STATE RESPONSE TO THE HIV/AIDS EPIDEMIC IN RUSSIA:
INSTITUTIONAL FACTORS

A Dissertation
Submitted to
the Temple University Graduate Board

In Partial Fulfillment
of the Requirements for the Degree
DOCTOR OF PHILOSOPHY

by
Elena Sokolova
May 2016

Exchanging Committee Members:

Hillel Soifer, Department of Political Science
Sandra L. Suarez, Department of Political Science
Richard Deeg, Department of Political Science
Jennifer K. Ibrahim, College of Public Health
ABSTRACT

In the second half of the twentieth century, political scientists observed a remarkable increase in policy convergence across disparate issue areas. The literature on policy diffusion suggests that countries are likely to converge around internationally accepted norms of behavior. These include, for example, public health policies designed to deal with epidemics such as polio, tuberculosis, SARS, and HIV/AIDS. Most countries treat these epidemics in similar and in some cases almost identical ways. States where epidemics emerge relatively late are at an extraordinary advantage. They not only have the expertise of a number of international organizations and their technical assistance at their disposal, but also the experience of other states. Once successful policies to address such epidemics are identified, many states choose to adopt these approaches. However, when it comes to the prevention of HIV/AIDS, Russia’s policy is an outlier. While the Russian Federation is facing the fastest growing HIV/AIDS epidemic in Eastern Europe, it remains one of the few states that refuses to implement key interventions. The goal of this dissertation is to examine why this is the case. I investigate the role of domestic factors in shaping HIV/AIDS policies in Russia. Existing literature suggests that the political regime, the development of civil society, and patterns of federalism are some of the factors that might explain variation in state responses to the HIV/AIDS epidemic. In contrast, I demonstrate that path-dependent factors, such as the influence of the medical epistemic community and the politics of morality, account for the absence of HIV/AIDS policy diffusion in Russia. I argue that in the Russian Federation, HIV/AIDS prevention policies are undermined due to lack of state will and centralized authority. Therefore, individual agencies conduct interventions without a specific mandate to prioritize a
response to the HIV/AIDS epidemic. These agencies design and implement interventions in accordance with their established priorities, norms, and practices, which are strongly path-dependent. In particular, I show that institutionalized influence of the domestic medical epistemic community and the politics of morality on policy-making processes prevent the adoption of best practices in Russia’s response to the HIV/AIDS epidemic.
ACKNOWLEDGMENTS

I am indebted to my friends, teachers, mentors, and family for helping me succeed in graduate school and finish this dissertation. I am grateful to my colleagues who accompanied me through the ups and downs of graduate school life. I am also grateful to those who inspired me to pursue this path in the first places and who believed that I would succeed in my endeavors.

My dissertation advisors, Hillel Soifer and Sandra Suarez, guided me through this dissertation project from its very beginning. Hillel Soifer was always willing to discuss potential ideas for the project, provide detailed feedback on all of my drafts, and help with the methodological aspects of the dissertation. He spent many additional hours during a directed reading seminar discussing ideas in comparative politics. He helped me to break this big project into manageable parts and locate new ideas in times when it felt like new ideas or motivation would never come. Hillel also helped me to develop greater discipline in the process of writing by persuading me to set and comply with self-imposed deadlines. I am grateful to Hillel for his patience, support, encouragement, and guidance.

Sandra Suarez provided support for the project, encouraged me to pursue fieldwork in Russia, brainstormed ideas with me, helped me to think about the broader theoretical framework and, most importantly, helped to see a bigger picture beyond this dissertation. Her enthusiasm about my project and my development as a scholar has been of a great support while writing this dissertation. Beyond that, Sandra Suarez helped me to improve my teaching and showed me how to construct beautiful sentences in academic writing.

I am also very grateful for the useful suggestions from my other committee members, Richard Deeg and Jennifer Ibrahim. I thank Richard Deeg for chairing my
defense and for being a third reader for this dissertation. I am grateful for his questions and comments that helped me think about how to advance this research further. Jennifer Ibrahim, an external examiner of my dissertation committee, gave me insightful feedback and helped me to think about the public health aspects of my dissertation more rigorously.

I thank other professors with whom I worked at Temple University and who were helpful in developing ideas towards this dissertation and building research and writing skills: Mark Pollack, Orfeo Fioretos, Sean Yum, Meghan Mullin, Ryan Vander Weilen, Kevin Arceneaux, Heath Fogg Davis, Michael Hagen, Robin Kolodny, Gary Mucciaroni, and John Masker. I especially thank Roselyn Hsueh for being an excellent mentor, discussing research ideas with me, showing me how to conduct interviews, sharing with me how to overcome challenges that women face in academia, and for being supportive of my pursuits.

Ariadna Alexandrovna Petrova, my undergraduate advisor at St. Petersburg State University, has been an unwavering supporter of my academic pursuits and encouraged me to follow the academic path further. I am grateful for her friendship and encouragement.

I am also grateful to have a group of supportive colleagues who made this path a worth-while endeavor. I thank them for their friendship, help, support, and also for discussing ideas, reading drafts, providing feedback, and simply sharing this path. I especially want to thank my theory colleagues, whose ways of teaching, doing research, building human connections, and thinking about justice have been inspirational to me. I am grateful for Alex Melonas, Desiree Melonas, Susan Alunan, Brett Miller, Erin Maher,
Brinn Cassidy West, and Ashish Vaidya. I also thank Gorana Draguljich, Justin Murphy, Arnold Kim, Heather Bosak, Stefanie Kasparek, Meghan Rubado, John Hebert, Amanda Milena Alvarez, Aja Binette, Arnold Kim, Nick Anspach, Pat Amberg-Blyskal, Everett Vieira, Theresa Cotter, Lauren Farmer, Daniel Scherer, Caroline Tynan, Michael McCarthy, Josh Leon, Krystina Litton, and Merim Baitimbetova.

I thank the Political Science department for supporting conference travel and providing me the opportunity to further expand my research skills at the Institute for Qualitative and Multi-Methods Research. I also thank the department and Graduate School for grants that helped me to have uninterrupted time to work on the dissertation manuscript.

The Open Society Foundation provided funding to conduct interviews in Russia, which were crucial to the success of this project. I am grateful for the opportunity, provided by the Open Society, to participate in a conference in New York, where I had an opportunity to present my research and connect with other scholars from Eastern Europe and former Soviet States.

I thank Vladimir Zolotov for helping with the logistics of my fieldwork in Moscow. I thank the People’s Friendship University of Russia, which provided me with accommodations during my stay in Moscow.

My writing greatly improved with the help of tutors at Temple University's Writing Center. Leslie Allison and Lorraine Savage do an excellent job of making the Writing Center a valuable resource for graduate students and the friendliest place on campus. I thank writing center tutors, Mark Emerick and Deirdre Kellher, for readings drafts of all chapters in this dissertation, for patiently helping me to formulate my ideas,
and for introducing me to the intricacies of writing in English. I received other invaluable support in writing from Anne Louise Antonoff and Louis O’Neill, who read drafts of my applications and papers. I would also like to thank Ariel Weiss, my Alexander Technique teacher, who made sure that I do all my writing with a proper posture. I also thank Talya Escogido for teaching me wisdom and for her advice, insights, and support.

It was only with the love and support of my friends and family that I was able to pursue graduate school and finish this dissertation. They helped me stay focused and cheered me up on the gloomy days—for that reason I believe it takes a village to write a dissertation. I will never be able to adequately return their kindness.

I thank Omur Arslan, my greatest champion, for sharing experiences in Philadelphia, reading everything that I write, and being my most supportive friend and partner. I thank Lyuda Dunayeva for being my friend for as long as I can remember, with whom I can confide in pretty much anything.

I also am grateful to have met friends in Philadelphia who shared with me many adventures and with whom many memories were created—Arjun Bhgavata, Kseniya Gorbenko, Kevin Gruenfeld, Igor’ Safonov, Andrew Wrigley, Sundeep Kaur, Maria Kozitska, and Suzan Tandojo. I thank Alfonso for his wonderful spirit. My wise friend and mentor Gabor Solano has always been a support and inspiration.

My friends in Russia patiently waited for me to finish the dissertation, occasionally visited me in the US, made me feel as if I have never left during my short visits home, and believed that graduate school is a worthwhile endeavor. I am very grateful to have in my life Natasha Somova, Veronika Somova, Andrey Krylov, Lesha Evstafiiev, Dima Matenko, Lena Petiforova, Nadya Vasilyeva, Alyona Sukhanovskaya,
Anya Serova, Anton Lyutynskiy, Olya Vorobyeva, Lena Leshko, Lesha Bratakhin, and Artyem Zhirnov.

I also want to thank my family. My mom’s Yevgeniya eternal enthusiasm and unconditional love made me believe that anything is possible. I particularly thank her for introducing me to English in the third grade. I am grateful to my late father Nikolay for showing me what it means to think deeply and that one does not have to be a conformist in any political regime. I thank my late grandfather Ivan for his love, kindness, and sense of justice. His passion for history and politics has greatly inspired my path. I wish I could mention all of my relatives who cheered for me and showered me with support: I thank my brother, Sasha; Tanya; my nephews, Semyen and Ivan, with whom conversations on Skype is the greatest joy; my late grandfather Oleg, and grandmother Tamara. I thank Irina Gorokhova, Yegor and Volodya Mukhiny; Marina, Sergey, Vanya, and Misha Mukhiny; Marina, Andrey, Vanya, and Zhenya Sokolovy; Graham Froud; Irina, Oleg, Pasha, Natalya, and Aleksandr Petrovich Startsevy. I am grateful to my almost relatives—Ol’ga Kolotilova, Irina Surova, Tatyana Durova, late Vera Ivanovna Milyukova, Marina Kuznetsova, Ol’ga Bondarenko, Lyudmila Nikolayevna, and Tatyana Vasil’yevna Syachina.

I am especially grateful to my three American families, whom I have known since I was a teenager, for helping me find my way in the U.S., for their love, support, and inspiration, and for showing me that life is much bigger than my hometown of Vologda: I thank Bob and Kathryn Sanders, Carrol, Dennis, and Sean Conley, and Karen and late Brad Woodford for always being there and supporting me in my education and my path. I am especially grateful to Karen for being a kind and warm presence in my life.
# TABLE CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>v</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>xix</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>xx</td>
</tr>
<tr>
<td>CHAPTER 1 SOVIET LEGACIES IN RUSSIA’S RESPONSE TO THE HIV/AIDS EPIDEMIC</td>
<td>1</td>
</tr>
<tr>
<td>1 The Puzzle</td>
<td>1</td>
</tr>
<tr>
<td>Policy Convergence and Policy Diffusion</td>
<td>3</td>
</tr>
<tr>
<td>Theoretical Predictions of Diffusion and Learning in the HIV/AIDS Epidemic</td>
<td>4</td>
</tr>
<tr>
<td>2 Research Design</td>
<td>6</td>
</tr>
<tr>
<td>The International Consensus on HIV/AIDS</td>
<td>7</td>
</tr>
<tr>
<td>Russia as an Outlier Case of HIV/AIDS Response</td>
<td>9</td>
</tr>
<tr>
<td>and Policy Diffusion</td>
<td>9</td>
</tr>
<tr>
<td>History of the HIV/AIDS Epidemic in Russia</td>
<td>13</td>
</tr>
<tr>
<td>Methods</td>
<td>18</td>
</tr>
<tr>
<td>3 A Theory of Russia’s Response to the HIV/AIDS Epidemic</td>
<td>19</td>
</tr>
<tr>
<td>Russia’s Response to the HIV/AIDS Epidemic:</td>
<td>19</td>
</tr>
<tr>
<td>Absence of Political Will</td>
<td>19</td>
</tr>
</tbody>
</table>
The Argument .................................................................................................................. 22
Prevention of Intravenous Transmission of HIV/AIDS ............................................ 23
Prevention of the sexual transmission of HIV/AIDS ................................................. 28
4 Literature Review ............................................................................................................. 35
Soviet Legacies .................................................................................................................. 36
Classification of Legacies ............................................................................................... 37
How to Recognize Legacies ............................................................................................. 39
Institutional Legacies in Russia ....................................................................................... 40
Conclusions from Legacies Literature ............................................................................. 40
5 Alternative Explanations ................................................................................................. 41
Political Regime ................................................................................................................ 42
Civil Society ........................................................................................................................ 45
Level of Economic Development and Funding of HIV/AIDS Programs ...................... 46
Domestic Institutions ....................................................................................................... 47
Federalism and Decentralization ...................................................................................... 49
Inaccurate Perceptions of the Scale of HIV/AIDS Epidemic ...................................... 49
The Role of State Identity ............................................................................................... 51
Western Linkages .............................................................................................................. 53
6 Conclusion ......................................................................................................................... 54
7 The Structure of the Dissertation .................................................................................... 56
CHAPTER 2 THE INTERNATIONAL CONSENSUS
ON HIV/AIDS AND RUSSIA AS AN OUTLIER CASE
OF STATE RESPONSE TO THE HIV/AIDS EPIDEMIC ........................................58

1 The International HIV/AIDS Regime ...............................................................58

2 Conceptualizations of HIV/AIDS Response in Political Science Literatures ......................................................61

Kravtsov’s Idea of the International Consensus .............................................62
Lieberman’s Idea of the International Consensus ...........................................63
The International Consensus on Response to the HIV/AIDS Epidemic.................................................................64
Framing of the epidemic and protection of human rights ................................65
Treatment programs .......................................................................................69
Developments to create accessible medication ..............................................75
HIV/AIDS Prevention Programs ................................................................80
Prevention of Sexual Transmission ...............................................................82
Prevention of Mother-to-child Transmission ...............................................84
Prevention of Transmission through Contaminated Blood ..........................84
Prevention of HIV/AIDS Transmission in Drug Users ...............................85

3 Russia’s Response to the HIV/AIDS Epidemic .............................................94

Framing of the HIV/AIDS Epidemic in Russia ..............................................96
Treatment Provision in the Russian Federation .............................................98
ARV Shortages .............................................................................................101
High Costs of the ARV Treatment ...............................................................104
CHAPTER 3 PSYCHIATRY AND NARCOLOGY

IN RUSSIA AND THEIR INFLUENCE ON

THE HIV/AIDS POLICY-MAKING PROCESS

1 Introduction

2 Historical Development of Addiction Medicine in Russia

   Theoretical Development of Psychiatry in Russia

   Psychiatry and the State

   Dominance of Strong Authoritarian Figures
   in the Field of Psychiatry

   Relative Independence of the Discipline from the State

   Narcology

   Conclusion

3 Current Scientific Debates within the Discipline of Narcology

   Scientific Crisis of Narcology

   Denialism in the Field of Russian Narcology
Opposition to Opioid Substitution and Lack of Evidence-Based Methods ..................................................138

4 Scientific Views of Russian Narcology on the Treatment of Drug Addiction: Analysis of Publications .................143

Founder of Russian Narcology. Textbooks on Treatment of Drug Addiction ..................................................................................................144

Discussion of Harm Reduction in Journals ........................................................................................................147

Narcology Does Not Associate the Lack of Harm Reduction with a Growth of HIV/AIDS and Drug Addiction Epidemics........150

Discussion of the HIV/AIDS Epidemic in Narcology Journals.................. 151

Limited Access to the Literature in Foreign Languages and Limited Contacts with the International Scientific Community ..................................................................................................153

The Orthodox Church: Publications in Scientific Journals .........................154

Discussion of Alternative Practices for Treatment of Drug Addiction in Medical Journals ...........................................154

Alternative Treatment ........................................................................................................................................ 155

Alternative Approaches to Drug Addiction Prevention .................. 156

5 Conclusion .........................................................................................................................................................158

6 The Role of the Medical Community of Drug Addiction Specialists (Narcologists) in Formulating the HIV/AIDS Policy in Russia ........................................159

Policy Influence of the Epistemic Community of Narcology ....................160

Narcology’s Influence on the HIV/AIDS Policy ........................................ 163
Denial of the HIV/AIDS Epidemic by Narcologists................................. 164
An Historical Role of the Specialty of Narcology in Drug Addiction Prevention Policy-Making.............................................167


The Official Position of the Ministry of Health on Prevention of Drug Use .................................................................172
Tatyana Dmitrieva, Minister of Health 1996 - 1998............................... 172
Yuriy Shevchenko, Minister of Health 1999 - 2004............................... 174
Mikhail Zurabov, Minister of Health 2004 - 2007 .............................. 175
Tatyana Golikova, Minister of Health 2007 - 2012............................... 176

The Official Position of the Ministry of Education on the Prevention of Drug Use of the Russian Federation.............................177
Concepts of Addressing Drug Addiction in Education........................... 177
Opposition to the Universality of Drug Testing ..................................... 183

8 Conclusion ...........................................................................................186

CHAPTER 4 POLITICS OF MORALITY, POLICY CONTINUITY, AND PREVENTION OF SEXUAL TRANSMISSION IN THE HIV/ADS EPIDEMIC ....187

1 Morality Politics......................................................................................187
The Soviet Union: Communist Morality .................................................. 189
Codification of Communist Morality........................................................ 191
Russian Thinkers Who Shaped Politics of Morality ............................... 192
Prostitution: Effects of Morality Politics ................................................... 195

xvi
<table>
<thead>
<tr>
<th>Era</th>
<th>Topics</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1930 - 1950s</td>
<td>Khrushchev: the Moral Code of the Builders of Communism</td>
<td>197</td>
</tr>
<tr>
<td></td>
<td>Morality Education [Vospitaniye] in Morality Politics</td>
<td>198</td>
</tr>
<tr>
<td></td>
<td>Discourse of Blame in the USSR</td>
<td>199</td>
</tr>
<tr>
<td>2 Morality Politics: The Russian Federation</td>
<td></td>
<td>200</td>
</tr>
<tr>
<td></td>
<td>Vladimir Putin: Defending Traditional Values</td>
<td>202</td>
</tr>
<tr>
<td></td>
<td>Family Policy</td>
<td>204</td>
</tr>
<tr>
<td></td>
<td>Politics of Morality and Protection of Children</td>
<td>208</td>
</tr>
<tr>
<td></td>
<td>Persecution of Homosexuality in Russia</td>
<td>210</td>
</tr>
<tr>
<td>3 Sex Education: Policy Continuity</td>
<td></td>
<td>214</td>
</tr>
<tr>
<td></td>
<td>Sex Education in the Soviet Union</td>
<td>214</td>
</tr>
<tr>
<td></td>
<td>1920s</td>
<td>216</td>
</tr>
<tr>
<td></td>
<td>Women and the Family Question</td>
<td>217</td>
</tr>
<tr>
<td></td>
<td>1930-1955</td>
<td>220</td>
</tr>
<tr>
<td></td>
<td>Khrushchev 1955-1964</td>
<td>222</td>
</tr>
<tr>
<td></td>
<td>1980s</td>
<td>223</td>
</tr>
<tr>
<td></td>
<td>Sex Education in the Russian Federation</td>
<td>224</td>
</tr>
<tr>
<td></td>
<td>The Morality Education Tradition</td>
<td>231</td>
</tr>
<tr>
<td></td>
<td>Scientific Publications</td>
<td>232</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>233</td>
</tr>
<tr>
<td>4 Contraception Policies and Prevention of HIV/AIDS</td>
<td></td>
<td>233</td>
</tr>
<tr>
<td></td>
<td>Policies during the Soviet Union</td>
<td>235</td>
</tr>
<tr>
<td></td>
<td>Abortion and Contraception policies</td>
<td>235</td>
</tr>
</tbody>
</table>
The Current Policies of the Russian Federation ............................................240
Prevention of Sexually Transmitted Diseases.................................243

5 Conclusion ...........................................................................................................245

CHAPTER 5 CONCLUSION.................................................................................246

1 Summary of the Dissertation .................................................................246
Summary of Chapter 1 .........................................................................................246
Summary of Chapter 2 .........................................................................................249
Summary of Chapter 3 .........................................................................................249
Summary of Chapter 4 .........................................................................................252

2 Implications for Future Research...............................................................253
Political Will to Address the HIV/AIDS Epidemic ....................................254
Absence of State Will in Russia: Future Research ....................................255
Medical Epistemic Community ........................................................................257
Path Dependency of Domestic Institutions .....................................................259

3 Russia’s Response to the HIV/AIDS in Comparative Perspective ............262

4 The Future of Russia’s HIV/AIDS Policy .......................................................264

BIBLIOGRAPHY .....................................................................................................266

LIST OF SCIENTIFIC JOURNALS OF NARCOLOGY AND PSYCHIATRY .......292

LIST OF INTERVIEWS ..........................................................................................294
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1 The Geneva Consensus on Response to the HIV/AIDS Epidemic</td>
<td>8</td>
</tr>
<tr>
<td>Table 2 Harm Reduction Interventions</td>
<td>9</td>
</tr>
<tr>
<td>Table 3 Harms Reduction interventions in Russia</td>
<td>17</td>
</tr>
<tr>
<td>Table 4 Russia’s Compliance with the International Consensus</td>
<td>96</td>
</tr>
<tr>
<td>Table 5 Total Health Expenditure as a Share of GDP in the Russian Federation</td>
<td>111</td>
</tr>
<tr>
<td>Table 6 Conceptualization of the Global Policy Consensus on HIV/AIDS (Kravtsov)</td>
<td>113</td>
</tr>
<tr>
<td>Table 7 Conceptualization of the Global Policy Consensus on HIV/AIDS (Lieberman)</td>
<td>114</td>
</tr>
<tr>
<td>Table 8 Opinions about Abortion in Russia and Selected Post-Communist and Western Societies. ISSP Religion II Data, 1998 (Percentage)</td>
<td>240</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1 People Living with HIV</td>
<td>10</td>
</tr>
<tr>
<td>Figure 2 People Living with HIV and People Injecting Drugs</td>
<td>11</td>
</tr>
<tr>
<td>Figure 3 Adult HIV Prevalence amongst IDUs</td>
<td>11</td>
</tr>
<tr>
<td>Figure 4 Legislative Resistance to Harm Reduction</td>
<td>12</td>
</tr>
<tr>
<td>Figure 5 Number of Syringe Distributions per Person</td>
<td>12</td>
</tr>
<tr>
<td>Figure 6 Intravenous Drug Users Reached by HIV Prevention Services</td>
<td>13</td>
</tr>
</tbody>
</table>
CHAPTER 1
SOVIET LEGACIES IN RUSSIA’S RESPONSE TO THE HIV/AIDS EPIDEMIC

1 The Puzzle

Since the onset of the HIV/AIDS pandemic, the accumulated record of state responses has grown exponentially. Knowledge and experience gained by the international community and organizations resulted in an international consensus on how states should structure their responses to and implement evidence-based approaches to HIV/AIDS. This became possible due to the discovery of an effective treatment for HIV/AIDS that turned this once devastating disease into a chronic, manageable condition. This international consensus stipulates measures that states are expected to implement to ensure a successful response to epidemics (Lieberman 2009). States vary in their economic and institutional capacities to successfully implement recommended measures and, oftentimes, require external technical and financial assistance. For a successful response, any state should acknowledge this international norm and align domestic policies accordingly.

States where HIV/AIDS emerged relatively late are at an extraordinary advantage. They not only have the expertise of a number of international organizations and their technical assistance at their disposal, but also the experience of other states. Once successful policies to address the HIV/AIDS epidemic are identified, many states choose to adopt these approaches. This policy diffusion was one of the conditions necessary to counter the global HIV/AIDS pandemic.
However, despite the gravity of the problem that HIV/AIDS imposes on states, the response of some states is not effective and is not commensurate with the scale of the problem it aims to resolve. The implementation of suboptimal policies is even more perplexing when an international regime and an agreed upon set of best practices exists and when their effectiveness has been tested in other instances of epidemics. The Russian Federation, where the HIV/AIDS epidemic began in the 1990s, is one of such cases. While most of the states in the post-Soviet space that experienced a delayed onset of the HIV/AIDS epidemic either implemented a full set of policy interventions or adopted them on the legislative level, Russia failed to employ key prevention interventions and prohibited them legislatively. Yet, from a theoretical perspective of policy diffusion, Russia appeared to be likely to adopt recommended provisions. The central question that motivates this study is what explanatory factors led to a lack of policy diffusion within the Russian Federation in response to an HIV/AIDS epidemic.

I argue that in the Russian Federation HIV/AIDS prevention policies were undermined due to lack of state will and centralized authority. Therefore, individual agencies conducted interventions without a specific mandate to prioritize a response to the HIV/AIDS epidemic. These agencies designed and implemented interventions in accordance with established priorities, norms, and practices which were strongly path dependent. Preventive policies were formulated and influenced mainly by the medical epistemic community and conservative politics of morality.
Policy Convergence and Policy Diffusion

In numerous issue areas, policies are very similar across states. This phenomenon of policy clustering in international relations and comparative political science literature is often explained by policy diffusion. The process of simultaneous policy adoption by several states in a region is thought to be “systematically conditioned by prior policy choices made in other countries” (Simmons 2006, 767). When policy is successfully adopted by one state in a region, the waves of policy diffusion might ensue, particularly, when—due to its success—a policy becomes an attractive option for other states in the same region. Therefore, policy diffusion has a strong geographic component (Weyland 2005; 2009). Policy diffusion is also perceived as a process in which ideas play a key role, even though there is no unanimity over how they matter. The process of diffusion is seen in the literature as an uncoordinated process with a high degree of unpredictability (Elkins and Simmons 2005).

The literature suggested both international and domestic level explanations for policy diffusion and convergence. Despite the process of globalization, international pressure is not always a deterministic factor in states’ decisions regarding the adopted policies (Elkins and Simmons 2005). Political science literature recognizes that domestic actors also have leverage in policy choice and traditional policy approaches suggest that policy choices are determined by domestic factors alone (Sabatier and Weible 2014).

While an international component in policy diffusion is present—policy choices in one country are influenced by policy choices in other countries—the key to understanding diffusion rests in discerning the motives of domestic actors to adopt similar policies. Diffusion theories contend that policy convergence occurs because
domestic governments do not make policy decisions independent of each other (Dobbin, Simmons and Garrett 2007, 450). When political scientists answer the question of why policies diffuse, in essence they are also asking the question of why certain domestic actors accept a certain type of policy.

*Theoretical Predictions of Diffusion and Learning in the HIV/AIDS Epidemic*

Most of the political science literature on state responses to epidemics does not separate the concept of state response into separate components (Kravtsov 2015, Lieberman 2009, Paxton 2010; 2012). However, some studies demonstrated that for examining causes of successful and unsuccessful responses, it is imperative to discriminate between state will, policy outputs, and epidemiological outcomes (Bor 2007). The distinction between political will and policy outputs is particularly noteworthy. In state responses to epidemics, political will is defined as “the extent to which top-level government leaders (viz. heads of state and their appointees) support AIDS as a priority on the national agenda” (Bor 2007, 1586).

Presence of political will is highly correlated with a successful response to the HIV/AIDS epidemic. In cases where political will is weak or nearly absent, we would not expect to observe that the state would be successful at mobilizing resources, building partnership with civil society and businesses, or building infrastructure to address the epidemic at the same rate as when strong state will is present. However, we would still expect the adoption of appropriate policy solutions, at least on paper. In fact, broader

---

1 I discuss conceptualization of political will and its measurement in detail in section 3.1.
patterns of diffusion predict that policy diffusion would occur in the case of HIV/AIDS independent of the presence of state will to aggressively address the epidemic. In practice we observe that countries adopt similar if not identical approaches in treatment, prevention, and bureaucratic institution building in response to the HIV/AIDS epidemic. However, some states refuse to adopt recommended policy solutions that were tested in other settings.

State response to the HIV/AIDS epidemic offers an opportunity to further examine domestic factors that might impede policy diffusion. The HIV/AIDS epidemic represents a case where policy diffusion is expected. Literature suggests that policy diffusion becomes more likely when there are states in geographic proximity that adopted similar policies (Dobbin, Simmons, & Garrett, 2007; Weyland 2005; 2009). In the HIV/AIDS epidemic these factors are present. There are vertical linkages with international organizations that pressure states to adopt interventions to counter HIV/AIDS as specified by the Geneva Consensus. Policy diffusion is also desirable for the international community since the HIV/AIDS pandemic can only be resolved by united efforts of the affected states.

A state’s decision to borrow effective policy solutions against HIV/AIDS are motivated by domestic interests as well. The HIV/AIDS epidemic presents a complex and urgent pressure on the state; it is also an entirely new problem for some states and thus an area lacking complete information. Theorists of policy diffusion expect states to turn to the experience of other states and international organizations along with developing their own expertise to address the epidemic by pursuing information, knowledge, and appropriate policy solutions... This would be particularly true about countries where the
HIV/AIDS epidemic developed at a later time compared to the outset of the HIV/AIDS pandemic.

Most states choose to implement some combination of internationally suggested policies to address the HIV/AIDS epidemic. While absolute compliance with an international norm is something that we do not observe in practice, cases of non-response to an HIV/AIDS epidemic are limited. These cases allow for an examination of domestic factors that preclude the adoption of the international norm on HIV/AIDS.

While response to an epidemic is mainly an effort of domestic actors, in the HIV/AIDS epidemic, the role of the international medical community and political community has become very prominent. A health issue very rarely has captured the attention of international organizations as much as HIV/AIDS (Smith and Whiteside 2010). While economic capacity of states vary and may determine the success of state responses, we have a significant degree of confidence to expect, even states where conditions to address the HIV/AIDS epidemic are not present, to adopt norms of the international consensus on HIV/AIDS.

2 Research Design

This study seeks to examine domestic factors that preclude policy diffusion in the HIV/AIDS epidemic. It also seeks to further discern ways in which domestic factors interfere with factors at the international level in the process of policy diffusion. To understand lack of policy diffusion, I examine an outlier case of state response to the HIV/AIDS epidemic. To identify outlier cases, first, I examine the content of the international Geneva Consensus on HIV/AIDS and identify policy interventions that are
specified as mandatory by this consensus; second, I identify a universe of cases from which the outlier case is selected; third, I explain why Russia can be considered an outlier case of state response to the HIV/AIDS epidemic; and, finally, I discuss the methodology of within-case analysis that I plan to use in this study.

*The International Consensus on HIV/AIDS*

The international Geneva consensus on HIV/AIDS stipulates a set of treatment and prevention interventions that states should follow to ensure a successful response. This consensus became possible when an effective treatment for HIV/AIDS was discovered (Lieberman 2009, 98). My examination of the international consensus on HIV/AIDS reveals that there are three important areas of state response to the HIV/AIDS epidemic: framing of the epidemic; treatment provision; and prevention of HIV/AIDS transmission (see Table 1). While prescriptions from each of these three areas of consensus have to be implemented in response to the HIV/AIDS epidemic, the nature of the HIV/AIDS epidemic matters as well. When an HIV/AIDS epidemic is driven by intravenous drug use, the implementation of harm reduction preventive approaches becomes of paramount importance (Des Jarlais 1993). Harm reduction interventions are based on the notion that intravenous drug addiction, which can lead to HIV/AIDS transmission, is a chronic condition (Erickson 1995). Rather than implementing policies that seek to completely cure individuals from drug addiction, measures to reduce side effects of addiction are implemented instead.
Table 1 The Geneva Consensus on Response to the HIV/AIDS Epidemic

| Structure of the International Consensus on Response to the HIV/AIDS epidemic |
|-----------------------------|-----------------------------------------------------------------------------|
| Framing of the epidemic     | - The HIV/AIDS epidemic should be framed as a public health problem         |
| Treatment provision         | - The availability of ARVs for the eligible HIV/AIDS patients               |
|                             | - Adherence to the internationally recommended treatment protocols          |
|                             | - The universality of access to treatment                                    |
| Prevention of HIV/AIDS      | - Prevention of sexual transmission                                         |
| transmission                | - Prevention of mother-to-child transmission                                 |
|                             | - Prevention of transmission through blood supply                            |
|                             | - Prevention of intravenous drug transmission                               |

Sources: UNAIDS, WHO

The World Health Organization specifies nine harm reduction interventions. It gives priority to needle and syringe exchange and sterilization programs, as well as opioid substitution therapy (see Table 2). The WHO further requires harm reduction programs to be implemented in combination with other programs (WHO and UNICEF 2010, 45). A state response to HIV/AIDS that is driven by intravenous drug use and that does not include harm reduction approaches into its policy response would be considered an outlier case of HIV/AIDS policy diffusion.
Table 2 Harm Reduction Interventions

<table>
<thead>
<tr>
<th>Interventions Stipulated by the Geneva Consensus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needle and syringe programs (NSPs)</td>
</tr>
<tr>
<td>Drug dependence treatment, in particular opioid substitution therapy</td>
</tr>
<tr>
<td>Targeted information, education and communication for IDUs</td>
</tr>
<tr>
<td>Enabling people to know their HIV status</td>
</tr>
<tr>
<td>HIV treatment and care</td>
</tr>
<tr>
<td>Promoting and supporting condom use</td>
</tr>
<tr>
<td>Detection and management of sexually transmitted infections</td>
</tr>
<tr>
<td>Prevention and treatment of viral hepatitis</td>
</tr>
<tr>
<td>Tuberculosis prevention, diagnosis and treatment</td>
</tr>
</tbody>
</table>

Source: WHO 2010, 45

Russia as an Outlier Case of HIV/AIDS Response and Policy Diffusion

Russia’s response to the HIV/AIDS epidemic qualifies as an outlier case of a response to the HIV/AIDS epidemic among the states of the former Soviet Union, Eastern, and Southern Europe that experienced the advent of the HIV/AIDS epidemic in the 1990s (see Figures 1, 2, 3). The HIV/AIDS epidemic in these states is accompanied and, in some cases, driven by the epidemic of intravenous drug use (see Figure 1). A deviant case of response to the HIV/AIDS epidemic satisfies the following criteria: it is a case, where 1) a state faces a rapidly escalating HIV/AIDS epidemic; 2) a set of internationally accepted evidence-based prevention and treatment interventions is available to address HIV/AIDS; and at the same time 3) a state implements response policies that are incommensurate with the scale of the epidemic and inconsistent with internationally accepted guidelines. While it is sufficient for a state to decline any one of the areas of the international consensus to be considered an outlier (see Table 1), in an
epidemic driven by intravenous drug addiction, I select a case of state response where the state rejects to implement policy innovation—harm reduction interventions—not only recommended by international organizations, but also widely implemented by other states in the region (see Figures 4, 5, 6).

I demonstrate that Russia’s response to the HIV/AIDS epidemic represents an outlier case of response that fits the abovementioned criteria. While the Russian Federation is faced with a rapidly growing HIV/AIDS epidemic driven by intravenous drug use, it legislatively prohibits implementation of recommended harm reduction approaches. Moreover, it does not implement recommended measures to prevent sexual transmission of HIV/AIDS either.

Sources: UNAIDS Country Progress Reports

*Figure 1 People Living with HIV*
UNAIDS: Country Progress Reports

**Figure 2 People Living with HIV and People Injecting Drugs**

**Figure 3 Adult HIV Prevalence amongst IDUs**
Sources: UNAIDS Country Progress Reports

Figure 4 Legislative Resistance to Harm Reduction

Sources: UNAIDS Country Progress Reports

Figure 5 Number of Syringe Distributions per Person
History of the HIV/AIDS Epidemic in Russia

The Russian Federation’s HIV/AIDS epidemic started much later than the epidemics in African and Western states that experienced the outset of HIV/AIDS in the beginning of the 1980s. During the Soviet era, citizens’ foreign travel was limited and travel restrictions were applied to foreigners as well. However, with the collapse of the Soviet Union and increased rates of migration and of drug trafficking, the HIV/AIDS epidemic spread to Russia. In fact, starting in 1998, the Russian Federation was faced with two epidemics simultaneously—drug addiction and HIV/AIDS. In addition to increased mobility and drug trafficking, the introduction of neoliberal reforms that
undermined the welfare state and the provision of public health expressly were contributing factors to the onset of these epidemics in the Russian Federation.²

In the context of other countries’ responses to the HIV/AIDS epidemic, the Russian case stands out. When the HIV/AIDS epidemic occurred in post-Soviet countries, many states, to a varying degree, adopted the international norm of state response to the HIV/AIDS epidemic, including harm reduction approaches, or at least, gave legislative permission for such practices³ (see Figure 4). While the HIV/AIDS prevalence rate in Russia is not nearly as high as in some states,⁴ the incidence rate of HIV/AIDS in the Russian Federation has been steadily rising since the onset of its HIV/AIDS epidemic. However, in many states, including some poor African countries, the prevalence rate of HIV/AIDS has been steady or declining over the last decade.⁵ Refusal of the Russian Federation to implement internationally accepted policies in response to its HIV/AIDS epidemic sets Russia apart from other states in the post-Soviet space.

---

2 Michelle Rivkin-Fish (2005) documented the effects of neoliberal reforms on provisions of women health care in the Russian Federation after the collapse of the Soviet Union.

3 Substitution programs are not available in the Russian Federation, Tajikistan, Turkmenistan, or Uzbekistan.

4 Prevalence of HIV among adults aged 15 to 49 in 2013: Botswana – 21.9 percent; Lesotho – 22.9 percent; Malawi – 10.3 percent; Mozambique – 10.8 percent; Namibia – 14.3 percent; South Africa – 19.1 percent; Swaziland – 27.4 percent; Zambia – 12.5; and Zimbabwe – 15 percent. WHO, Global Health Observatory Data Repository.

5 Notable cases of success in response to the HIV/AIDS epidemic are Zimbabwe, where the adult prevalence rate has declined from 25.6 percent in 2001 to 15 percent in 2013; Thailand from 1.8 percent in 2001 to 1.1 percent in 2013; and Botswana from 27.7 percent in 2001 to 21.9 percent in 2013. WHO, Global Health Observatory Data Repository.
A distinguishing factor in the wave of HIV/AIDS epidemics in many countries outside the African continent is that many of these epidemics coincide with an epidemic of intravenous drug use and oftentimes are mainly driven by it. This is largely the case in Russia. Therefore, while comparison of Russia’s response to the HIV/AIDS epidemic to other cases with a delayed response, such as the case of South Africa, might seem an appropriate approach to the study of the response to the HIV/AIDS epidemic, I contend that a better approach would be a comparison of cases with similar epidemics. While there are attempts to compare the Russian case to the South African case (see Kravtsov 2015), I propose to study it as an outlier case instead. My analysis reveals that while prevention is a crucial element of response to the HIV/AIDS epidemic, in cases where the spread of HIV/AIDS is driven by intravenous drug use more so than through sexual transmission of the disease, the implementation of harm reduction aspects drawn from international norms becomes a crucial factor in response to an HIV/AIDS epidemic. The causes for non-compliance with the international norm differ greatly between the cases of epidemics driven by sexual transmission versus the cases involving intravenous transmission of the disease. Russia is an outlier case in its response to the HIV/AIDS epidemic because of its refusal to implement the international norm on prevention of HIV/AIDS and harm reduction approaches in particular (see Figures 4, 5, 6).

