicted for the “acquisition and keeping without purpose of sale of narcotic drugs” because the meaning of “large scale” established by the Standing Committee is so very low. The Research Institute of the Prosecutor General’s Office (RIPGO 2000) has presented data which supports the fact that,

“It must be admitted that in most cases the growth of drug offences is caused by the registration of drug users’ offences. This practice existed even earlier and it goes on up to now. Nevertheless, the criminal prosecution of drug users does not solve a problem, but, indeed, produces a worsening of the general situation. The vacant places of convicted drug users are rapidly occupied by new people and drug dealers multiply their profits and proceeds.”

(MPI 2000)

Thus, it appears that the primary targets of law enforcement and often police repression are drug users and petty dealers, those who do not pay the krisha, (protection tax) to police officers and other high-ranking officials (MPI 2000).

Anecdotal reports from drug users in Russia state,

“the law enforcement agencies detain either drug users or petty dealers, they make no effort to catch people involved on the upper levels of the drug distribution chain. For this reason, it is too early to say that the fight against drug trafficking goes on already” (MPI 2000).

“the impression that the police ‘close their eyes’ on the retail and wholesale distribution of drugs. The corruption of law enforcement is widespread. In order ‘to fulfill a target’, sometimes they look for an addict, maybe put heroin on him, and then arrest him. It is nearly always possible to buy one’s freedom. Indeed, they frequently put drugs on you, just to get the money” (MPI 2000).
The fear of those working for public drug treatment centers and NGO's is that restrictive drug laws and the focus of law enforcement on drug users may discourage users and addicts from seeking treatment. Ludmila Markoryan (Markoryan 2000), a drug worker, has stated,

“In my opinion, the new drug law does not solve the drug problem and may, on the contrary, worsen it, since it does not address the reasons of the spread of drugs, but only its consequences; it does not fight the drug business, drug trafficking and the drug dealers, but the drug users. As a result of this strategy, drug users go ‘underground’, trying to keep away as far as possible not only from law enforcement agencies, but also from medical help” (MPI 2000).

A key principle of Russian drug law is the supposed priority on preventive measures for drug abuse along with the development of treatment and rehabilitation. Article 54 of the federal drug law states that “the state guarantees help to drug addicts, including examination, consulting, diagnostics, treatment, and social-medical rehabilitation.” However, due to budgetary restraints, only a portion of Article 54 has been implemented. Narcologists, drug treatment providers and the staff at state and foreign run NGO’s agree that more needs to be done in the areas of prevention, treatment and harm reduction. A lack of funding has prevented the inclusion of a provision for the “social and medical help for drug addicts” in Russian law (MPI 2000).

For the most part, state run drug treatment centers have been unable to deal with the recent explosion in drug use. They lack the “financial, material and human resources” even to fulfill the tasks charged to them under Russian drug law. Anecdotical information obtained from drug users in Moscow, St.
Petersburg and Vladikavkaz report that it is "common practice to pay for services that should have been obtained gratis." Additionally, the fear of being reported to authorities keeps many drug users from seeking help at state run drug treatment centers. Ironically, this leaves many public facilities operating below capacity. According to Eliko Ciklauri at the North Ossetian Narcological Center (Ciklauri 2000),

"the technical equipment of the state centres and the supply of medical drugs are described as very bad by the local Ministry of health, and the heads of the centres. The quality of treatment is decisively conditioned by these factors despite the high costs of treatment, which the user must pay themselves. Most drug addicts simply cannot afford to start long-term treatment. The consequence is that even the limited capacity of these centres is not employed. In January, 2000, most of the 20 places for drug users were not occupied" (MPI 2000).

Though present in virtually all Russian cities, private drug treatment centers fall woefully short in their attempt to compensate for the flaws of the public centers. In addition, private centers must operate contra legem, as Russian drug law clearly states, "medical treatment of drug addicts is done only in state and municipal health institutions" (Art. 55). Although popular because they offer the guarantee of anonymity, private facilities remain a viable alternative only for those able to afford up to $200 (US) per day for treatment (MPI 2000).