Although reluctance to implement harm reduction programs exists in other states besides Russia, most of the states faced with a needle-transmission HIV epidemic implemented comprehensive evidence-based policies, including both needle-exchange and opioid-substitution treatments (Hathaway and Tousaw 2008). Few existing theories adequately explain cases of response to HIV/AIDS where the epidemic is predominantly
Driven by intravenous drug use and where states refused to legalize and implement harm reduction. Since opioid substitution interventions are recognized as a necessary component of HIV/AIDS prevention and of epidemic containment, the criminalization of the medications used in treatment is sufficient to consider this kind of state response as contradictory with the international norm. Russia’s refusal to implement harm reduction programs (see Table 3) is a deviant example even in the context of other post-communist states. It is the only state in Eastern Europe that bans methadone and buprenorphine, the two medications crucial for the treatment of opioid addiction and HIV/AIDS prevention among drug users. It is also one of the few states which does not allocate funds for needle and syringe exchange programs (Ferris-Rotman 2011). These policy choices demonstrate that Russia is an outlier case for both state responses to HIV/AIDS and for HIV/AIDS policy diffusion because in the face of a growing epidemic it refused to implement key preventive interventions including key harm reduction approaches.
Table 3 Harms Reduction interventions in Russia

<table>
<thead>
<tr>
<th>International Organizations’ Recommendations</th>
<th>Russia’s Policy and Practice</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needle and syringe programs (NSPs)</td>
<td>The government does not finance NSPs NSP programs existing in Russia were financed by international organizations</td>
<td>No</td>
</tr>
<tr>
<td>Drug dependence treatment, in particular opioid substitution therapy</td>
<td>Methadone and buprenorphine, two main drugs approved by WHO for the use in drug substitution therapy are prohibited for the therapeutic use in the country (methadone is illegal, buprenorphine can only be used for pain relief purposes) Drug dependence treatment is not evidence based</td>
<td>No</td>
</tr>
<tr>
<td>Targeted information, education and communication for IDUs</td>
<td>Medical services do not reach IDUs with information and education</td>
<td>No</td>
</tr>
<tr>
<td>Enabling people to know their HIV status</td>
<td>Russia widely implements testing (yearly tests about 16% of its population) Testing does not reach vulnerable populations</td>
<td>Partial</td>
</tr>
<tr>
<td>HIV treatment and care</td>
<td>No universal access IDUs do not have access to ARVs medication shortages high prices of ARVs does not follow treatment protocols</td>
<td>No</td>
</tr>
<tr>
<td>Promoting and supporting condom use</td>
<td>No wide distribution of condoms limited sex education</td>
<td>No</td>
</tr>
<tr>
<td>Detection and management of sexually transmitted infections</td>
<td>Major epidemic of sexually transmitted infections</td>
<td>Partial</td>
</tr>
<tr>
<td>Prevention and treatment of viral hepatitis</td>
<td>Hepatitis B vaccine is part of the national immunization programs for newborn babies No prevention of hepatitis B and C among drug users</td>
<td>Partial</td>
</tr>
<tr>
<td>Tuberculosis prevention, diagnosis and treatment</td>
<td>Russia complies with DOTs treatment program for tuberculosis</td>
<td>Partial</td>
</tr>
</tbody>
</table>
A within-case analysis of Russia’s response to the HIV/AIDS epidemic allows me to: 1) demonstrate the stability of preventive policies over time; 2) verify that hypothesized factors—a medical epistemic community and a politics of morality—not only shape preventive policies, but also lead to a rejection of internationally recommended approaches; and 3) uncover causal mechanisms between hypothesized factors and preventive policy outputs. I implement a process tracing analysis to verify a causal relationship between a politics of morality, a medical epistemic community, and the respective policies that they shaped (George and Bennett 2005, 6).

Since a politics of morality and views of a medical epistemic community have their origins in the early years of the Soviet Union, I examine a historical period that begins with the emergence of the Soviet Union to the first two decades of the Russian Federation. I separately explore: 1) the development of a conservative politics of morality in the Soviet Union and in the Russian Federation; 2) the development of the views of the psychiatric medical community; and 3) the relationship between these factors and the policies that each shaped.

To examine views of the medical epistemic community and its influence on policy, I conducted semi-structured interviews in Moscow with leading professionals in the fields of infectious diseases and HIV/AIDS, as well as with narcologists and
psychiatrists during the summers of 2012 and 2013. To understand the scientific position of psychiatry on resistance to harm reduction, I examined publications in leading medical journals and in textbooks on treatment and prevention of drug addiction used in medical schools from the 1980s to the present (see Appendix 1) as well as anthropological studies. For the preceding period, I used secondary sources on the history of psychiatry and its relationship with the state. I also conducted interviews with members of the Ministry of Health charged with HIV/AIDS and drug addiction policy-making as well as with members of the Duma. I also conducted a small set of exploratory interviews with activists working on HIV/AIDS and drug addiction problems (see Appendix 2). I reviewed social legislation that was enacted by the Duma, as well as speeches and statements made by the country’s officials regarding problems of HIV/AIDS and drug addiction (1996 to 2014) to infer the degree of political will to resolve both drug addiction problems and the HIV/AIDS epidemic.

3 A Theory of Russia’s Response to the HIV/AIDS Epidemic

Russia’s Response to the HIV/AIDS Epidemic: Absence of Political Will

Research on responses to HIV/AIDS demonstrates that a country’s successful response to the HIV/AIDS epidemic is related to the strength of political will, or political commitment, to respond to the epidemic (Bor 2007, Patterson 2001, Putzel 2004). Will or

6 See for example Raikhel 2006; Raikhel 2012.
7 See Joravsky 1989.
commitment can be conceptualized as the demonstrated intention of the government to address the HIV/AIDS epidemic (Patterson 2001). While the concept of political will is undertheorized, efforts are made to develop a narrow category that would exclude influences from the private sector, civil society, and local government (Bor 2007, 1886). In Bor’s definition, political will in state response to an epidemic is:

the extent to which top-level government leaders (viz. heads of state and their appointees) support AIDS as a priority on the national agenda…As defined here, political commitment is only one component of the broader government response to AIDS… It is analytically distinct from the specific types of programs implemented, with policy needs and options varying over time and space. (Bor 2007, 1586)

One of the possible measures of political will is the “political support” indicator in the AIDS Program Effort Index (Bor 2007). Through a series of interviews with country-respondents, this indicator seeks to measure whether “the head of the government and/or other high officials, speak publicly and favorably about AIDS issues” and whether “there is a National AIDS Council or Commission outside the Ministry of Health that coordinates the multi-sectoral AIDS program” (Bor 2007, 1586).  

Despite the significant scale of the HIV/AIDS epidemic in the Russian Federation, the federal government and political elites were reluctant to address the epidemic. Using the API index for “political support” (100 is the highest possible score), Russia ranks very low: 20 in 2001 and 21 in 2003. The regional average for “political support” in Eastern Europe was 48 in 2001 and 50 in 2003 (Bor 2007, 1588). With the

8 The AIDS Program Effort Index (API) was developed by UNAIDS, USAID, WHO and the POLICY Project. Data for the API index were collected through personal and group interviews with informants in 54 countries and then weighted quantitatively.

9 For the full questionnaire, see “The Level of Effort in the National Response to HIV/AIDS: The AIDS Program Effort Index (API) 2003 Round.”
lack of centralized authority managing the HIV/AIDS response, policy measures were formulated not within a specialized body established to address the epidemic, but were conducted by individual agencies in accordance with their traditional priorities, norms, and practices established prior to the onset of the HIV/AIDS epidemic which are strongly path dependent. These agencies functioned without a directive to prioritize HIV/AIDS in designing and implementing their policies. As a result of their poorly designed response, the prevention of HIV/AIDS was affected the most.

Since the national plan to address the HIV/AIDS epidemic was not generated along with an agency that could handle coordination, prevention policies were carried out as they were prior to the epidemic, without HIV/AIDS being one of the primary issue areas of the policymakers. Prevention of the HIV/AIDS epidemic was not articulated as a separate policy issue area. It was instead addressed within two other issue areas: 1) prevention of intravenous drug use, the domain of narcologists in the Russian Federation and 2) prevention of sexual transmission, the domain of family planning and prevention of sexually transmitted diseases that are handled by the Ministry of Health and the Ministry of Education. The presence of the HIV/AIDS epidemic in the country only marginally affected the policy-making within these domains. Since HIV/AIDS did not become an urgent matter for institutions and actors that create preventive interventions, the policy-making and policies themselves did not undergo significant changes. In the Russian case, the lack of government will to address the HIV/AIDS epidemic or make any policy changes on the transmission of diseases through sexual contact and intravenous drug use, even while under the threat of a serious epidemic, the presence of
international pressure, the availability of resources, and international technical expertise, are surprising.

The Argument

This dissertation examines policy-making to address the prevention of HIV/AIDS infection through sexual and intravenous transmission as two separate processes in the Russian Federation. Although prevention policies of intravenous drug use and sexual transmission are shaped by two entirely different sets of factors, both sets of policies share a great resemblance with their respective policies that were put in place before the fall of the Soviet Union. First, this dissertation demonstrates that preventive policies of drug use and sexual transmission of HIV/AIDS have a continuity with similar preventive policies in the Soviet Union. Second, through examination of factors that shaped these policies, the dissertation shows that the policies of intravenous drug use prevention are shaped by the domestic medical community and that the sexual prevention policies are shaped by a conservative politics of morality. Third, the dissertation also shows that these policies have undergone only minor changes since the fall of the Soviet Union even in the face of the HIV/AIDS epidemic and that this lack of change can be traced to the fact that state will to address the epidemic was absent. Meanwhile, the factors that initially shaped and exerted continuous influence on these policies—the medical epistemic community and a conservative politics of morality—persisted from the Soviet era and continued to operate in the Russian Federation.

The section below begins by briefly outlining the development of intravenous drug use prevention in the Soviet Union and in the Russian Federation and the role of the
epistemic medical community in policy-making. Second, it traces the sexual transmission prevention policies in the Soviet Union and in the Russian Federation and explains the role of morality politics in its development. Finally, it provides evidence that state will in the Russian Federation to address the HIV/AIDS epidemic was absent.

*Prevention of Intravenous Transmission of HIV/AIDS*

The policy for the prevention of intravenous transmission was influenced by a domestic medical epistemic community that holds theoretical views on drug treatment and prevention that are distinct from those held by the international medical epistemic community. This is reflected in the fact that the domestic epistemic community in Russia presents an alternative viable view of the policy problem, an alternative viable solution, and has had a historical influence on policy-making in Russia. The absence of state will led to the fact that policy in response to the epidemic was formulated under the influence of a strong domestic epistemic community that precluded even any deliberation regarding the possibility to implement the international norm.

Previous research on the role of epistemic communities in the HIV/AIDS epidemic suggests that international epistemic communities can play a role in formulating domestic policy preferences. For example, Youde (2005) in his research regarding state response to the HIV/AIDS epidemic in South Africa, suggests that because western medical norms were antagonistic with the identity of the South African state and the policy makers, South Africa aligned instead with the norms of the alternative, or, as Youde calls it, the counter-epistemic community to create policy in response to the HIV/AIDS epidemic. The alternative international HIV/AIDS denialist movement
rejected the link between HIV and AIDS and contended that AIDS is caused by a range of other factors such as, for example, poor sanitation, use of recreational drugs, and malnutrition. Notably, the South African government rejected the international norm on the HIV/AIDS epidemic. While the government accepted the reality of AIDS, it rejected the causal link between the Human Immunodeficiency Virus and the Acquired Immunodeficiency Syndrome. Thus, in Youde’s explanation of the response to the HIV/AIDS epidemic in South Africa, the domestic policy makers internalized an alternative norm of understanding and response to HIV/AIDS. Youde contends that whenever there is a “disjuncture between the [international HIV/AIDS] regime’s message and the identities of member states, states are unlikely to participate in that regime” (Youde 2005, 422).

Central to understanding the response to the HIV/AIDS epidemic is understanding the role of the epistemic community. The study of epistemic communities has a foundation in Peter Haas’s work (Haas 1992). He defines epistemic community as “a network of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area” (Haas 1992, 3). Moreover, an epistemic community is a group of professionals that “believes in the same cause-and-effect relationships, truth tests to accept them, and shares common values; its members share a common understanding of a problem and its solution” (Haas 1990, 55). According to Haas, whenever the states are faced with complex problems, epistemic communities provide information for policy makers. When there is a need for information, international epistemic communities emerge and proliferate. According to Haas, epistemic communities explain the
emergence of cooperation at the international level (Haas 1990, 63). In chapter 3, I show that Russian narcologists represented an epistemic community and shaped the policy of drug treatment and prevention that became the foundation of prevention of HIV/AIDS in the epidemic.

Since the HIV/AIDS epidemic in Russia is spread through intravenous drug use, ensuring safe drug use and maintenance therapy with opioid substitutes such as methadone and buprenorphine is essential. In the chapters that follow I demonstrate that in Russia, the alternative community of narcologists, subspecialty discipline in the field of psychiatry, had formulated a response that excluded interventions recommended by the international norm. To demonstrate that this epistemic community exerted such a powerful influence on the state’s policy, I will demonstrate that, first, the Russian epistemic narcological community is qualitatively different in its theoretical views regarding opioid substitution therapy from the English/global psychiatry community regarding the nature of drug addiction and venues for treatment. These views of the Russian psychiatric community preclude it from accepting the international norm’s protocols on harm reduction approaches. Then, I will show that the historical trajectory of the development of psychiatry in the Russian Federation explains its authoritative position in its relation to the Russian state. I will also demonstrate that in Russia the institutional structure of the field of narcology makes it unreceptive to the influence of international theoretical developments in treatment and prevention of addiction. Finally, I will demonstrate that the community of narcologists and psychiatrists has been closely linked to the state’s policies regarding drug addiction in the Soviet Union and that it has continued to influence policies in post-Soviet Russia as well.
The Medical Epistemic Community in Russia and HIV/AIDS Policy-making

First, this dissertation demonstrates that psychiatry in the Russian Federation is strongly dominated by the views of the Moscow school of psychiatry that views addiction as a “habit,” at least during the earlier stages of the development of the diseases. The fundamental theoretical views of this school that shaped the development of both psychiatry and narcology as disciplines are not compatible with accepting opioid maintenance therapy. Maintenance therapies are supported by the theoretical view of addiction as a chronic medical condition. On the one hand, Russian psychiatry views addiction as potentially curable. Therapies to treat drug addiction are based on complete abstinence from narcotic substances. On the other hand, the medical community rejects maintenance therapies as an unscientific and an unethical treatment of addiction. My analysis of publications in scientific journals of narcology and psychiatry demonstrates this unanimity of theoretical positions of the psychiatric community on the unacceptability of maintenance therapies.

Second, the discipline of psychiatry in the Soviet Union and in the Russian Federation had a rather authoritative position vis-a-vis the state. Psychiatry, unlike other scientific fields, has managed to avoid direct political control; however, it remained ideologically resonant with the state. The field of narcology inherited these characteristics of relations with the state. Currently, a few figures with abundant authority dominate the field, lead discussions in scientific journals, and preside over dissertation committees. They define the boundaries of scientific discourse in the field as well as the direction of research. This structure of the discipline of narcology prevents dissenting views from being widely disseminated and influencing the field. It also precludes a process of
learning through exposure to the international norm on treatment and prevention of drug addiction.

While HIV/AIDS specialists in the Russian Federation advocate for the use of harm reduction approaches in its response to the epidemic, with the absence of state will to create a coordinated approach, the medical community of narcologists had a strong influence on the policy-making process. Narcologists historically had the most leverage on policy regarding treatment and prevention of drug addiction and have remained a major force in the opposition to harm reduction approaches. The discipline of narcology identified the range of possibilities in the treatment and prevention of drug addiction from which other agencies could choose from appropriate policies and acceptable interventions. As the HIV/AIDS epidemic emerged, prominent narcologists began to actively oppose harm reduction interventions making their views known to general public as well as to policy makers.

Prominent narcologists were also a part of the government agencies that enacted drug legislation and initiatives. Their policy initiatives were not exclusively focused on domestic policies, but also helped to enact UN conventions on drug control, as well as subsequently interpreting them for the domestic implementation in Russia. While UN drug conventions do not recommend a zero tolerance drug policy; nevertheless, these conventions were interpreted for USSR and Russian legislation to prohibit harm reduction entirely. Opposition to harm reduction became the cornerstone in the career of one of the first narcologists in Russia, who was also a head of the Russian delegation in the UN Commission on Narcotic Drugs.
Third, the review of the role of prominent narcologists in the Ministry of Health and the Ministry provides additional evidence that the primary prevention of drug abuse was shaped by a small elite of drug addiction specialists who occupied key positions in these ministries from the onset of the HIV/AIDS epidemic.

Prevention of the sexual transmission of HIV/AIDS

Prevention of the sexual transmission of HIV/AIDS is another key part of the international consensus on HIV/AIDS and central to primary prevention. In Russia, while some measures to prevent sexual transmission are undertaken, policy analysis demonstrates that these measures constitute an absence of compliance with the international norm and best practices. In the second part of my argument I explain why this is the case. Building on Gomez’s research (2006) that compares governmental response to the HIV/AIDS epidemic in Russia and Brazil, I apply James Morone’s (2003) theory of a “politics of morality” to the Russian case to explain the reluctance on the part of the government to provide social goods in the form of preventive policies. First, I discuss Morone’s theoretical approach to the study of the politics of morality. Second, I trace the development of conservative politics of morality in the Soviet Union. Third, I show that conservative politics of morality in the Soviet Union shaped family, reproductive health, and women’s policy that determined provision of contraception and prevention of sexually transmitted diseases. A conservative politics of morality also shaped attitudes towards sex, sexuality, and sex education, which was replaced by morality education, a tradition that was carried into the Russian Federation as well. Finally, I demonstrate that the prevention policies, developed during the Soviet era
remained unchanged in the Russian Federation during the HIV/AIDS epidemic and was only reinforced by conservative morality politics in Russia. I show that although morality politics undeniably influenced multiple political, public policy, and cultural spheres in Russia and shed the element of communist ideology, the principal explanations of social phenomena and grounds for provision of social goods remained intact. The newly formulated conservative politics of morality contributed to the longevity of the Soviet policy approach to contraception and sex education.

*James Morone’s Theory of Moral Politics*

James Morone (2003) argues that a moral tradition that dominates a society might influence a country’s health policy. In discussing the politics of morality, Morone delineates two traditions—conservative morality and the Social Gospel morality. Social unity is understood quite differently in these moral traditions: for example, if a Social Gospel politics of morality dominates, society does not draw strict lines between categories of the moral “us” and the immoral “them” (Morone 2003). These attitudes are reflected in policy-making—social groups are not excluded from the provision of public health based on the status of their moral deservedness. When a conservative moral tradition prevails, there is a tendency to place blame on individuals themselves instead of looking for structural causes of what is perceived as sinful behavior—for example alcoholism and prostitution. Under a conservative moral tradition, rather than addressing possible structural causes of the social or health problem, social groups that are perceived as “sinners” are marginalized. Additionally, the enacted policies seek to protect the “pure”—families, mothers and children—from any infraction by sinners and exposure to sinful behavior or influence. The dominating moral tradition has a direct effect on the
welfare and healthcare provisions. Healthcare programs are more likely to be generous at a time when a Social Gospel form of morality politics predominates. Moreover, healthcare programs are expected to be inclusive. Regarding implications for an HIV/AIDS epidemic, under a Social Gospel-type morality, it would be expected that the HIV/AIDS epidemic would be addressed as a problem that affects society as a whole, rather than it being viewed as a problem stemming from marginalized “sinful” populations.

**Politics of Morality in the Soviet Union**

In the Soviet Union, a conservative politics of morality emerged to explain the moral shortcomings of Soviet society. From the very early years, the Soviet government conceptualized the model Soviet citizen in moral terms. The conceptualization of the Soviet man led the Soviet government and its ideologists to identify not only the model citizen, but also the “moral others” (Cullen and Cullen 1977). The “sinners” and the morally corrupt were claimed to exclusively belong to bourgeois societies outside of the Soviet Union. However, at the end of the 1920s, it became evident that behaviors and attitudes seen to be inconsistent with the moral ideals of the Soviet man—or the socially deviant behavior—could not be entirely obliterated from the Soviet Union. Criminality, prostitution, alcoholism, and other forms of “social deviance” were an intractable part of Soviet society. A need emerged for ways to not only identify but also explain this behavior in ways consistent with the morality of Soviet society (Cullen and Cullen 1977, 392). A conservative politics of morality developed in the Soviet Union as an attempt to reconcile the communist ideology with the reality of the Soviet society that was plagued by the same sins as the bourgeois society of Tsarist Russia and the West. The notion of
social-parasitic elements was born. A category that included different social groups disenfranchised by the state. If members of these groups of people could not be re-educated, they could be officially viewed as socially harmful elements (Panin 2004). Soviet society became divided into the moral “us”—“good” Soviet citizens—and the immoral “them”—deviant elements that did not fit the model of the Soviet man. During the first three decades of the Soviet Union, communist morality existed as an unwritten principle; however, it was eventually codified in the 1960s with the adoption of the Moral Code of the Builders of Communism. The moral principles, formulated in the early years of the Soviet Union and subsequently codified during Khrushchev’s tenure, had characteristics that became consequential for the policy-making process in the areas of family planning and prevention of sexually transmitted disease. Soviet morality identified moral others—deviant elements—within Soviet society as well as the morally pure—predominantly mothers and children who needed protection. These moral principles became part of the public health discourse to justify family planning and contraceptive policies.

*Family planning and Reproductive Health Policies in the Soviet Union and Politics of Morality*

During the early years of the Soviet Union, a genuine debate about traditional family, equality for women, sex, and sex education took place. The traditional family was perceived as harboring bourgeois values. This debate was resolved with the emergence of a conservative morality politics. The debate about the family ended with the resolution to protect the traditional family unit. The debate about sex ended with policies recommending sexual abstinence before marriage, sexual restraint within marriage,
monogamy, and reproduction as one of the major obligations to society. This politics of morality exalted the traditional family ideal and at least rhetorically intended to protect women and children.

These attitudes towards family had consequences for the provision of contraception and sex education in the Soviet Union. The conservative position regarding family was consolidated with the adoption of a new family law in 1936, having children proclaimed to be a “sacred parental duty” (Madison 1972). The discussion of contraception became taboo and was only allowed insofar as it helped to regulate high abortion rates (Heer 1965, 539). Abortion was the predominant method of contraception in the Soviet Union. It was banned from 1936 to 1955; nonetheless, high abortion rates persisted even after the ban was lifted.

However, sex education in the Soviet Union was affected the most by these developments in a politics of morality. It was subsumed under a morality education. Morality education emerged in the late 1920s and became the main means through which communist morals were supposed to be inculcated. The Twelve Commandments that were published at the time and dealt with questions of sex had a strong influence on sex education. The idea of the commandments was that “the energy of the proletarian should not be deviated to sexual connections, irrelevant for its [proletariat’s] historical role” (Stepanov 2004). One of the prominent theorists of education, Anton Makarenko, also did not support special methods for sex education. He believed that sex education of children should be achieved through morality education in the family. Makarenko’s views on morality education and emerging attitudes towards sex led to the fact that sex
education was never introduced in the Russian Federation. Instead, the government created morality education as an indirect method to teach morality through sex education.

The outcomes of the Soviet policies regarding family planning, reproductive health, and sex education became evident during the Perestroika period. The uncovered statistics of induced abortions in the Soviet Union revealed that the rate of abortions in the Soviet Union was the highest in the world (Popov 1990; 1991). The population’s knowledge about contraceptive methods was nearly absent (Popov, Visser and Ketting 1993) and the topic of sex itself became taboo (Kon 1993).

*Morality politics in the Russian Federation and prevention of HIV/AIDS*

After the collapse of the Soviet Union, Russian society was faced with the uneasy task of searching for a new identity. While it managed to distance itself from communist ideology, a conservative morality politics—recast to represent a new system of values—continued to greatly influence social policy-making by providing explanations for social and political processes in the country. Analysis of the political discourse adopted by political leaders reveals that they embraced the conservative politics of morality as well. The cornerstone of a conservative politics of morality attributes blame for social ills to individuals themselves and concentrates on the protection of the “pure” in society.

Analysis of social legislation enacted by the Duma allows me to demonstrate that a politics of morality is not merely a discourse, but also reflects how policy-makers understand social problems. The recent legislative initiatives that focus on family, family values, and protection of children are a reflection of a conservative politics of morality. On the one hand, policy-makers reify the family and define policy values evoking religious terms, but on the other hand, they contend that the responsibility for the
protection of family values lies with the individuals themselves, rather than on a society as a whole. Policy-makers either enact or discuss measures that are punitive in their character. Instead of analyzing and addressing structural factors that weaken nuclear families in Russia, policy-makers suggest punitive measures such as taxing divorce.

Another set of evidence that a conservative politics of morality are influencing Russia’s process of policy-making is the prominence of the discourse to protect children and their purity. Homosexuals were cast as a threatening social group for children. The 2013 law seeks to protect children from the “propaganda of non-traditional sexual relationships” (Federal Law from June 29, 2013 N 135-FZ). Not only did this discourse become extremely visible in domestic affairs, but also spilled into the international conflict regarding international adoptions of Russian children. Specifically, the Russian Federation legislatively prohibited American adoptions of orphaned Russian children (On Sanctions 2012). The conservative morality politics discourse identifies social groups and threats that affect children’s wellbeing and purity and seeks to legally protect them.

However, it is the desire of policy-makers to protect children from sex education that became particularly consequential for the prevention of the HIV/AIDS epidemic. The resistance of policy-makers towards sex education is cast in a conservative politics of morality language that goes as far as seeking to protect children from any mention of sex. Despite the fact that the Russian Federation has ratified several international conventions that make sex education mandatory, it did not make any steps to introduce sex education. What the Russian Federation relies on instead is morality education, research on which continues in the Russian Academy of Education and has strong ties to the morality education tradition of the Soviet Union. Although the positions of the Health Ministers on
Sex education were not consistent, most of them strongly preferred traditional morality education. Morality education is supported in Russia by both the Ministry of Health and the Ministry of Education, the two institutions in Russia that, in coordination, develop and implement policies on the prevention of sexual transmission.

Thus, I contend that resistance to implement a comprehensive educational program on sexual health in the Russian Federation can be explained by the dominance of the political sphere by a conservative politics of morality that precluded the implementation of sex education and condom contraception methods that are considered by the international norm to be effective and important methods of prevention of HIV/AIDS.

4 Literature Review

In my explanation of Russia’s response to the HIV/AIDS epidemic, I examine the medical epistemic community, the politics of morality, and the policies of prevention as institutional legacies of a previous historical period. These policies function as path-dependent institutions that determine state response to the epidemic. In the post-Soviet space, institutional continuity and change have been examined extensively in the literature on communist legacies.

There exists general reluctance in political science literature to consider policies to be institutions. There are several difficulties with the study of policies and their effects. First, policies, due to their plasticity, are viewed as epiphenomenal and, second, the range of policies or their heterogeneity also make it difficult to create a unified research agenda for their study (Pierson 2006, 4). However, Paul Pierson contends that objections to study
policies as institutions could be easily overcome and that recognition of policies as important instances of political institutions would allow us to better understand the activities of a government (Pierson 2006, 3). Following these observations, in this study, I adopt an approach of examining policies as institutions rather than as policies per se. A demonstrated stability of preventive health policies over time in the Russian Federation allows me to examine policies as institutions during Russia’s response to the HIV/AIDS epidemic. While the literature on post-Soviet legacies previously examined the influence of institutional legacies on political outcomes in the Russian Federation, it rarely treated policies as institutions that can produce political outcomes. I review insights from literature on Soviet legacies, their theorized impact on the politics in the post-Soviet space, and delineate how these insights could be applied to understanding institutional legacies in the context of the HIV/AIDS epidemic in the Russian Federation.

**Soviet Legacies**

Initially, immediately after the fall of the Soviet Union and the collapse of communism, there were two camps regarding the prospects of political and economic development in the post-Soviet space. One camp contended that legacies of the past, generated under the Soviet Union, would shape political and economic development (Comisso 1995). Another camp believed that political and economic development would occur predominantly under the influence of the institutions that emerged or were engineered immediately after the fall of the Soviet Union (Sachs 1992, Sachs and Lipton 1990). Political transition that occurred following the fall of the Soviet Union represented an opportunity for the study of the continuity and change of political institutions. The
collapse of the Soviet Union is considered within the literature a critical juncture.\textsuperscript{10} There was an expectation that many of the institutions of the Soviet Union would be rejected due to a “democratic impulse” in post-communist politics (see for example Luong 2002). There was an impetus to examine political space in the Russian Federation as a tabula rasa not connected to the previous political period. However, despite the emergence of new, formal political institutions, such as electoral systems, parliaments, and judicial systems, there was an increasing awareness that while many institutions from the previous political period dissolved, many formal and informal institutions persisted. There is consensus in the literature that the communist past matters. Yet, there is much less agreement and precision in the literature regarding the conceptualization of legacies, the degree of the importance of existing legacies, and the mechanisms through which legacies exert their influence on political processes of the current historical period.

\textit{Classification of Legacies}

Legacies research is complicated by an absence of an agreed upon concept of legacies and previous historical analysis that do not explicitly refer to the phenomena of communist legacies in their analysis by some political scientists (LaPorte and Lussier 2011, 638). While political science attempted to do both—to explain causal mechanisms that held these legacies in place after the fall of the Soviet Union and to interpret these

\textsuperscript{10} Critical juncture could be defined as “a period of significant change, which typically occurs in distinct ways in different countries (or other units of analysis) and which is hypothesized to produce distinct legacies” (Collier and Collier 2002, 29).
legacies as causes of some other political outcomes—the literature on Soviet, communist, or Leninist legacies does not offer a unified framework for treating these legacies as a dependent or an independent variable in the political process.

However, there were some fruitful attempts in the literature to create typologies of Soviet legacies to explain their influence on political outcomes and to clarify causal mechanisms that lead to the persistence of these legacies. LaPorte and Lussier, for example, offer a two-dimensional typology that divides social, political, and economic Soviet legacies into behavioral, attitudinal, and institutional types (LaPorte and Lussier 2011).

The relationship of legacies literature to the historical institutionalism literature remains unclear. Historical institutionalism literature developed explanations for institutional continuity over time, institutional change, and the role of critical junctures. Yet, the legacies literature makes a claim that it differs from historical institutionalism because it examines not only institutions, but also the persistence of attitudes and behavior from the Soviet period (LaPorte and Lussier 2011).

One robust observation of contemporary politics in the post-Soviet space is the factor of the weakness of civil society (Howard 2003). The Soviet legacies that lead to a weakness of civil society are the persistence of personal networks (a behavioral legacy) and mistrust in formal institutions of the state (attitudinal legacy) (LaPorte and Lussier 2011, 468). I contend that legacies literature provides additional insight into the studies of how the past matters in current politics and provides a framework to look beyond formal institutions to understand the political process of the present.
How to Recognize Legacies

Most of the research on Eastern Europe considers the collapse of communism in 1989-1991 as a critical juncture with the greatest significance. Therefore, for events to be considered communist legacies, they should be present both under communist regime and persist into the period after its collapse (LaPorte and Lussier 2011, 645). However, the literature does not draw a clear distinction between legacies and non-legacies. Wittenberg suggests the following steps to recognize a legacy: first, there should be an “outcome (or a pattern of outcomes) that appears inexplicable given contemporaneous circumstances” (Wittenberg 2013, 6); second, “there must be a precursor of the outcome that is identified as a cause or correlate of that outcome” (Wittenberg 2013, 7); and third, there should be a mechanism proposed that connects the cause or precursor to the outcome.

Wittenberg suggests two caveats in the study of legacies: to verify that in both historical periods, before and after the critical juncture, it remains the same phenomenon. Sameness of the phenomenon should not be understood as “unchangingness,” but rather as the “stability of key features, unbroken existence, or pragmatic comparison of what counts as the phenomenon in each period” (Wittenberg 2013, 21). Another one is a distinction that should be drawn between two conceptions of legacies: first, it could be viewed as a continuation of itself overtime or second, it could be viewed as an outcome of a causal chain where the outcome is phenomenologically different from the prior elements. Most of the communist legacies literature concentrated on observing legacies as causal outcomes of phenomena from prior historical periods.
Institutional Legacies in Russia

Legacies literature instructs us that Russia’s response to the HIV/AIDS epidemic was shaped by Soviet legacies. First, in Russia’s dealing with the HIV/AIDS epidemic there was a policy response that cannot be explained well by current circumstances. This discussion of legacies literature, demonstrates that in Russia, the content of preventive policies as well as the policy-making process had not changed fundamentally since the Soviet Union. While some of the elements of preventive policy undoubtedly evolved, the core principles of policy approaches remained constant in the post-Soviet period. Therefore, we observe phenomena that represent sameness quality (Wittenberg 2013).

To Wittenberg’s second condition of phenomena having a precursor or a correlate of the outcome, we observe that a conservative politics of morality, that shaped social policy in the Soviet Union, was informed and shaped by communist morality. In the Russian Federation, the ideological framework of conservative morality changed; however, the core principles of this conservative morality and its influence on social policy remain very much the same. Similarly, the medical community of drug addiction specialists did not change its views on the nature of drug addiction in fundamental ways. In the same way, the process of preventive policy formulation, while evolving over time, has retained similar principle factors that structure policy outputs.

Conclusions from Legacies Literature

Several observations could be drawn from the Soviet legacies literature. First, post-communist Russian society cannot be viewed as a blank slate upon which any social or political institution could be drawn (Pop-Eleches and Tucker 2011). Second, processes
that significantly diverge from theoretical expectation become suspect for the influence of Soviet legacies in the form of institutions, behaviors, and beliefs. Vis-à-vis legacies literature, this dissertation explores a case when communist legacies function as a causal variable. I seek to examine the effects of Soviet legacies on political outcomes in the post-Soviet space. Yet, this work also contributes to understanding the strength of these legacies themselves and their persistence in Russia after the fall of the Soviet Union.

In this account, I use communist legacies as an explanatory variable that illuminates politics of current day Russia. I treat policies of HIV/AIDS prevention as an institutional outcome of the Soviet Union. However, I also explain the emergence of these legacies and explain why they became impermeable to change. In my research I do not intend to black-box communist legacies, but rather seek to delineate their content and explain the causal links that connect these legacies to the political process in current day Russia. In response to the HIV/AIDS epidemic, policy options available to policy-makers were restrained by the legacies of the past. As a result, the medical epistemic community and drug addiction policies were shaped and influenced by these legacies. Similarly, policies regarding the prevention of HIV/AIDS through sexual transmission were shaped by a politics of morality.

5 Alternative Explanations

Diffusion of HIV/AIDS policy is examined within the growing political science literature on state response to epidemics. This literature seeks to address variation of state response and does not address policy diffusion as a separate question. Factors that would intuitively be suspect in improving responses to the HIV/AIDS epidemic, such as high
economic capability and a democratic governance, do not serve as predictors of a successful response: “the governments that have responded most effectively and vigorously to [the challenge of HIV/AIDS] are not the wealthiest, best institutionalized, or even the most democratic” (Boone and Batsell 2001, 6). This section reviews alternative explanations that could offer insight into Russia’s reluctance to implement the entire set of preventive and treatment measures from the Geneva consensus on HIV/AIDS in the country. The section demonstrates that: 1) the literature on state response to epidemics does not provide conclusive explanations regarding state response and 2) explanations that have been previously offered within the literature, generally and pertaining specifically to the Russian case, exclusively examine current actors and do not take into account the influence of path-dependent processes in influencing policy-making.

**Political Regime**

The type of political regime appears to be one of the factors that could potentially explain variation in state responses to epidemics. Democratic governments are expected to be more responsive to the HIV/AIDS epidemic than non-democratic ones. Amartya Sen, in his inquiry into causes of famines, discovered that independent democratic governments with a free press historically did not experience significant famines (Sen 1983). Based on these findings, we would expect to observe that democratic governments have a much quicker response to the HIV/AIDS epidemic along with a more comprehensive implementation of the norm from the Geneva consensus on HIV/AIDS. In a democratic government, the unrestricted flow of information would make the issue of
HIV/AIDS salient and would lead to pressure on the government to act. In an undemocratic government, where information is much easier to suppress, the issue of HIV/AIDS would be much easier to eliminate from public view and a state’s response could be delayed.

However, the public health literature suggests that, contrary to Amartya Sen’s expectations, response to healthcare threats might be more successful in authoritarian regimes. In fact, literature that examines relationships between a given state’s regime and extent of immunization programs suggests that a democratic regime does not correlate with an implementation of more extensive immunization programs. Gauri and Khaleghian, in their study of variation in immunization rates in democracies and autocracies, find that democracies have lower coverage rates than autocracies (Gauri and Khaleghian 2002, 34). However, this effect is not visible in low-income countries (Gauri and Khaleghian 2002, 35). The mechanism that could explain why there is a difference between democracies and autocracies in the allocation of resources in public health programs needs further examination.

An explanation of this discrepancy in implementing public health measures might lie within the logic of public health interventions. A utilitarian reasoning behind immunization programs maintains that, for the greater good of a society, most individuals have to undergo the inconvenience of immunization, which could potentially have harmful side-effects for some. Restriction of individual freedoms and liberties of those opposed to immunization inevitably occurs as a result of immunization campaigns. Therefore, immunization is more successful in autocratic regimes that are shielded from negative public opinion and where individual rights and freedoms are easier to suppress.
This logic might apply in a state’s response to the HIV/AIDS epidemic as well. For example, Uganda’s successful response to the HIV/AIDS epidemic is attributed to the country’s lack of democratic governance (Putzel 2004). The efforts of central government to coordinate organizational and international aid resources, as well as the actions of the non-governmental sector, were not scrutinized by the public and the government was able to use its authority in an unrestricted way in manufacturing response. Studies of the responses to the HIV/AIDS epidemic also reveal that the effect of the state’s regime on the state’s response to the epidemic is mixed (Boone and Batsell 2001, Gauri and Lieberman 2006, Hyden and Lanegran 1993). Regime theories do not predict success of state response to the HIV/AIDS epidemic.

It is not clear what role authoritarianism played in Russia’s response to the HIV/AIDS epidemic. Its political regime can be characterized as authoritarian, with a short-lived democratic opening after the fall of the Soviet Union.11 Press is also significantly controlled (Shleifer and Treisman 2005, 165). On the one hand, it can be argued that the government is not responsive to the demands of civil society to implement aggressive measures to address co-existing HIV/AIDS and the drug addiction epidemic. On the other hand, in the past, the authoritarian regime of the Soviet Union was successful in taking care of epidemics. In the Soviet Union, efforts to address the malaria and plague epidemics after the civil war (Izmailova 1996), the polio epidemic in the 1960s (Chumakov, et al. 1961), and the large-scale vaccination against influenza

11 From 2001 to 2004, Freedom House ranked Russia “partly free” with a score 5 for civil liberties and a score 5 for political rights. From 2005 to 2014, Freedom House ranked Russia “not free” with a score 5 civil liberties and a score 6 for political rights (1=best; 7=worst).
(Slepuskin, et al. 1967) were quite successful. The Soviet Union was also able to carry out invasive mass vaccination campaigns as well as mass screening for tuberculosis that covered 75% of the population in 1985 (Rechel, et al. 2011, 295). Given Russia’s experience with invasive public health campaigns, I conclude that the lack in state’s current effort to respond adequately to its HIV/AIDS epidemic cannot be explained by its political regime alone.

Civil Society

Boon and Batsell observe that democracies, by addressing publicly the AIDS challenge, are more likely to create partnerships with NGOs to advance AIDS prevention and education efforts (Boone and Batsell 2001, 12). Also, research on the AIDS epidemic in Africa demonstrates that NGOs played an important role in evoking a state response in the first place. However, the presence of a strong civil society, such as in South Africa, was not sufficient to ensure an effective response. Decision-makers there were insensitive to the mobilized civil society network (Gauri and Lieberman 2006, 57). Therefore, the presence of civil society organizations is not sufficient for motivating an aggressive or comprehensive response to the HIV/AIDS epidemic from the government.

In the Russian Federation, as in many other post-communist states in Europe, civil society remains weak and poorly organized.12 It lacks resources to successfully pressure _________________

12 Weakness of civil society in post-Soviet states is well documented in the literature. Citizens of post-communist regimes do not join civil society organization because of distrust in public organizations, satisfaction with personal networks and disappointments with the development in the post-communist politics (Howard 2003, 145).
the government for a more aggressive response. Moreover, in recent years, the Russian Federation has even restricted further the activity of the NGOs in its territory. In 2012, the government passed a law that stipulated that all nongovernmental organizations which had foreign funding to list that they were “foreign agents” in their title. Civil society did not become a prominent factor in ushering in an HIV/AIDS policy. Despite these shortcomings, NGOs did play a role in addressing the epidemic predominantly on local and regional levels (Pape 2013).

My very limited number of interviews with some of the leaders and members of NGOs reveal further weakness in the role of NGOs in the epidemic. Russian NGOs remain divided on the implementation of prevention measures. Some organizations, particularly those that do not receive funding from the government, express support for harm reduction measures and criticize the government’s response. Some of those that receive funding adopt the viewpoints of the state. Because these interviews were so limited, I cannot conclude that this is a general underlying trend in civil society organization. However, it is clear that NGOs were not able to effectively challenge the authority of the state in the HIV/AIDS epidemic.

**Level of Economic Development and Funding of HIV/AIDS Programs**

The level of economic development of the state has been used as an explanation of failure of some states to respond to the HIV/AIDS epidemic. While funding of HIV/AIDS programs has not been a priority for the Russian government, the lack of funding itself does not explain the substandard response to the epidemic. Russia allocated significant funds to address its HIV/AIDS epidemic, particularly by 2006 (Goliusov, et
al. 2008). However, I argue that HIV/AIDS and drug addiction policies influence the way this funding is allocated. It leads to a disproportional underfunding of preventive policies. Yet, this is the outcome of drug addiction policies, rather than their cause. There are two patterns in fund allocation that exacerbate the epidemic. First, even with increased funding to address the HIV/AIDS epidemic, the government allocates insignificant funds to be spent on prevention. For example, the country pledged to increase HIV/AIDS spending to $600 million in 2012, but only less than 3 percent of this money would be allocated for preventive interventions (Ferris-Rotman 2011). Second, another strong preference in Russia’s policy is to address supply rather than the demand side of drug addiction. Therefore, a significant portion of resources is allocated to enforcement institutions, including the police. These funding patterns and policy restraints further exacerbate the lack of implementing effective prevention in the HIV/AIDS epidemic (Malinowska-Sempruch and Gallagher 2004, 195). However, these patterns are consequences of drug addiction policies rather than their causes.

**Domestic Institutions**

Another set of explanations examines the role of domestic institutions in preventing an effective response. In countries with significant ethnic cleavages, where boundary institutions separating these ethnic groups are present, they can deter a prompt governmental response. In Brazil and South Africa complexes of formal and informal institutions “which involve monitoring or regulating citizens according to particular group identities “play a significant role in policy formation (Gauri and Lieberman 2006, 47, Lieberman 2009). In those societies with divisive institutions, elites are less likely to
feel vulnerable and the government response is not likely to be aggressive. Although racial cleavages exists in both Brazil and South Africa, in Lieberman’s study, the presence of strong boundary institutions in South Africa significantly slowed policy formulation and implementation in response to its HIV/AIDS epidemic. Brazil, on the other hand, without such an institutional impediment, was able to respond effectively and in a timely manner (Gauri and Lieberman 2006, Lieberman 2009). Lieberman recognizes that while there might be other groups constructed by boundaries of class, gender, and age, his theory is primarily concerned with groups constituted by ethnic boundaries. While gender and class are also categories that create social groups, the variation of gender and class is less observable across societies than ethnicity and therefore less useful to serve as an explanatory variable (Lieberman 2009, 31).

The boundary institutions argument, suggested by Lieberman, provides insight to explain variation in response to the HIV/AIDS epidemic in the countries where ethnic cleavages are present. Although the Russian Federation has a multiethnic society, ethnicity is not a category that has political salience with the exclusion of several regions, such as the North Caucuses and where migrant workers from former Soviet Republics reside. In Lieberman’s story, the response to HIV/AIDS might be delayed because the threat of the disease can be interpreted as a “selective bad” (Lieberman 2009, 42). However, in the Russian Federation, the discourse surrounding the HIV/AIDS epidemic was not discursively interpreted as a disease that exclusively affects some ethnic groups but not others. Similarly, in Russia, ethnic boundary institutions do not have a significant effect on policy-making. In Moscow, the emergence of the HIV/AIDS epidemic was blamed on migrant workers, who belong to minority ethnic groups. However, this
narrative regarding causes of the HIV/AIDS epidemic did not receive prominence in Russia’s response.

*Federalism and Decentralization*

The level of centralization of power has been hypothesized to play a role in state response to epidemics. However, current research is not conclusive on the effect of power centralization upon state response. For example, Gauri and Lieberman observe that in Brazil, where power is much more fragmented due to the legacy of federalism, the response of the national government to the epidemic has been much more aggressive compared to South African, where power is centralized (Gauri and Lieberman 2006). However, reversal of this logic is also foreseeable: states with strong vertical hierarchies of power could be more efficient in adopting a national plan of response and in mobilizing resources. In such cases, with presence of state will, a successful response could be very likely.

Although Russia is a federation, the power is predominantly concentrated in the central government and the government is not responsive to its constituencies at the local level. The sluggish response to the HIV/AIDS epidemic in Russia might be explained by a general impervious orientation of the state to local demands.

*Inaccurate Perceptions of the Scale of HIV/AIDS Epidemic*

Countries in the post-Soviet space, including the Russian Federation, experienced the advent of the HIV/AIDS epidemic with a delay. Although the rate of the epidemic itself is high, Russia has not seen a large number of deaths due to HIV/AIDS, since it
takes anywhere from 10 to 12 years for the development of the disease. According to official statistics, since the beginning of the epidemic in the year 2002, only 2,095 people died from the disease (Grisin and Wallander 2002, 4). The scale of the epidemic is not felt by the population at large. Additionally, the problem of inaccurate statistics undermines the possibility for an adequate response. According to the UNAIDS 2009 Country report, the Federal AIDS Center reported 516,167 registered cases as of October 31, 2001 (UNAIDS 2009). However, the actual number of HIV/AIDS patients according to the estimates of international and some Russian experts could be as high as 940,000 with the estimated range from 630,000 to 1.3 million (UNAIDS and WHO 2008, 224). The government might not have accurate statistics because the infected population may consist of high risk groups like sex workers and drugs users who are unlikely to seek medical help for their conditions. Thus, these populations are not captured by official medical statistics.

Another strongly held belief about the epidemic which might interfere with the state response concerns the stages of the HIV/AIDS epidemic development. There is a “commonly held belief that the AIDS epidemic has peaked” (Grisin and Wallander 2002, 4). However, the executive director of UNAIDS Peter Piot contended in 2002 that the HIV/AIDS epidemic has not even reached its peak in Africa (Grisin and Wallander 2002, 4).

The inaccuracy of HIV/AIDS epidemic statistics internally distorts the scale of the epidemic not only for the state itself, but also for the workers in the medical sector. Public health officials and public health workers who deal directly with the HIV/AIDS problem do not regard the HIV/AIDS epidemic as severe. The results of Gerber and
Mendelson’s survey of Russian doctors regarding the HIV/AIDS epidemic demonstrate that while most doctors perceive the epidemic as “catastrophic,” only 15 percent believe it to be the most serious health problem (Gerber and Mendelson 2006, 1). Some doctors believe that HIV/AIDS is a result of moral decline and that “certain groups of HIV patients should not receive government subsidized ARVs” (Gerber and Mendelson 2006, 2).

Also, “[f]ew believe that the disease poses a major threat to Russia’s economy or military capabilities” (Gerber and Mendelson 2006, 28). HIV/AIDS is perceived by the population as a problem confined to intravenous drug users. The demand for the dramatic government response to address the epidemic is rather low (Gerber and Mendelson 2006, 36). There is no direct pressure from the physicians working with HIV/AIDS patients because of an absence of awareness about the scale of the epidemic on the national level and a stigmatized view of drug users and people with HIV/AIDS.

The Role of State Identity

Some demonstrate that state identity might play a role in Russia’s failure to respond appropriately to the HIV/AIDS epidemic (Kravtsov 2015). Kravtsov argues that the demands of the epidemic were not consistent with the emerging social purpose of the state. He builds on Rawi Abdelal’s theory that state social purpose can define a state’s policy orientation (Abdelal 2001). Kravtsov suggests that the social purpose can function as an intervening variable that can alter the process of policy learning and therefore of policy transfer. This approach to understanding the response to the HIV/AIDS epidemic
has a lot of merit. It serves to explain not only the general unwillingness of the government to respond, but also the selective implementation of international policies.

In the Russian Federation, Kravtsov argues, elites’ conceptions of social purpose were formulated as a “Sovereign Democracy”. The values of sovereign democracy were the “ultimate value of stronger state power … with a special stress on its social responsibility and economic delivery in the context of a state-led economy, and the necessity to reassert and actively exercise Russia’s great power status in global politics” (Kravtsov 2011, 442). This newly coined identity of the state defined in turn conceptions of common good that determined which policies were legitimate and suitable for this overarching social purpose (Kravtsov 2011, 387). Provision of antiretroviral therapy for treatment of the disease became the “fundamental common good” because the HIV/AIDS pandemic “threatens the existence of the state and hinders the physical survival of population” (Kravtsov 2011, 387). According to Kravtsov’s theory, certain international policy choices could challenge domestic legitimacy and therefore were out of reach for domestic policy-makers (Kravtsov 2011, 444). Therefore international best-case practices were significantly filtered when adopted in the Russian Federation; this explains discrepancies between international norms of response and policies adopted in the Russian Federation. In his account, Kravtsov mainly concentrates on the provision of treatment as a common good and explains the absence of harm reduction practices by their incompatibility with the social purpose of the state.

Applying an elite-level explanation to Russia’s entire response to the HIV/AIDS epidemic appears to be somewhat problematic. Kravtsov contends that some aspects of the international norm and best-case practices were not considered by the country’s elite,
even when exposed to international norms, due to the newly emerging identity of the state. However, I argue that the story in the Russian Federation is complicated by other domestic factors whose influence Kravtsov did not consider in his explanation. First, Russian elites and members of the Russian legislature did not consider HIV/AIDS significant enough to even be a part of their political agenda as members of the Russian Parliament. At the time of my interviews, only one member of the Duma was still actively pursuing a response to HIV/AIDS as part of the political program. A multisectoral Governmental committee on HIV/AIDS which was supposed to construct a national HIV/AIDS strategy gathered only a handful of times. Policy-making and the implementation of a response to the HIV/AIDS epidemic and its prevention were left to the devices of the Ministry of Health and the Ministry of Education, where, I contend an entirely different set of dynamics explains lack of preventive policies in response to the HIV/AIDS epidemic. The involvement of the political elites and the Duma in response to the epidemic ended with the enactment of the 1995 Legislation to address the epidemic.

Western Linkages

Insights from the research on linkages and regime change could also provide insight into the causes of partial policy adoption. Levitsky and Way understand linkages as the density of a country’s ties with the United States, the European Union, and Western-led multilateral institutions (Levitsky and Way 2005). In Levitsky’s and Way’s account, these ties can contribute to regime change: varying levels of Western leverage and linkages raise the cost of an authoritarian regime. Levitsky and Way theorize five
dimensions of ties to the West: economic, geopolitical, social, communication, and transnational civil society linkages.

It appears that the presence of linkages can, first, facilitate learning in response to the epidemic, not only on the elite level as IR theories generally suggest, but direct learning from corresponding actors on domestic level. Civil society linkages would be one of the important factors contributing to the state response to the epidemic. Supported by NGOs from abroad, Russian NGOs would be better equipped to pressure policymakers to make changes in HIV/AIDS policies.

Another pathway through which linkages could work is through professional exchange of the Russian medical community (international influence and the support of the Russian medical community, availability of research funding, and opportunities for scientific exchange.) The majority of representatives of the medical profession were trained in the Soviet Union and received limited educational and clinical training in harm reduction interventions which is largely insufficient to address the challenges they face (Sivolap, interview).

6 Conclusion

In the recent decade, political science, following the lead of such disciplines as public health, sociology, and anthropology, greatly advanced our understanding of state response to the HIV/AIDS epidemic. Previously, studies examined the role of political regime, civil society, level of economic development, inaccurate perception of the scale of the HIV/AIDS epidemic, and the role of state identity in HIV/AIDS response among other factors. These studies concentrated on identifying causes of variation of state will in
response to the epidemic. A weak state will—defined as a demonstrated support for measures against HIV/AIDS by political elites—is correlated with a poor response. However, I show that policy diffusion is an important component of state response to the HIV/AIDS epidemic as well. When countries adopt policies that were implemented elsewhere and shown to be effective in addressing HIV/AIDS epidemic, it provides a further guarantee of success. Why then do some countries shun successful experiences of other states in their response to the HIV/AIDS epidemic as well as international norms and provisions? The question that I consider is which domestic factors preclude policy diffusion in the HIV/AIDS epidemic and shape domestic policy outputs. To examine this question further, I study the response to HIV/AIDS in the Russian Federation, an outlier case in both response to the HIV/AIDS epidemic and in HIV/AIDS policy diffusion.

In my account of Russia’s HIV/AIDS epidemic, I demonstrate that the country did not adopt internationally recommended prevention interventions because of the persistence of Soviet institutional legacies and their influence on policy outputs. I demonstrate that the medical epistemic community and conservative politics of morality shaped preventive policies in the HIV/AIDS epidemic. The role of Soviet legacies in Russia’s response to HIV/AIDS presents a challenge to the alternative explanations of state response that were developed in the literature.

My dissertation further explores the limits of the policy diffusion as well. The case of Russia’s policy development demonstrates that Soviet legacies interfered with constructing policy response commensurate with the scale of the HIV/AIDS epidemic. My examination of path dependent views of Russia’s medical epistemic community and their influence on preventive policy suggests that the role of domestic medical
communities in adoption of harm reduction should not be overlooked in the future research. Moreover, institutional legacies in other parts of the world, such as colonial legacies in African states, and their role in producing political outcomes might further explain instances of poor response to the HIV/AIDS epidemic in Africa as well. This work also suggests that state response should be conceptualized with more precision.

Finally, policies regarding the HIV/AIDS epidemic, shaped by the Soviet legacies, have dire consequences for the people in the Russian Federation. Effects of Soviet legacies create conditions of structural violence that affect vulnerable populations—inmates, people suffering from drug addiction, and sex workers—who are most susceptible to HIV/AIDS infection. The extent of resistance by the Russian medical epistemic community regarding harm reduction solely on theoretical grounds and their support of abstinence approaches for treatment of drug addiction create conditions that some foreign NGOs equate with torture (Albers et al. 2012).

7 The Structure of the Dissertation

The question that I seek to address is what are the causes and causal mechanisms within the Russian case that lead to rejection of internationally recommended policies and adoption of alternative, but suboptimal approaches, to deal with the country’s HIV/AIDS epidemic.

The next Chapter (Chapter 2), first, analyses the structure of the international Geneva consensus on HIV/AIDS. Then, it outlines Russia’s policy response to the HIV/AIDS epidemic and identifies policies that are not consistent with the provisions of the international consensus. Finally, Chapter 2 establishes that intravenous and sexual
transmission of HIV/AIDS are the most neglected areas in Russia’s response to the
HIV/AIDS epidemic.

Then, Chapter 3 examines the intellectual history of psychiatry in Russia and the
psychiatry’s views on treatment and prevention of drug addiction. This chapter reveals
that the psychiatric community and its drug addiction subspecialty (narcology) form the
bedrock of resistance to the implementation of internationally-accepted harm reduction
approaches, which are crucial elements of response to an HIV/AIDS epidemic. Herein, I
establish the causal connection between theoretical beliefs of psychiatry and actual policy
outputs in response to the HIV/AIDS epidemic.

Chapter 4 examines the state’s resistance to implement preventive programs
addressing sexual transmission of HIV/AIDS in Russia. I demonstrate how the role of
conservative ideology, embedded in state institutions, affected policy-making responses
to the HIV/AIDS epidemic in Russia. I maintain that in Russia the conservative
communist ideology shaped the interpretation of the causes of social ills. I examine the
emergence of a conservative morality in Russia in historical context. In this chapter, I
establish the continuity between conservative social policies in the Soviet Union and the
HIV/AIDS policy-making in modern Russia.

Chapter 5 discusses the empirical findings in relation to theories of policy
diffusion. The chapter concludes with a brief discussion of implications for broader
scholarship on policy diffusion and other states that are faced with HIV/AIDS epidemics.
CHAPTER 2
THE INTERNATIONAL CONSENSUS ON HIV/AIDS AND RUSSIA AS AN OUTLIER CASE OF STATE RESPONSE TO THE HIV/AIDS EPIDEMIC

During the second half of the twentieth century, we observed a remarkable increase in policy convergence across disparate issues. The literature on policy diffusion suggests that countries are likely to converge around internationally accepted norms of behavior (Dobbin, Simmons, and Garrett, 2007). These include, for example, public health policies designed to deal with epidemics such as polio, tuberculosis, SARS, and HIV/AIDS. Most countries treat these epidemics in similar—and in some cases, almost identical—ways. When it comes to the prevention of HIV/AIDS, Russia’s policy is, however, an outlier. The goal of this dissertation is to examine why this is the case. In this chapter, I explain the components of the international policy consensus on HIV/AIDS and Russia’s HIV/AIDS policies. The objective is to 1) gain a deeper understanding of the international consensus on state response to the HIV/AIDS epidemic and to examine the ways in which political scientists theorize about this consensus; 2) describe how Russia’s policy response to the epidemic differs from the international consensus; and 3) highlight the ways in which Russia’s approach can be assessed as suboptimal when analyzed through the prism of international norms.

1 The International HIV/AIDS Regime

The international community plays an important role in shaping domestic health policy and defining the basis of domestic response. When the HIV/AIDS epidemic developed as a global threat at the end of the 1980s, cooperation at the international level
to address the global threat of HIV/AIDS became significant. The international institutions lead by UN agencies played a central role in the construction of the international regime to address this epidemic.\textsuperscript{13} As a result of the cooperation of international organizations, NGOs, national governments, scientific communities, and activists, a global norm on how to most effectively respond to the HIV/AIDS epidemic emerged. Besides stipulating how states should frame the epidemic in governmental discourse, the international consensus also specifies measures on treatment provision for HIV/AIDS and on the prevention of the disease.\textsuperscript{14}

The international community reached a consensus on the treatment of HIV/AIDS due to the discovery of the effective treatment of this disease. Initially, the unanimity on the treatment of HIV/AIDS in the international medical community stemmed from the discovery of antiretroviral therapy (ARVs) in 1997 (Montaner et al. 1997, 1042). The guidelines for the therapeutic use of ARVs became the bedrock of the public health response to the HIV/AIDS epidemic and were adopted by international organizations.

By contrast, a consensus on prevention was made difficult by the fact that preventive methods were more contested at the country level and because of the existence of multiple routes of transmission. Initial instances of large-scale epidemic spreading, particularly on the African continent, were driven by the transmission of HIV/AIDS through heterosexual contacts. In some Eastern European countries, however, the

\textsuperscript{13} Krasner (1983) provides a definition of a regime as “implicit or explicit principles, norms and decision-making procedures around which actors expectations converge in a given area of international relations.”

\textsuperscript{14} The international organizations publish a \textit{Handbook for Legislators for the States Facing HIV/AIDS Epidemics} with the guidelines for implementation of effective legislation (WHO 1999).

59
HIV/AIDS epidemic spread later and primarily through intravenous drug use. As the epidemic became more widespread, the international community felt compelled to issue strict guidelines regarding the prevention of HIV/AIDS.

The consensus on HIV/AIDS is somewhat weakened by the fact that the guidelines for states’ response to the HIV/AIDS epidemic are scattered among several documents issued by international organizations and that there is no enforcement or consistent monitoring mechanism from international organizations. Also, while there is an agreement about state response to HIV/AIDS in the international medical community, the international documents dedicated to the HIV/AIDS issue are a subject of interpretation by the states seeking to address the epidemic. States decide which aspects of this consensus prevail. Yet, the international organizations collect data from the states through country progress reports and issue recommendations, consult, and provide resources to train professionals in countries that face the epidemic. Therefore, the international organizations ensure that countries have access to informational resources on response measures and interpret the international consensus correctly.

The interpretation of the international consensus on HIV/AIDS offers a baseline against which states’ performance in their fight against HIV/AIDS can be evaluated. However, in the interpretation of the consensus in the literature, there is no agreement

15 Currently, states facing the HIV/AIDS crisis are advised to closely follow interventions and guidelines for implementation of prevention and treatment interventions created by the Joint United Nations Program on HIV/AIDS (UNAIDS), the United Nations Office on Drugs and Drugs (UNODC), and the World Health Organization (WHO) (Donoghoe et al, 2008).

whether, in order to evaluate state response, researchers should include the evaluation of preventive measures implemented by the state along with the evaluation of treatment. Particularly, harm reduction programs and opioid substitution therapy are not treated as an agreed-upon part of the consensus most of the time.

In my opinion, omitting the analysis of harm reduction policies leads to a misinterpretation of the international consensus on HIV/AIDS. In the section below, I examine conceptualizations of the international consensus developed in political science literature. Then, I provide a historical overview of the development of the consensus and demonstrate that the prevention of HIV/AIDS—and harm reduction programs in particular—is an indispensable part of this consensus. I also explain the role of harm reduction approaches in addressing the HIV/AIDS epidemic. Finally, I analyze Russia’s response to the epidemic, compare it to the expectations of the international norm, and make a conclusion that Russia fails to implement the norm in their response to the HIV/AIDS epidemic.

2 Conceptualizations of HIV/AIDS Response in Political Science Literatures

While political scientists have made a substantial contribution to understanding states’ response to the epidemic, the concentration of the states’ role has been primarily in the provision of treatment for HIV/AIDS (Lieberman 2009). It is not accidental that the international consensus has emerged as a consensus on treatment, given that the effectiveness of the antiretroviral therapy has been well demonstrated and the prices of treatment made it accessible beyond the western world. Later on, treatment was conceptualized as a form of prevention as well, since diminished viral load resulting from
successful treatment leads to lowered possibility of HIV transmission. However, I argue that, since then, the consensus has grown to include prevention and implementation of harm reduction approaches, particularly in epidemics transmitted by drug addiction. Below, I review the contributions of Kravtsov (2011) and Lieberman (2009) in understanding the international consensus on HIV/AIDS. Both authors examine suboptimal state responses to HIV/AIDS through the prism of domestic institutions.

Kravtsov’s Idea of the International Consensus

Kravtsov, in his analysis of the response to the HIV/AIDS epidemic in Russia and South Africa, interprets consensus predominantly as centered on the provision of treatment. He contends that there are three main policy components of the international consensus: treatment, universality, and partnership, for which he offers qualitative indicators (see Table 6). It is problematic that Kravtsov does not treat prevention as a major component of the international consensus. Rather than including prevention as an independent indicator of response, he includes it into the “universality of access to treatment” (Kravtsov 2011, 488-493). Furthermore, he does not include harm reduction programs as an indicator of compliance with prevention norms. Kravtsov’s understanding of the international consensus reflects the global response to the first wave of the HIV/AIDS epidemic. This consensus emerged when the HIV/AIDS epidemic was largely driven by sexual contacts; however, with the development of the epidemic in China, Asia, Eastern Europe, and post-Soviet states, the international consensus has evolved to include prevention and treatment of drug addiction as a major component of internationally recommended interventions.
Yet, even when Kravtsov’s model is used to assess Russia’s response to HIV/AIDS, it can be easily observed that the response of the Russian state deviates from the international consensus on important policy areas: universality of access and treatment. Such indicators as “exclusion of vulnerable groups” and “criminalization of IDUs [intravenous drug users]” already demonstrate that the state does not fully extend treatment to marginalized groups, and in particular, to intravenous drug users. However, with the absence of indicators for harm reduction interventions, the extent of this deviation from the international norm in this policy area cannot be estimated accurately. Also, by concentrating entirely on treatment provision in Russia, we would omit important factors of Russia’s poor response.

*Lieberman’s Idea of the International Consensus*

Lieberman agrees that a global governance regime developed in order to guide global response to HIV/AIDS, which he names the Geneva Consensus because of the leading role of the UN institutions in its creation (Lieberman 2009, 61). An agreement on each one of these areas of consensus required a distinctive group of global actors and initiatives; political consequences of these areas are also expected to be different (Lieberman 2009, 88). Lieberman emphasizes the universality of the access to antiretroviral (ARV) treatment as the main pillar of international consensus and divides its policies into four categories: general bureaucratic development, prevention, treatment, and rights orientation (see Table 7).

While Lieberman does include prevention in his model, he does not include prevention of intravenous transmission of HIV/AIDS as part of the consensus. He argues
that the international consensus regarding needle and syringe programs is not particularly strong and treats the problem of harm reduction approaches in his work rather superficially. He contends that states’ anti-intravenous drug use norms are always stronger compared to harm reduction norms, and therefore there is no global agreement on adherence to these norms. Nevertheless, international documents strongly recommending harm reduction interventions have been agreed upon, and, regardless of the dominant mode of HIV/AIDS transmission, many states adopted harm reduction programs in accordance with international provisions. Central Asian states are one such example. Although such states have prohibitionist policies against drug use, they allow implementation of harm reduction programs. Therefore, while some states continue to reject harm reduction approaches, these preventive interventions occupy a prominent place in the international consensus on response to HIV/AIDS, particularly in the epidemics driven by intravenous drug use.

Between the two discussed models of the international consensus, Lieberman’s is a more comprehensive one. It treats HIV/AIDS prevention as an important aspect of the international global governance regime on HIV/AIDS. However, a major weakness of Lieberman’s model is how it conceptualizes prevention and omits the prevention of HIV transmission among intravenous drug users. I will use Lieberman’s conceptualization of the international consensus as a basis for my own interpretation.

*The International Consensus on Response to the HIV/AIDS Epidemic*

My analysis of the international consensus reveals that framing, treatment, and prevention of HIV/AIDS are the three main areas of international consensus.
Additionally, I demonstrate that harm reduction approaches are an indispensable part of the international consensus on the prevention of HIV/AIDS that is preceded by an agreement of the international medical community on the effectiveness of harm reduction. Furthermore, I contend that in countries where the HIV/AIDS epidemic is primarily driven by the intravenous drug use, in order to assess state response to the HIV/AIDS epidemic, the level of compliance with harm reduction should be considered.

_Framing of the epidemic and protection of human rights_

Some states attempt to portray the HIV/AIDS epidemic as a security threat or a demographic problem, as well as attempt to criminalize the epidemic. Nevertheless, the international consensus encourages states to frame the epidemic primarily as a public health problem. Other ways of framing the epidemic may serve as a justification to further non-compliance with international HIV/AIDS policies; it may lead to discrimination against vulnerable populations, and other human rights violations.

Both framing the HIV/AIDS epidemic and the discourse surrounding HIV/AIDS that states choose to promulgate are not only rhetorical tools of naming the problem but also have significant practical implications. Framing the HIV/AIDS problem in governmental discourse has tangible consequences for resolving the HIV/AIDS problem in a given country. It is a defining foundation for the policies that are devised and implemented by the state to address the epidemic. Also, the official framing determines how the public views the problem, as well—whether the public perceives the HIV/AIDS epidemic as a universal problem or as a health issue affecting only marginalized populations.
The international consensus speaks against some forms of framing because they might entail violations of human rights for individuals with HIV and for people who inject drugs. As I discuss below, securitization of HIV/AIDS has a particularly detrimental effect for people living with HIV/AIDS, though defining the epidemic as a developmental issue is permissible as long as it is not the primary way of framing. The international consensus advises against the criminalization of drug use in the HIV/AIDS epidemic, and this remains a highly contested part of the framing of the problem by nation states.

According to international consensus, the priority for states should be to first frame the epidemic as a public health problem (Kravtsov 2011, 55). Framing the HIV/AIDS epidemic as an economic development issue is also permissible despite some doubts regarding a direct link between the HIV/AIDS epidemic and lagging economic development expressed in the literature. The severity of the effects of the HIV/AIDS epidemic on economic development and consequences for the level of poverty are contested, and some express doubts that HIV/AIDS leads to severe developmental consequences (Haacker 2011). Some argue that it may be more likely that the HIV/AIDS policy agenda have driven conclusions regarding the severe effects of HIV/AIDS on development in general, since HIV/AIDS occurs in already economically disadvantaged countries, possibly further reinforcing their economic difficulties (Haacker 2011, 64). Despite these arguments, the international documents do not find it problematic in the framing of the HIV/AIDS to discuss economic effects of the epidemic in addition to its primary framing.
While framing the epidemic as an economic development issue is permitted by international organizations, they advise against casting the discourse surrounding the HIV/AIDS epidemic as a security problem. On the international level, particularly in the early stages of the epidemic, there were attempts to vest HIV/AIDS discourse into the securitization language. For example, when talking at the UN Security Council session in 2001, the president of the World Bank, James Wolfensohn, pointed to the dangers of HIV/AIDS for international security:

Many of us used to think of AIDS as a health issue. We were wrong: nothing we have seen is a greater challenge to the peace and stability of African societies than the epidemic of Aids...we face a major development crisis, and more than that, a security crisis. (Singer 2002, 145)

This is not an isolated example where HIV/AIDS is linked to conflict and violence. The international community eventually came to the conclusion that HIV/AIDS should not be framed as a security issue; however, nation-states’ attempts to securitize HIV/AIDS continue. International organizations advise against addressing the epidemic on the state level as a security dilemma mainly because of the negative consequences for the rights of people with HIV/AIDS that this type of framing might entail. There are both historical examples and theoretical accounts that link securitization to human rights violations.

A most convincing theoretical explanation against the securitization of HIV/AIDS maintains that addressing HIV/AIDS as a security threat is biopolitical. Foucault warns against the inclusion of health into the political sphere (Elbe 2005, 408).17 Yet, evidence of biopolitics in regulation of HIV/AIDS can be found both internationally and

---

17 Biopower for Foucault is the extension of the political power to control biological existence of individuals (Elbe 2005, 405).
domestically. Internationally, it is the tendency of international organizations to gather strategic information about HIV/AIDS, such as incidence and prevalence of HIV/AIDS. But more importantly, a potentiality for the new form of biopolitical racism lurks behind securitization of HIV/AIDS. The real consequences of the securitization of HIV/AIDS and biopolitical racism are attempts to isolate infected individuals and to restrict access to medication of certain groups of the population, particularly during the times of scarcity (Elbe 2005, 412). Elbe’s theorizing helps us understand why the prioritizing securitization of HIV/AIDS is undesirable.

Thus, the securitization of HIV/AIDS has detrimental consequences for human rights violations. Making HIV/AIDS a security threat leads to a new form of discrimination in society, where the population is divided into those who are HIV/AIDS positive and those who are HIV/AIDS negative, leading to increased discrimination and further marginalization of those with HIV positive status (Elbe 2005). It can also lead to normalization practices, or the declaring of those with HIV as abnormal. In the United States, this discourse led to the negative labeling of homosexuals, hemophiliacs, heroin addicts, and Haitians (Elbe 2005, 414). Additionally, the securitization of HIV/AIDS might lead to unwanted reification of a security sector in a country, as well (Elbe 2005, 415).

Therefore, I argue that talking about HIV/AIDS as a security threat serves as an indicator of non-compliance with the international consensus. The epidemic must be

18 “Especially in a context of material scarcity and competing pressure for limited funds, there is a danger with the securitization of HIV/AIDS in that some political leaders might conclude that in the long run the health and security of their population may be best served by simply letting the infected die” (Elbe 2005, 411).
framed by states primarily as a public health problem. It can additionally be framed as a socio-economic issue. Primary framing as a security threat is a strong indicator of states’ non-compliance with the international norm.

*Treatment programs*

The provision of antiretroviral therapy (ARV) as a treatment for HIV/AIDS became the foundation of the international consensus on response to the HIV/AIDS epidemic. The international norm maintains that states must provide treatment to all of those infected with HIV/AIDS without any exclusion and that this treatment must follow very specific treatment protocols. The dissenting views regarding efficacy of antiretroviral therapy, although they exist, are very few. The international consensus became possible because, first, the international medical epistemic community almost unanimously recognizes that treatment programs developed in the past two decades are effective. Second, because of decreased prices of ARV therapy, access to treatment has also recently become more widely available.

The norm on treatment for HIV/AIDS is based on treatment guidelines that have evolved over time. After initial failures to identify the HIV virus and to treat Acquired Immunodeficiency Syndrome (AIDS), in 1985 a test to identify HIV antibodies was developed. A cure for HIV/AIDS is still unattainable; however, there are treatments that can significantly diminish the viral load of HIV and postpone development of AIDS. Treatment of HIV/AIDS became less complicated over time, and the prognosis of treatment is favorable; however, strict observation of treatment protocols is required.
The reason for this is a fast mutation of the virus that became obvious when initial treatment of HIV/AIDS with just one drug, azidothymidine (AZT), was introduced. AZT was successful, initially; however, its brief benefits were superseded by its high toxicity and that the virus developed a resistance to AZT due to the HIV virus’ fast mutation. AZT could not, therefore, serve as a foundation for the international HIV/AIDS consensus. It was with the development of highly effective antiretroviral therapy (HAART), after the approval of medication Indinavir in 1996, that the consensus on treatment of HIV/AIDS became possible. The use of antiretrovirals completely changed the face of HIV/AIDS treatment, at least in the developed world. The level of collaboration necessary to arrive at the creation of the antiretroviral treatment is unprecedented. The antiretroviral treatment became the foundation of the international consensus on HIV/AIDS because the effectiveness of the ARV treatment is universally recognized and the protocols of treatment are being recognized and standardized by the international health and development organizations.

HAART not only increases the length and quality of life of the individual but also reduces the transmission of the virus (Eramova, Matic, and Munz 2007). The combination therapy addresses, albeit not perfectly, the quickly developing resistance to treatment that monotherapy leads to. In the past 30 years, the achievements of HIV/AIDS treatment has included increased life expectancy in people with HIV/AIDS, delayed development of opportunistic diseases, and delayed onset of AIDS. Although ARV does not cure AIDS, it significantly improves the quality of lives of people with HIV/AIDS.

19 For these reasons, single drug therapy, or monotherapy, is not used in treatment of HIV/AIDS anymore.
The guidelines on treatment evolved over time as more clinical information became available on the effectiveness of treatment. The international community recommends three- and two-drug fixed dose combinations for HIV/AIDS treatment and lays out the schedules of treatment (Eramova, Matic, and Munz 2007). However, there is still no agreement about when to start the ARV treatment after the initial contraction of HIV. Studies show that early initiation of antiretroviral therapy might lead to better survival; however, the chances of developing resistance to the medication used in therapy also increases. In 2010, the WHO changed its recommendation regarding the start of the ARV therapy to favoring an early initiation of treatment (Vella, et al. 2012). This change in the guidelines for HIV treatment means that more people are in need of ARV medications.

The second reason why treatment is viewed as a crucial part of the international consensus on the response to the HIV/AIDS epidemic is its affordability, even in the developing world. Initially, the cost of HAART was prohibitively high. The costs of the ARVs are high due to the patents held by the pharmaceutical companies for the production of these critically important medications. UNAIDS started to work with pharmaceutical companies in 1995 to address the costs of the ARVs.

The international consensus also stipulates that states facing HIV/AIDS epidemics should provide treatment for diseases concomitant with HIV/AIDS. The regiment of

\(^{20}\) The WHO recommends to start the medication course of treatment when the CD4 cell/ml level is below 350; however, in many industrialized countries the treatment is started at the CD4 cell/ml at 500.

\(^{21}\) At the early stages of the epidemic the cost of HIV/AIDS treatment was US $20,000 per patient per year in the United States.
treatment of HIV/AIDS is not exclusive to suppression of the HIV virus. As the immune system of those suffering from AIDS weakens, treatment of opportunistic infections becomes an important factor in addressing the HIV/AIDS epidemic. People living with HIV are particularly susceptible to tuberculosis, therefore, tuberculosis treatment is mandatory in successful response to the HIV/AIDS epidemic. Tuberculosis and HIV/AIDS are often referred to as the “terrible twins”: treatment of tuberculosis infection in HIV/AIDS patients is more costly and problematic (Barnett and Whiteside 2002). Tuberculosis is a treatable disease, and the WHO has recommendations for the DOTS regime (Directly Observed Treatment, short course). Evaluation of the programs implemented by states to treat tuberculosis and other diseases co-occurring with HIV/AIDS has become an important part of the international consensus on the response to HIV/AIDS epidemic.