Russian drug law also severely limits drug prevention activities. Most state institutions lack sufficient funds for drug information and prevention activities. However, the law prohibits international organizations and NGO's from providing these services. Article 46,
"forbids all forms of drug propaganda whatsoever; any activity, performed by citizens or organizations, that spread information about the production and use of narcotic drugs, psychotropic substances, and their precursors and the places where these substances are sold. It is also forbidden to spread and distribute this information in computer networks, mass media and it is forbidden to spread or distribute books and leaflets with the above mentioned information" (MPI 2000).

Harm reduction interventions used to inform drug users of the risks associated with drug use and the teaching of risk reduction strategies are made extremely difficult under this law. Though many harm reduction programs have received permission from local city and regional administrations, many report interference from police. Along with needle exchange, the Moscow Office of UNAIDS considers these programs vital to reducing the spread of HIV among drug abusers. Despite the lack of funding, most experts in the field of drug abuse agree that drug prevention, treatment and harm reduction should be given at least equal weight to supply side measures such as drug trafficking (MPI 2000).

B. Analysis of the Situation

This section contains an analysis of the impact of drug policy on the epidemiological situations in Russia, Finland and Norway. This paper will attempt to demonstrate cause and effect between the national approach to injection drug use and the incidence of HIV/AIDS and related infectious diseases in each of these countries.

Clearly, both Finland and Norway have adopted a well balanced approach to drug abuse, while the Russian Federation has not. For the most part, Finland and Norway have chosen to follow the UN guidelines which
recommend equal attention be paid to demand and supply side efforts, with a heavy emphasis on prevention and treatment. Despite pursuing a restrictive drug policy, Norway has not lost sight of the importance of including harm reduction as part of their overall strategy. Both governments have shown to be receptive to new ideas while actively involved in the research and education necessary to evaluate new theories and make policy decisions. Russia, on the other hand, is mired in a draconian approach to drug abuse, hampered by a lack of organization and funding with a heavy dose of corruption thrown in for good measure.

With a health care system based on the Nordic welfare policy, Finland and Norway have effectively controlled both drug use and the incidence of HIV/AIDS and related infectious diseases. A balanced strategy with equal resources devoted to both supply and demand reduction has enabled these countries to check the emerging outbreak of HIV, TB, hepatitis and STI’s among injection drug users in the late 1980’s. The proactive implementation of harm reduction strategies, including a heavy emphasis on prevention, treatment, rehabilitation and maintenance (after-care) has kept prevalence rates low among IDU’s. Incidence rates of HIV and related disease have been in decline since 1996.

Despite relatively strict supply side drug policies, the governments of both Finland and Norway moved quickly to embrace harm reduction strategies at the first sign of an epidemic of HIV and related infectious diseases in the mid-1980’s. Both countries commissioned committees to analyze the situation
and make recommendations to address the looming outbreak. Equally as important, legislation was rapid and budgets were established to put their plans into effect. Beginning often as pilot programs in potentially high risk areas, harm reduction strategies pre-empted a possible HIV outbreak among injection drug users which has successfully kept incidence rates low.

Prevention based information campaigns sounding the associated risk of HIV and related infectious diseases among IDU’s quickly sprang up throughout both countries. Information campaigns targeted wide sectors of the population including police, school administrators, teachers, psychologists and other medical professionals and the media. Information about the risk of HIV was distributed among the IDU population. Syringes and needle-exchange programs became widely available along with information regarding the disinfection of drug use equipment. Voluntary and confidential HIV testing was made readily available. Treatment centers were established and continue to expand their role. IDU’s arrested for drug use are given the option of a treatment facility in lieu of prison. Those completing treatment are provided with follow up rehabilitation, especially those IDU’s which are HIV positive (Aavitsland 2001).

The aggressive approach to harm reduction has enabled both Finland and Norway to keep a potentially devastating epidemic at bay. HIV/AIDS and related diseases do not limit themselves to the driving population. Eventually, these diseases will spread to the general population with a potentially dramatic effect on the health and vitality of a nation.
However, Finland and Norway have not had to deal with the social upheaval created by the break up of the Soviet Union as seen in Russia, which in turn, has spawned an outbreak of injection drug use and related infectious disease. The dramatic rise in HIV/AIDS among injection users noted in 1997, which has continued to this day, has gone hand in hand with the social and economic upheaval associated with the rise of independent states from the former Soviet Union. The rapid collapse of the Soviet Union has brought about a systematic transformation rarely seen in recorded history. The difficult transition from a socialistic to a free market economy has come at a high social cost. Economic inequality has spread throughout a population once dependent on the state leading to an overall decline in the standard of living.