Contestation of HIV/AIDS treatment

Although a strong international consensus on approaches to the prevention and treatment of HIV/AIDS emerged and a significant volume of evidence-based research exists on their effectiveness, these approaches have occasionally been contested within the medical and scientific community. One such denialist movement, headed by Dr. Peter Duesberg, questioned the causal link between retroviruses and their relation to AIDS. Denialists, as the movement was pejoratively labeled, questioned whether HIV indeed causes AIDS. Since AIDS is not a disease itself but an underlying condition—weakening of the immune system—HIV viral load and the level of CD4 lymphocytes are used to diagnose AIDS. Consequently, denialists put into question effectiveness of the
antiretroviral therapy for treatment of HIV/AIDS. This alternative scientific community of denialists is considered to be a counter-epistemic community in the HIV/AIDS epidemic (Youde 2005). It advances alternative truth-claims about the HIV/AIDS epidemic as well as seeks to influence policy decisions.

Denialists’ views neither influenced the professional medical community with any degree of significance nor were acknowledged by the international consensus. Many prominent scholars of HIV/AIDS made it clear that the position of denialists does not have any scientific ground (Diethelm and McKee 2009). Activities of scientific skeptics also did not evolve into a movement that might threaten the prominence of the international consensus. However, this alternative discourse was invoked by some national governments in their justifications of a suboptimal response to the HIV/AIDS, South Africa in particular. South Africa has significantly delayed the provision of ARVs, severely exacerbating the HIV/AIDS epidemic in the country. However, similar cases of other such invokings are very rare.

Another variation of denialism of HIV/AIDS is fueled through the attempts to preserve traditional medical practices and knowledge. Preservation of traditional medical practices is considered by international organizations as helpful to mobilizing participation and potentially reducing healthcare costs in poor settings. International organizations specify that traditional knowledge should be regarded as supplementary to conventional western practices and that traditional practices should be regulated. There are cases when the national response valued traditional approaches over internationally

---

22 For a review of AIDS denialism see for example Nattrass 2007; Nattrass and Kalichman 2009.
recommended practices with deleterious results. In South Africa’s response to the HIV/AIDS epidemic, its health minister Manta Tshabalala-Msimang recommended treating HIV/AIDS with lemon, beetroot, and garlic during the international conference on HIV/AIDS attended by 24,000 delegates (Karim and Karim 2010, 541). South Africa’s denialism is noteworthy, but unprecedented. Although denialism of either the link between HIV and AIDS or of the effectiveness of ARV treatment continues to exist, it is relegated to the margins of the scientific and medical community.

Lack of compliance with the norms of treatment in most nation states is not caused by the adherence of the states to the views of the denialist community, but rather by the lack of funding for the procurement of medication and non-compliance with the protocols of treatment issued by international organizations.

**Decrease in the cost of ARV treatment**

Emergence of the international consensus on HIV/AIDS only became possible because of the remarkable decrease in the costs of antiretroviral therapy. The reduced cost of ARVs decreased to approximately US $1200 a year by the 2000s, and individual pricing plans have been negotiated with 39 countries (Vella 2012, 1236). By 2002, the WHO had published guidelines for resource-limited countries of treatment and care for the HIV/AIDS with prices for the ARVs falling even further and with the WHO including ten antiretroviral drugs into its list of essential medicines (Vella 2012, 1236). In 2003, an innovation allowed for the generic drugs to be competitive with introduction of fixed-dose combination therapies: the number of pills in fixed-dose decreased form 10-15 to as few

---

23 Still, universal access to treatment – provision of ARV medication to 80 percent of people with HIV/AIDS – has been achieved in very few countries. In 2003, the international community adopted a 3 by 5 plan, which set the goal to increase access to HIV/AIDS treatment in 2005 by 3 million people. Although this goal has not been accomplished, it was demonstrated that universal access is possible even in the least developed countries. As a result of the efforts of the international organizations and their coordination with pharmaceutical companies, the cost of ARVs decreased to approximately US $1200 a year by the 2000s, and individual pricing plans have been negotiated with 39 countries (Vella 2012, 1236). By 2002, the WHO had published guidelines for resource-limited countries of treatment and care for the HIV/AIDS with prices for the ARVs falling even further and with the WHO including ten antiretroviral drugs into its list of essential medicines (Vella 2012, 1236). In 2003, an innovation allowed for the generic drugs to be competitive with introduction of fixed-dose combination therapies: the number of pills in fixed-dose decreased form 10-15 to as few
prices were due to the production of a generic form of ARV therapy, as well as specially negotiated prices for developing countries. The disparities in treatment of HIV/AIDs between developed and developing countries are still significant. Though there is a consensus on treatment, the guidelines are different for resource-limited settings. For example, the international consensus suggests that HIV/AIDS should be treated with the first line of medications and, in the case of failure, second-line medication should be used. The guidelines for switching between lines of treatment differ dramatically in resource-limited and in industrialized settings. It is estimated that in resource-limited settings, 80 percent of people with clinical need for treatment of HIV/AIDS not receive HAART in 2006 (Simon, Ho, and Karim 2006, 496).

_Developments to create accessible medication_

When the HAART treatment was discovered, it was highly expensive—as a result, it was not viewed as a solution to the HIV/AIDS epidemic across the world. At US $20,000 dollars per patient per year for crucial medication, its use would not be possible outside of the developed world, and even in developed western countries like the US, given the demographics of the people infected with HIV/AIDS, it was hardly affordable, especially without health insurance. The main reason for the economic inaccessibility of the HAART treatment initially was patent protection. The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) remains a significant roadblock in

as 2 a day. The price of first-line generic drugs decreased to as little as US $150-250 a year.

75
bringing the costs of antiretrovirals down and achieving universal access to HIV/AIDS treatment. The Trade-Related Aspects of Intellectual Rights agreement of the WHO requires that countries protect the intellectual property of pharmaceutical companies. TRIPS for pharmaceutical companies was introduced in 1995 and applies to all members of the WHO. According to TRIPS, pharmaceuticals are patented in the countries where they are being produced. Although poor countries might be exempt under TRIPS from these patenting standards since only developed countries have the capacity to produce new drugs, the conclusion can be made that “all new drugs are likely to be patented in all countries with the capacity to produce them” (Shadlen 2007, 566). Patents for antiretrovirals have consequences for the prices of essential HIV/AIDS medications, making them inaccessible in many developing countries. Pharmaceutical companies hold a twenty-year monopoly over the manufacturing of these drugs, and it is in their interest to prevent other states from manufacturing generic versions of these medications.24

TRIPS were contested by the global treatment access movement in the late 1990s, as the ideals of the Geneva Consensus clashed with the foundational ideas of the Washington Consensus. The international health organizations and NGOs responded to TRIPS on pharmaceuticals with a protest, which resulted in the signing of the 2001 Doha Declaration on TRIPS and Public Health. This declaration contends that patent rules can be changed in order to protect public health. Most of the supply of ARVs in the

24 In 1994, the global trade rules were changed with the creation of the WTO and with TRIPS coming into power in 1995. For the first time, many developing countries were required to offer patents on medications. TRIPS put an end to the diversity of patent agreements and required patents to last for 20 years, the nature of the good patented notwithstanding.
developing world is generic. Since the signing of Doha declaration, more than 60 countries have been able to use TRIPS flexibilities as stipulated by Doha declaration to acquire generic ARVs (Hoen, et al. 2011).

Universal access to treatment has become part of the international consensus. Yet, even with the wide availability of generic drugs in 2000 - 2001, because the majority of drugs are produced in Brazil, India, and Thailand, the price of brand-name ARVs remains relevant to the price of HIV/AIDS essential drugs overall (Shadlen 2007). A government, under the patent regime, can use compulsory licensing in order to negotiate prices for ARVs with pharmaceutical companies:

a country’s patent regime might permit the government to classify high prices or limited supply as violations of public interest or forms of patent abuse, and subsequently threaten to issue a license to an alternative firm if the patent holder fails to lower the price or increase supply. (Shadlen 2007, 566)

Under the compulsory license, a government can allow a local firm or governmental agency to produce a good without the consent of the patentee (Shadlen 2007, 566). The states therefore have the possibility to compel companies that have control over the prices of essential medications used in the ARV treatment to reduce the costs of those medications. A country can use compulsory licensing in order to negotiate the prices of ARVs with companies that hold patents for their development.²⁵ However,

²⁵ The government of Brazil, for example, has successfully negotiated with the pharmaceutical companies to lower prices for ARV treatment and managed to provide free HIV/AIDS treatment for those infected in the country. It uses the compulsory licensing threat to negotiate the price reduction of pharmaceuticals with the pharmaceutical firms Roche, Abbott, and Merck. Brazil was able to negotiate price reduction through demonstration of credible threats. It is a middle-income country with a well-developed pharmaceutical sector, and therefore these threats are credible
not all countries have the capacity to produce ARVs under compulsory licensing, and therefore, they might not be as capable at negotiating the reduction of ARV prices.

Competitive generic ARV medication is ultimately what allowed for the decrease in ARV prices. Currently, the first line of ARV treatment in low- and middle-income countries can cost as little as little as US $61 per patient per year (Médecins Sans Frontières 2011). However, access to other alternatives in the first line of treatment and the second line of treatment\(^{26}\) remains limited due to the fact that prices for these treatments remain non-competitive. For example, some companies exclude middle-income countries from discounted prices (Médecins Sans Frontières 2011). As a result, the costs of alternative first-line treatment and second-line treatment remain rather high.\(^{27}\)

The availability of generic ARV medications produced in developing countries, such as India, Brazil, and Thailand, reduced the prices of patented ARV medications. On the one hand, it seems that developing countries have been successful at implementing the safeguards of the TRIPS agreement. On the other hand, it is apparent that the implementation of compulsory licensing, for example, has proven to be very difficult for developing countries. Many of the large pharmaceutical companies have discontinued

\(^{26}\) Second line of treatment refers to the combination of drugs used as an alternative treatment to combat resistance developed to the first line of treatment or due to the high toxicity of the first line of treatment.

\(^{27}\) Though newer drugs are available, their generic versions are not. A country seeking access to newer ARVs has two options: voluntary licensing or compulsory licensing. In the case of voluntary licensing, to produce generic drugs the government or other entity may request licensing from the patent holder. In compulsory licensing, states do not need such permission from the patent holder.
offering ARV medications to the middle-income countries at discount prices. The high prices of ARV medications, particularly for the second line of treatment, remain a serious roadblock in achieving universal access to treatment in the developing world. Most people in developing world are on first line of treatment medication, and the high prices of the second line of treatment medication are increasingly becoming a problem. While some countries have been able to obtain second line of treatment medication, the prices for the second-line therapy remains high, impeding the achievement of universal access to anti-retroviral treatment around the world (Long, et al. 2010).

Therefore, since ARV therapy is not only effective for the treatment of HIV/AIDS, but the generic versions of ARVs are also comparably inexpensive, I can conclude that an international consensus on treatment of HIV/AIDS exists. While there have been some substantial achievements in provision of ARV treatment around the world, it still remains a challenge. The role of pharmaceutical companies, despite their resistance to the reduction of prices of ARV treatment, remains essential in the future of HIV/AIDS treatment. UNAIDS plans to create the Medicines Patent Pool, which would make ARVs licensing available for the production of low-cost generic versions. Patent holders of the pool would allow voluntary licensing for their patented drugs. While the program would make generic drugs available without changes to international law on TRIPS, this solution is however, not optimal since the project relies on the arbitrary will of the patent holders (Hoen, et al. 2011).
Prevention of HIV/AIDS is also an equally important part of the international consensus on the response to the HIV/AIDS epidemic. Tony Barnett and Alan Whiteside, two prominent scholars in HIV/AIDS research, contend that “[f]irst prize with any disease is to prevent it. If prevention programs had been successful, there would be no story to tell around HIV and AIDS” (Barnett and Whiteside 2002, 40).

The prevention of HIV/AIDS, unlike the treatment of the disease, has been contested in many countries. Yet, we can speak of prevention of HIV/AIDS as a critical part of the consensus because prevention interventions are based on evidence-based approaches and endorsed by international organizations. The main reason for the contestation of prevention interventions by nation states is that transmission involves private behaviors, such as sex, childbirth, and drug use. In some societies, individuals’ sex lives and policies regarding preventions of sexually transmitted diseases, contraception and sex behavior have been highly influenced by the church, and behaviors associated with intravenous drug users and drug users themselves have been also been highly stigmatized.

Some states devised prevention schemes that, although successful, can hardly be transferred to other states. Cuba, for example, has one of the lowest rates of HIV/AIDS infection in the world. Scientists attribute these low rates to the early and aggressive response of the state to the HIV/AIDS epidemic: in the 1980s, all of the population was tested and the infected were isolated in ‘sanatoria’ (Barnett and Whiteside 2002, 41). This approach to responding to the epidemic is associated with a vast violation of the rights of the individuals and is not recognized as a viable option for other states, particularly
democratic ones. Nonetheless, some of the elements of this approach, such as testing of a large proportion of the population for HIV/AIDS, have also been used by other states.

A key to understanding the international consensus on the prevention of HIV/AIDS is knowledge regarding the transmission patterns of the disease. The main pattern of HIV/AIDS transmission should define internationally recommended prevention interventions. There are four main routes of HIV/AIDS transmission: sexual transmission, mother-to-child transmission (MTCT), exposure to contaminated blood, and intravenous drug use.\(^{28}\) When addressing the epidemic, it is important for states to address each of these modes of HIV transmission to successfully prevent the spread of HIV/AIDS. A failure on the part of a state to address a main route of transmission would inevitably exacerbate the epidemic. I will briefly discuss the methods of prevention of sexual, mother-to-child transmission, and exposure to contaminated blood routes of transmission, and I will then discuss in detail the prevention of HIV/AIDS in cases of intravenous drug use.

The ideas of prohibition and abstinence, on the one hand, and harm reduction, on the other, in public health have influenced the way in which the consensus evolved. Each have been interpreted by different states and implemented within their health policy framework. The prohibition and abstinence approach assumes, in general, that certain behaviors associated with the HIV/AIDS epidemic can be eliminated and the efforts of the policy makers should be guided exclusively in that direction. Adherents of the harm

\(^{28}\) Transmission may occur through other modes as well—for example, through unsterilized surgical equipment or through open wounds during fighting—however, these types of transmissions are rare.
reduction philosophy of public health believe that human nature is fallible, and certain
human behaviors that might lead to contraction of HIV/AIDS will prevail no matter what.
Harm reductionists believe that rather than concentrating on elimination of these
behaviors, policy makers and public health practitioners should concentrate on making
these practices as safe as possible. While the voices of those in favor of harm reduction
have dominated in the prevention of sexual transmission, the battle for harm reduction in
intravenous drug transmission has been much more difficult, particularly within nation
states. However, I will demonstrate that harm reduction—in both the sexual prevention of
HIV/AIDS and intravenous transmission—is a legitimate part of the international
consensus.

Prevention of Sexual Transmission

The harm reduction approach stipulates that the use condoms is a highly effective
method of preventing HIV and other sexually transmitted infections (UNFPA, WHO, and
UNAIDS 2009). The use of condoms is the most widely available biomedical
intervention. Another effective biomedical intervention for this route of transmission is
the treatment of sexually transmitted diseases (STDs). Recognition that good sexual
health is important for the prevention of HIV/AIDS and the ability of developed states to
provide treatment interventions for STDs made an important contribution to controlling

Harm reduction approaches in the prevention of sexual transmission are contested
by some states—however, not because of the lack of scientific evidence of their efficacy,
but rather because of their incompatibility with the cultural norms of that society. Instead,
abstinence approaches are promoted by different religious groups and are aimed at preventing HIV/AIDS through alterations of sexual behavior. The Catholic Church, in particular, was in staunch opposition of condom use for the prevention of HIV/AIDS. The WHO, in compromise, endorses policies that can be viewed as abstinentialist, such as reducing the number of sexual partners and delaying the sexual debut. However, it also recognizes that these approaches cannot be effective in isolation. The WHO adopts an approach to prevent sexual transmission that represents a middle ground between harm reduction and abstinence approaches, which allows policy-makers and practitioners to emphasize one area depending on targeted population. The adherents of the harm reduction philosophy for the prevention of HIV/AIDS have not publicly reject abstinence and being faithful as part of the ABC approach; however, they pointed out that there is scant scientific evidence that such interventions are effective (Lieberman 2009, 94). Behavior-altering approaches to prevention used in isolation have also been critiqued by the medical community. Under some conditions, people might have the knowledge, but not always possess the power or incentive, to change their behavior. Women, for example, have not always had the power to demand their male partner to use a condom during sexual contact. Therefore, in devising prevention plans, a comprehensive preventive program would consider socio-economic factors of the HIV/AIDS epidemic.

29 This set of interventions is known as the Knowledge, Attitude and Practices and Behavior (KAPB) interventions (Barnett and Whiteside 2002, 42).

30 The medical community has endorsed the ABC approach to HIV/AIDS: A—abstinence, B—being faithful, C—condom use.
Prevention of Mother-to-child Transmission

Mother-to-child transmission (MTCT) of HIV/AIDS might occur prenatally, at the time of childbirth, or postnatally through breastfeeding. Studies demonstrate that the risk of MTCT can be significantly reduced with ARV treatment prenatally and during childbirth. Initially, when ARV treatment was not a part of the international consensus on HIV/AIDS and when the medications used in the therapy were very expensive, policymakers did not perceive it a possibility for ARV treatment of MTCT to become a part of the consensus. However, when the prices of ARV dropped, this approach towards prevention became not only feasible, but also a part of the best practices for HIV/AIDS prevention. Prevention of MTCT during breastfeeding is another agreed upon international intervention. However, it also comes with multiple caveats. While promoting formula feeding reduces the risk of MTCT, it exposes a child to other risk factors, such as risks associated with an absence of clean water supply. Additionally, breast feeding is recognized as a strategy for the health and survival of the infants. Formula feeding might be undesirable for mothers, as well, in countries where it leads to stigmatization of women.

Prevention of Transmission through Contaminated Blood

Transmission of HIV/AIDS through contaminated blood supply has the highest infection rate of 900-1000 infections per 1000 exposures (Barnett and Whiteside 2002, 31). The probability of MTCT is rather high with infection rate of 130-480 infections per 1000 (compared to 1-30 rate of infections per 1000 exposures during unprotected sex) (Barnett and Whiteside 2002, 38).
38). In the early stages of the HIV/AIDS epidemic, mass exposures—particularly of hemophiliacs—lead to HIV infections. However, when it was established that HIV/AIDS is a blood-borne disease, the international community took measures to regulate the international blood supply. As technology for testing donors and international blood supply became more widely available, the WHO made regulation of the international blood supply one of its strategic priorities in addressing HIV/AIDS (Lieberman 2009, 96). Although technical measures exist to test all donated blood, there is a period after being infected when the HIV virus is undetectable, which sustains the threat of contamination within the blood bank. Blood donation is discouraged for groups of people that might be at a higher risk for HIV/AIDS, and remuneration for blood donation imposes additional risk of infecting the blood supply (Barnett and Whiteside 2002, 40).

*Prevention of HIV/AIDS Transmission in Drug Users*

Containment of the HIV epidemic in some countries is particularly closely linked to the prevention of HIV/AIDS transmission among intravenous drug users. Since the early 1990s, medical research has shown that harm reduction programs, such as needle exchange programs and opioid substitution therapy, reduce the rate of HIV/AIDS contraction among intravenous drug users (Vlahov and Junge 1998; Vlahov, Jarlais, et al. 2001; Des Jarlais, Friedman and Choopanya, et al. 1992; Des Jarlais, Friedman and Sotheran, et al. 1994; Des Jarlais, Marmor, et al. 2000). In response, the WHO included
harm reduction programs on the list of the recommended preventive measures.\textsuperscript{32} Harm reduction is accepted by most of the international organizations that deal with the response to the HIV/AIDS epidemic.\textsuperscript{33} Harm reduction programs, including opioid substitution therapy (OST), have been widely implemented throughout the world. Substitution therapy is offered in more than 60 countries, and such programs exist in all countries of the European Union (Wodak and McLeod 2008).

In opioid substitution therapy, the use of heroin, frequently administered through shared injection equipment, is substituted with oral drug replacements: methadone or buprenorphine. In 2005, methadone and buprenorphine were added to the WHO’s list of essential medicines. Among the two drugs, methadone has been found to be more effective for the purposes of opioid substitution therapy (Amato, et al. 2004; Mattick, et al. 2008). What makes opioid substitution therapy particularly attractive is the relatively low cost of substitution drugs. Generic versions of buprenorphine cost US $300-600 per patient per year, compared with US $1750- 3500 for non-generic drugs, and methadone is even less costly (WHO 2005).

An important step in the legalization of harm reduction programs was the inclusion of these medications on the WHO list of essential drugs. Previously, methadone

\textsuperscript{32} Nine harm reduction interventions are currently recommended by the international norm: needle and syringe programs (NSP); drug dependence treatment, in particular opioid substitution therapy; targeted information, education and communication for IDUs; enabling people to know their HIV status; HIV treatment and care; promoting and supporting condom use; detection and management of sexually transmitted infections; prevention and treatment of viral hepatitis; and tuberculosis prevention, diagnosis and treatment (WHO 2010, 45).

\textsuperscript{33} The WHO, UNAIDS, UNICEF, and World Bank, The United Nations Office on Drugs and Crime (UNODC), the International Committee of the Red Cross, the Global Fund for AIDS, TB and Malaria (Wodak and McLeod 2008, 11).
was classified as a “schedule I drug” by the 1961 UN Single Convention on Narcotic Drugs, which meant that the drug could not be used for therapeutic purposes because of serious risks to public health. As a result of this classification, methadone was illegal in many countries. The WHO, UNAIDS, and the United Nations Office on Drugs and Crime have since decriminalized methadone and instead espoused drug substitution therapy as well as needle and syringe programs as part of their policy prescriptions to address the HIV/AIDS epidemic. However, all states that implement methadone maintenance policies introduce some degree of regulation of methadone programs.

This international political consensus on the inclusion of harm reductions programs into both the prevention of HIV/AIDS and the treatment of drug addiction has been presided over by a medical consensus on the effectiveness of harm reduction programs. Historically, both needle exchange and opioid substitution therapy have been used by many states in Europe and the U.S. to address the problem of drug addiction. Below, I provide a historical review of the implementation of needle exchange programs and opioid substitution therapy for both response to drug use and HIV/AIDS prevention.

**Historical overview of harm reduction programs**

International agencies stipulate that drug-fueled HIV/AIDS epidemics can be prevented from escalating by implementing comprehensive harm-reduction approaches, including opioid substitution programs and methadone maintenance therapies. However, these interventions have been consistently contested by some states, including the Russian Federation. I will review the literature suggesting that harm reduction approaches are effective for the treatment of drug addiction and HIV/AIDS prevention. I will also
explain how these programs work in those countries that, following the norm of the international law, choose to implement them.

**Opioid Substitution therapy: Methadone Maintenance Treatment**

Methadone and other drugs that can be used in opioid substitution therapy, such as buprenorphine, were created for purposes not related to HIV/AIDS. However, since methadone maintenance programs, according to research, reduce the risk of HIV/AIDS transmission among heroin users, they have been used in HIV/AIDS prevention (Ball, et al. 1988; Joseph, Stancliff and Langrod 2000, 357). As a part of HIV/AIDS prevention programs, methadone could be considered crucial in reversing the HIV/AIDS epidemic in some states. To understand the current complex politics of methadone regulation and prohibition, I will provide a historical context of methadone’s therapeutic use as a part of the internationally accepted harm reduction approach.

Methadone is the most commonly used drug in opioid substitution therapy and approved for the treatment of drug dependence and prevention of HIV/AIDS transmission by the WHO. The concept of using opioids in substitution treatment is not an invention of the 1980s when the global HIV/AIDS epidemic first emerged. Initially, opioids such as morphine were used by many states to treat drug addiction and to relieve pain, but eventually their use became restricted or prohibited by states during the twentieth century. Methadone was synthesized in Germany during WWII to be used as a substitute for opiate analgesics when supply of natural opiates was limited (Arif and Westermeyer 1990, 19).

Initially, as a part of drug addiction treatment, methadone was used exclusively for detoxification purposes, but therapeutic uses of methadone later widened to include
opioid substitution treatment. The goal of methadone therapy is to suppress abstinence symptoms in an individual for the time between doses, which is usually once daily.\textsuperscript{34}

Methadone therapy has a particular theoretical foundation underpinning the nature of addiction. Addiction is not viewed as a behavioral condition. People who use drugs or those who use substitution therapy are not weak-willed individuals uninterested in changing their lives (Arif and Westermeyer 1990, 23). Rather, drug addiction is viewed as a chronic disease. Many turn to methadone maintenance therapy because of the numerous failures of abstinence approaches. For some long term drug users, abstinence from opioids is simply not feasible.

abstinence from impure street drugs; relief from infection, malnutrition, immunological and endocrine impairment; relief from the economic demands of purchasing drugs; alternating intoxication and withdrawal; and possibility alleviation of illegal status or criminal activities (Arif and Westermeyer 1990, 82).

The social benefits of methadone maintenance are produced by methadone’s ability to reduce the cycle of intoxication and withdrawal. Precisely because a person who is dependent on drugs does not have to seek another does, he has a chance to have stronger social relationships and have steady employment.

The significance of methadone substitution therapy in the HIV/AIDS epidemic is due to both its medical and social benefits. First, methadone therapy prevents a person addicted to drugs from being exposed to HIV/AIDS via intravenous drug use. Methadone’s ability to prevent abstinence syndrome is used in maintenance therapy to

\textsuperscript{34} Methadone is a long-acting agonist with a half-life of about 12 to 24 hours which is administered orally. Heroin has a much shorter life-cycle and compels a person with addiction to inject it as many as 8-9 times a day, depending on the severity of addiction and purity of heroin.
prevent a person addicted to drugs from using intravenous illegal drugs. Since methadone is administered orally, the chances of sharing needles and being potentially exposed to the HIV/AIDS virus diminishes. Second, opioid substitution therapy provides better HIV/AIDS treatment for HIV/AIDS positive drug users. Methadone substitution therapy makes it possible for an addicted person to return to a normal life during the course of treatment. One of the difficulties in treating HIV/AIDS is the strict adherence to the treatment protocol needed: HIV/AIDS medication must be administered several times a day with very precisely defined time intervals. For addicted persons who are concerned with the procurement of the next heroin dose, it is extremely difficult to adhere to the HIV/AIDS treatment protocol. Skipping medication doses or taking them irregularly can lead to the development of virus resistance to one or several medications used in treatment. Methadone maintenance programs allow addicted persons to not only lead normal lives and remain steadily employed, but also be more likely to adhere to their HIV/AIDS treatment. This aspect of the therapy serves as one of the key arguments for its implementation across the world (Ball, et al. 1988, 216). Medical research concludes that methadone is a safe and non-toxic drug that is suitable for treating drug addiction, even during pregnancy. It does not “cure” drug addiction, but rather significantly improves the quality of life of people living with drug dependency. It could be prescribed for a short period of treatment; however, some people remain on methadone for their entire lives.

Political aspects of methadone therapy

Implementation of methadone programs in democratic settings remains a political challenge. Public opinion regarding methadone programs is expressed with a “not in my
“backyard” attitude towards the further liberalization of methadone programs in some states. There is concern regarding the impact of methadone clinics on local communities. This fear of methadone, however, is unsubstantiated. The influence of methadone on a community is only inferred from a “criminal model” of addiction. However, the effect of methadone programs on a community is predominantly positive. Crime rates associated with heroin use are reduced with the introduction of methadone programs; additionally, drug arrests, hepatitis rates, and deaths related to drug dependence are reduced significantly (Joseph, Stancliff, and Langrod 2000, 354). Because of the negative reputation of methadone clinics and the perceived dangers that they introduce to a community, it is conceivable to imagine that their promotion would represent political risks—particularly in democratic settings. We would expect that methadone’s influence on a community are more significant in democratic settings, where public opinion is more strongly considered by policy-makers. In authoritarian states like the Russian Federation, where central decisions regarding public health are isolated from public opinion, the public image of opioid substitution therapies would have much less significant consequences.

Recently, another side of opioid substitution therapy and its relation to power has been examined in the literature. These studies apply a Foucauldian approach to understanding methadone programs. They seek to present methadone substitution programs as an “oppressive attempt to produce docile bodies” (Keane 2009, 450).

35 See, for example, Friedman, and Alicea 2001. Surviving Heroin: Interviews with women in methadone clinics; Bourgois, 2000, Disciplining addictions: the bio-politics of methadone and heroin in the United States; Bull 2013, Governing the heroin trade: From treaties to treatment.
Bourgois’ account of methadone programs is particularly telling—methadone clinics deny heroin users autonomy by subjecting them to rules and regulations that serve as a way to exercise arbitrary power. This view of methadone programs and clinics allows us to hypothesize that the methadone clinics would still be attractive to both the medical community and the state as tools of control over marginalized populations. I believe that a Foucauldian analysis of harm reduction also addresses the immediate dismissal of harm reduction in Lieberman’s work (Lieberman 2009). Lieberman contends that the norm of drug supply control or the criminalization of drugs policies usually prevails (Lieberman 2009, 97). However, as works that use Foucault’s theoretical approach to analyze harm reduction demonstrate, the government—through its exercise of biopower—might, in fact, prefer reduction of demand approach in their attempts to address the problem of drug use. Opioid maintenance programs, therefore, would not be excluded from the arsenal of interventions employed by the government, given the fact that the government could exercise biopower.

Foucault’s inspired theorizing regarding opioid substitution therapy is similar to the voices of those in the international public health community and in the medical community in the Russian Federation who draw attention to the negative effects of the methadone treatment on the individual level. While maintenance programs serve the utilitarian purpose of public health to benefit society as a whole, they give secondary importance to the concerns of the individuals subjected to these programs.

Since the literature draws attention to these political and ethical problems concerning opioid substitution therapy, I find it important to engage with them—particularly because I examine the theoretical and ethical views of the Russian medical
community as one of my explanations of the state’s response to the HIV/AIDS epidemic in Chapter Three. However, while these theoretical and ethical considerations regarding harm reduction treatment exist, they are predominantly relegated to academic circles and do not exist among policy makers. Therefore, I maintain that these theoretical considerations have not interfered with the emergence of the international consensus on the provision of harm reduction programs in preventing HIV/AIDS.

The use of needle and syringe exchange and sterilization programs is also based on the knowledge that many people with drug addiction fail to completely abstain from the use of drugs. Distribution of needles for harm reduction purposes first started through unofficial programs in California. In the early stages of the HIV/AIDS epidemic in San Francisco, some doctors provided needles for patients known to inject drugs (Lang 1993). In New York, the awareness concerning clean needles grew because of drug addiction and the HIV/AIDS epidemic in the early 1980s. Studies demonstrated that people were concerned about safe injection equipment and were attempting to develop strategies to avoid being infected with HIV/AIDS (Lang 1993). The first needle exchange program that had the support of government funding began in the Netherlands in 1984, when a drug advocacy group started to exchange needles and syringes. In that same year, the HIV/AIDS virus was discovered by the scientific community. Des Jarlais and Hopkis were the first scientists in the U.S. to recommend access to sterile equipment as a means

______________________________

36 First public exchanges in the U.S. were a personal initiative of former drug user Jon Parker, who started to distribute needles in Boston in 1986. First needles exchange program organized with community consensus began in Takoma, Washington. Later on, the public needle distribution and syringe exchange programs were organized in San Francisco, New York, and Portland.
to prevent HIV/AIDS. In 1988, the results of needle exchange program in the Netherlands was evaluated. It was demonstrated that the needle exchange program led to a decrease in the sharing of injection equipment (Vlahov 2001, S70). Around that time, needle exchange programs were implemented in Australia and the United Kingdom.

The opponents of needle and syringe exchange programs often argue that these interventions promote drug use. However, extensive evidence suggests that these programs do not have such effect. The accumulated scientific evidence instead suggests that needle exchange programs fulfill the criteria of effective public health interventions (Wodak and Cooney 2006).

Certainly, harm reduction programs are not a panacea for HIV/AIDS among intravenous drug users. Particularly, stand-alone interventions do not work in isolation and often are not enough. Recognizing this, the WHO stresses that isolated interventions have little impact and, therefore, recommends that individual interventions should be implemented alongside of other interventions (WHO 2010, 45).

3 Russia’s Response to the HIV/AIDS Epidemic

Although the international consensus on the HIV/AIDS epidemic emerged, it has not led to universal compliance with its provisions. Compliance by states varies greatly. The Russian Federation is one of the states where domestic policies regarding the HIV/AIDS epidemic differ significantly from the international norm. Below, I assess Russia’s policy according to the following parameters: framing of the epidemic, treatment programs, and prevention of HIV/AIDS (see Table 4). I demonstrate that
Russia misinterprets the requirements of the response to the HIV/AIDS epidemic on all three of the abovementioned aspects of the consensus.

A special note should be made regarding the problem of credible figures in drawing a conclusion about Russia’s compliance with international law. The statistics of the epidemic became a subject debated by almost everyone invested in the problem of HIV/AIDS in Russia. The government intentionally underestimates the threat of the HIV/AIDS epidemic. It not only underestimates the prevalence rate of HIV/AIDS—the number of people already infected with HIV—but also, and what is even more problematic, the incidence rate or the growth rate of the epidemic—the number of new cases registered every year (Gerber and Mendelson 2005, 28; Grisin and Wallander 2002; Webster 2005). The government’s capacity for HIV/AIDS testing also implies that the official data is manufactured.

The problem of accurate statistics regarding the HIV/AIDS epidemic is not innocuous: neither for the development of the HIV/AIDS epidemic in the country, nor for making scientific assessments of the state’s response to the epidemic. The underestimation of the number of those infected with HIV in the country has ramifications for estimating the rate of treatment provision. When official statistics on the scale of HIV/AIDS are used, the provision of treatment might appear to be adequate. However, when the international estimates are considered, Russia appears to have one of the lowest rates of HIV/AIDS treatment provision in the world (Kravtsov 2011). Below, I assess Russia’s compliance with the HIV/AIDS international consensus based on the three main parameters: framing of the epidemic, treatment provision, and prevention provision.
Table 4 Russia’s Compliance with the International Consensus

<table>
<thead>
<tr>
<th>Framing of the epidemic</th>
<th>International Consensus</th>
<th>Russian Policies</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>The HIV/AIDS epidemic should be framed as a public health problem.</td>
<td>The epidemic is discussed by the government officials as a security issue and problem of the marginalized groups</td>
<td></td>
<td>NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment provision</th>
<th>International Consensus</th>
<th>Russian Policies</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The availability of ARVs for the eligible HIV/AIDS patients</td>
<td>- Not enough ARVs for everyone who needs HIV/AIDS treatment</td>
<td></td>
<td>NO</td>
</tr>
<tr>
<td>- Adherence to the internationally recommended treatment protocols</td>
<td>- High costs of the ARV treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- The universality of access to treatment.</td>
<td>- Noncompliance with international ARV treatment protocols</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Access of intravenous drug users to ARV is practically non-existent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prevention of HIV/AIDS transmission</th>
<th>International Consensus</th>
<th>Russian Policies</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Prevention of sexual transmission</td>
<td>- Inadequate prevention</td>
<td></td>
<td>NO</td>
</tr>
<tr>
<td>- Prevention of mother-to-child transmission</td>
<td>- Opposition to sex education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Prevention of transmission through blood supply</td>
<td>- Low rate of condom distribution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Prevention of intravenous drug transmission</td>
<td>- Universal pre-natal screening of HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- High levels of prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Exacerbated through policies of remuneration for blood donations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- No federal needle and syringe programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- No opioid substitution therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: UNAIDS Country Progress Reports

Framing of the HIV/AIDS Epidemic in Russia

It is the prerogative of the government to set the tone that will dominate the discourse surrounding HIV/AIDS in a country, as well as guide the response to the epidemic. The way a government frames the HIV/AIDS epidemic resonates throughout
society and affects how civil society, bureaucracies, and the medical community will address the problem. Therefore, discourse has an effect on the expediency of response, as well as on the protection of the rights of individuals living with HIV/AIDS. This makes framing the epidemic a central tenet of the consensus on HIV/AIDS response. The Russian Federation does not formally acknowledge the severity of its HIV/AIDS problem, nor has it developed a unified course of action to address it. Governmental officials downplay the HIV/AIDS threat, claiming that the prevalence and incidence statistics are not nearly as high as they are in some other countries in Western Europe. The epidemic is framed, in the government’s discourse, as both a demographic and a security threat—or as a problem that merely affects marginalized groups.

As discussed earlier, the securitization of AIDS leads to even further human rights violations of marginalized groups. Already disadvantaged due to their marginalized status, people who inject drugs, sex workers, and men who have sex with men are further deprived of their rights due to the stigma associated with HIV/AIDS. Government officials generate moralizing discourse surrounding this epidemic by sometimes publicly claiming that the behaviors surrounding HIV/AIDS are sinful: “[t]he question about morals currently is a question about survival of the nation; and the question regarding HIV transmission is not so much a medical question but a behavioral one” (Vremena 2007).

These attitudes not only lack scientific ground, but also prevent addressing HIV/AIDS as a public health issue. This discourse precludes the possibility of implementing evidence-based medical interventions for prevention and instills bio-racism
demonstrating that treatment of those suffering from HIV/AIDS perhaps should not be a priority of the state.

In general, when the government does not recognize HIV/AIDS as a nation-wide problem, as has the government in the Russian Federation, there would be less expectation for pressure from below to escalate efforts against HIV/AIDS. While this recognition plays a role in the response to epidemic, the role of the regime also matters. We would not expect a significant increase in pressure on the Russian government from the population, given that the nature of the regime in the Russian Federation is considered an authoritarian or a competitive authoritarian regime (Levitsky and Way 2002).