Although discouraging individualism and motivation, the heavily localized industry of the former Soviet Union at the very least provided social structure in areas such as employment, education and health care. The fact that this support system vanished almost overnight has left the public with little time to make psychological adjustments. Thus far, the private sector has been unable to compensate for lost production and provide services once supplied by the government. The burden of providing a social support structure has been shifted from the state to individuals (DET 1999).

The declining standard of living coupled with a growing list of social problems has spread to the health care system as well. The decline in Gross Domestic Product (GDP) has caused Russia to make drastic cuts in health
care spending. Thus, health policies have been unable to stem the rising tide of health concerns, including, alcoholism, cigarette smoking, drug abuse and associated infectious diseases.

In particular, the social upheaval found in Russia has created an atmosphere conducive to the spread of HIV/AIDS and related infectious diseases such as TB, hepatitis and other STI's. Factors such as widespread poverty, increasing gaps between the wealthy and the poor and subsequent economic migration have resulted in the disruption of family support systems, education and health care. The shift in ideology from communism to individualism has spawned an increase in risk-taking which has translated into unsafe sexual practices and drug use (DET 2001).

Large increases in the number of children who no longer live with their parents are a function of the growing disillusion, hopelessness and loss of purpose among Russian youth. Many have sought respite through criminal activity or escape through alcohol and drug use. The combination of strong demand for and easy access to illegal drugs has resulted in a dramatic rise in drug abuse. Practices associated with drug use including drug preparation and injecting practices along with rising prostitution has led to the increased risk of contracting HIV. The socioeconomic crisis has also spawned a dramatic rise in the prison population which is at great risk of HIV due to sex and drug use (DET 2001).

The epidemic of HIV/AIDS and related infectious diseases cannot be blamed solely on Russian policy or the lack there of. Rarely in history has a
population had to cope with such rapid changes in social structure of a nation. However, the response of the Russian government to this growing catastrophe has thus far, been woefully inadequate. The lack of effective legislation has allowed the incidence of HIV/AIDS, driven primarily by injection drug use, to increase at a rate unequalled anywhere in the world.

The legal response to the acceleration of drug abuse in Russia has been to assume a highly restrictive approach with a heavy emphasis on supply reduction. In 1998, Russia passed comprehensive Federal Law on Narcotics and Psychotropic substances including the criminalization of the purchase and/or possession of illegal substances, even without the intent to distribute. The laws clearly emphasize law enforcement strategies to increase police powers, especially in the area of trafficking. However, institution of policy remains difficult in an unstable political and economic climate. Available funds for demand side measures such as treatment and prevention are minimal at best. Virtually no programs have been established for prevention and treatment outside of existing compulsory treatment in under funded government institutions (Fedworld 2000). Policy decisions and actions taken in the coming years will ultimately determine if the current epidemic of HIV in the Russian Federation and other countries of Eastern Europe continues its explosive growth rate (UNAIDS 2001).

With regard to drug policy, the Russian Constitution has modeled itself after the United States in an effort to strengthen cooperation with the US. Much of Russian drug law is prescribed by the US in exchange for financial
help. The United States has, and continues to encourage Russia to develop a comprehensive strategy based primarily upon supply reduction. In return, the US provides funding, training, personnel, equipment, technical assistance and law enforcement advisors. The emphasis on supply side measures has brought questionable success in politically and economically stable countries such as the United States. Employing such strategies in an unstable region such as the former Soviet Union has only worsened the growing epidemic of drug abuse and related infections.

Restrictive drug laws coupled with a serious lack of funding has bred corruption among law enforcement personnel. Fear of the police sends many drug users “underground” and hinders the few examples of harm reduction practices in effect, such as needle exchange programs, education, treatment and rehabilitation.

Russia has struggled with an ineffective criminal justice system since the break up of the Soviet Union in 1991. Only after a small pilot program in Moscow in 2002, has Russia instituted jury trials. For example, the Siberian city of Izhevsk held its’ first jury trial in over 85 years on February 17, 2003 (Wines 2003). Currently, the accused often spend long periods in jail awaiting trial in a prison system highly conducive to the spread of drug abuse and infectious disease.