Treatment Provision in the Russian Federation

Treatment provision is one of the spheres of state response to the HIV/AIDS epidemic where Russia’s response deviates from the international norm. The international norm supports universal provision of treatment, which means provision of treatment to all those who need it, without exception. In practical terms, this means that the government would provide at least 80 percent of the population with treatment. In order to assess whether Russia follows the norm on treatment provision, we should evaluate 1) the availability of ARV medications for eligible HIV/AIDS patients; 2) adherence to internationally recommended treatment protocols; and 3) the universality of access to treatment. In its provision of treatment, the Russian Federation has never denied the effectiveness of antiretroviral therapy. As soon as AZT became available in 1988, Russia started to not only import it, but to also produce the analogue of this medication (Rakhmanova 2004).
Originally highly expensive, HAART is now accessible not only in developed countries, but also in middle-income, low-income, and the least developed countries. Russia, as many other middle-income countries, has an economic and political capability of invoking the provision of the 2001 Doha declaration on TRIPS and Public Health in order to either use compulsory licensing to produce generic versions of ARVs or negotiate lower prices with the original producers of these medication.

However, while the Russian government manages to procure essential ARVs, the medications that the country buys are not sufficient to provide treatment for all people with HIV who need them. Russia also does not adhere to the internationally accepted protocols of treatment. The international organizations issue specific recommendations regarding the first- and second-line of treatment for the disease. Adherence to these protocols is important in order to prevent the virus’ resistance to medication. Finally, the universality of treatment, understood as 80 percent or more of the population having access to ARVs, is far from being achieved. In the Russian Federation, very few people who inject drugs have access to ARV treatment; furthermore, even if they have access to treatment, with a lack of proper rehabilitation and the absence of methadone therapy, their adherence to treatment protocols is highly unlikely.

Since 2006, the Russian government has noticeably scaled up the provision of HIV/AIDS treatment. Yet, shortages of medications remain a problem. Shortages of ARVs in 2010 affected many regions in the country. A second line of ARV treatment is not always available, nor are the tests to examine drug resistance. Opportunistic infections accompanying HIV/AIDS, such as tuberculosis, are also not being properly monitored.
International organizations, Russian NGOs, and HIV/AIDS activists contend that the Russian Federation does not observe internationally accepted norms on the provision of HIV/AIDS treatment (Godlevskiy, Nedzel’skiy, and Sarang, interviews; see Appendix 2). However, the Russian government staunchly asserts its position that it procures sufficient quantities of ARV medication yearly. To analyze compliance, I rely on the statements of government officials, Russian NGOs, and reports of international organizations. Jointly, these provide a more accurate understanding of where Russia stands in terms of treatment provision for HIV/AIDS.

The 2010 shortages were caused by the Ministry of Health’s delays in procuring medication—not by a lack of funding. Several sources suggest that the government’s ARV procurement system and the organization of the HIV/AIDS treatment system were at fault (ARV terapiya 2008). The ARV reserve fund also exacerbates the issue of shortages. An emergency fund for ARV medication could eliminate the problem of out-of-stock medication. Another problem in the way the government handles treatment is a lack of tests for resistance to ARV treatment. Tests play a crucial role in determining whether the current treatment protocol is working and effectively treating HIV/AIDS. Also, some of the problems with ARV procurement stem from the centralization of the drug procurement system by the state. The information about how much medication needs to be purchased for the following year is gathered from the regional HIV/AIDS centers; only people who are registered with the HIV/AIDS centers have access to the ARVs financed by the federal budget.

Initially, with the onset of the HIV/AIDS epidemic, Russia made commensurate efforts to provide treatment. When it was discovered that AZT was able to suppress the
HIV virus, Russia started to produce a generic version in 1993. It was almost identical to the original version in its pharmaceutical properties and side effects. By 1998, Russia had developed another version of AZT with fewer side effects. However, as the HIV/AIDS epidemic propagated further, the government failed to provide treatment for all. In Russia, the HAART treatment did not become widely available until 2006—in 2005, only 1 percent of those infected with HIV/AIDS had been receiving HAART, and no intravenous drug users had access to this therapy (Long, et al. 2006, 2010). Studies have found that the most cost-effective approach would be to target both IDUs and non-IDUs for treatment, and the least effective approach is to target only non-IDUs (Long, et al. 2006, 2211). Russia, by excluding drug users from treatment, has chosen a non-effective approach to addressing the epidemic.

ARV Shortages

According to the data of the Russian government, the country fully complies with the international norm, providing nearly universal ARV coverage. The 2008 official country progress report for the United Nations states that Russia provides HAART to 90 percent of people in need of treatment (Goliusov, et al. 2008, 26). These official statistics are questionable, however—not least because the nongovernmental organizations point out the shortages of ARV provision. Russia’s increase in HIV/AIDS treatment provision did take place and was remarkable, indeed: from approximately 2,000 people provided with ARV treatment in 2002 to 79,430 people provided with ARV treatment in 2010. However, during that period of time, the HIV/AIDS prevalence rate also increased.
There is a formidable discrepancy between the official Russian data and international estimates of treatment coverage. While the actual numbers of people receiving ARV treatment might be accurate, the officially estimated percentage of people covered appears to be largely exaggerated. Some international observers contend that only between 21 percent to 29 percent of the HIV-infected received treatment between 2009 and 2010. Others estimate that the number is even lower at 2 - 4 percent of the infected population (Kravtsov 2011, 307). These statistics of treatment provision in Russia are particularly low compared to a 47 percent average treatment coverage in other low- and middle-income countries in 2010 (Chernykh 2015). Given that ten countries worldwide have achieved universal access to antiretroviral therapy, Russia’s statistics on HIV/AIDS coverage are particularly lagging (WHO, UNAIDS and UNICEF 2011, 90). Between 2009 and 2010, access to treatment in the country has increased by only 5 percent, while some countries scaled up access to treatment by as much as 43 percent (in South Africa) and 32 percent (in China) (WHO/UNAIDS/UNICEF 2011, 98). Given that so many countries have universal ARV access or near universal coverage, Russia’s access to HIV/AIDS treatment by global standards is extremely low.

However, it is not only the underestimation of the HIV/AIDS prevalence rate that leads to the conclusion that ARV therapy does not reach everyone who is in need—how the “need” for ARV therapy is determined matters, as well. To make a decision whether to begin ARV treatment, the viral load of a person is taken into account.\(^\text{37}\) In Russia, ARV therapy is started at a later stage of HIV/AIDS development—that is, at a lower

\(^{37}\) The viral load is measured as a level of CD4 cells/mm\(^3\).
CD4 cell count compared to international standards. This practice allows Russian officials to contend that the cumulative number of people in need of treatment is lower. Therefore, the official estimates of access to ARVs in Russia are artificially high.

Another way in which the Russian Federation deviates from the international norm of treatment provision is its failure to supply ARV therapy consistently to those who already use it. Fear of ARV shortages is part of life of people living with HIV/AIDS in Russia.\(^3\) To compensate for the lack of medication, during periods of shortages some HIV/AIDS patients have been forced to buy expensive ARV medication abroad.

However, the Ministry of Health and Social Development contended that it procured sufficient quantity of ARVs. Alexey Mazus, the head of the Moscow Center for HIV/AIDS prevention and treatment, confirms in several interviews that the Ministry of Health provided budgeted HIV/AIDS medications and that those medications were sufficient to cover all HIV/AIDS patients. Activists, however, contend that the out-of-stocks were so severe that even HIV/AIDS positive pregnant women at times did not have access to life-saving medications (Trefilova and Bakulev, 2010). Through collaborative online efforts, common pools of medication were created for those who did

\(^3\) Most recent ARV out-of-stocks took place during the summer of 2010. The branch of the International Treatment Preparedness Coalition assessed the extent of shortages in Russia in 2010, which lasted from April to September (Parfitt 2011, 369). Out of 19 cities in the study, out-of-stock medications have been registered in 30 percent of the cities; changes to the ARV provision schemes as a result of out-of-stocks took place in 36 percent of the cities; inaccessibility of one or more medications of ARV treatment due to out-of-stocks were registered in 30 percent of the cities.
not have access to them.\textsuperscript{39} HIV/AIDS activists assert that these medication shortages existed since at least 2005.

\textit{High Costs of the ARV Treatment}

The cost of ARV treatment in Russia remains high, as well. Governments are encouraged by the international consensus to lower the prices of the ARV treatment through negotiations with the original pharmaceutical companies or through issuing compulsory licensing in accordance with the 2001 Doha declaration on TRIPs and Public Health. In Russia, a reduction in price for the five most expensive ARV drugs from 2009 to 2011 was almost non-existent (Godlevskiy, et al. 2011, 19). Moreover, before price reduction, one of the drugs was supplied at a higher price than in Britain.

\textit{Noncompliance with International ARV Treatment Protocols}

Observation of ARV treatment protocols is recognized as key for the effectiveness of treatment. Russian NGOs and external observers report that Russia does not follow HIV/AIDS international treatment protocols. HIV/AIDS treatment protocols in Russia differ from international ones in two major ways: 1) treatment is oftentimes initiated with significant delays and 2) changes in medication occur haphazardly, without medical indications, due to shortages of medication and HIV/AIDS tests.

1) ARV treatment is prescribed with delays not only in remote locations, but also in many cities. The international consensus recommends initiating ARV treatment not

\textsuperscript{39} See, for example, Pereboi.ru.
immediately upon discovery of the HIV positive status, but when CD4 cell count falls to a level of 350 cells/mm3. However, in many cities in Russia, treatment is prescribed when the CD4 level drops to 300, 200, and sometimes even 100 cells/mm3.\textsuperscript{40} Such low levels of CD4 cells are one of the clinical indications for the onset of AIDS. The initiation of treatment at such low levels of CD4 cells might jeopardize the success of the treatment of the disease.

2) According to international standards, treatment schemes should be only changed due to medical indications: development of drug resistance or individual intolerance to a particular scheme of treatment. However in Russia, shortages of particular drugs in the scheme of treatment cause changes to treatment. The problem with arbitrary changes in treatment might lead to premature development of resistance to medication and exhaustion of treatment options:

It's very important what's replaced with what. You need to look at the individual case of each patient. If you're talking about long-term treatment the changes can be harmful. A resistance can build up to a particular drug, or to a whole class of them. And there are side effects like skin irritations, nausea, and headaches. (Parfitt 2011, 369)

If you stop taking antiretrovirals for just a few days then resistance can build up and they become redundant. We are talking about lives at risk.” (Parfitt 2011, 370).

While HIV/AIDS with proper treatment is not very much different from other chronic diseases, interruptions of treatment even for a few days might lead to dangerous drug resistance. In Russia, changes in treatment protocols oftentimes happen because one or more drugs in the treatment regimen are not available.

\textsuperscript{40} CD4 level of 100 cells/mm3 is considered to be AIDS.
Access of Intravenous Drug Users to AR is Limited

While Russia has begun widely implementing highly effective antiretroviral therapy since 2006, this treatment largely does not reach intravenous drug users (IDUs) (Maron and Meylahs 2010). Exclusion of this population from treatment is problematic for several reasons. As discussed above, providing treatment to IDUs is a cost effective response to the epidemic. Also, current studies demonstrate that access to antiretroviral treatment can be seen not only as part of HIV/AIDS treatment but also as a method of prevention. HAART not only delays the onset of AIDS, but also decreases the possibility of HIV transmission (Long, 2006). In Russia, where the HIV/AIDS epidemic is largely driven by intravenous drug use, the intravenous drug users’ restricted access to ARV treatment only exacerbates the epidemic.

The fact that IDUs in Russia, for the most part, do not receive ARV treatment is a result of government policies, medical practices, and the stigma attached to the status of a drug user. ARV treatment requires strict compliance with treatment protocol. Often, physicians view intravenous drug users as not capable of remaining in treatment and exclude them from therapy under the conditions of already tight ARV supply (Antiretroviral Treatment 2004).

41 A study of dynamics of the HIV/AIDS in St Petersburg, Russia, demonstrate that extension of HAART to intravenous drug users could slow down the development of the epidemic. The Long et al. study contends that in 2005, none of the IDUs received ARV and only 1 percent of those who needed treatment had access to it. The study concludes that immediate introduction of HAART to wide groups of population, including IDUs is necessary in order to curb the development of the epidemic.
The international consensus on the response to HIV/AIDS stipulates that a successful response can be achieved when the state undertakes comprehensive measures to address HIV/AIDS. Russia, since the onset of the epidemic, has systematically overlooked prevention. Not only have prevention programs been underfunded, but also the norm on prevention has been implemented only selectively. While Russia has achieved blood supply safety and addressed the mother-to-child transmission problem, it almost completely neglects the prevention of HIV/AIDS among intravenous drug users and during the course of sexual transmission. Opioid substitution programs are prohibited in the country, as are methadone and buprenorphine, which are used in maintenance therapy.42

Prevention of HIV/AIDS is one of the aspects of state response where a schism exists between different agencies in the Russian government. While the Federal Center for Treatment and Prevention of HIV/AIDS recognizes the necessity for preventive programs among intravenous drug users—particularly needle exchange and syringe programs and opioid substitution maintenance programs—this is not a part of the larger governmental approach. Other governmental agencies, such as the Federal Drug Control Service [FSKN], oppose these approaches at the policy level.

Prevention of the sexual transmission of HIV/AIDS is also a subject of controversy. The government mainly implements an abstinence approach, which is not

42 While buprenorphine might be used for therapeutical purposes other than drug addiction, methadone is entirely banned in Russia.
recommended as an independent intervention by the international consensus (WHO 2011). Sex education is contested in the legislature, and condom provision is very limited. Discourse regarding lack of HIV/AIDS prevention rarely finds its way into the media, and Russian society remains uninformed regarding issues of HIV/AIDS prevention and of the epidemic’s development in general (Grisin and Wallander, 2002: 5).

**Prevention of Sexual Transmission of HIV/AIDS in Russia**

There is a consistent discrepancy between official sources and international analysis regarding the main route of HIV/AIDS transition in Russia. Some, like the head of the Moscow HIV/AIDS Center Alexey Mazus, contend that HIV/AIDS is predominantly transmitted through sexual contacts (Mazus 2011). Regardless of recognizing the importance of the sexual route of transmission, the government resists prevention through sex education and condom distribution. Moreover, the state interferes with the efforts of NGOs to promote condom use among marginalized populations, such as sex workers. According to surveys, 80 percent of sex workers in Russia said that police used condoms as evidence against them (Shields 2012).

**Intravenous Drug Transmission Prevention**

The international consensus stipulates that harm reduction programs should be implemented in order to reduce the risk of HIV/AIDS transmission through intravenous drug use (see Table 2). In the Russian Federation, where intravenous drug use has played a major role in the HIV/AIDS epidemic, the implementation of harm reduction programs
is considered by the international norm a critical element of the recommended response (Elliott, et al. 2005). However, key interventions, such as opioid substitute therapy (OST), are excluded from preventive interventions in Russia. Furthermore, methadone and buprenorphine, the two medications used in OST and included in the WHO list of essential drugs, are illegal to use in opioid substitution therapy (see Table 3).43 Throughout the history of the HIV/AIDS epidemic, there have been no actions undertaken by the Russian government to prevent intravenous transmission of HIV/AIDS. In addition, the government also precludes both local and international NGOs and international organizations from implementing needle exchange and sterilization programs interventions. Approximately 75 such programs function in the territory of Russia sponsored by NGOs; however, such efforts are insignificant for the country’s intravenous drug users.

Funding of HIV/AIDS Prevention Programs. State Capacity

Although expenditures on health as a percentage of the GDP in a state do not have a direct correlation with health outcomes, cumulative health funding proportional to epidemiological threats as well as allocation of this funding does matter (Savedoff 2005). As a general practice, the Russian government’s spending, as well as its overall spending on health, is lower compared to other states with similar cumulative funding and conditions. Russia’s expenditure on health is also lower compared to other European

________________________

43 Circulation of methadone is completely banned in the Russia, buprenorphine is not allowed for use in OST.
countries in the region and other countries of the Commonwealth of Independent States, as well (Popovich, et al. 2011, 67). Additionally, when compared to countries with similar resources and conditions, such as Poland and Mexico, for example, Russia is less successful in improving health outcomes (Clark 2013, 711-712).

Not only does a country’s government spending on health and public health matter (see Table 5), the allocation of funding also plays a role in addressing the HIV/AIDS epidemic. The top leadership in Russia expressed concern over public health and contributed funds to address the problem of demographic decline (Poslaniiye Federal’nomu Sobraniyu 2006). While overtime the funding of HIV/AIDS programs has increased, the underfunding of prevention programs in particular have contributed to the inability of the state to contain the HIV/AIDS epidemic.

The funding of HIV/AIDS related activities comes from federal or regional funds, city/municipal budgets, and health insurance funds according to UNAIDS (UNAIDS 2009). At the onset of the epidemic, the HIV/AIDs programs funding was meager. However, since then the country has scaled up its efforts. A surge in federal funding occurred in 2006 when the federal budget allocated 18 times more funds compared to 2005. In 2007, federal HIV/AIDS funding increased further, reaching US $444.8 million—three times more than in 2006 (in 2006 it was approximately US $148 million) (Goliusov, et al 2008: 32). However, this general increase in funding has not been reflected in substantial changes for prevention programs. Only 2 percent of the funding from a federal program targeting HIV/AIDS, “Zdorov’ye,” is allocated to prevention programs. Given the central role of prevention as stipulated by the international consensus, prevention programs are thus gravely underfunded.
Table 5 Total Health Expenditure as a Share of GDP in the Russian Federation

<table>
<thead>
<tr>
<th>Year</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spending as a % of GDP</td>
<td>5.2</td>
<td>5.3</td>
<td>5.4</td>
<td>4.8</td>
<td>5.4</td>
<td>6.9</td>
<td>6.7</td>
<td>6.5</td>
<td>6.5</td>
</tr>
</tbody>
</table>


4 Conclusion

This chapter first contends that the international consensus on the response to HIV/AIDS emerged with the discovery of effective treatment for the disease. It examines conceptualizations of state response to the epidemic that were previously developed in the literature. Furthermore, it maintains that to both understand the state response to the epidemic and measure state response, three areas should be taken into consideration: framing of the epidemic, treatment of the disease, and prevention of HIV/AIDS. This chapter demonstrates that the consensus on harm reduction, including needle exchange and sterilization programs and opioid substitution programs, is a part of the international consensus, particularly when the epidemic in a state is driven by intravenous drug use.

Second, this chapter evaluates Russia’s compliance with international norm on HIV/AIDS. While it establishes that the Russian Federation does not fully comply with all three norms on framing, treatment, and prevention of HIV/AIDS, it demonstrate that since most of key prevention programs are absent in the country, including the prevention of the main route of transmission of HIV that drives the epidemic, it is of particular importance to explain the absence of sexual and intravenous drug transmission prevention in Russia.
Third, in this chapter I argue the epidemic in the Russian Federation is driven mainly by intravenous drug use, and Russia does not implement key harm reduction interventions, unlike other states with similar epidemics. This makes the Russian Federation an outlier case of state response to the HIV/AIDS epidemic.
<table>
<thead>
<tr>
<th>Policy Component</th>
<th>Treatment</th>
<th>Universality</th>
<th>Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>Addressing the epidemic as a public health crisis with standardized protocol</em></td>
<td><em>Providing the access to treatment to everybody who needs it, ideally free of charge</em></td>
<td><em>Including all stakeholders in the policy formulation and implementation</em></td>
</tr>
<tr>
<td>Indicators of standardized policy response</td>
<td>- Public health crisis - Standardized protocol (ARVs) - Check on prices (generics)</td>
<td>- Inclusion of vulnerable groups - Scaling up access - Prevention (ABC)</td>
<td>- Public-private partnership - Civil society /nonprofit sector - International organizations</td>
</tr>
<tr>
<td>Indicators of opposite to the standardized policy response</td>
<td>- Any secondary framing - Substandard protocols - No check/excessive control</td>
<td>- Any forms of stigma and exclusion - Scaling down - No prevention/ or as a substitute</td>
<td>- Selective engagement - Exclusion from policy- making - Any restrictions and challenges</td>
</tr>
</tbody>
</table>

Source: Kravtsov 2011
Table 7 Conceptualization of the Global Policy Consensus on HIV/AIDS (Lieberman)

<table>
<thead>
<tr>
<th>General bureaucratic development (indicators)(^{44})</th>
<th>Prevention (indicators)(^{45})</th>
<th>Treatment (indicators)(^{46})</th>
<th>Rights Orientation (indicators)(^{47})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bureaucratic structure</td>
<td>Education and outreach</td>
<td>Monotherapy</td>
<td>Workplace nondiscrimination</td>
</tr>
<tr>
<td>Number of HIV/AIDS program stuff</td>
<td>Condom distribution</td>
<td>Highly active antiretroviral therapy (HAART)</td>
<td>Other rights-related policies (deportation of HIV-positive migrants; establishment of ethical treatment policies for HIV-infected).</td>
</tr>
<tr>
<td>Appearance of HIV/AIDS as budget line item</td>
<td>Prevention of mother-to-child transmission (PMTCT)</td>
<td>People on treatment</td>
<td></td>
</tr>
<tr>
<td>Partnerships with NGOs</td>
<td>Safety of blood supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring and testing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Lieberman 2009\(^{48}\)

\(^{44}\) ibid, 116.
\(^{45}\) ibid, 119.
\(^{46}\) ibid, 122.
\(^{47}\) ibid, 124.
\(^{48}\) Lieberman, 2009: 88.
CHAPTER 3
PSYCHIATRY AND NARCOLOGY IN RUSSIA AND THEIR INFLUENCE ON THE HIV/AIDS POLICY-MAKING PROCESS

1 Introduction

Unlike HIV/AIDS epidemics of the first wave, the HIV/AIDS epidemic in the Russian Federation is driven by intravenous drug use. However, the country does not implement interventions to prevent intravenous transmission of HIV/AIDS. To understand why the state does not prevent intravenous transmission in a country’s response it is crucial to examine the rationale behind the state’s treatment and prevention approaches to drug addiction. While the state does not take the initiative to address the epidemic, path dependent policies shape the response leading to rejection of harm reduction approaches, key in the prevention of intravenous transmission of HIV/AIDS. In this chapter, I demonstrate that policies regulating drug addiction treatment and prevention that came to influence the response to the HIV/AIDS epidemic were influenced by the field of narcology that rejects implementing measures of harm reduction. Narcology, a medical field that studies addiction in the Russian Federation, has a unique route of development divergent from its Western counterpart in the field of treating addiction. Narcology originated within the field of psychiatry and is strongly influenced by its theoretical assumptions, which lead to the rejection of harm reduction approaches.

This chapter establishes a continuity between drug addiction treatment and prevention policy in the Soviet Union and the Russian Federation. It shows that the resistance to harm reduction can be found in the historically formed views on prevention
of drug addiction. The chapter, first, traces the historical development of the discipline of psychiatry and narcology to demonstrate that the theoretical position of narcology to reject harm reduction approaches is rooted in a Pavlovian neurophysiological paradigm that has shaped the development of psychiatry in the Russian federation and was supported by the political developments within the Soviet Union in the early 20th century. Understanding addiction based on a neurophysiological paradigm explains addiction as a conditioned response, at least in the earlier stages of development of the disease; therefore, an individual with addiction is believed to be susceptible to a full recovery. However, the use of harm reduction is based on the understanding that addiction is the result of a biochemical response of the brain. Second, tracing the historical development of psychiatry and narcology also allows me to demonstrate the authoritative position of both psychiatry and narcology vis-à-vis the state as well as the hierarchical nature of this field which resulted in suppressing theoretical discussion of harm reduction within the field itself. Third, through an examination of views of psychiatry and narcology in scientific publications in leading journals and current scientific debates, I demonstrate that currently the field rejects harm reduction approaches to the treatment of drug addiction. Fourth, I demonstrate that the policies to prevent drug addiction that were key in addressing the HIV/AIDS epidemic are path dependent and institutionalized within governmental bodies that did not have a mandate to prioritize prevention of the HIV/AIDS epidemic. Finally, I demonstrate that policies to prevent drug addiction were shaped by the medical epistemic community of drug addiction specialists both in the Soviet Union and in the Russian Federation.
To explain positions on treatment of drug addiction within narcology in the Russian Federation, I examined the scientific history of psychiatry and narcology—a subspecialty of addiction medicine in Russia that emerged in the 1970s and became an independent field in the 1980s. First, historical analysis of theoretical developments within Russian psychiatry explains the rather authoritative position of the field in its relation to the state. Second, it explains the perception and theorizing about addiction by this medical field. The neuro-physiological paradigm, initially based on the Pavlovian teaching on reflexes, underpins the dominant Moscow school of psychiatry. This approach considers addiction a “habit,” at least during the earlier stages of the development of the disease. Therefore, drug or alcohol addiction is viewed as being potentially curable. Third, the history of the development of this discipline explains a range of recent patented treatments for drug addiction, including an array of conditioning treatments and hypnosis in post-Soviet Russia that are not supported by rigorous evidence-based studies (Soshnikov, et al. 2011). Finally, theoretical foundations of narcology and its clinical practices help to partially explain the ambiguity and resistance within the narcological community to methadone treatment and other harm reduction approaches. In contradiction to theoretical understandings in the narcological community, the theoretical foundation of harm reduction approaches conceptualizes addiction as a chronic condition that cannot be completely cured but only managed through interventions such as opioid substitution treatment and prevented through needle and
syringe exchange programs. Below, I examine the development of psychiatry’s paradigms in Russia as well as an historical understanding of addiction within the field.

Theoretical Development of Psychiatry in Russia

Psychiatry as a discipline was shaped by the interplay of social and political transformations both in pre-Revolutionary Russia and in the Soviet Union. A distinct and repressive nature of Soviet psychiatry is most well-known for coining the term “sluggish schizophrenia” that was applied to political dissidents (Bloch 1978, 129). However, a field of psychiatry in Russia became distinctive from its counterpart discipline in the West when, after the Revolution, Pavlov’s doctrine came to dominate the sciences of the mind field in Soviet Russia. Psychiatry, closely interconnected with the changes taking place in science, society, and political spheres, was greatly influenced by politics of knowledge, mind, and brain (Raikhel 2012). While in the early years of the Soviet Union the discipline of psychiatry was engaged with Western ideas of the mind, when Pavlov’s ideas, supported by the Bolsheviks, come to dominate the field, the discipline developed an “uncontestably peculiar to Russia” direction (Joravsky 1989, xvi). An encroachment from the state during Stalin’s years further confines the development of the discipline by stifling any contestation of Pavlov’s doctrine. A dialogue with Western science at the time also did not occur. As a consequence, Russian psychiatry and narcology developed a unique clinical and theoretical understanding of addiction. While Pavlov’s ideas were subsequently challenged in the 1960s—their influence on the field of addiction studies was evident in the post-Soviet period (Raikhel 2012). Russian psychiatry is exceptional “to have a union of mind and brain in one science” (Joravsky 1989, xvi).
Ivan Mikhaylovych Sechenov was one of the first scientists in Russia to reduce psychological phenomena to material process in his “Reflexes of the Brain” published in 1863. The materialist understanding of the brain was appealing to the radicalizing intelligentsia at the end of the 19th to the beginning of the 20th century. At the turn of the century, Russia was not secluded from the developments in the Western mind sciences field and Freud’s ideas were popular both within the Russian intelligentsia and within the medical community. The debate that further structures disciplines studying the mind was between Ivan P. Pavlov and Vladimir M. Bekhterev. Both of the scientists based their findings on Sechenov’s ideas. Pavlov acknowledged that there is the “psychic element” in animal functioning. He explained it through the “conditioned reflex.” Bekhterev referred to it as “associative reflex.” The conditioned or associative reflexes were linked to human psychology and used to explain “reflexology” or “higher nervous activity” (Janousek and Sirotkina 2003, 434). It would be an overgeneralization to state that Pavlov thought to reduce all psychological activity in human beings to their biology; rather, he was seeking to open a doorway for physiologists in an area previously considered to be the exclusive scientific domain of psychologists (Raikhel 2010).

Bekhterev’s approach was “more ecumenical than that of Pavlov. Bekhterev’s approach reflected both a penchant for organizing (his Institute for Psychoneurology welcomed researchers in a number of disciplines) and a Spinozist ontology which viewed mind and brain as two aspects of one substance” (Raikhel 2006, 45). Bekhterev was the founder of the St. Petersburg school of psychiatry, a rival of the dominant Moscow School, where scientists who espoused Pavlovian doctrine started to occupy key positions.
Two debates in the early history of mind disciplines in the Soviet Union—between “materialism” and “idealism”—are relevant for explaining personhood as well as the role of political forces in shaping the discipline of psychiatry and subsequently of narcology in the Russian Federation. Pavlov’s theories were more amenable to the Bolsheviks’ ideology of materialism and the Bolsheviks favored them to other theoretical approaches. They made possible a link between human biology and environment (Raikhel 2010, 34). Biological explanations of human nature were used “as a theory of learning in a new society” and Pavlov’s theory was pronounced to be a “tool out of the iron toolkit of the materialist ideology” (Nikolai Bukharin quoted in Janousek and Sirotkina 2003, 438). A discussion of human nature was very important as a part of state ideology. Marxists viewed human nature as socially and culturally determined and therefore being amenable to change. Pavlov’s ideas about reflexes and his explanation of higher nervous activity were a pathway for the Bolsheviks to connect, on one hand, a Marxist understanding of human beings as historical actors and, on the other, as material beings (Raikhel 2010, 142). For Marxists, Pavlov’s theory was important because it provided “material mechanisms for learned behavior” (Raikhel 2006, 53) as well as the “‘dialectical’ relationship between human biology and the environment” (Raikhel 2010, 142).

These main theoretical developments within the field of psychiatry had implications for the theoretical understanding of addictions as well. In the 1920s, social hygienists made an attempt to study alcoholism as a “social disease.” The roots of the disease, according to this interpretation of the pathogenesis of addiction, could be addressed through the changes in social policy (Raikhel 2006, 57). This would inevitably
place responsibility for addiction on the Soviet state. The state preferred instead to understand addiction as an individual pathology: it made an individual a responsible party and was ultimately consistent with the state’s political ideology and its views of the individual (Solomon quoted in Raikhel 2006, 60). Therefore, the hygienists’ line of theorizing of addiction was very promptly curtailed.

*Psychiatry and the State*

Psychiatry as a discipline was influenced by the state, particularly during the beginning of the 20th century, through official support of Pavlov’s theory. Some even conclude that psychiatry is a creation of the Russian state (Lavretsky 1998, 539). These complex relationships between psychiatry and the state shaped theoretical beliefs and clinical practices within the discipline of both psychiatry and, consequently, of narcology. However, the state not only controlled psychiatry, but the field also exerted its influence upon the state. Leaders of psychiatry became traditionally involved with creation of state policies (Lavretsky 1998, 539). After a prolonged competition between two centers, in Moscow and St. Petersburg, for the dominance in the field of psychiatry, the “Moscow school” gained leadership in the profession. With that leadership of scientists from the Moscow school also came “strategic control over policy-making and publishing” (Lavretsky 1998, 539).

The state relentlessly meddled in the field of psychiatry ensuring that the specialists supported the state’s ideology. It also controlled all alternative theoretical

---

49 Bekhterev Psychoneurologic Institute in St. Petersburg became a place for the alternative views of Psychiatry even in the post-Soviet Russia.
views in the field. From the 1920s to the 1930s, nearly the entire staff of the Serbsky Institute in Moscow was replaced with specialists “politically sympathetic to the Soviet regime” (Joravsky 1989, 415). This infraction on the authority of psychiatrists resulted in fewer diagnoses of insanity [*nevmenyaemost’*], allowing for the mentally ill to be viewed as “‘chargeable’ criminals” instead (Joravsky 1989, 416). From the 1930s to the 1950s, many psychiatrists lost their positions because of theoretical opinions that were inconsistent with state ideology.

With Stalin’s ascent to power, the state sought to create new Soviet specialists who would favor their affiliation to the state rather than to their professional community (Fitzpatrick 1993). These specialists’ primary ideological affiliation would be to the party state and not to the scientific community of their profession. During the 1950s, an overall Russification of science took place in Soviet Russia—an attempt to create a uniquely Soviet Russian science across all fields. The most famous example of this process, which created a major setback for some disciplines, is the scientific triumph of Trofim Lysenko’s doctrine of “acquired characteristics”\(^{50}\) which became the prevailing theory within the field of genetics. In the sciences of mind, Pavlovian approaches eventually triumphed in the 1950s. During a psychiatric conference held in 1936, it was apparent that only one form of theorizing prevailed—“the Stalinist mode of discourse” (Joravsky 1989, 424). During the 1951 Pavlov Session for Psychiatrists, the profession was remodeled in a “distinctively Soviet Russian style” (Joravsky 1989, 426). As a result, entire schools of brain pathology and neuropsychiatry were destroyed. Unwanted

\(^{50}\) The doctrine maintained inheritance of acquired characteristics.
theoretical dissent was silenced. The Leningrad schools that held divergent theoretical views, although not denied publishing their findings entirely, were only able to express their dissent in vague terms (Joravsky 1989, 438).

_Domination of Strong Authoritarian Figures in the Field of Psychiatry_

While the Soviet state was belligerent towards most scientific fields in its intention to establish ideological authority over science, political power in the Soviet Russia had a different relationship to the field of psychiatry: “political bosses have not been very assertive in this field” (Joravsky 1989, xix). Because of the early involvement of the state in shaping psychiatry, the sciences of mind field did not challenge the state’s authority and ideology, unlike other scientific and professional fields. The development of the field of sciences of the mind is characterized by an absence of radicalism. Moreover, the field of psychiatry, during Stalin’s regime, became dominated by strong authoritarian figures supported by the regime. As a result, the Stalinist mentality took hold over the profession of psychiatry and its effect persisted in this scientific field long after Stalin’s death. It manifested itself through the absence of open discourse within the field and challenges from influential psychiatrists working and researching in the field. (Joravsky 1989, 419).

One such powerful figure in psychiatry was A.V. Snezhnevskiy. Political authority brought A.V. Snezhnevskiy to power and turned him “from an unpretentious clinician to an unanswerable boss” (Joravsky 1989, 429). His authority remained uncontested in the field from 1951 to 1987. He was an administrator from the Moscow school offering the type of theorizing in the field that public health officials were ready to
support. The discussions that Snezhnevskiy organized in his journals in the 1950s, of schizophrenia for example, were “a classic Stalinist caricature of a genuine discussion” (Joravsky 1989, 429). This “clinical dogmatism” established by Snezhnevskiy has kept it isolated from new research that has been carried out in the mind disciplines in the West (Joravsky 1989, 432). While there was a short period when hygienists attempted to explain addiction through the presence of societal factors, such explanations became no longer permissible (Raikhel 2006, 60). After Stalin’s death, Soviet scientists of the mind remained dedicated to “Pavlov’s doctrine” and remained unable to engage critically with theoretical approaches in the field: “So Marxist and Pavlovian doctrine remained elevated above meaningful discussion, ritually avowed and practically ignored until Gorbachev called for glasnost” (Joravsky 1989, xvi).

Snezhnevskiy’s role in psychiatry illuminates a consistent pattern in the development of mind disciplines, psychiatry, and narcology in the later period of the Soviet Union and the post-Soviet space. The field of narcology, that became an independent field in the 1980s, inherited these characteristics from psychiatry: a few authoritative figures dominating the field, leading discussions in scientific journals, and presiding over dissertation committees. As a result, scientific discourse, pertinent to treatment of drug addictions and implementations of harm reduction and opioid substitution programs, remains superficial.

Relative Independence of the Discipline from the State

Because of this role of the state in defining the theoretical development of psychiatry, the conclusion seems to follow that psychiatry turned into a discipline highly
dependent on the will of the state. Experiences of punitive psychiatry in the Soviet Union might further support this point of view. The effect of state influence on psychiatry, however, was the opposite. Suffering through political assaults on its autonomy from an authoritarian leader, psychiatry eventually emerged as a professional field with its own despotic tendencies:

In the Soviet Union until very recently the profession has enjoyed almost unrestricted autonomy in its power to treat patients, and psychiatrists have displayed very little self-assertive or fractious spirit. They have been almost as submissive to the authoritarian leaders of their profession as their patients have been to them. (Joravsky 1989, 419)

The current state of Russian psychiatry and narcology represent legacies of the relationship between these disciplines and the state. A new relationship between the discipline of psychiatry and the state is only emerging. A substantive shift in such relationships cannot clearly be observed in the current state of these disciplines and the practical field compared to that of the Soviet period. The portrayal of psychiatry and narcology as fields not blindly subservient to the needs of the state, but fields with their own authority further explains the role of narcology on the policy-making process on drug addiction. Psychiatry’s and narcology’s authoritative tendencies and hierarchical structures help explain why these fields had power to exert significant influence on state policy.

*Narcology*

Currently, narcology is a distinctive medical field specific to the Russian Federation. The development of addictology is unprecedented in comparison to other countries’ medical experience. In Western states, the study of addiction remains a sub-
field of psychiatry. Initially, the medical study of addiction was also nested under the broader field of psychiatry and was shaped by its theoretical assumptions. In Russia, narcology emerged as a separate field in the 1980s and inherited from psychiatry its peculiar outlook on the treatment of addiction and connection to the state: “we always have had our authentic narcology, to a lesser extent than our own psychiatry, … from here all of this [differences in treatment of addiction] is coming” (Sivolap, interview).

Despite the fact that narcology became an independent field, the influence of larger theoretical trends that initially shaped psychiatry currently persists in narcology as well. Close examination of theoretical developments within psychiatry and addiction treatment in Russia will explain the current state of narcology as a discipline. It will also explain the resistance of narcology to harm reduction programs.

An anthropological study of alcohol addiction treatment in post-Soviet Russia demonstrates that disciplinary assumptions of addiction medicine differ from those accepted in Western medicine. The model of addiction that became a dominant paradigm of addiction in Western countries is of “chronic, relapsing brain diseases” (Raikhel 2012, 231). While observing “paradoxes” of alcohol addiction treatment in the Russian Federation, the study concludes that intellectual and institutional conditions that formed narcology provide the answers to currently used and seemingly illogical approaches to addiction treatment (Raikhel 2006, 36). Since Pavlov’s neurophysiological paradigm came to dominate psychiatry, the field offered functional explanations of addiction rather than an etiological (social or hereditary) one (Raikhel 2012, 237). For example, causes of alcoholism would typically be explained by scientists as consequences of heavy drinking, not due to physical or psychological predisposition (Raikhel 2012, 236). While
differences between Russian and English-language addiction medicine are theoretical, they have consequences for the views on the treatment of addiction as well. Raikhel argues that placebo treatments for alcoholism that proliferated in post-Soviet Russia are congruent with Pavlov’s theory of reflexes (Raikhel 2012, 238). These theoretical understandings affect the practice of rank-and-file clinicians. These practices of treatment and diagnoses of addiction based on a neurophysiological Pavlovian framework have been widely institutionalized. I argue that a neurophysiological understanding of addiction rather than as a biological neurochemical phenomenon leads to the rejection of harm reduction by Russian narcology specialists.