Thus, the tightening of drug laws has yet to quell the explosion in drug use since breakup of Soviet Union, particularly since 1997. In fact, one might argue that Russian drug policy has been counter productive in that while
failing to curtail drug use it has fanned the flame of HIV and related disease. The explosive growth of substance abuse throughout the Former Soviet Union has facilitated an epidemic of HIV, Hepatitis, Tuberculosis and STI's such as syphilis, gonorrhea, chlamydia and trichomoniasis. Failure to control these epidemics will surely lead to a second epidemic in the not to distant future among the non-injecting population through sexual transmission. Recent evidence of a possible leveling off in this epidemic will likely be offset by a secondary outbreak among heterosexuals, particularly females. An explosion in drug use is often followed by an explosion in prostitution as individuals seek ways to support their habit. HIV and other diseases spread from addicts to prostitutes and finally to the general population.

This is a tremendous concern not only to Russia and the countries of the former Soviet Union, but to Border States which include Finland and Norway. Prevention based programs encompassed in the Nordic Welfare policy which have kept prevalence rates relatively low and incidence rates declining may go for naught as disease spreads from northwestern provinces of Russia into Scandinavia. Immigration for prostitution and search for work can spread disease which can potentially spread throughout the general populations of these countries. The potential for such a disaster is real, as evidenced by the HIV epidemic among injection drug users and sex workers in the Northwestern territories of Russia.

Many in Russia feel that while they agree drug use is a problem, there are many more pressing concerns facing their country. Much of Russia
suffers from public disinterest with the drug problem citing "bigger problems", such as the economy and the ongoing war with Chechnya. However, this may prove to be a short-sighted approach, which shows a serious lack of understanding of the new social issues facing the country. The marginalization of drug users is likely to produce effects on the economy which may be staggering for years to come as this crisis affects primarily the young (18-24). World Bank experts forecast economic damage through 2020 based upon current rates of HIV infection (AP 2002).

The difficult transition from socialistic to free-market economy has spread to health care as well. One of the most significant social consequences of the break up of the Soviet Union has been the virtual collapse of the health care system. While Soviet-era conditions were poor, marked by uneven standards of care, current problems are more basic. Public hospitals and clinics lack even the most basic equipment and medicine (NY Times 2001). The decline in health care is occurring in the face of increasing rates of infectious diseases as outlined in this paper. Some within the health care community have speculated that Russia may not be ready for a free market health care system and would be better off at this point to maintain a socialistic health care system (Garrett 2001).

VII. **Recommendations: A New Approach for the Russian Federation**

This section will provide an overview of successful science-based harm reduction strategies which have been employed throughout the world. It will then provide a model based upon these strategies which can and should be
implemented in the Russian Federation to reduce the harm associated with injection drug use.

There is ample evidence that supply side reduction is ineffective in quelling substance abuse. Expensive and often counterproductive law enforcement continues to be the primary international response to illegal drug use. Reliance upon criminal penalties often results in the violation of the human rights of injection drug users. These policies eventually lead to poor health outcomes in this population. The complications of injection drug use, as alluded to in the previous section, have become more serious. It is estimated that 5 to 10 percent of global HIV infections are transmitted through contaminated needles and through sexual contact between IDU’s and their partners. These figures reach as high as 90% in urban areas and in areas of the Russian Federation such as the Murmansk and other northwest territories (Aavitsland 2001). Therefore, HIV prevention and control among IDU’s is essential to both their health and to control the spread of HIV to the broader public (Wodak 1998).

Several promising risk reduction strategies have been employed throughout the world. Ethnographic studies of IDU’s in major HIV epicenters have demonstrated that drug users who were knowledgeable about the risks associated with intravenous drug abuse employed behavior changes to reduce their risks. Conversely, laws and regulations restricting the sale, distribution or possession of syringes made it difficult for users to obtain sterile syringes (Needle et al 1998).
Needle et al (1998) cite over 36 studies reporting significant reductions in HIV risk behaviors in IDU's who participated in community-based outreach programs. Community-based outreach programs are an effective public health strategy to reach “underground” IDU populations to diminish their risk behaviors and consequent risk of HIV/AIDS. Since most IDU’s (85%) are not in drug treatment on any given day, they are at significantly greater risk of HIV infection since they are more likely to inject drugs and to share drugs and injecting equipment (Needle, et al 1998).

The hiring and training of indigenous members of a community (mostly former heroin addicts) to provide outreach to active IDU’s in heavy drug use areas has been successful in the United States and other countries. Trained, mobile teams of indigenous outreach workers are able to access, engage and intervene with IDU’s not in treatment within their own communities. Once trust and rapport has been established, risk reduction activities can be established in a neighborhood setting. This intervention strategy enables trained personnel to reach IDU’s who are either unable or unwilling to access drug treatment and change their behaviors associated with the risk of HIV/AIDS (Needle, et al 1998).

Vlahov and Junge (1998) reviewed scientific findings indicating that needle exchange programs have substantially positive effects on the prevention of adverse health consequences associated with injection drug use, do not promote drug use and do not pose a risk to the non-drug using public. They concluded that if the legal penalties associated with the purchase
and/or possession of syringes were removed, IDU's would modify their behaviors to reduce the spread of infection. As a significant number of needles and syringes are exchanged (and removed from circulation), the frequency of exchange increases and the circulation time decreases. Empirical studies have demonstrated that a decline in the circulation time of needles and syringes is associated with a decline in the infection rate of returned syringes, a decline in the probability of infection and a reduction in the frequency of needle sharing among program participants (Needle et al 1998).

According to Heimer, HIV transmission among IDUs is influenced mainly by four factors: (1) the prevalence of active infection within a community, (2) infectivity given injection with a contaminated syringe, (3) durability of the virus inside the syringe, and (4) the level of sharing among IDUs (Needle et al 1998). These four factors can then be incorporated into a mathematical formula which characterizes incidence rate. Therefore, the incidence rate of HIV among IDUs is equal to the rate at which needles are shared, multiplied by the probability of using an infected syringe, multiplied by the rate at which needle/syringe exposure transmits the infection (Needle et al 1998). This model is useful in targeting the elements which have the most significant impact on incident rates.

Metzger and colleagues note cumulative evidence that drug treatment provides protection against HIV because drug abusers who enter and continue treatment ultimately reduce their drug use and corresponding drug-related risk
behaviors, such as the sharing of needles and sexual risk behaviors. Injection drug users who enter substitution therapy early and remain in treatment have lower HIV rates than those who do not enter treatment or drop out. Drug treatment is a necessary component of a comprehensive prevention program to assist at-risk populations in changing their behaviors and reducing their risk for HIV. Clearly, drug users in treatment are less likely to inject drugs and therefore, less likely to be exposed to HIV. Thus, there is a need to increase the capacity of drug treatment for injection drug users (Needle et al. 1998).

Empirical data provides evidence for the complementary roles of community-based outreach, needle/syringe exchange programs and drug treatment in HIV prevention. Community based outreach provides access to communities of drug users to prevent HIV. Needle and syringe exchange programs provide sources for the referral of IDUs to drug treatment, which are ideal mechanisms for delivering HIV prevention interventions. Retention in drug treatment has proven to be a strong predictor of a positive outcome. Des Jarlais and Friedman conclude from their assessment of HIV prevention strategies that “the most important barrier to reducing HIV transmission among IDU’s is not a lack of knowledge but the failure to implement effective prevention programs in many parts of the world” (Needle et al 1998).

These studies indicate that prevention and science-based interventions have been effective in reaching at-risk populations enabling them to reduce their risk of acquiring HIV, Tuberculosis, Hepatitis and other sexually transmitted diseases. These strategies underscore a need to anticipate the
changing dynamics of the interrelated epidemics of drug abuse and HIV and effectively respond to prevent the further spread of HIV and other related diseases. Research indicates that the spread of disease in the drug-using population and beyond is clearly preventable through effective harm and risk reduction programs not supply side legal interventions (Needle et al 1998).