An extensive examination of patents, filed by narcologists, reveals that many treatment approaches are not evidence-based. They are based on a placebo effect. Such interventions are not acceptable according to the standards of evidence-based medicine (Soshnikov, et al. 2011). Leading departments and institutes of narcology as well as prominent narcologists and psychiatrists also support treatment innovations and design patent treatments that are not supported by evidence-based studies.

Historical legacies in the discipline are rather persistent. Some critically-minded specialists in the field recognize that their discipline is in many ways defined by its development under the Soviet Union and is unable to change: “There is inertia [in narcology] from the Soviet Union, from Pavlov’s theory” (Snedkov, interview). A distinction between Moscow and St. Petersburg schools, although currently diminishing, still exists:

Moscow’s psychiatric school in its ideas about psychiatric diseases differs from a St. Petersburg one. It differs rather significantly. In Moscow, it is thought that exogenous psychiatric disorders can be instigated, but they have their own course of development...In St. Petersburg, they think that
anything is possible after anything. In other words any harmful influence can lead to what Moscow school calls schizophrenia (Gofman, interview).

After the fall of the Soviet Union, they also manifested themselves in calls for a revival of former practices, such as mandatory treatment within the Occupational Therapy Detox Centers \textit{[lechebno-trudovoy profilaktoriy or LTP]}. These are suggested practices for drug and alcohol addiction among the options for responding to drug addiction and the HIV/AIDS epidemic in the country. Current sentiments for the revival of the former practices within narcology are stem from the institutional legacy of the former relationships of authority between narcology and the state. In addition, new theoretical developments are contextualized within the theoretical proclivities already present in the disciplines of psychiatry and narcology. Divergent opinions on the nature of addiction and the possibility of implementation of harm reduction measures are excluded from mainstream publications in narcology journals.

\textit{Conclusion}

This review of the historical development of psychiatry—a discipline within which narcology originally was situated as a scientific field—is significant for the discernment of contemporary positions of narcology regarding the treatment and prevention of drug addiction and the rejection of harm reduction approaches. First, through the theoretical domination of the Moscow school of psychiatry, influenced by Pavlov’s paradigms, led to a peculiar Russian understanding of the nature of drug addiction and, therefore, views on prevention and treatment of drug dependency. Second, the discipline of psychiatry, and, subsequently, of narcology, began to occupy a rather independent position regarding the Russian state. Third, the possibilities of dissent in the
field and productive scientific discourse were limited because of the authoritative power of key scientific figures who directed the development of the discipline. Fourth, in the early 20th century psychiatry openly and productively engaged with ideas developed in the West, and for ideological reasons, this exchange was significantly limited and disciplines of the mind became limited in their theoretical development. The intellectual isolation of the field further directed the development of the discipline and paradigms of addiction treatment and prevention in ways that diverge from the paradigms accepted in English language/Western literature. Factors such as absence of dissent, the dominance of one school of thought, the control of the discipline by a few powerful figures, the resulting historical influence on policy-making, and a blocked discussion of harm reduction and opioid substitution therapies all contributed to the dominance of a narcological perspective on policies regarding addiction and treatment.

3 Current Scientific Debates within the Discipline of Narcology

During interviews many of my respondents, HIV/AIDS activists and medical specialists in infectious diseases, commented that the position of narcologists on the treatment of drug addiction and their opposition to harm reduction programs appears to be irrational:

It is difficult to understand. “Russia cannot be understood with the mind alone.” One has to look for some other interests behind it [rejection of harm reduction programs]. It appears that so called narcologists, specialists in narcology, do not like the use of methadone, because of some reasons. Perhaps, economic? They should be uncovered. They are not totally clear. If we suppose that those are some kind of mercantile interests, then, on the contrary, they would receive a much wider contingent of people for treatment than what they have now. And they will treat the same people after methadone with the help of some
psychotherapeutic methods and so on. One cannot say that the interest here is purely mercantile. There should be some other explanation which I do not completely grasp. They are against. Why? I tried to understand several times the logic, but everything boils down to: one cannot treat with a drug dependence from another drug. (Pokrovskiy, interview)

They contended that narcologists completely ignore the clinical nature of drug addiction and are not concerned with the consequences addiction treatment has for the transmission of HIV/AIDS:

I think it has to do with the fact that they [narcologists] narrowly understand their task. They do not think about prevention of HIV infection, and hepatitis. They are not worried about this because of their narrow specialization. (Pokrovskiy, interview)

To some it is not clear where the source of resistance to harm reduction is located:

as if there sits a spider. And he understands that if there would be methadone, he wouldn’t have profit. And this spider—it is very influential. This is not entirely clear. I think this is related to the Serbsky Research Center. Earlier, Babayan was there, now—Dmitriyeva [sic]. All of them were in the International Commission on Narcotic Drugs. They have [initiated] repressive psychiatry. This is the source of contemporary narcology. And plus purchases of all those neuroleptics. (Sarang, interview)

This resistance from the narcological community appears illogical. However, my investigation of the intellectual and institutional history of narcology as a specialty demonstrates that hostility towards harm reduction programs is forged through scientific beliefs and clinical practices of the discipline. A deviation from the internationally-recognized practices of addiction treatment was exacerbated by the years of intellectual isolation of Russian narcology as well (Zobin 2012).

In this section, I examine current debates in narcology in Russia to explain the resistance of drug addiction specialists to evidence-based approaches, including opioid substitution therapy. According to research findings published in leading
Western/English languages journals of addiction treatment and epidemiology, harm reduction is an evidence-based approach effective in managing drug addiction and effective in the prevention of HIV/AIDS (Maremmani, et al. 2006). Additionally, harm reduction programs are endorsed by the World Health Organization because of their effectiveness in address the HIV/AIDS epidemic. While some narcologists in Russia support harm reduction as a treatment for drug addiction, most addiction specialists, including leading specialists in the field oppose this type of public health intervention. Instead, Russian narcology uses treatment approaches that are based on a research and scientific tradition existing in Russia and advocates for a return to policies and treatment principles of the Soviet Union which were cancelled with the onset of democratization in the 1990s. The legislative initiatives coming from a narcological medical community call for the implementation of mandatory treatment and hospitalization of people suffering from substance abuse and addiction.

While the discipline of narcology was not in charge of the response to the HIV/AIDS epidemic, policies influenced by the views of this field precluded implementation of harm reduction approaches that are key for prevention measures in an HIV/AIDS epidemic driven by intravenous drug use. Below, I examine the state of the field of narcology to demonstrate that its views on addiction treatment in fact differ from the understanding of addiction in Western medicine. First, I show what can be described as a “scientific crisis within the field” of Russian narcology that manifests itself in: 1) a practice of denial of the problematic theoretical developments within the field due to

51 Some narcologists that support implementation harm reduction approaches include E. V. Snedkov, Y. P. Sivolap, E. M. Krupitskiy, and V. D. Mendelevich.
dominating hierarchical structures that prevent productive scientific discourse; 2) a lack of evidence-based methods; and 3) the use of treatment methods for addiction that are based on placebo effect. Second, this section examines how textbooks and publications in scientific journals address questions of the prevention of drug addiction to demonstrate that the implementation of harm reduction approaches is not considered a scientific or useful approach.

*Scientific Crisis of Narcology*

The scientific discourses held within narcology regarding the treatment of addiction reveals a theoretical crisis within this field. Even though harm reduction approaches are viewed as a rational solution to prevent the transmission of HIV/AIDS and address drug addiction by psychiatric traditions in North America and Europe, they are rejected by the majority of narcologists in the Russian Federation. Only a small number of addiction specialists in Russia perceive harm reduction approaches in treatment of both alcohol and drug addiction as legitimate. The discourse, which took place in the Russian Society of Psychiatrists [*Rossiyskoye Obshchestvo Psikhiatrov*], portrays the nature and the depth of the crisis in Russian narcology. This discourse demonstrates that despite the hopes to integrate internationally recognized treatment practices, diagnostic criteria, and theoretical views on the nature of addiction, Russian narcology implements practices that differ significantly from practices recognized by the international community.

A discussion of the state of the field and treatment of addiction began after a group of leading specialists in psychiatry, narcology, psychotherapy, and psychology sent
a letter to professor Nikolay Neznanov, the Chair of the Board of Society, protesting the legislative initiative of the Head of Narcology to radically change narcological services and, in particular, protest to the reinstatement of compulsory treatment [принудительное лечение] of addictive disorders, which had been proscribed in the 1990s. Psychiatrists who submitted the letter contended that an attempt to reinstate compulsory treatment contradicted the principles of clinical psychiatry. The letter protests the position of some narcologists, including the position of the specialists from the National Narcology Research Center [Национальный Научный Центр Наркологии] to equate addiction disorders with psychotic illnesses.

The discussion of this legislative initiative for involuntary treatment highlights a deep schism within the ranks of the narcologists. However, the dissenting voices are an ostracized minority. The theoretical discussion that ensued reveals that while the discipline is deeply divided along theoretical lines, the discourse is dominated by several prominent specialists in the field whose views remain authoritative. The points of contention are the theoretical reformulation of the diagnosis for drug addiction and addiction in general, compulsory treatment and hospitalization, problems with the integration of evidence-based principles into medical research, and the rejection of harm reduction programs. For example, Gofman advances a theoretical view regarding psychotic disorders that is currently being challenged by both international science and Russian specialists:

from my point of view, shortcomings of this classification is that there is no distinction between alcoholic psychosis and ...[they are] completely different things] … a person suffering from alcoholism can have a psychiatric condition and he will have a completely different psychosis. But according to the ICD 11 [the international classification of diseases] if you are suffering from alcoholism, whichever psychosis you might have, it
is always an alcoholic one. This is a principled matter and from my point of view a mistaken position and this is the position of a Moscow psychiatry school. This is the difference [between international and Russian schools] but this is a purely theoretical question. (Gofman, interview)

The discourse among narcologists is not only about compulsory treatment of drug addiction, but mainly regarding the theoretical justification of such measures (Kruglyy stol 2012). The Head Narcologist not only justifies compulsory hospitalization through the necessity of “social pressure” for treatment, but also offers new diagnostic criteria for drug addiction by suggesting that drug addiction is a form of a psychotic disorder. This new interpretation of addiction led to protests by professionals both in psychiatry and in narcology.

The dissenting voices in the field were able to make connections between the failure of narcology in treatment and prevention of drug addiction with its views on drug addiction; however, most specialists attribute the failure to other causes. The opposition within the field of psychiatry and narcology in its general critique describes the state of the field as “strange and peculiar” (Kruglyy stol 2012, 102). Evgeniy Krupitskiy, the Head of the Bekhterev Research Institute in St. Petersburg, a research center that historically had secondary positions, contends that the narcology in Russia differs from the narcology of developed countries of Europe and America due to decades of isolated development (Kruglyy stol 2012, 102). In particular, Krupitskiy outlines four characteristics of Russian narcology which make it unique: first, he contends that the standards of narcological help in Russia are not evidence-based; second, an array of methods of treatment used abroad are not being implemented in Russia; third, a lot of publications in Russian journals of narcology do not use evidence-based methodology;
and fourth, the gap in scientific methods of treatment is filled with unscientific or “shamanist” methods of treatment and propositions for involuntary treatment (Kruglyy stol 2012, 102).

Denialism in the Field of Russian Narcology

Despite accumulating evidence, the presence of a scientific crisis in narcology is rejected by many specialists. Furthermore, some deny the urgency to reexamine treatment and prevention of drug addiction approaches in light of the escalating HIV/AIDS epidemic. Professor Aleksandr Gofman\(^{52}\), for example, rejects the existence of both drug addiction and HIV/AIDS epidemics: “HIV is not connected to drug use” (Gofman, interview). He states that levels of mortality among people using drugs and people with HIV/AIDS are merely indicators of higher percentage of both groups compared to the percentage of the entire population in the country (Gofman 2012). However, such claims by Gofman are not valid because statistical comparisons between states for epidemiological purposes are conducted not in absolute numbers, but as percentages of the population.

When assessing the responses of narcology to the drug addiction epidemic, narcology denies its contribution to the growing problem. Instead, it concentrates on factors that directly drive the drug addiction epidemic. Despite discrepancies between the internationally prescribed approaches and ineffectiveness of treatment and prevention methods that originated in Russia, most narcologists do not perceive failures to treat drug

\(^{52}\) Alexandr Gofman: Chair, Department of Psychiatric Disorders, Moscow Research Institute of Psychiatry; Board member, The Russian Society of Psychiatrists.
and alcohol addictions and growing rates of intravenous drug users in the country as a failure of treatment approaches or of narcology as a discipline. They agree that the country indeed faces a substantial problem of drug addiction; however, they attribute the problem to an underfinancing of narcological services and the government’s failure to control drug supply (Gofman 2012a):

The solution of the difficult situation is not to handout drugs under a glib excuse, but to make drugs inaccessible/discontinue illegal drug trade. For that it is necessary to close the borders to the transition of drugs. It is expensive and difficult, but this is the only realistic resolution of this uneasy situation. (Gofman 2012a)

Most of the Russian psychiatrists do not critically examine the divergence of treatment standards from the practices in Western Europe and North America. They also do not find it controversial that Russia rejects recommendations of the World Health Organization concerning treatment and prevention of drug addictions:

Some of the theoretical views of Russian narcologists indeed differ from the provisions of the WHO, but does it attest to the crisis [in narcology]. This only shows the difference of the views. Why should the recommendations of the WHO be considered the final truth? Science is science and limiting the scientific notions by the provisions of the WHO is hardly reasonable. (Gofman 2012b)

You know, to come and give everyone methadone...First, we need scientific approaches. This is my opinion...In Russia, there is no sufficient scientific foundation to implement [substitution therapy]...but what I saw abroad, there as well [such scientific foundation does not exist]. (Kozlov, interview)

Moreover, the development of Russian psychiatry and narcology are viewed superior to the development of these medical sciences in the West:

The difference of the domestic narcology from the Western is that in Russia, qualified narcologists not only use psychopharmacological substances to treat addiction patients, but they do it with the consideration of their [patients’] mental state. (Gofman 2012a)
Through making claims about the superiority of Russian approaches, specialists also take pride in a unique route of the development of their discipline. They claim that being superior in science justifies their refusal to implement harm-reduction treatment programs and instead use its unique approaches and strategies. In cases when such approaches do not exist, Tatyana Kozhinova\(^{53}\) contends, narcology should still attempt to find its own solutions, “taking into consideration age-old traditions, culture and characteristics of the socio-political system” (Kozhinova 2012).

The discipline is impervious to external critique and appears to be not capable of integrating constructive theoretical discourse regarding changes and innovations in the treatment of drug addictions, as well as the possibility of implementing new approaches. Supporters of harm reduction admit that while in narcology, “there is a sufficient number of specialists who have a healthy view of the problem…there is no sufficient space for constructive discussion” (Snedkov, interview). A mere mentioning of harm reduction in the form of opioid substitution therapy on scientific fora is a cause of great consternation for narcologists. The comments of Professor Vladimir Al’tshuler about the 2008 conference “Effective and evidence-based treatment of drug addiction in a HIV era”\(^{54}\) are telling. Al’tshuler deplores that the colleagues grouped in the Kazan’ Institute for Research of Problems of Mental Health portrayed Russian narcology in a negative light; he believes unjustly so (Al’tshuler 2008). Al’tshuler contends that critics of Russian drug

\(^{53}\)Tatyana Kozhinova is a narcologists at the Moscow State Research Institute of Psychiatry.

addiction treatment, such as Vladimir Mendelevich, portrayed a situation in Russia “tendentiously, one-sidedly, with a multitude of exaggerations and factual distortions” (Mendelevich 2012b). He is afraid that the experience “aggregated during the years of existence in Russia of the unique narcological service would be lost.” Moreover, he claims that the Russian narcological system is the subject of envy of the majority of Western colleagues and that Western systems of drug addiction treatment are not even systems per se.

**Opposition to Opioid Substitution and Lack of Evidence-Based Methods**

The scarcity of evidence-based approaches in the field of narcology on the one hand leads to rejection of harm reduction programs and opioid substitution therapy without substantial scientific evidence, and, on the other hand, to a proliferation of approaches to treatment and prevention of addiction that are not supported by robust scientific evidence. Vladimir Mendelevich, a proponent of harm reduction, points out that until recently, there has not been serious scientific discourse within narcology, and the discipline has distanced itself not only from international addiction science, but also from psychiatry (Mendelevich 2012b). Moreover, he points out that suggestions to the leadership of the discipline—and narcology is highly hierarchical—to discuss pending questions of theoretical and clinical importance do not find any response. Many theoretical claims Russian narcologists make are contrary to the findings of the numerous evidence based studies (Sivolap, interview). There are many examples of such controversial claims.
In her discussion of the clinical picture of drug addiction, T. A. Kozhinova, for example, contends that the use of drugs leads to the development of a pathological personality. Provision drugs within the framework of methadone program, would, according to her, subject a person to an increased development of symptoms as well as to moral and physical death (Kozhinova 2012). However, these inferences about the outcomes of substitution therapy are not supported by any studies about the progression of the disease with the use of methadone programs. Kozhinova further claims that, since the progression of the disease leads to increased tolerance to the administered substitution drug, larger doses of medication would eventually be needed:

Attempts to give a controlled dosage of drugs (according to the principles of a methadone program) will not lead to the ending on this dosage, because this contradicts all the mechanisms, pathogenesis of the disease and is a mere utopia. In any case there is a chance of acquisition and consumption of street drugs and this, invariably, will be leading to the ‘failure’ and exit of the patient from the program, how it often happens currently during any rehabilitation program. Mendelevich understands this perfectly well and, there are reasons to believe, delicately and skillfully evades discussing this symptom of the disease, switching the attention of the interlocutor to the discussion of other problems. (Kozhinova 2012)

The author does not support these conclusions on the ineffectiveness of substitution therapy based on evidence from either international or Russian research. The results of the studies regarding effectiveness of opioid substitution therapy published in English language journals are not readily accepted. Methadone therapy is mostly viewed as a “handout” [razdacha] of drugs or imitation of treatment [imitatsiya lecheniya]: “[methadone] is like giving a ration [payek]” (Kozlov, interview).

The ethics of harm reduction is also questioned. Scientists ask, in all seriousness, whether the principles of harm reduction would suggest people with alcohol addiction “to continue drinking, but in smaller amounts and higher quality alcohol” (Gofman 2012b):
To give a drug—it is also probably not very right not to free [a person from drug addiction] but that he lives with this methadone … There are 1-2 percent of people with drug addiction who have HIV, hepatitis, and all the rest … After 15 years of using drugs, his heart fell apart [as well as his] liver, brain, [he has] psycho-organic syndrome, he is a criminal, he has hepatitis...These criteria would allow to say: “yes, this patient, he needs to receive something because our traditional treatment that consists of detoxification and treatment of post-abstinence, is not suitable. (Kozlov, interview)

Opioid substitution therapy in treatment of drug addiction is viewed as a treatment of last resort:

[Administering methadone] is not right…this is an exception from the rule … [it should be given to a person when he or she] commits criminal acts, [has] hepatitis, HIV, tuberculosis, in other words, somatically destroys himself. This is an exception. Medicine is helpless here. It is similar to oncology. If a woman comes [with] a fourth stage of cancer, metastasis. Then, what can you do? Yes, she is given narcotics already, because a person is dying. In this case, there is also a category of drug addiction patients who need such help. It is comparable with oncological patients who have metastasis. But not to everyone indiscriminately, as in low-threshold [methadone] programs. To give [methadone] so that there is no criminality … From a hundred [patients] … to three-four such brutal ones, I would, perhaps, give this methadone or buprenorphine or some other [medication]. (Kozlov, interview)

Mainstream narcologists are concerned about the epidemiological outcomes of the implementation of opioid substitution therapy. They worry that methadone programs would exacerbate drug addiction problems in the country:

Of course if to hand out drugs, you do not have to do anything else. The only thing you can achieve this way is proliferation of drug addiction and corruption. If to evaluate the success of Western science based on handout of drugs, then Russia indeed does not yet need such a ‘science.’ (Gofman 2012b)

While the discipline of narcology rejects some harm reduction approaches, it also widely uses medications not recommended by the World Health Organization. For example, antipsychotic medications are widely used in Russia to remove symptoms
associated with the abstinence syndrome\textsuperscript{55} in drug addiction. However, the instruction for antipsychotic medications does not give recommendations to use them for such purposes (Mendelevich 2012b). The use of antipsychotic medications for drug addiction is also not supported by Cochrane Reviews.\textsuperscript{56} The research design of many Russian studies of the effectiveness of antipsychotic medications for addiction treatment is lacking. Moreover, many authors of such studies want their results to be accepted “without further scrutiny: without any confirmation of the facts and without asking superfluous questions [\textit{poverit’ na slovo; ne zadavat’ lishnih voprosov}]” (Mendelevich 2012b). The opponents of Mendelevich, in turn, question why Cochrane Reviews guidelines should be used as the foundation for treatment (Gofman 2012b).

Professor Yuriy Sivolap of the Korsakov’s Clinic of Psychiatry in Moscow emphasizes that the approaches of Russian narcology are indeed distinct in that they do not comply with recommendations of the World Health Organization. Instead, in clinical practice there exists a “wide and baseless use of neuroleptics and other psychotropic drugs in treatment of addiction of psychoactive substances” that are not supported by evidence-based research (Sivolap 2012, 81). Sivolap points out that there are no studies which could corroborate the effectiveness of the use of neuroleptics to treat substance dependence. In fact, he thinks that side effects of neuroleptics worsen the conditions of patients and lower the compliance rates in the programs. Sivolap firmly believes that

\textbf{55} Abstinence syndrome is “physiologic changes undergone by people or animals who have become physically dependent on a drug or chemical who are abruptly deprived of that substance.” MediLexicon. Accessed at: http://www.medilexicon.com/medicaldictionary.php?t=87620

\textbf{56} The Cochrane Reviews is a database summarizing results of health care research. They are viewed as the highest standard of the evidence-based medicine.
haloperidol and other widely used neuroleptics are the main cause of high attrition rates in narcological clinics. The use of neuroleptics also contradicts the principles of rational pharmacotherapy (Sivolap 2012, 82). Sivolap disparages theoretical proponents of the use of neuroleptics for substance dependence treatments such as M. A. Mikhaylov (2010) who offers a novel theoretical approach to addiction also supported by Head Narcologists and other prominent physicians (Sivolap 2012, 82). However, this new theorizing of the nature of drug addiction is not consistent with the internationally accepted classification of the disease.

Meanwhile substance dependent patients are routinely and widely treated with antipsychotic medications. People who were formerly treated with haloperidol perceive it as a form of punishment because of the severe side-effects this powerful medication produces. Several organizations submitted a join report to the UN Committee Against Torture, where they argue that drug dependence treatment methods, including the use of haloperidol, equate to torture:

If they think you are “guilty” of something, they inject you with haloperidol. It leads to horrendous feelings—all body is as twisted, as if the washing is wrung. All muscles are twisted by spasms and you cannot do anything. The head is thrown back, and the feeling as if muscles are contracted and you are all twisted. The spine is wrenched. Legs. And you cannot control the saliva coming out of your mouth. But you cannot relax at all. Everything is contracted, all muscles, the body is screwed in spasms. And until you take Trihexyphenidyl [tciklodol] you are not going to get better. They injected me at around 11 a.m., in the morning. In the beginning it gives effect of a sleeping agent, but then the side effects kick in, and you are all twisted. After four hours I could not take it any more … please do something … or I slit my veins. It was so painful! This is just horrible! And you cannot control your body at all, you are all twisted and contorted in spasms! …. Haloperidol is not used for medical purposes, that’s for sure. It’s a punishment. (Golichenko and Sarang 2011, 9)
In the meantime, mainstream narcologists contend that the use of haloperidol is safe for the treatment of addictions (Izyumina, Kinkul'kina, and Ivanets 2012). However, a few marginal voices in the discipline adhere to the point of view that: “a substantive harm can be caused by the therapy with neuroleptics for ending addiction craving, and not by leaving the patient without psychiatric help” (Mendelevich 2012a).

4 Scientific Views of Russian Narcology on the Treatment of Drug Addiction: Analysis of Publications

The analysis of publications in medical journals and textbooks, which are used in the course of the narcology studies in Russia, help to demonstrate the pervasiveness of opposition to harm reduction and the strength of the discourse in the medical community of narcologists. Scientific publications also reflect the state of the field of narcology. They show that the discourse is not only biased against opioid substitution treatment and other harm reduction programs, but that non-scientific methods of treatment are being promulgated. The Russian Orthodox Church that does not support harm reduction attempts to legitimize its position on drug addiction treatment through publications in these journals as well.

Contemporary attitudes of narcologists can be traced through publications in scientific journals. This analysis leads to several conclusions about discussion of harm reduction programs: 1) journals of narcology in Russia are dominated by one group of scholars manly from the Serbsky Institute and the National Narcology Research Institute in Moscow; 2) medical journals have never held an impartial discourse regarding the possibility of implementation of harm reduction or opioid substitution therapy in the
Russian Federation; and 3) one-sided positions on harm reduction programs are also reflected in the main textbooks of narcology used by future narcology specialists. The analysis of these publications indicates that anti-harm reduction views are deeply engrained in the field of narcology and had been held prior to the onset of the HIV/AIDS epidemic. With the onset of the HIV/AIDS and the drug addiction epidemic in the 1990s, the paradigm on drug addiction treatment, although challenged by internationally recognized norms on treatment, did not change.

*Founder of Russian Narcology. Textbooks on Treatment of Drug Addiction*

As Snezhnevsky was an indisputable authority in psychiatry in the beginning of the 20th century, a similar role played Eduard Babayan, who initiated the development of narcology into an independent field. He authored textbooks, which are still used today in medical schools, wrote extensively on the nature of addiction, served as a head of the Serbsky Center in Moscow, and, most importantly, consulted the government on issues of drug addiction.

In his theoretical views, that transfer into his policy recommendations as well, he equated measures of harm reduction and opioid substitution therapy with drug legalization. He mentions that legalization of narcotic substances can be achieved on several levels—“full, partial, controlled and selective.” He rejected the possibility of existence of substitution therapy in Russia. He opposes the legalization of drugs in any form. He says that although there are attempts to condone drug use because of the HIV/AIDS epidemic, it can be considered “indirect” legalization. He does not find sufficient evidence to view syringe exchanges effective to combat HIV/AIDS: “[i]n any
case in the CIS [the Commonwealth of Independent States], as it is known to us, there are very few registered HIV/AIDS cases among the drug users” (Babayan 1992, 65). He says that the only route to limiting HIV/AIDS is to prohibiting the nonmedical use of drugs: “It is not acceptable in order to fight with one evil to condone another one, not less dangerous, and to sacrifice drug users to solve another problem – prevention of HIV/AIDS” (Babayan 1992, 66).

Babayan finds that maintenance therapy is a form of masked legalization and it is against the 1961 Joint Convention on Narcotic Drugs that he helped to author and therefore would mean surrendering on the face of the difficulties of controlling narcotic substances. Babayan’s reasons that methadone belongs to the Schedule 1 of narcotic substances of the Convention. However, since then, the convention was amended and methadone fell into the category of Schedule 2 drugs, which can be used for medical purposes. He also cites an injunction of the Ministry of Health of the USSR which excludes methadone [fenadon] from the list of medical substances and prohibits its use (Babayan 2002, 20). Thus, in the discussion of the possibility of the use of harm reduction in the form of the syringe and needle exchanges or of methadone in the maintenance therapy, Babayan mostly cites legal decrees and negative results of drug use without giving an evidence-based analysis of effectiveness of harm reduction programs including methadone for treatment of drug addiction and prevention of HIV. This characterizes most of the publications regarding the possibility of the implementation of harm reduction and opioid substitution therapy in journals.

57 According to the Convention, Schedule 1 drugs are substances that are not accepted for medical use.
Babayan’s views on the possibility of implementation of substitution therapy have been registered in his textbook for medical students (Babayan and Gonopol’skiy 1987). This textbook has been used by several generations of Russian narcologists and is still in use today. Filled with Soviet era ideological discourse, it postulates that narcology as a discipline is based on the principles of deontology. An entire chapter is dedicated to the discussion of these ethical principles. These ethical principles, in turn, are used by rank-and-file narcologists and eminent specialists to reject opioid substitution programs including methadone and also needle and syringe exchange programs.

The textbooks used in universities are overall outdated. They convey views on narcology that are not evidence-based:

The problem is … we have very archaic, very outdated, silly textbooks on narcology. Textbooks and manuals—they are practically useless. Nonsense is written there, which has been written for about 50 years. If we take any textbook, handbook, manual, which is written in English … We should say that American or British ones slightly differ in approaches … But in principle, with some differences, not substantial, they [authors] write from the fundamental sense … Based on what are their texts compiled? Based on clinical reality—that which exists—and from the other hand, based on modern scientific understanding. And even if we take any foreign textbook on psychiatry, even if it is 20-30 years old, we will not find there obvious silliness … Our textbooks are still … filled with silliness, because they are not based on contemporary research. They are based on speculative notions … Their authors, they write this from their head. They do not cite other sources. [They write] the way they understand the narcological picture of the world … And that is why in our textbook we can read such silliness as three stages of alcoholism, which do not exist at all, they simply do not exist … And that all addictions, including complications of addictions, it is necessary to treat with drop counter, in other words through detoxification … There are no even thin books, not to mention textbooks, where everything would be written the way it should be. (Sivolap, interview)

Narcologists who represent a minority view in the field recognize that textbooks do not base their conclusion on evidence-based approaches. However, textbooks are not
the only factor that contributes to lack of evidence-based approaches in the field. The overall level of educational expectations in narcology is also perceived as a problem:

we have a very low level of professional standards. Deplorably … And since there are low professional standards, it cannot be any other way, because we have the subject taught in such way—incorrectly—that you can demand, but in any case, normal adequate knowledge in students’ and young doctors’ heads is not going to develop. (Sivolap, interview).

Because of these factors,

Many narcologists still adhere to the classical theory … classical understandings, archaic, outdated, our domestic ones, that in treatment of any addiction only full remission [is desirable]. All other results are not needed. [They believe] that harm reduction is [the same as] tolerating drug use. (Sivolap, interview)

Discussion of Harm Reduction in Journals

To examine the views of the narcological community, I analyzed publications on the treatment of drug addictions in the two most prominent Russian journals of narcology. Questions of Narcolege [Voprosy Narkologii], established in 1988, is a journal of the National Narcology Research Institute, situated in Moscow and dominated by scholars who hold outwardly hostile positions towards harm reduction programs (see Appendix 1). Another journal, Narcolege [Narkologiya], was established in 2002 by the Russian Academy of Science in a self-proclaimed effort of the most prominent scientists to “discover effective methods of treatment and prevention for drug and alcohol addiction” (see Appendix 1). Publications in these journals reflect official positions of narcology on narcotic substance policies as well. These scientific journals did not reflect the genuine scientific discussion of the problems of the treatment of addiction diseases, but instead made a one-sided position of academicians, opposing harm reduction, more prominent.
Findings regarding needle exchange programs are presented in the scientific community as mixed and inconclusive. The overarching argument maintains that needle exchange and rehabilitation programs have been implemented jointly and therefore it is difficult to distinguish the results of rehabilitation effects and the effects of needle exchange on the level of HIV/AIDS. For example, a study in *Questions of Narcology* briefly discusses some of the findings from international journals on needle exchange:

For example, in Australia, the level of infection among intravenous drug users during many years does not exceed 3 percent. In Edinboro [*sic*], where needle exchange programs have been prohibited the level of HIV infection among intravenous drug users in the middles of 80s reached 50 percent; at the same time, in Glasgow, which is 80 km away from Edinboro [*sic*], where these programs were carried out, the level of HIV infection among intravenous drug users was less than 5 percent. (Zverev and Sarankov 1999)

The conclusion, which the authors arrive at from the data, are that more clear evidence is needed to theorize about the effects of needle exchange programs in the prevention of HIV/AIDS infection: “In order to contest one of the theories, absolutely precise valid data is necessary, which, unfortunately, neither professionals (general physicians, narcologists, sociologists, psychologists, etc.), nor general public possesses” (Zverev and Sarankov 1999, 18).

Severity of the HIV/AIDS epidemic led scientists to ask questions regarding the use of methadone for patients with addictions. They cite international research which for the most part contends that methadone programs are the preferable route of treating drug addiction patients with symptoms of HIV/AIDS infection (Rohlina and Ivanets 1999, 43). Rohlina and Ivanets come to the conclusion that it is permissible to use methadone only
during pre-terminal\textsuperscript{58} and terminal stages of AIDS. Thus, narcologists find international research inconclusive and do not recommend the use of methadone for prevention of the HIV/AIDS among addiction patients, but only as the course of a last resort in cases of advanced progression of AIDS.

There is an acceptance of some, but very limited, elements of harm reduction programs by narcologists. Scientists believe that narcology can be viewed as a preventive model; however, they accept only those aspects which do not include needle exchange and substitution programs. However, some authors view outreach programs as having the potential to have a positive effect on the prevention of HIV/AIDS and drug addiction in Russia (Zverev and Sarankov 1999, 17).

The Serbsky Research Center’s analytical review of the opioid substitution programs demonstrates that it becomes harder for the specialty of narcology to disregard opioid substitution programs entirely. However, while reviewing scientific findings on these programs, the scientists cannot endorse them due to their professional commitments. Therefore, they have to find some loopholes in order to demonstrate that resistance to the programs, in fact, has some scientific validity. The authors go as far as to misinterpret the results of the Cochrane collaboration review (Gowing, et al. 2008). The conclusion referenced in the Russian review contests that most of the studies reviewed by Gowing, et al. were not randomized and therefore conclusions have an exceedingly limited scope. The authors, according to the Russian synopsis, contend that Gowing, et al.

\textsuperscript{58} Stage b according to Valeriy Pokrovskiy’s classification of stages of AIDS.
are hindered from making any kind of final conclusions (Klimenko, et al. 29). However, the Cochrane review reads differently:

Available data are limited, but it appears that the reductions in risk behaviour [sic] related to drug use do translate into actual reductions in cases of HIV infection amongst opioid-dependent injection drug users receiving oral substitution treatment...these findings add to the stronger evidence of effectiveness of substitution treatment on drug use, and treatment retention outcomes shown by other systematic reviews. On this basis, the provision of substitution treatment for opioid dependence in countries with emerging HIV and injecting drug use problems as well as in countries with established populations of injecting drug users should be supported. (Gowing, et al. 2008, 30)

*Narcology Does Not Associate the Lack of Harm Reduction with a Growth of HIV/AIDS and Drug Addiction Epidemics*

Publications on pages of journals of narcology do not discuss the threats of a growing HIV/AIDS and drug addiction epidemic in the country. Narcologists are aware of the landscape of the HIV/ADS epidemic and the fact that it reaches beyond identified risk groups and into the general population (Kontseptsiya preventivnogo obucheniya 2006, 11).

Narcologists are informed about the official position of the government regarding drug addiction problems through publications on the pages of professional journals of articles reflecting Russia’s drug policy. While articles maintain that “because of the government mistakes in drug policies, narcotization of the population of the country increased to epidemiological proportions,” the failure is generally viewed as the failure on the part of the state to control drug supply (Kontseptsiya sistemy 2006, 8). Also, it is demonstrated that the pressures to change the policy from “limiting drug supply” to harm
reduction is caused by political forces interested in widening the illegal drug market (Tsimbal 2005, 8).

Discussion of the HIV/AIDS Epidemic in Narcology Journals

Discussion of HIV/AIDS takes place intermittently in the pages of the Journal of Narcology and is associated with legislative landmark events regulating either the HIV/AIDS or drug addiction epidemic. In 2006, the journal Narcologiya published a concept for the prevention of HIV/AIDS through education based on materials from the website narkotiki.ru. The article contends that it is the domain of the Ministry of Education to develop a strategy for addressing prevention of HIV/AIDS since sexual transmission is responsible for half of all new HIV/AIDS infections (Kontseptsiya preventivnogo obucheniya 2006, 11).

Some narcologists view substitution therapy as their prerogative and not a question of concern for epidemiologists and HIV/AIDS specialists. Tatyana Klimenko, the Main Specialist on the Drug Addiction Prevention division of the Health Ministry criticizes HIV/AIDS specialists for interfering with opioid substitution programs. She claims that opioid substitution therapy is not their domain of expertise and therefore these specialists should not interfere:

Specialists on HIV/AIDS all of a sudden became specialists on substitution therapy. Not logical...Epidemiologists became specialists on substitution therapy. But it would be better if epidemiologists...would provide us with accurate numbers on drug use...We know that we have about 550 thousands registered. Drug users. But in reality not all [of the drug users] are registered. Epidemiologists must tell... Where are they? They are occupied with opioid substitution treatment. But they should do their direct work. (Klimenko, interview 2012)
Through these claims Klimenko defends scientific interests of narcologists and prerogatives of her institution. While Klimenko contends that epidemiologists do not come to the Ministry of Health to dispute opioid substitution therapy, during HIV/AIDS scientific conferences, half of the time is dedicated to the question of opioid substitution therapy. She deplores such a state of affairs, when HIV/AIDS and epidemiology specialists, according to her account, do not dedicate sufficient time to develop other potentially necessary and effective venues of prevention.

Narcology underestimates the scale of the HIV/AIDS epidemic in the country. In their statements to the press and during interviews narcologists stated that HIV/AIDS is not currently a problem, even though it was in the past. Valeriy Krasnov, the Head of the Moscow Research Psychiatry Center, in response to questions regarding harm reduction programs reveals that “the idea [of needle exchange] is more or less justified. The other question is how it is built. How it is implemented” (Krasnov, interview). His reservations about needle exchange programs are justified partly due to the waning threat of an HIV/AIDS epidemic: “Especially as nowadays HIV does not represent such a formidable threat with unequivocally pessimistic prognosis. AIDS can be treated” (Krasnov, interview). Another reservation for Krasnov stems from the fact that heroin addiction is not the only type of drug addiction in Russia:

Couple of years ago there were such initiatives for syringe exchanges—but now I do not hear [about them]…when there was a more serious threat of AIDS. But now a more significant problem for the population, for its health, for life expectancy, particularly of a young generation, represent artificial drugs … and the problem of dependency now cannot be relegated to heroin or opioid dependence. Because more and more … it [opioid addiction] is joined by the use of synthetic concoctions… with far greater toxicological effects. (Krasnov, interview)
According to Krasnov’s perception, the HIV/AIDS epidemic in Russia has waned and drug addiction itself represents a far greater threat.