Therefore, based on the evidence gathered thus far, it is the recommendation of this paper that the Russian Federation put into place the following strategies to reduce the rate of HIV and related infectious diseases in the injection drug use population:

1) Create an environment where the principles of Harm Reduction can not only be put into practice, but do so without government interference.
   - Facilitate the establishment of community-based outreach programs run by non-governmental organizations.
   - Police should allow IDUs to keep their injecting equipment and not interfere with needle/syringe exchange programs.
   - Reduce the penalties for the possession and use of small amounts of drugs to allow IDUs to participate in harm reduction programs and to limit prison overcrowding.
   - Make the increase in the funding of and accessibility to drug treatment centers a high governmental priority.
   - Legalize substitution therapy.
   - Provide anonymous HIV testing free of charge.

2) Encourage the establishment of community-based outreach programs run primarily by non-governmental organizations.
   - Assemble and train a group of indigenous workers to engage injection drug users within their own communities.
   - Establish a set of behavioral options and the means for behavioral change to reduce the risk of HIV
   - Behavioral options should constitute a hierarchy which includes: stop injecting drugs, if you cannot stop, do not share injection equipment, if you must share, disinfect with bleach.
   - Disseminate information on safer drug use and bleach.
   - Disseminate information on safer sex and distribute condoms.
• Provide referrals to community-based programs for anonymous HIV testing and counseling, drug treatment and other medical and social services.
• Peer driven intervention can reach a large and diverse population of IDUs and is cost effective.

3) Expand the presence of needle/syringe exchange programs (NEP/SEP)

• Encourage pharmacies to continue to make clean needles and syringes available at modest cost to the injecting population.
• Establish a wide variety of satellite exchange locations in addition to local pharmacies, including fixed sites (drug treatment centers, storefront clinics) and mobile vans. Satellites create large transaction networks thereby extending coverage and effectiveness.
• Increase the hours of operation of fixed and mobile sites.
• Vary the exchange ratio, e.g. two new needles/syringes for each used one.
• Provide information about safe injection techniques using bleach.
• Provide referrals to drug treatment centers.
• Provide information regarding safe sex practices and make condoms available.
• Provide ancillary services such as anonymous HIV testing, counseling, crisis intervention and screening for TB, hepatitis, and other sexually transmitted infections.

4) Establish network paradigms which represent social interconnections between individuals and groups among the IDU population.

• Shift the perspective from examining risk behaviors from an individual perspective to examining them as behavioral transactions between and among individuals and groups.
• Focus on the context in which drugs are procured, prepared, mixed and shared.
• Focus on sexual risk-taking behaviors.
• Network approach can be used to identify key players within the injecting community. These individuals may then be recruited to intervene with members of their IDU and sexual risk-taking network.
• Network characteristics will affect behavioral practices and ultimately the risk of HIV transmission.
5) Increase the public awareness of HIV and its risk factors.

- Spread knowledge about HIV and reduce the general public’s fears associated with contact with HIV positive individuals.
- Strengthen the self-esteem of HIV infected individuals.
- Employ the mass media to “de-mystify” HIV. Depict HIV infected individuals as productive members of society.
- Strengthen HIV information in schools, churches and other social organizations.
- Strengthen training about injection drug use and associated risk factors among law enforcement personnel.
- Encourage the development of organizations and support groups for HIV infected individuals.
- Provide access to anonymous HIV testing.

6) Address overcrowding and other risk factors for HIV and related infectious diseases in the prison system.

- Eliminate the use of “SIZO's” or pre-trial detention centers for accused illegal drug users.
- Distribute information to drug users in prison about HIV and safe injection practices.
- Establish needle/syringe exchange centers in prisons, which would also make bleach available for disinfection of injecting equipment under controlled conditions.
- Distribute information on safe-sex practices and make condoms readily available.
- Provide anonymous, voluntary HIV testing for prisoners.

7) Develop and implement public health strategies to control TB, hepatitis A, B & C and sexually transmitted infections.

- The risk of sexual transmission of HIV is increased in the presence of syphilis or gonorrhea.
- Individuals with hepatitis and/or tuberculosis will likely have compromised immune systems which are less able to control the effects of HIV.
- High-risk centers should implement free and accessible diagnostics of hepatitis A, B & C, TB and STI’s through the use of community-based outreach, drug treatment centers, clinics and NEP/SEPs.
- High-risk centers should implement free, single-dose (where applicable) treatment for these diseases through the use of
community-based outreach, drug treatment centers, clinics and NEP/SEPs.

- Provide vaccination against hepatitis A and hepatitis B free of charge to all injection drug users.
- Increase the coverage for Directly Observed Treatment, Short-Course (DOTS) for tuberculosis with the goal of 100% coverage.

8) Establish partnerships with groups in Finland and Norway to provide assistance with the development and implementation of these strategies.

- Partnerships may provide advice and perhaps funding for setting up and running community-based outreach programs, drug treatment centers, clinics, NEP/SEPs, networks, etc.
- Partnerships may provide advice and perhaps funding for educational materials.
- Partnerships may provide advice and perhaps funding for diagnostic equipment and antibiotics.


Clearly, the implementation of these strategies will not be easy and will require a substantial monetary investment from the Russia Government in addition to their support. However, there is ample evidence that the science-based interventions listed above have been effective in reaching at-risk populations, enabling them to reduce risk behaviors and consequently, their risk of HIV infection. HIV transmission among the injection drug using population is preventable.

**VIII. Conclusions**

The treaties of the 60's, 70's, 80's and 90's were designed to provide enforceable international law with which to control the use of illegal drugs. Early drafts relied primarily on supply side measures with a heavy emphasis on drug control through law enforcement. Over numerous iterations,
culminating with the 1998 Drug Summit, a gradual paradigm shift towards
demand side measures, which seek to reduce the harms associated with drug
abuse, can be noted. The demand side approach encompasses harm
reduction strategies, which include an emphasis on prevention, treatment,
rehabilitation and maintenance (after-care). Despite this ideological shift, most
countries continue to devote the majority of resources towards supply side
measures. This strategy flies in the face of mounting evidence that supply
side measures do little to quell drug abuse and may even contribute to the
harms associated with high risk behaviors such as injection drug use. The
connection between injection drug use and the spread of infectious diseases
such as HIV, TB, hepatitis and other sexually transmitted infections is clear.
On the other hand, empirical data continues to support the efficacy of harm
reduction strategies in limiting the transmission of infectious diseases
associated with injection drug use.

Thus, world wide drug use continues to increase along with the
associated harms. And no where is this calamity more evident than in the
Russian Federation. Despite the stiffening of penalties under the 1998
Russian Law on Narcotics and Psychotropic Substances, drug abuse
continues to spiral out of control. Socioeconomic factors associated with the
break up of the Soviet Union in 1991 have given rise to an epidemic of
injection drug use. The rise in injection drug use has paralleled an equally
dramatic rise in the incidence of HIV/AIDS. Nationally, 54% of HIV infections
are transmitted through injection drug use, with figures as high as 90% in
localized areas. Concomitant rises in the incidence of associated infectious
disease such as TB, hepatitis A, B & C, and sexually transmitted infections
have jumped on board.

The situation in Russia is in clear contrast to that of neighboring Finland
and Norway. While publicly reinforcing the ideals of a “drug free society”, both
Finland and Norway have been relatively quick to embrace the components of
harm reduction. While maintaining strict drug laws, the emphasis of both
governments has focused on demand side strategies which seek to limit the
harms associated with drug abuse. Prevention strategies, accessible
treatment for drug use and infectious diseases, rehabilitation and maintenance
have been the focal point of the national public health strategies in these two
countries. The result has been low and stable incidence rates of HIV, TB
hepatitis A, B & C and other sexually transmitted infections.

The national epidemic of injection drug use will surely wrought
devastation on the fledgling capitalist economy of Russia. Centered on the 16
– 24 age groups, the effects of this outbreak will surely be felt for years to
come. Another concern is that the burgeoning epidemics of drug abuse and
related infectious diseases in Russia will spill over into neighboring countries
such as Finland and Norway. Thus, while it is apparent that the Russian
Federation needs to develop a public health approach which embraces the
strategies outlined in this paper, it behooves the countries of Finland and
Norway to assist in any way possible.
The grace period for the development of an action plan has come and gone. The time is now for representatives from these three countries to form a tri-national public health committee to address this problem. The transmission of HIV and related infectious diseases through injection drug use is clearly preventable, but only if the tenets of harm reduction are embraced on a national level and in a timely fashion.
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