Limited Access to the Literature in Foreign Languages and Limited Contacts with the International Scientific Community

The isolation of Russian scientists from the international community is a widespread phenomenon. This isolation is exacerbated by the fact that few scientists and practitioners have a level of proficiency in English language which could allow them to have direct access to publications in English. Some of the articles regarding harm reduction and opioid substitution programs are reprinted in leading journals; however, the selection of articles is biased towards harm reduction. Keystone articles on the effectiveness of opioid substitution therapy and methadone programs are rarely mentioned. Effectiveness of harm reduction to prevent HIV/AIDS among drug users are rarely discussed either. However, some observe that the absence of knowledge of Russian scholars regarding international research has a foundation in their bias against international science:

But in reality there is such moralistic approach to this [drug addiction treatment], there is a schematic understanding of this, which stems, which is being reproduced with inertia. [This occurs] because people do not read anything. Many of our doctors, including our professors, either do not read contemporary international research, or, if they do it, they in advance have a critical negative predisposition, preconception and believe that this is a form of a covert pressure on our country. (Sivolap, interview)

Those articles by foreign scholars that do reach the pages of these journals express an explicitly anti-drug legalization position. The 2005 issue of Narkologiya printed an article by the director of the NGO European Cities Against Drugs Hollberg.
The article expresses a position which echoes widely through circles of narcologists. It explains why harm reduction programs should not exist and proposes that control of the narcotic substances should be implemented instead saying the following: 1) “75 percent of people with drug addiction continue to use the same needle, although free clean needles are at their disposal”; 2) “for people with drug addiction it is a habit to mix doses in shared…container[s], which can become the most common source of infection”; and 3) “people with drug addictions have sex” (Hollberg 2005, 25).

The Orthodox Church: Publications in Scientific Journals

Another potent actor which emerged in the fight against HIV/AIDS and treatment of drug and alcohol addictions in Russia is the Russian Orthodox Church. The beliefs expressed by the Orthodox Church also played a role in opposing the implementation of harm reduction programs in the Russian Federation. Not only that, the Church also widely distributed its position on harm reduction programs to the general population and its position has been published in scientific journals of narcology. In Anatoliy Berestov’s article in Narkologiya, he reasons whether it is legitimate to use opioid and methadone substitution therapies for drug addicts, making them “dependent” on yet another drug, when the treatment of patients with alcohol addiction does not involve a related type of therapeutic measure (Berestov 2009, 76).

Discussion of Alternative Practices for Treatment of Drug Addiction in Medical Journals

Rejection of internationally accepted practices and theoretical explanations of addiction lead to a situation in the field of narcology when, instead of evidence-based
approaches, interventions based on placebo effect became wide-spread. Domestically invented approaches are labeled as “pioneering” or “unique.”

*Alternative Treatment*

Publications in scientific journals of narcology demonstrate a clear bias against methadone interventions; however, they praise questionable practices authored by scientists in Russia. One such study, the “Latest Achievement in Narcology” published in the *Questions of Narcology* in 1991, serves as an illustration of such bias. The article praises the method of non-pharmacological treatment with cryogenic methods *[kriopunktura]*—the use of extremely low temperatures of -180C. The article places high value on the “simplicity of the method, its effectiveness” (Noveyshiye dostizheniya 1991, 45). *The Questions of Narcology* negatively characterizes the outcomes of methadone treatment (Mediko-biologicheskiye problemy 1991, 46). The article reviews effectiveness of methadone use in Australia and claims that the results are negative; however, the review fails to provide any citations on the publications which evaluated the use of methadone. Articles that review methadone use in addiction reveal that there is a formidable discrepancy between Russian and Western science in what it means to treat addiction. Russian science rejects the amelioration of symptoms and improvement of quality of life as components to treating addiction. Russian medicine takes a maximalist position, favoring a “cure” of addiction, which is consistent with its theoretical approach.
Alternative Approaches to Drug Addiction Prevention

While the effective approaches of drug addiction treatment prevention are being shunned by the narcological community, the need for preventive measures in the face of a growing drug addiction epidemic is glaring. Prevention of drug addiction and HIV/AIDS among school children through education is not possible for doctors and bureaucrats in the Ministry of Health. Narcologists advance the implementation of widespread testing for drug use in schools. This approach is advocated by Tatyana Klimentko who currently is the Ministry of Health specialist on drug addiction prevention and treatment and Aleksandr Kozlov, the main specialist on drug addiction of the Moscow Psychiatry Research Center. These scientists collaborate on publications and the promotion of their views. They are self-described progressives in their views on harm reduction and opioid substitution programs; nonetheless, they also find the grounds to reject harm reduction programs of prevention in favor of testing for drug testing. In their co-authored paper, they contend that the blanket involuntary testing in schools for drugs, even without any apparent signs of drug use, is a necessary approach to prevention. According to their account, this approach is “unprecedented in the world practice case of organization of prevention” (Kozlov and Klimentko 2011). They contend that: “[p]ractically in none of the countries in the world widespread blanket testing of students has been realized. Hence, in Russia, … an innovative in its ideological core and scale approach to prevention of narcotization is being offered” (Kozlov and Klimentko 2011).

This tactic to prevention is also shared by the Head Narcologists of the Russian Federation. While blanket testing of school children might seem like an appealing method of prevention on paper, it has been widely criticized by marginalized narcologists
as ineffective. Sergey Soshnikov, a narcologist and a proponent of evidence-based medicine in Russia, pointed out that this approach is not scientific—it is not evidence based medicine. Soshnikov contends that the reason why blanket testing is not used elsewhere is because it is simply not effective in reversing drug addiction epidemic (Soshnikov, interview 2012).

While Kozlov and Klimenko propose to use wide-scale testing, they have to admit its economic inexpediency and overall ineffectiveness. They agree that no more than 1-2 percent of drug users have been detected during extensive pilot tests (Kozlov and Klimenko 2011). However, they observe that there is an inconsistency with the epidemiological data, which reveals that in some regions, anywhere from 2 - 3 to 9 - 10 percent of school children can be drug users (Kozlov and Klimenko 2011). They simply declare that the reason for it could be “procedural error” or the “large number of the refusals to test for drugs from students or their legal guardians” (Kozlov and Klimenko 2011). The scientists do not offer citations for these claims nor suggest that further study is necessary. Moreover, they refer to the sociological study of the Russian Education Ministry conducted in 2010, based on which they suggest the necessity for drug testing. Neither the original data nor scientific publications are cited (Soshnikov, interview 2012).

Kozlov and Klimenko also question the validity that extensive testing for drug use in schools qualifies as a violation of human rights, a view held by their opponents (Kozlov and Klimenko 2011). Their literal reading of the constitution of the Russian

59 Chief of the Department of Mathematic Modeling in Public Health in the Federal Research Institute of Health Organization and Informatics of the Ministry of Health.
Federation allows them to make the conclusion that the right to use drugs could qualify as a basic human right. This right to use drugs is not found in the Universal Declaration of Human Rights either and therefore since drug users represent a “threat” to other students, a legal foundation exists for the implementation of testing.

Finally, and rather controversially, they claim that the testing is necessary not only for the detection of drug users, but also for offering medical help to drug users. Several legal problems stem from these assertions, one of which is the legality of involuntary treatment for drug addiction including hospitalization.

The Head narcologist is also a proponent of the testing for drug use in schools and universities. He has widely collaborated with the Ministry of Education to promote this agenda to implement these testing. He admits that mandatory drug testing in schools has been a decade-long platform of his that is finally being put into action (Brun, interview 2012).

5 Conclusion

This section demonstrates that existing approaches in Russia are not effective in the treatment and prevention of drug addiction. Therefore, people who suffer from drug addiction are left without viable alternatives to address this health problem. While official statistics published in journals report the number of people treated, they do not reveal statistics about the effectiveness of existing interventions.

I conclude that narcology in Russia has views on the nature of drug addiction that differ from the international norm. Since narcology, a highly hierarchical field in Russia,
only positions of prominent narcologists are translated into policy. Opposing views are not represented in medical journals and are not admitted into scientific discourse.

6 The Role of the Medical Community of Drug Addiction Specialists (Narcologists) in Formulating the HIV/AIDS Policy in Russia

The absence of state will in the Russian Federation to address the HIV/AIDS epidemic in a timely manner resulted in the implementation of a suboptimal policy approach. Although the legislation to address the HIV/AIDS epidemic was enacted in 1995, the government failed to create a plan which would ensure coordination of efforts of state ministries. The government did not have a nation-level strategy to address the HIV/AIDS epidemic nor an agency which would unify the efforts to address the HIV/AIDS epidemic. With the absence of a coherent government program, the prevention of drug addiction is shaped by drug addiction specialists. I demonstrate that there is no unanimity within the medical community over how the HIV/AIDS epidemic should be addressed; mainly, there is no consensus on prevention. While most of the epidemiologists and HIV/AIDS specialists support recommendations by the WHO’s harm reduction approaches, physicians from other fields maintain conservative views on the prevention of HIV/AIDS and drug addiction that drives the epidemic. At the same time, narcologists, due to their historical ties to the Federal Drug Control Service [Federal’naya Sluzhba Rossiiyskoy Federatsii po Kontrolyu za Oborotom Narkotikov—FSKN], have more leverage on policy, compared to other fields and remain a major actor in the opposition to harm reduction approaches.
The evidence presented in sections above demonstrates that narcology as a field holds a collective position against key preventive measures. In a section below, I demonstrate that narcology as a scientific community also influenced the policy-making process. I show that key administrative positions in the field of narcology are held by specialists who are strongly against the World Health Organization’s recommendations on the implementation of harm reduction measures and who expressed their opinions publicly, suggesting their role had been important in formulating the state’s policy on HIV/AIDS and drug addiction treatment.

In this section, I also show that psychiatrists and narcologists in Russia historically influenced the policy-making process and continue to shape policy to exclude harm reduction. I separately examine policy-initiatives of two governmental bodies, the Ministry of Health and the Ministry of Education, on drug treatment and prevention. I demonstrate that these Ministries as institutions are against harm reduction. I also show that narcologists occupied leading positions in both of these state institutions and played important roles in policy development.

*Policy Influence of the Epistemic Community of Narcology*

Historical examination of the discipline of narcology demonstrates that academic and administrative elites in this field have had substantial influence on policy decisions regarding treatment and prevention of drug addiction. Their unwavering stance on this issue subsequently influenced HIV/AIDS policy as well, because narcologists refused to accept the necessity of implementing crucial HIV/AIDS preventive measures that would help slow down the epidemic. Public statements by psychiatrists in administrative
positions in the media indicate their strong involvement in policy decision-making on treatment and prevention of drug addiction. The narcological medical community does not believe that HIV/AIDS prevention is within their domain of responsibility, even though prevention and treatment of drug addiction are. They are not willing to admit to the existence of a connection between the treatment and prevention of drug addiction on the one hand and the prevention of HIV/AIDS on the other.

Several governmental bodies play a role in determining the HIV/AIDS policy. However, the Ministry of Health and the Federal Drug Control Service [FSKN] are main agencies that shape prevention of intravenous drug transmission. Boris Al’tushuler, a member of the Public Chamber and an advocate for the prevention of mother-to-child transmission of HIV/AIDS in Russia, contends that the Ministry of Health mimics directives of the FSKN (Al’tushuler, interview 2013). However, a closer investigation of the relationships between these two governmental bodies reveals that, in fact, the official position of narcology directly influences both the position of the Ministry of Health and the FSKN.

The Narcological community and the Federal Drug Control Service [FSKN] appear as two competing bodies in the development of the prevention of the drug addiction epidemic. The study of the role of the medical community in prevention

60 One of these bodies is the Federal Consumer Rights Protection and Human Health Control Service [Rospotrebnadzor], another one is the Ministry of Health and the Federal Drug Control Service (FSKN), and also the Ministry of Education. While the next chapter deals with policies initiated by the Ministry of Education, the other bodies have direct influence on the HIV/AIDS and drug addiction treatment policy. Rospotrebnadzor in Russia takes a rather progressive stance towards the HIV/AIDS epidemic.
policies demonstrates that the FSKN and its positions have also been influenced by the community of narcologists in Russia. While the FSKN has a lot of authority, decisions on prevention and treatment are still shaped by the official stance of narcology. The ubiquitous perception is that the FSKN is a decisive force in formulating all approaches in drug addiction-related matters, including treatment and prevention. However, FSKN’s approaches were also affected by the views of the narcological community. Narcology identifies the range of possibilities in the treatment and prevention of drug addiction from which other agencies may choose appropriate policies and acceptable interventions.

One of the former FSKN specialists61 directly admits that the policies of the FSKN were being shaped by the narcological community:

You know, the FSKN is a hostage of this particular scientific community, which initially identified for us some rules of the game. It means that not to let a person use drugs is permissible only in such a case, when he is deeply convinced that if being a drug addict, he will never become a normal person. (Kakoy bit’ 2009, 93)

In response to the allegations that the FSKN and narcological community are equally responsible for failing drug addiction prevention and treatment measures he contends that:

Regarding motivation [for treatment]. My eleven year practice of work demonstrates that most of the drug addicts that seek treatment have motivation. Those who do not have any motivation, do not come at all. They want [to address drug addiction] indeed, but they should be explained how they can temper their drug use. We have such a situation: people are told that it is impossible. This is being transmitted by the FSKN

61Aleksandr Mikhaylov is the former Head of Intradepartamental Information Committee of the FSKN [Departament Mezhvendomstvennoi i Informatsionnoi Deyatelnosti Gosnarkokontrolya]. Currently the Head of the Center of the Studies of Contemporary Drug Politics and Drug Terrorism.
and the scientific community. This is what the problem is. (Kakoy bit' 2009, 93)

The epistemic community of narcologists scientifically identifies approaches to treatment and prevention of drug addiction, and the FSKN is bound by these possibilities. I seek to further explore the role and influence of the community of narcologists on the policy-making process.

_Narcology’s Influence on the HIV/AIDS Policy_

Besides holding theoretical views and clinical practices that are incompatible with harm reduction approaches, the scientific community of drug addiction specialists indirectly influenced the HIV/AIDS policy-making process by resisting harm reduction approaches. Not only did drug addiction specialists lobby for the rejection of harm reduction policies in Russia, but they also recognized the absence of harm reduction as a result of their effort and their achievement (Brun, interview 2013).

When discussion of harm reduction programs was only starting to emerge in Russia in response to the rapidly developing HIV/AIDS and drug addiction epidemics, leading narcologists launched a lobbying effort in the government against these interventions. In 2005, they published a memorandum against harm reduction. In this document, psychiatry and narcology specialists point to the inconclusive findings of studies on which harm reduction programs were based (Krasnov, et al. 2005). The international medical community responded by defending the refuted aspects mentioned in the memorandum of these programs and their suitability for the Russian Federation (Maremman, et al. 2006). However, this involvement of foreign specialists did not have much effect on either the position of the Russian community or on domestic policy.
development. This further confirms that external factors play a small role in domestic HIV/AIDS policy development in Russia.

The statements upheld by narcologists that contradict the international norm on harm reduction approaches have weight in the public sphere. Besides rejecting the scientific foundation for harm reduction, the community of narcology specialists denies connections between the HIV/AIDS problem and the drug addiction epidemic in the country. Below, I examine public statements made by the main narcologists in the Russian Federation: Yevgeniy Brun, the head narcologist of the Russian Federation and Evgeniya Koshkina, the chief specialist and director of the National Narcology Research Institute to demonstrate the public position of this scientific community on harm reduction approaches.

**Denial of the HIV/AIDS Epidemic by Narcologists**

The Head Narcologist Yevgeniy Brun promulgated his position and the official position of narcological community through multiple media outlets. He contended that for a decade he lobbied for the implementation of compulsory drug use testing in schools and in universities and made his position publicly known (Brun, interview). Eventually, the Ministry of Education proposed legislation on obligatory drug testing in schools.

The Head Narcologist in the Russian Federation is one of the most influential actors in translating the views of the narcologist epistemic community to the public and policy-makers. His views are aligned with the views of the most influential scholars in the field. He makes three types of statements against harm reduction approaches: first, he denies the severity of the HIV/AIDS epidemic in the country and allegations that
treatment of drug addiction is implicated in growing rates of the epidemic; second, he makes sociological arguments regarding the rejection of needle and syringe programs; and third, he rejects opioid substitution therapy on theoretical grounds.

Yevgeniy Brun, stated that it is a “fiction that the epidemic is growing.” Moreover, he claims that the positions of epidemiologists and HIV/AIDS specialists is indicative that they “work on bourgeois money” (Brun, interview). Narcologists indeed hold a very narrow view on how the HIV/AIDS epidemic is connected to drug use and what the possibilities of public health interventions should be. To the question about the role of narcology in the HIV/AIDS epidemic, Yevgni Brun simply mentioned that the treatment is provided for people with addiction who are also HIV positive in the clinics (Brun, interview). 62

The Head Narcologist believes that needle and syringe programs are not suitable for Russia. He contends that introduction of such programs raises the rates of HIV/AIDS infection: “in those territories where harm reduction programs were introduced numbers [the HIV/AIDS incidence rate] went up” (Brun, interview). The alleged ineffectiveness of harm reduction programs, originating in the West, is due to a qualitative difference between the Russian and Western populations of drug users: “there are no drug dens” (Brun, interview). He maintains that since there is no conglomeration of people who use drugs, harm reduction would not be effective.

62 There are special wards for people with drug addiction infected with HIV/AIDS in narcological clinics. HIV/AIDS patients not only undergo treatment but participate in rehabilitation groups (Brun, interview 2013).
Brun maintains that treatment approaches in Russia have “higher and more reliable [effectiveness] than the use of buprenorphine and methadone…I am not ready to give drugs to drug addicts” (Brun, interview). Methadone for Brun “does not have a place in medicine,” since methadone addiction represents a problem in opioid substitution therapy. In Brun’s view, opioid therapy leads to the inevitable demise of a person and he “cannot put up with a person dying [from methadone addiction].” He insists that methadone is a harsh medication which increases the viral load of HIV. He says that he “read somewhere that, in fact, replication of HIV virus increases due to the use of this medication” (Brun, interview).

Yevgeniy Brun’s statements reveal inconsistency in his explanations of the treatment of drug addiction. On the one hand, he claims that Western governments actively engage in harm reduction programs because it more cost effective for the American medical insurance system. On the other hand, he finds these programs incompatible with medical findings:

I already contend for 15 years that we have to maximally test people for drug use and to prevent the development of the disease. The disease is too expensive for the state in terms of human resources and in terms of the economics. That is why it is better to test early, and deter these people [from further drug use]. (Press-konferentsiya 2012)

As a result of these lobbying efforts, the state Duma adopted the law to implement drug testing in schools. Narcologists said that the testing program has been initiated as a result of a sociological study conducted in Moscow which found that 78 percent percent of the population supported the use of drug testing in schools (Press-konferentsiya 2012). Yet, the program of testing was jointly developed with the Ministry of Health and Ministry of Education. Yevgeniy Brun believes that the law should go further and test all
citizens for drugs. However, the findings of this sociological study were never published, which led some to question its results (Soshnikov, interview 2013).

An Historical Role of the Specialty of Narcology in Drug Addiction Prevention Policy-Making

Narcologists influence policy-making through their prominent presence in the Ministry of Health. The Ministry of Health, both in the Soviet Union and in the Russian Federation, uses a lot of discretion in proposing solutions for the treatment of drug addiction. According to Russian law, the Ministry of Health has the executive power to promulgate orders and therefore has direct influence on the policy-making process. Narcologists in the Soviet Union, and subsequently in the Russian Federation, hold key positions in the Ministry of Health and were influential in the policy-making process.

Eduard Babayan represents just one example of how physicians participate in policy-making. First, Babayan is a psychiatrist and a narcologist, and the former head of the Serbskiy Institute of Psychiatry, the leading addiction treatment clinic in the Soviet Union. He also occupied a number of administrative positions throughout his career: from 1953 to 1986, Babayan worked in the Ministry of Health of the USSR; served as a chairman of the Standing Committee on Narcotic Drug Control of Ministry of Public Health of the USSR; and initiated the creation of a separate field of narcology in the Soviet Union. As part of his position in the Ministry of Health, Eduard Babayan had oversight of many legislative initiatives regarding the control of the narcotic substances (UNODC 1968). Rejection of harm reduction is one of his significant legacies within the medical field and in Russia’s policies.
The role of Eduard Babayan was not limited to domestic policy-making. From 1964 to 1993, he worked with the Russian delegation to the Drug Commission of the ECOSOC (the Economic and Social Council of the UN), serving the head of that committee in 1977 and in 1990. From 1995 to 2004, Babayan was also a member of the International Narcotics Control Board. The fact that a narcologist was a part of the Soviet delegation to the international body, which was to resolve questions regarding the control of drugs and other narcotic substances, and not, for example, a member of the Russian Drug Control Services [FSKN], suggests that narcologists in fact had a significant influence on the policy-making process when the challenge of drug control was addressed at the international level.

The interpretation of the Single Convention on Drug control by Eduard Babayan continues to serve as the foundation of the approach to harm reduction programs in the Russian Federation. Eduard Babayan and others after him interpreted UN documents on drug control as prohibitive; however, this interpretation of UN documents is inaccurate, as the convention does not stipulate prohibition of methadone and other schedule II drugs.

While Russia, along with many other states, is party to all three UN conventions on drug control, many states still permit harm reduction programs. However, in the Russian state, the position of narcology plays an important role in the interpretation of these conventions. Russian legal documents cite these UN conventions as the reason for not allowing methadone and harm reduction programs to be a part of drug control treatment. However, UN conventions do not recommend a zero tolerance drug policy; nevertheless, both the USSR and the Russian Federation pursue one. The Russian
Federation interprets the three major UN documents in such a way that prohibits the use of opioid substitution therapy and needle and syringe exchange programs.

There are three important UN documents regulating drug possession and drug trade. First, the 1961 Single Convention on Narcotic Drugs required “states to limit in their domestic law the production and possession of, and the trade in, scheduled drugs exclusively to medical and scientific purposes.” Second, the 1971 Convention on Psychotropic Substances expanded the list of prohibited drugs. Lastly, the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances expended the scope of the convention “to include restrictions on demand as well as supply” (Utyasheva and Elliot 2009, 83).

The Russian Federation is party to all three of these conventions which continue to play an important role in Russia’s drug policy. While legislators cite these conventions as a source of Russia’s legal stance on drug control, narcologists also represent a strong force to implement extremely prohibitionist policies. Eduard Babayan served as an advisor to the state on drug policies. He contended that “neither of the UN conventions requires states parties to follow fully the structural or terminological patterns of the international schedules.” This follows logically from the right of the parties of states to follow convention and adopt “stricter measures of control or, on the contrary, exclude some of them” (Babayan and Gayevsky 2000 cited in Utyasheva and Elliot 2009, 85). Furthermore, this justifies a stricter position on drug control which was adopted by the USSR and, consequently, the Russian Federation. Babayan also notes that Russia is practically the only state which not only completely fulfills requirements of the 1971 Conventions, but implements even stricter measures (Utyasheva and Elliot 2009, 85).
Babayan’s position on harm reduction is widely cited within the narcological community and particularly by the opponents of the methadone programs:

Practical experience gathered by many physicians at the end of 70s of the XX century demonstrated, that the use of methadone in opioid substitution therapy for patients of heroin addiction led to quick development of a new, more grave in terms of prognosis, group of addicted, and this time, addicted to methadone. (Berestov, Shevtsova and Kaklugin)

Using these maximalist interpretations of international legislature, Russia seeks not only to implement draconian measures on the supply side of the drug use, but also to implement measures to severely criminalize the demand side of drug policies.

Babayan played an important role in developing international drug legislature including the 1961 Single Convention on Narcotic Drugs (Eduard Babayan 2005). The USSR was active in drafting the text of the convention and sent its proposals. In 1961 the UN held a conference which adopted the Single Convention and where the decision was made to create a Special Commission on Narcotic Drugs. Babayan became the leader of the Russian delegation in this Commission from 1964 to 1993. Babayan’s active role in international drug regulation suggests that Babayan was interested not only in creation of Russian national drug policies, but was also interested in translating the Russian position on narcotic drugs to the international arena. In 1977 and 1990, Babayan was elected as chair of the Commission. Again, when the convention of 1971 on Psychotropic Substances was initiated, Babayan was the head of the delegation from the USSR.

During the construction of the 1961 Convention, the USSR belonged to an informal group of states which preferred weak international control over national affairs in order to deal with domestic drug issues:

This group was led by the Soviet Union and often included its allies in Europe, Asia and Africa. They considered drug control a purely internal
issue and were adamantly against any intrusion on national sovereignty, such as independent inspections. With little interest in the drug trade and minimal domestic abuse problems, they were opposed to giving any supranational organ excessive power, especially over internal decision-making. (Sinha 2001)

The nature of the 1961 convention is extremely prohibitionist; only very briefly does it deal with the problem of drug abuse. This is a weakness of all three conventions regulating drugs: there was very little time spent during these conferences discussing the actual problems of drug abuse and the medical side of the issue (Sinha 2001).

Babayan contends that he is concerned with the intentions of international society to legalize light drugs. According to his views, this intention is against the position of the 1961 Convention. However, medical considerations serve as the main reason for his opposition to the legalization of drugs and narcotic substances (Eduard Babayan 2005).

7 Position of the Health Ministry and the Ministry of Education on Preventive Measures in the HIV/AIDS Epidemic

This section discusses the position of the Ministry of Health and the Ministry of Education on preventive measures to address the drug use epidemic in Russia. It examines the role of the narcological community in shaping policy initiatives advanced by these ministries and the role of these ministries in shaping policy response to the drug addiction and the HIV/AIDS epidemic. Below, I focus on examining the role of individual narcologists who held administrative positions in the Ministry of Health and influenced the drug addiction treatment making process.
The Official Position of the Ministry of Health on Prevention of Drug Use

Directives of the Ministry of Health are consistent with scientific views of Russian narcologists on the treatment and prevention of drug use: the Ministry, as an institution, rejects harm reduction programs in the Russian Federation. Instead, in coordination with the Ministry of Education, it supports universal testing for drugs at schools and institutions of higher education. To explain the Ministry of Health’s policies on drug use prevention, I examine directives of the Ministry and public statements made by Ministers of Health on issues of the prevention of drug addiction and HIV/AIDS as well as their view on harm reduction approaches. The analysis of the position of the Ministry of Health on the prevention of drug addiction reveals that their policy recommendations are not consistent with the official position of the Federal Drug Control Agency (FSKN) which is thought to dictate drug related policies. Conversely, the policy process analysis demonstrates that narcology specialists and psychiatrists had a direct influence on policy by either participating in drafting official recommendations, being on committees of experts, or serving as Ministers of Health. I examine positions on treatment and prevention of drug addiction that Health Ministers had from the onset of the drug addiction epidemic.

Tatyana Dmitrieva, Minister of Health 1996 - 1998

Tatyana Dmitrieva served as a Minister of Health in Russia from 1996 to 1998, during the time when drug addiction and the HIV/AIDS epidemic escalated. Dmitrieva was a renowned psychiatrist and the Head of the Serbsky National Center for Social and Forensic Psychiatry in Moscow. She also served as the Chief psychiatric specialist for the
Ministry of Health and the UN Commission on Narcotic Drugs. In 2005, Dmitrieva was one of the leading psychiatrists who signed the memorandum “Say no to Methadone” (Krasnov, et al. 2005). In 1996 Dmitrieva became a chair of the Health Committee of the Security Council of the Russian Federation. In one of the meetings of the Security Council, speaking as a deputy chair of the International Narcotic Control Board, Dmitrieva conveyed that

Russia is against the introduction of harm reduction policy. This is a really very difficult topic because we are facing very powerful pressure which undoubtedly has political implications … We are not for harm reduction, we are for supply reduction. (Dmitrieva cited in Rhodes, et al. 2010)

The policy positions of Dmitrieva were very much aligned with her scientific views on the treatment and prevention of drug addiction. She published extensively in co-authorship with Tatyana Klimenko, a narcologist and a current adviser to the Ministry of Health and Aleksandr Kozlov, a narcologist at the Moscow Research Institute of Psychiatry. Jointly with these scholars, Dmitrieva drafted a position paper in 2009 which served as one of the foundations of the National Anti-Drug Strategy of the Russian Federation (Dmitrieva, Klimenko and Kozlov 2009).

Shevchenko also held consistent positions against the implementation of harm reduction programs including opioid substation programs, citing both medical and legal reasons to oppose the implementation of needle exchanges and methadone programs. He contended that the approach to the treatment of drug addiction should be an “attempt to attract those suffering from drug addiction to treatment, oriented to full withdrawal from drugs” expressing a view consistent with scientific views of narcologists of finding a complete cure from drug addiction (Nadezhdin 2002). Shevchenko supported the ban on harm reduction approaches, saying that while the unanimity among agencies was not reached, they rejected “condoning” drug use. He justified his position on harm reduction referring to the beliefs of the narcological community:

Domestic narcologists, practicing complete discontinuation of drug use, cannot agree with the politics of minimizing harm. By the way, all main UN conventions on drugs also advocate for complete discontinuation of drug use…The opinion on the substitution methadone therapy of the Ministry of Health is strictly negative. (Nadezhdin 2002)

In another interview, Shevchenko stressed that medical measures for the prevention of drug use were not viable: “Propaganda and, of course, raising the culture—this is what doctors can do. The main portion of combatting drug addiction is the task of law enforcing agencies and military apparatus” (Nadezhdin 2002). Shevchenko did not follow the position of the FSKN or of the Ministry of Internal Affairs on prevention of drug use; he stated the official position of the Ministry of Health, significantly deviating from the views of those government agencies. For example, in a 2001 meeting in the Duma, Yuriy Shevchenko contended that those suffering from drugs should be sent to hospitals for rehabilitation, justifying it with the fact that drug addiction is a disease:
“Drug addiction is an incurable problem. As soon as first withdrawal symptoms occurred – that is it…Only few can escape” (Farizova 2001). With this statement, Shevchenko contradicted the position of the Minister of Internal Affairs Boris Gryzlov who advocated for repressive measures against people with drug addictions.

While approaches to rehabilitation remain a point of discord among physicians, in 2003 Shevchenko approved the protocol for the rehabilitation of people with drug addiction (Prikaz Minzdrava N 500 Z50.3). This protocol of the Ministry of Health is drafted based on the recommendations of leading narcologists and psychiatrists such as Nikolai Ivanets, director of National Research Narcology Center of Ministry of Health and Evgeniya Koshkina, a professor at the National Scientific Narcology Center. All but one article in the bibliography of the official protocol for rehabilitation represented the scientific knowledge of Russian narcologists on the subject of rehabilitation and treatment of drug addiction. Dissenting narcologists did not participate in drafting of the documents.

*Mikhail Zurabov, Minister of Health 2004 - 2007*

Mikhail Zurabov’s tenure as a Health Minster was short and controversial. Zurabov did not have a medical education background and supported the implementation of harm reduction and methadone programs in the Russian Federation. His views on harm reduction were rather progressive:

We have to admit, that our state healthcare system does not use a system of preventive measures, oriented primarily to drug addicts and sex workers, in an optimal way. In this sphere we often use experience and health of nongovernmental organizations. We finance programs, which render distribution to drug addiction disposable syringes. Along with that
educational and information campaigns are being carried out. (Karish 2006)

Yet, despite activists sent a request to the minister to consider a change in protocols of drug addiction treatment and prevention (Denisov 2007), more extensive harm reduction programs were not introduced. Zurabov’s tenure was plagued by problems with the procurement of medication for HIV/AIDS treatment and corruption scandals. The Ministry decided to switch to more expensive lines of HIV/AIDS treatment and more expensive medications, which was not justified by medical necessity and comprehensive planning (Gorlanova 2007). These decisions were harshly criticized by Russian nongovernmental organizations and HIV/AIDS patients alike as shortages of HIV/AIDS drugs exacerbated.

*Tatyana Golikova, Minister of Health 2007 - 2012*

Golikova strictly opposed harm reduction policies. In February 2011, in a meeting with the UN High Commissioner for Human Rights, Navanethem Pillay, dedicated to questions of the protection of human rights of people infected with HIV/AIDS in Russia, she contended that: “methadone therapy is prohibited by the Russian legislation. According to her in the 1990s, after an experimental implementation of such programs in 10 regions of the Russian Federation, an increase of HIV/AIDS and hepatitis infections and increased drug addiction was registered” (Golikova 2011).

Golikova stated directly that the scientific evidence that could support the use of such programs in Russia was lacking: “Till now we do not have from the world community evidence that methadone therapy is effective” (Kondratyuk 2011). Golikova also expressed her great discontent about the autonomy of the UN Global fund in
addressing HIV/AIDS in the country: “We would like that those programs, which The UN Global Fund to Fight AIDS has intention to implement on the territory of our country, would be coordinated with the government of Russia” (Golikova 2011). At the same meeting, Golikova said Russia is “categorically against” providing “substitution treatment for drug addicts” and that:

the distribution of sterile needles and syringes stimulates social tolerance of drug addicts and violates the Criminal Code of the Russian Federation. Unfortunately, purchasing sterile needles and syringes is not a problem in the Russian Federation. Today, the price for sterile syringes is much lower than the price for the cheapest narcotic drugs available. (Rhodes, et al. 2010)

The Minister of Health supported the policy of prevention of the HIV/AIDS epidemic which actively excluded harm reduction programs and methadone programs.


The Ministry of Education adopted a position on drug addiction prevention inspired by and consistent with the views of the narcological community as well. Drug addiction specialists were an integral part of this Ministry’s decision-making process, serving as advisors for the Ministry, as members of committees, and by drafting legislative proposals. As a policy recommendation, the Ministry of Education supported the universal testing for drugs at schools and institutions of higher education.

_Concepts of Addressing Drug Addiction in Education_

The Ministry of Education recognized that the problem of drug use among young people existed and that it was serious. The Ministry conducted a sociological study in
2011 which confirmed that 25 percent of young people aged 11 to 24 came into contact with drugs in one way or another (Dulinov 2011). The preventive measures the Ministry of Education chose to implement were based on the Directive of the Ministry of Education to adopt “The Concepts of the Prevention of Abuse of Psychoactive substances in Education” (the Concepts) and approved by the decision of the Government Committee on Resistance to Drug Abuse. Although The Concepts was put into law by the state Duma, the initiative for its implementation came from the Ministry of Education and from drug addiction specialists.

“The Concepts” were developed with the help of the Ministry of Health of the Russian Federation under the leadership of Andrey Gerish, the main specialist of the Ministry of Health on the prevention of drug addiction. The goal of The Concepts was to prevent the spread of drug use in educational institutions. “The Concepts” is the official approach of the Ministry of Health and contends that primary preventive measures, such as “improvement of health of the students” and “improvement of education through improvement of health and the value systems of the students, are recognized as the most effective” (O kontseptsii profilaktiki 2000).

64 Preventive measures of in education institutions are based on The Concepts of Drug Abused affirmed by the directive of the Ministry of Education and approved by the decision the Government Committee on Resistance to Drug Abuse and to Their Illegal Trade from May 22, 2000 (Dulinov 2011).

In creating the program of the prevention of drug addiction in schools and universities, the Ministry of Education closely collaborated with drug addiction specialists. Initially, they jointly created methodological recommendations for preventive programs, such as the “Early detection of children and youth abusing psychoactive substances” (O kontseptsii profilaktiki 2000). These recommendations were written by Andrey Gerish, with two other specialists from leading drug addiction clinics, Taras Dudko of the National Scientific Narcology Center, and Nikolai Vostroknutov, a member of the National Serbsky Institutes (Dudko, Vostroknutov, and Gerish 2000).

Taras Dudko, in his commentaries regarding drug addiction, reveals that his views are consistent with the views of the narcological community. For instance, he claims that drug addiction is not like cancer, it can be cured (Dudko, presentation). “Narcological diseases from societal perspective and personal perspective they can be cured. They are not cancer disease, they are not oncological disease. A person can be rehabilitated. Our role should be to help” (Dudko, presentation). While Dudko talks about the fact that drug addiction is not fatal, he does not recognize in his remarks the chronic nature of drug addiction illness, but advocates this view that a person through rehabilitation can be restored to perfect health. Dudko contended that testing of drug use at schools was highly recommended:

Testing on drugs should be implemented. This question was already raised 11 years ago. But it should not be a universal testing, as the head of the FSKN, Viktor Ivanov suggests, but selective, depending on the condition of the student. At school everything is rather transparent; there is known who smokes and who dabble in drugs. In cases of suspicious behavior…. a nurse at the school medical center can test for drugs; it does not require special qualification. (Gorbacheva 2011)
According to Taras Dudko, drug testing would be a preventive intervention. He thinks that the explanation of the adverse effects of drug use should be explained as early as kindergarten. Taras Dudko is a part of the scientific community of narcologists and published extensively with other scholars such as Tatyana Klimento, the Head Narcologist of the Ministry of Health, Alexandr Kozlov of the Moscow Research Institute of Psychiatry and Yevgeniy Brun, the Head Narcologist of the Russian Federation. 66

Narcology has been advising the Ministry of Education on the prevention of drug addiction since the early stages of the drug addiction epidemic. In 2000, when it became apparent that the drug addiction epidemic was definitively growing in the Russian Federation and affected youth, the former Minister of Education, Vladimir Filippov,67 ordered the creation of an expert committee for the Ministry of Education to control drug use programs in schools. Along with members of the Ministry of Education and other


educational services, several prominent narcologists\textsuperscript{68} became members of the created committee.\textsuperscript{69}

Despite the opposition, the Ministry of Education’s initiative for universal testing was finally supported by President Dmitry Medvedev in April 2011 who relegated the responsibility of drafting legislation to the Ministry of Education and the Ministry of Health to jointly draft the bill (Minobrazovaniya predlozhilo 2012). The recommendation of the Ministry of Education, crafted with the help of narcologists, was put into law which was adopted by the state Duma in the first reading.\textsuperscript{70} According to the new law, drug testing and preventive medical check-ups would be held in all schools, colleges, vocational colleges, and institutions of higher education. Testing for drugs, according to law, could be carried out only with the consent of the students. If they were under 15 years of age, consent of their parents or legal guardians was required.

Testing for drugs in schools was planned for implementation in two stages. The first stage seeks to identify risk groups among students based on psychological evaluations. The second stage is actual testing of students for drug use. The Ministry of

\textsuperscript{68} Egorov V. F. – Head Narcologist of Ministry of Health; Vostroknutov – The Serbskiy Institute of Psychiatry, Chair, Department of Psychogenic Diseases in Children; Dudko T. N. – National Narcology Research Institute, Chair, Department of Narcological Rehabilitation.


\textsuperscript{70} “O vnesenii izmenenyi v otdel’nye zakonodatel’nnye akty Rossiyskoy Federatsii po вопrosam profilaktiki nezakonnogo potrebleniya narkoticheskikh sredstv i psikhotropnikh veshchestv.” Federal Law of the Russian Federation from June 7, 2013 N 120-FZ.
Education contends that with the use of modern test systems, it could be conducted at the school itself without the need to use an external laboratory. Methodological recommendations from narcology specialists contend that early detection of drug use and at risk groups for drug use should form the cornerstone of preventive strategies of the Ministry of Health (Klimenko and Kozlov 2010).

The Ministry of Education made the decision to implement universal testing for drugs despite the presence of ample scientific evidence that this intervention would not be effective. International organizations do not recommend the implementation of universal testing for drugs (Kern, et al. 2006).

The new law immediately caused a lot of controversy. The current Minister of Education, Dmitri Livanov, downplayed the importance of the law on testing for drugs in schools:

Details are not written into the law. The law only gives such a right to schools and institutions of higher education. And it is implemented on voluntary basis. Nobody can become an object of testing if he did not express his consent in the written form. We are developing the procedure for testing jointly with the Ministry of Health. (Aksenova 2012)

The previous Minister of Education Andrey Fursenko71 was not consistent in his position on testing for drug use in schools. Initially, he was opposed to this idea. In April 2011, he admitted that “even if it is necessary, we are not ready for it” (Andrey Fursenko 2011). The President Dmitry Medvedev already stated in 2009 that the discussion of mandatory drug testing at schools was necessary in the Security Council meeting.

71 Andrey Fursenko was the Minister of Education of Russian Federation from 2004 to 2012.
Eventually, Fursenko changed his position and contended that if drug testing should be implemented, it should be voluntary (Aksenova 2012):

Any imperative we perceive with opposition. I am for free choice and for voluntary testing... I believe that every person, school children and students and their parents should decide for themselves... I am certain that it can be one of the effective measures, one of the most serious expressions of the public relation to the drug addiction. We are intending voluntary testing, demonstrating our rejection of this phenomena [of drug addiction]. (Aksenova 2012)

Fursenko went as far as to say that testing for drugs should be treated as standard procedure and should be viewed similar to routine vaccinations at schools (Testy na narkotiki 2011):

A student is faced with a situation of choice: you are either strictly following rules, excluding use of drugs and voluntarily participate in testing, or you are obviating norms accepted by the school; but then, the education institution reserve the right to react to what you are violating. (Testirovaniye 2011)

The Ministry of Education and Ministry of Health promoted a response to the drug addiction epidemic heavily influenced by the views of drug addiction specialists in Russia. While the primary prevention of substance abuse is of crucial importance, testing for drugs as a preventive intervention is recognized as ineffective. However, in Russia, because of the influence of narcologists and their advocacy for testing as intervention, it was supported by the Ministry of Education and was finally made into law.

Opposition to the Universality of Drug Testing

While there is a consensus in the narcological establishment regarding prevention and treatment, there were dissenting voices; however, they were usually not included into expert committees and they did not participate in drafting recommendations or
legislation. For example, Oleg Zykov, the president of the fund “No to Alcoholism and Drug use,” and a member of the Public Chamber contends that testing for drugs at school should be exclusively psychological:

If the goal is to help a child in a difficult life situation (and drug use is a difficult life situation), then it is imperative to carry out psychological testing, not the collection of bio fluids, which does not provide any information about what happened to a child and would should be done to help him. Testing should be based on a dialogue with the child in the form of professional questions, which would allow to uncover the risks, affecting the child and how these risks could be overcome. (Gorbacheva 2011)

We can conclude that in an adoption of standards of primary prevention of drug use, the views of the small elite of drug addiction specialists dominated the policy-making process and dissenting voices were not taken into an account. The opponent to the adopted approaches on the treatment and prevention of drug addiction, Vladimir Mendelevich, laments that there is no true collegiality and transparency in the decision-making process of the Ministry. The directive of the Ministry of Health for the development of standards of medical help stipulates that in the drafting stage the Ministry of Health has to organize a working group and cooperate with scientific organizations. However, Vladimir Mendelevich believes that a tradition of wide scientific discussion of standards is absent in the policy-making process. As a result, interventions not supported by scientific findings become adopted into law. Our discussion of universal testing for

________________________

72 "Ob organizatsii v Ministerstve zdravookhraneniya i sotsial'noy razvitii Rossiyskoy Federatsii raboty po razrabotke poryadkov okazaniya otdel'nykh vidov (po profilyam) meditsinskoy pomoshchi i standartov meditsinskoy pomoshchi." Prikaz Minzdravsotsrasvitiya Rossii from August 11, 2008, N 410.
substance abuse is just one example of the shortcomings of the policy-making process in healthcare.

Moreover, the statements of officials in healthcare, point out that drug addiction specialists are not a subservient branch to the FSKN. While it is believed that the FSKN dictates a lot of the policy in the country associated with matters of drug use, it appears that the FSKN does not always dominate policy-making process. Specifically, when the law on testing for drugs in schools was passed, Viktor Ivanov, the Head of the FSKN expressed his dismay at the new law. He contended, during a round table in the state Duma, that “universal testing [for drugs] is not only a colossal waste of money, but also an ideal way to escape reality to the area of manufacturing of fictitious demonstrative product, and simpler—a show-off, a primitive imitation and simulation of real work” (Glava FSKN 2013). Viktor Ivanov argued that testing for drugs is “distracting and [a] little effective preventive measure.” Ivanov continues noting that:

 even if we suppose that testing will effectively detect drug user, which is highly unlikely, particularly because no one has a right, according to the Russian legislation, to coerce a young person to undergo testing. Even if drug users are detected, how to motivate them and who will work with them? (Glava FSKN 2013)

The Head of the FSKN contended that it is a family matter between children and their parents: “I am skeptical about the compulsory drug tests in schools. This is largely a problem of the children’s upbringing in the family and certain school programs” (Drug agency 2013). Positions of FSKN and health care representatives clash around other matters, such as the rehabilitation of drug users in the country. Despite the universal testing for drugs in education being extremely controversial, even among drug addiction specialists, it was adopted into law by the State Duma in 2013. This approach was widely
supported by the field of narcology who had influence in the Ministry of Health and the Ministry of Education.

8 Conclusion

This chapter argued that the rejection of harm reduction policies in Russia has historical foundation. Without state will to address the HIV/AIDS epidemic, neither the Ministries of Health or Education, nor the medical epistemic community, have incentive to reconsider their positions on harm reduction. I show that the narcological community’s views on harm reduction are rooted in an understanding of addiction that is different from views on the topic in Western science. I also show that the views of the psychiatric community gained policy relevance in the early 1960s when drug addiction specialists began to participate in the drug treatment and prevention policy-making process at the international level.
CHAPTER 4
POLITICS OF MORALITY, POLICY CONTINUITY, AND PREVENTION OF SEXUAL TRANSMISSION IN THE HIV/AIDS EPIDEMIC

1 Morality Politics

Current preventive HIV/AIDS policies in Russia represent a remarkable continuity with the policies of the past and are dually reinforced by a prevailing discourse of conservative morality. While policy-makers frame demographic decline and problems of reproductive health as issues related to national security threats, they do not take decisive steps to address these problems. Due to a conservative morality discourse and a discourse of blame, policies intended to prevent the sexual transmission of HIV/AIDS infection in Russia were not revised by the legislature and responsible agencies to meet the challenges of a growing epidemic. I contend that a conservative politics of morality support an existing policy framework in the Russian Federation that excludes prevention interventions recommended by the international norm. In this chapter, I show that a conservative politics of morality discourse originated in the process of building of a socialist society and was subsequently codified in the later years of the Soviet Union. This discourse shaped women’s health and prevented implementation of policies related to sexual disease in the Soviet Union and in the Russian Federation.

Recently, moral arguments have influenced a plethora of debates in Russian politics. Morality is interwoven into issues ranging from public health, minority rights, and to the prohibition of adopting Russian orphans by American citizens (Stenogramma, 19 December 2012). While the exacerbation of this moral discourse appears to be a current phenomenon, its roots lie in an historical past of government institutions and
earlier moral constructions. The political landscape is dominated by a conservative moral politics which hold individuals responsible for social ills and reject communitarian solutions to such problems. This tendency leads to limited policy solutions for social problems. HIV/AIDS is just one example. Dominant moral discourse in the Russian Federation provides insight into decisions made by the Ministry of Education and the Ministry of Health. Individual positions of members of the Federal Assembly can be linked to this overarching discourse of moral conservatism.

Morality politics serves as a foundation for my discussion of policy in Russia regarding the prevention of sexual transmission of HIV/AIDS. In the Russian Federation, morality politics are shaped by puritanical tendencies of communist morality. I suggest that policies of HIV/AIDS prevention, such as sex education, contraception, and other related policies, can be explained through morality politics. In the Soviet Union and in post-Soviet Russia, they manifest themselves in segregating society into the moral “us” and the immoral “them,” thus protecting the moral “us” through means of policy. In the case of the Soviet Union and the Russian Federation, the “morally pure” refer to women and children. Policies that seek to protect them favor the nuclear family norm and education that follows such themes of morality.

In this section I will: 1) examine the foundations of a communist morality in the Soviet Union; 2) delineate the moral discourse in the Russian Federation and the construction of categories of the moral “us” and the immoral “them” in the Russian context; and 3) show how policies of the primary prevention of sexually transmitted diseases and HIV/AIDS, in particular, were shaped by a politics of morality in the Soviet Union and in the Russian Federation.
The Socialist Revolution and ensuing state-building were a foundational moment for the development of a morality politics frame in the Soviet Union. After the October Revolution, the task before the government was not only state building, but also constructing a new Soviet political and moral persona (Cullen and Cullen 1977). Thus, the Soviet government was participating in the process of social and cultural construction of the moral “us” via its Soviet citizens. In morality politics, the idea of the moral “us” is metonymically associated with purity and the contrasting binary component of the immoral “them” with sin or dirt. Buchli, (1999, 520) in his description of post-Revolutionary Russia, discusses that dirt and poor health were associated with the pre-Revolutionary petit-bourgeois consciousness. The idea of moral purity draws from the distinction between the dirty pre-revolutionary bourgeois consciousness and the post-revolutionary worker consciousness. When Lenin discusses the idea of the new Soviet worker he contends that: “Workers are building a new society without having become new people, cleansed from the dirt of the old world, and who still stand up to their knees in this filth” (Lenin in Buchli 1999, 53).

Initially, the category of the moral “us” encompassed the entire population of Soviet citizens. Soviet society was considered to be more moral in comparison to a capitalist one. Based on the idea that the “exploitative” economic structure of capitalist societies negatively affected the character of its citizens, Soviet society and Soviet men were deemed to be devoid of the ills and the characteristics observed in societies with capitalist economic systems (Cullen and Cullen 1977, 390). However, the image of the everyday Soviet person was a utopian one and social ills persisted. Social ills like
prostitution, alcoholism, and crime, all associated with capitalist economic systems, persisted in Soviet society, indicating a disjuncture between the idealized moral “us” and social reality. Initially, it was believed that Soviet deviance could be corrected through a system of character education administered through the primary family unit, schools, and communist social groups (Cullen and Cullen 1977, 392).

In the early years of the Soviet Union, the explanation for deviant behavior of individuals, their sins or criminality, was attributed to “bourgeois propaganda from the West” or was seen as a form of “vestiges” from the past (Cullen and Cullen 1977, 392). However, with the realization of the impossibility to rid Soviet society of social sins, Soviet society itself was divided into a moral “us” model Soviet citizen and an immoral “them,” those deviating from the moral social norm. While Soviet authors stressed the prominence of capitalist influence in producing social deviance, the final blame was essentially put on the imperfect functioning of the Soviet system itself:

> [t]hey attribute deviance to the inability of their character education system … to work at full potential. If the system could perform at maximum efficiency, they say, then it would be impossible for individuals to develop anything but a moral consciousness strong enough to resist the assault of capitalist ideology, thus precluding the possibility of deviance. (Cullen and Cullen 1977, 392)

Soviet society was supposed to rehabilitate any deviant behavior. Thus, it was logical for the government to accept that “aberrance is rooted in the faulty structure of their system” (Cullen and Cullen 1977, 392).

This view of society and social sins was consistent with prevailing social policies in the Soviet Union which proposed implementing large scale rehabilitation and educational programs focused on a corrective, rather than a punitive, approach to deviant behavior. Moreover, as a consequence of this form of theorizing social deviance, morality
education became an important aspect of morality politics. Morality education served to create a morally sound “New Soviet Man” (Cullen and Cullen 1977, 389).

Codification of Communist Morality

The development of a communist morality was an ongoing task throughout the existence of the Soviet Union. This process emerged in the 1920s and peaked in 1961 with the drafting of “The Moral Code of the Builders of Communism” (Boldyrev 1963). Official details of communist morality were elaborated in speeches and other pronouncements by party leaders. A theoretical and philosophical discourse accompanying these official documents also sought not only to interpret these norms, but to make these norms accessible to the general public (Kon 2012). In the very early years of the Soviet Union, Lenin called for the education of youth to be “in the spirit of communist morality” (Lenin in Kon 2012). Communist morality became an important aspect of the educational system.

However, initially, the communist party refused to implement any kind of moral code for its members and for the party elites. Immediately after the revolution, morality was perceived to be an element of bourgeois capitalist society. In ethical debates, communists contended that an absolute moral code did not exist (Hoffmann 2003, 58). Morality was perceived by Marxists to be a system of control created by the ruling class (Hoffmann 2003, 59). Lenin proclaimed that “morality is subordinate to the interests of the proletariat’s class battle” (Lenin in Hoffmann 2003, 59).
Several public figures from different spheres have contributed to the discourse of constructing morality principles in the post-Soviet period. After a brief liberal period and contributions from thinkers like Alexandra Kollontai, communist morality gained its conservative attributes. Below, I discuss contributions of the most prominent thinkers in constructing a politics of morality discourse.

The theorists of communism had to redefine morality separately from religious and traditional norms and to explicate for Soviet citizens what a model Soviet citizen would do in different spheres of life. The family and sexual spheres of an individual were not an exception. In her attempts to describe new norms of morality, Alexandra Kollontai, a member of Lenin’s Bolshevik party, redefined the meaning of the family for the Soviet state (Kollontai 1921). Kollontai argued against traditional family organization. She contended that “the family teaches and instils egoism thus weakening the ties of the collective” (Kollontai 1921). Thus, Kollontai argued that the absence of family strengthens the collective organization of society: “[t]he narrow, closed family, with its parental squabbles and its habit of thinking only about the well-being of relatives, cannot educate the New Person” (Kollontai in Hoffmann 2003, 91). In the period of the dictatorship of the proletariat, communist morality—and not the law—regulated sexual relationships in the interest of the workers’ collective and of future generations. Kollontai specified principles of moral relationships between men and women:

1. All sexual relationships must be based on mutual inclination, love, infatuation or passion, and in no case on financial or material motivations. All calculation in relationships must be subject to merciless condemnation.
2. The form and length of the relationship are not regulated, but the hygiene of the race and communist morality require that relationships be
based not on the sexual act alone, and that it should not be accompanied by any excesses that threaten health. (Kollontai 1921)

While there was a lot of opposition, particularly towards Kollontai’s ideas about sex and family, there was an agreement in general regarding what to consider as moral in Soviet society: “the morality of a given act should be determined by whether it advanced Socialism” (Field 2007, 10).

However, in the mid-1920s, newly developed theories on moral education prescribed sexual abstinence before marriage, sexual restraint within marriage, monogamy, and reproduction as one of the major obligations to society (Lapidus 1979, 89). “Sexual dissoluteness” that occurred following the October Revolution led some to call for a moral code (Hoffmann 2003, 60). In 1920, a Central Control Commission was created to oversee a system of other commissions endowed with the task, among others, to address “breaches of Communist ethics” (Hoffmann 2003, 61). Further steps of development towards the communist moral code included the essays “On Party Ethics” ["O partiynoy praktike"] by Aron Soltz (1924) and more detailed discussion of what constituted ethical behavior.

Psychiatrist Aron Zalkind published in 1924 The Twelve Commandments that recommended sexual behavior based on proletarian ethics. The policies of the Soviet government on sexuality and sex education and their implementation were consistent with Zalkind’s recommendations. The idea behind the Commandments was that “the energy of the proletariat should not be deviated to sexual connections, irrelevant for its [proletariat’s] historical role” (Stepanov 2004). Zalkind had a strong influence on education as well and became involved with the newly emerged discipline “pedology,” a new science about children. He was the founder of the Society of Marxist
Psychoneurologists and chaired a commission intended to develop a research program further developing the emerging discipline of “pedology.” In his commandments, Zalkind outlined proper sexual behavior as monogamous relationships; he was against homosexuality, any sexual perversions, and promiscuity (Zalkind 1924). While Zalkind and other sexologists clearly justified their stance against promiscuity, citing the highly distracting nature of sex for the builders of socialism, they also “sought to control and limit all sexual activity, even when it did not involve promiscuity” (Hoffmann 2003, 93).

Overall, the Bolshevik leaders held very conservative views regarding marriage and were not persuaded by communist theorists like Kollontai. Hoffmann contends that “Lenin and other Communist leaders held rather Victorian notions about morality and the importance of marriage. They regarded sexual liberation and the elimination of the family as distractions from socialism, if not perversion of it” (2003). Lenin contended that “[p]romiscuity in sexual life is bourgeois: it is a sign of degeneration” (Hoffmann 2003 92). Soviet leaders linked sexual morality to political ideology. They believed that abstinence until marriage was “a means both to preserve young people’s energy for the tasks of socialist construction and to prevent the corruption of socialist principles by sexual hedonism” (Hoffmann 2003, 94).

The end of the 1920s, therefore, brought an important shift in morality politics of the state. Initially, the morality discourse created categories of the moral “us”—the socialist person—as opposed to the immoral “them”—the bourgeois society. However by the end of the 1920s, this process of assigning the categories “us” and “them” took place within the Soviet society itself.
Prostitution: Effects of Morality Politics

A set of policies regulating prostitution most vividly demonstrates the overall shift in morality politics of the state and the effects of morality politics on social policy. The state’s regulation of prostitution from the 1920s to the 1930s highlights the shift in morality politics and the emergence of a conservative morality politics that accounted for the existence of social ills by placing blame on the individual rather than the flaws and injustices of the social system. Igor Kon contends that the state’s regulation of prostitution shifted from addressing the social causes of prostitution to repressive policies to eliminate prostitutes themselves (Kon 2010, 225). Through an examination of policies regulating prostitution, I demonstrate how numerous state policies hold individuals accountable for social deviance, while ignoring possible social or structural causes. I show that: 1) the shift in the politics of morality occurred in the 1920s and 1930s in the Soviet Union; 2) the social policies were framed to attribute blame to individuals for social deviance; and 3) the politics of morality affected the development of policy.

Prostitution was addressed in the “Thesis regarding prostitution” published at the end of 1921. The thesis embodied the spirit of the Social Gospel morality predominant in the early Soviet state. For instance, the thesis found that the origins of prostitution could be located in the capitalist order of society: “[p]rostitution is closely linked to the basis of the capitalistic household and wage labor” [osnovami kapitalisticheskoy formy hosyaystva i nayemnym trudom] (Popov 2004, 114). The document also asserted that “[t]he fight against prostitution is the fight against its causes—i.e., with capital, private property, and with class society” (Popov 2004, 114). It was also stated that prostitution was a remnant of the bourgeois-capitalistic way of life (Panin 2004, 114). In 1924,
Bronner, the leading expert on sexually transmitted diseases for the Health Narkomat [Health Ministry], contended that “the premise which underlies our work is that the fight against prostitution should not be substituted with the fight against the prostitute. Prostitutes are only victims of either social conditions or those bastards that entice them into this kind of business” (Panin 2004, 114).

Legislation of the time did not criminalize prostitution; prostitution was not considered either a felony or a misdemeanor. Police or criminal investigators were only allowed to arraign prostitutes as witnesses and were instructed to treat them “with courtesy and respect” (Panin 2004, 114). The dominant view on prostitution at the time stipulated the provision of complex social services to prostitutes. A majority of the members of the Interdepartmental Committee to Address Prostitution established in 1919 shared this view as well (Panin 2004, 115). Policy-makers attempted to remedy the problem of prostitution through finding employment for “delinquents” in the industry.

However, as Igor Kon notices, such policies were soon replaced by a more prohibitionist approach. In the mid-1920s, a new conception of prostitution was born. Prostitutes now belonged to a larger category of people also disenfranchised by the state, regarded as social-parasitic elements. They were considered incorrigible (Panin 2004, 116). In the second half of the 1920s there was a growing understanding of prostitution as an anti-societal phenomenon. The policy focus shifted from the fight against prostitution to the fight against the prostitute herself. The decision in 1929, “About Measures to Address Prostitution”73 stipulated that in cases when a “prostitute voluntarily left work

73 June 29 1929 directive of VCIK and SNK of RSFSR.
after mandatory re-education [*perevospitaniya*] in the closed-colony, she had to be viewed as a socially harmful [vrednii] element, and severe methods of influence should be used against her” (Panin 2004, 118). The last years of the 1920s ushered in a new era of morality politics within the state.

In the 1920s, the official consensus on morality values was not yet present; however, attempts “to identify and stigmatise [*sic*] problematic groups” already existed (Iarskaia-Smirnova and Romanov 2009). The politics of morality discourse found its full embodiment in the 1930s, under Stalin, when consensus on values finally emerged. Categories of otherness adapted to reflect this convergence on those identified as undesirable: “parasites,” various forms of violating rules of labor discipline, and “enemies of the people” (Iarskaia-Smirnova and Romanov 2009).

1930 - 1950s

In the mid-1930s, discussions were held within the party circles to write the moral code of communist behavior. It was argued that communist moral values had to determine political tasks of the party (Hoffmann 2003, 62). By the end of the 1930s the unwritten code was more clearly delineated. Hoffmann argues that the emergence of the moral code was associated with the purges of 1936 – 1938 and the emergence of a new party elite. There was a necessity to draw a code that would establish the behavior of the party members. Among the most important values were “sobriety, sexual propriety, honesty, openness and loyalty” (Hoffmann 2003, 85). Hoffmann contends that since both Lenin and Stalin adhered to conservative moral values, conservative moral norms came to dominate the moral code (Hoffmann 2003, 86).
Moral transgressions were one of the charges that victims were accused of during the Great Purges, at the end of the 1930s. “Moral degenerates,” more specifically, were accused of “drunkenness,” “sexual debauchery,” and “swindling” (Hoffmann 2003, 73). Initially during the purges, moral deviation and political deviation were separate accusations. However, after Kirov’s death, the political aspect of accusations became more permanent. Eventually, moral and political degeneration were linked through the accusations of the “enemies of the people” and of being “politically and morally corrupted” (Hoffmann 2003, 74).

**Khrushchev: the Moral Code of the Builders of Communism**

After the consolidation of power at the end of the 1950s, Khrushchev introduced reforms that were supposed to launch Soviet society into a new state of communist development. During the Twenty-Second Communist Party Congress, Khrushchev proclaimed that the foremost value is “a new man—an active builder of communism” ([novyy chelovek—aktivnyy stroitel’ kommunizma] (XXII S”ezd 1962, 98). Along with labor, education, and legal reforms, Khrushchev also introduced a program for reshaping Soviet men into a new type of Soviet citizens. He maintained that the “communist moral education of workers” [kommunisticheskoye vospitaniye trudyashchikhsya] was one of the prominent goals of the party after the XX Congress (XXII S”ezd 1962, 51). These new ethical aspirations for both party members and rank-and-file citizens were codified in the “Moral Code of the Builders of Communism” of 1961 (Field 2007, 11). The twelve precepts of the Moral Code stressed such values as “honesty and truthfulness, moral purity, unpretentiousness and modesty in social and private life” (The Moral Code,
1961). The Code also identified values that were perceived as immoral:


The inclusion of moral principles into the party program signified that the party intended to use moral ethical principles in order to control the private lives of individuals (Field 2007, 12). Thus, the Moral Code had an instrumental value for party leaders; it served to legitimize the post-Stalinist regime. Persuasion and mobilization served as the measures of societal control. While Khushchev’s politics sought to impose moral regulations on the private lives of citizens in accordance with the new moral code, this regulation of private life became possible as well since its regulation became a part of the public agenda. The Moral Code was an instrument of ethical conduct. As a part of the official Party program, it was consistent with the Party vision of Communism. Under the Party’s vision of the communist future, “morality, rather than law or force, would be ‘the only form of regulation of the relations between people’” (Field 2007, 12).

**Morality Education [Vospitaniye] in Morality Politics**

With a shift in political attitudes about finding a justification for lack of rapid socialist progress in the 1930s, morality education [vospitaniye] became an important aspect of morality politics. Vospitaniye was a term used to signify “education, upbringing, and the molding of personality and values” (Field 2007, 18). Inculcation of morality education was not only the responsibility of the party and party organizations, but the responsibility of every citizen as well. References to communist morality and morality education were also common among writers and journalists (Field 2007, 18).
After, the adoption of the “Moral Code” references to communist morality became more prevalent throughout society. Morality education was an important aspect of socialization into the Soviet system and the building of a “New Socialist Man.” From its very foundation in the Soviet Union, morality education was devoid of any aspects of sex education. The tradition of morality education persisted into the Russian Federation as well. Numerous educational scientific publications argue for the necessity of morality education and against the introduction of sex education in Russian schools (see, for example, Danilyuk, Kondakov, and Tishkov 2009).

**Discourse of Blame in the USSR**

An important aspect of conservative morality politics is the existence of a discourse of blame of the individual for social shortcomings and deviance. It was employed throughout the existence of the entire Soviet Union to explain social conditions and justify punitive legislation. The discourse of blame logically followed from the idea of the infallibility of the communist system (Field 2007, 24). It was also closely linked to an imagined source of danger coming from individuals who committed transgressions and threatened the public good. Since principles of communist morality were part of an official state discourse, opposition to its principles were not possible; as a result of this monopoly of the official communist ideology, diverging viewpoints were not considered (Field 2007, 24). The discourse of blame was accompanied by a search for sinners within society to whom social ills subsequently were attributed. Although the intensity of the discourse of blame fluctuated over time, this process of looking for the “sinners” and protecting the “pure” was a constant presence throughout the Soviet Union.
During Khrushchev’s rule, the adoption of extensive legislation against “social parasites” was the outcome of the discourse of blame. Under Stalin, the law of 1951 already focused on what was perceived as socially undesirable elements, like beggars, tramps, and prostitutes (Fitzpatrick 2006, 337). However, the 1957 law “had a much broader definition of what constituted the ‘anti-social, parasitical’ part of society” (Fitzpartick 2006, 337). The law was supposed to save the moral “us” from the immoral “them, the “speculators, black-marketeers and spongers” (Fitzpatrick 2006, 337).

The philosophy of fighting sinners in Soviet society was quite different between the tenures of Stalin and Khrushchev. While there were some similarities in morality discourse, the politics of morality emphasized the presence of sinners in the society (Dobson 2003, 199). However, under Stalin, the goal was to search for enemies, while under Khrushchev, the philosophy was to believe that “all Soviet sinners could be redeemed” (Dobson 2003, 198). Under Khrushchev, “[i]nstead of incarceration, re-education and 'correction' within society became the order of the day” (Dobson 2003, 200).

The project of looking for sinners or the moral “other” within society was monumental as citizens were encouraged to participate. Involvement of citizens in fighting sins reached unprecedented proportions:

Members of Soviet society were thus encouraged to take an active role in raising moral, healthy citizens of the future. In the task of stamping out ‘unhealthy and amoral’ tendencies amongst the young, the Soviet community [obshchestvennost’] had a great and, as yet, underused
potential. When they witnessed abuses, Soviet citizens must henceforth speak out. (Dobson 2003, 181)

This section discussed the development of a morality politics in 20th century in Russia. It demonstrated that within the discourse of morality politics, the discourse of blame of deviant elements in society for social sins and the discourse of the protection of the “pure” were present. I showed that this discourse was important at the state level to justify shortcomings of the Soviet state and Soviet society. In the early Soviet Union, politics of morality shaped policies regarding developing questions regarding women’s emancipation, family, and family planning.

2 Morality Politics: The Russian Federation

In the early 1990s, drastic changes occurred in many policy areas in the Russian Federation. In 1996, Russia joined the Council of Europe and signed legislation that stipulated changes to domestic laws. However, the anticipated policy changes in many issue areas, including policies on prevention of sexually transmitted diseases, family planning, and reproductive health, did not occur. Although Russia ratified international legislation, whenever its complete implementation was not desirable, Russia ignored widely shared interpretations. I argue that in the issue areas of family planning and prevention of sexually transmitted diseases, the policy was dictated instead by the politics of morality.

74 There is little research on politics of morality following Khrushev’s period. The most current systematic treatment of this question in the Soviet Union is Deborah Field’s “Private Life and Communist Morality in Krushchev’s Russia” (2007).
The politics of morality re-emerged in the Russian Federation by the end of the 1990s. On the one hand, references to Soviet morality permeated political discourse. On the other hand, the Russian Orthodox Church emerged as a new participant in the policy process. Morality politics in the Russian Federation gradually identified categories of the moral “us” and the immoral “them”; policy-decisions regarding social and public health policy were made consistent with these categories. By the first decade in 2000, the moral “us,” associated with moral purity, was aligned with heterosexuality and Orthodox Christianity. Children, mothers, and the family, the quintessence of purity, were vehemently protected from the influence of the impure marginalized social groups and Western influences. They became the focal point of many political debates in the Duma and in the president’s agenda. Protection of “our children” became a regularly reiterated claim. The “other” in Russian politics of morality were those belonging to marginalized social groups, such as sexual minorities, drug users, and Western religious groups. Politics of morality discourse also defined the Russian Federation’s approach to international politics, permeating interactions with international organizations and shaping relationships with Western Europe to justify positions on social and public health policies. Protection of family values and children became part of the discourse of many public health and social policies. Russia became defined by its moral tradition. James Morone suggests that because of morality politics, in the U.S., family “remains ground zero in the struggle for a good society” (Morone 2003, 482). Similarly, in Russia, the political protection of family values became an important aspect of its politics of morality. The definition and protection of family values became an indispensable part of public discussion of legislation concerning women and children.
Policy-makers consistently draw parallels between morality politics in the Russian Federation and the Soviet Union to justify policies that place the burden of responsibility for persistent social sins on individuals, instead of rooting these explanations in the failures of the social system itself. The politics of morality place the blame for social sins upon individuals themselves and marginalize entire social groups instead of explaining deviant behavior through the political and economic structural failures of the state. Policy-makers justify shortcomings of social and health policies through politics of morality. For example, a member of the Samara Region Committee on Social Politics, Valentina Petrenko contended:

In the USSR, the law against parasites [“o tuneyadstve”] was employed according to which shirking from work was a criminal responsibility. I think it would not be bad to return to it. Many simply do not want to work: it is easier for them to live on welfare, scratch along by mendicancy, moving from city to city ostensibly for the search of a better life. The law, I think, could be a kind of deterrent factor. At least a part of the population could realize that shirking from work will lead not to welfare support, but to severe punishment. (Pryanikov 2013)

Russian officials not only make references to the practices of the Soviet Union era, but also demonize “‘parasites’—people who lead an asocial lifestyle” (Pryanikov 2013).

Vladimir Putin: Defending Traditional Values

Much of the discussion surrounding social and public health policies in the Russian Federation became structured by politics of morality. The presidential position on public health policy has directly reflected the importance of a politics of morality in defining policy. The end of the 1990s and the first decade of the 2000s were a search for national identity; it became defined through moral values. The metamorphosis of Vladimir Putin’s discourses was evident in his statement to the Federal Assembly in 2013
stating how the Russian Federation and Western Europe have orthogonal moral values. The emergence of traditional values in presidential agendas was very gradual. Political analysts note that the theme of spiritual unity and spirituality are common themes in the agendas of all three Russian presidents and Putin continues this tradition of conservative discourse (Lednev and Tsoy 2012). However, some observers believe that the inclusion of content on traditional values in important speeches made by Vladimir Putin is perhaps not only used to mobilize a conservative electorate base before an election, but has been in fact internalized by the president (Krechetnikov 2012).

Since his first term as president, Vladimir Putin has been mentioning traditional, moral, and family-oriented values in his state speeches, including annual presidential addresses to the Federal Assembly. In 2000, Putin proclaimed in an address to the electorate that “[f]or citizens of Russia, moral values that they initially acquire in the family are of paramount importance” (Bagrov 2000). He also contended that besides common material goals society should strive to achieve “spirituality and morals” (Presidential Address to the Federal Assembly 2015). Vladislav Surkov, the Kremlin’s ideologist at the time, when referring to building social capital in Russia in 2004, concluded that post-totalitarian Russian society was experiencing a moral crisis and was faced with the task of building a “moral majority” as opposed to “scammers and grafters” of the old Soviet times. In 2006, the president mentioned the question of family values in his address. In 2007, he referred to both moral and family values:

The spiritual unity of the people and the moral values that unite us are just as important a factor for development as political and economic stability. It is my conviction that a society can set and achieve ambitious national goals only if it has a common system of moral guidelines. We will be able to achieve our goals only if we maintain respect for our native language, for our unique cultural values, for the memory of our forebears and for
each page of our country’s history. (Annual Address to the Federal Assembly 2007)

Putin stated that moral values could only be religious: “You could say that it is my deep conviction that the moral values without which humankind cannot survive cannot be other than religious values” (Person of the year 2007) Moreover, in a 2007 address, the president stated that 2008 would be the “Year of the Family.” In 2011, addressing the Council on the Development of the Russian Film Industry, Putin discussed moral values in movie content. He called for the Council to not lower the moral standards of viewers and advocated embracing the Hay’s Ethical Code of Cinematography adopted in the U.S. in the 1930s by Russian filmmakers (Working Day, November 21, 2011).

Traditional values became a central part of the 2012 presidential campaign. Putin stressed the spirituality and the unity of Russian people, as well as “partisanship to family values” [приверженность семье]. He announced that he wanted to fight for morality in the media and the internet. Family values and education were also among some of the important points of his campaign program. In his address to the Federal Assembly in 2013, he firmly defended traditional values as an inherent component of Russian culture:

This destruction of traditional values from above not only leads to negative consequences for society, but is also essentially anti-democratic, since it is carried out on the basis of abstract, speculative ideas, contrary to the will of the majority, which does not accept the changes occurring or the proposed revision of values.

We know that there are more and more people in the world who support our position on defending traditional values that have made up the spiritual and moral foundation of civilisation [sic] in every nation for thousands of years: the values of traditional families, real human life, including religious life, not just material existence but also spirituality, the values of humanism and global diversity. (Presidential Address 2013)

During the Valdai Forum in 2013 he stated even more explicitly:
We can see how many of the Euro-Atlantic countries are actually rejecting their roots, including the Christian values that constitute the basis of Western civilisation. They are denying moral principles and all traditional identities: national, cultural, religious and even sexual. They are implementing policies that equate large families with same-sex partnerships, belief in God with the belief in Satan.

The excesses of political correctness have reached the point where people are seriously talking about registering political parties whose aim is to promote paedophilia. People in many European countries are embarrassed or afraid to talk about their religious affiliations. Holidays are abolished or even called something different; their essence is hidden away, as is their moral foundation. And people are aggressively trying to export this model all over the world. I am convinced that this opens a direct path to degradation and primitivism, resulting in a profound demographic and moral crisis. (Meeting of the Valday 2013)

President Putin’s support of traditional values led to a question from a journalists during a press conference in 2014 regarding Putin’s assertion of Russia’s moral values and critique of values in the West. Jill Daugherty noted that in the 1990s and early 2000s, Western moral values were not of utmost concern for the president. The answer that Putin provided was highly consistent with the politics of morality discourse:

What’s important for me is not to criticise Western values but to protect Russians from certain quasi-values that are very hard for our people to accept. The issue is not to criticise someone but to shield us from the rather aggressive behavior of certain social groups, which, in my opinion, not just live the way they like, but also aggressively impose their views on other people and other countries. That is the only thing behind my position on certain issues that you alluded to. (News Conference 2013)

Putin drew from the code of the builder of communism and compared it with religious paradigm. He contended that the code is a “poor copy of a bible,” while he admitted the demise of the Code of the Builder of Communism: “To its place can only come traditional values…Without these values the society will degrade” (News conference 2013).
The most profound manifestation of the politics of morality is expressed through family policy in the Russian Federation. The discourse surrounding family policy is consistently characterized by the need to preserve traditional values expressed by the protection of nuclear family. The Duma Committee on Family, Women and Children, the main body responsible for family policy initiatives, assumed a very conservative position, particularly, under Elena Mizulina’s leadership beginning in 2008. The reification of traditional family values and status of mothers is characterized by a number of laws proposed by the Committee on Family, Mothers, and Children (see for example, Draft of the Federal Law N 664208-6).

The chair of the committee, Elena Mizulina, has long espoused a very conservative position regarding the question of sex education and promotion of traditional family values. Perhaps positions regarding family values expressed by Mizulina and reports regarding her views were somewhat exaggerated by the press. This position is indicative of the conservative discourse permeating discussion of questions related to matters of family and of children and questions related to HIV/AIDS. Policy-makers seek to preserve the nuclear family at any cost; Elena Mizulina suggested including tax for divorces and justified it by the need to protect children in divorced families (Chinkova 2013). In the Concept of Family Policy, Mizulina described traditional family values as “strengthening and development of the institution of family, preservation and restoration of traditional family values” (Concepts 2013, 12). She continues noting how the “restoration of spiritual pillars of family life is at the same time
overcoming of spiritual vacuum of the society as a whole” (Concepts 2013, 31). Further expounding, Mizulina notes:

In the folk consciousness of an Old Russian man kin (family, relatives, tribe), nationality, Motherland are connected not only by the same morphological root, but reflect the specificity of the world view, the idea of the development of the society. Russian orthodoxy strengthens spirituality of kin and the family. The family is not only a social community of spouses, parents and children, but also a spiritual cell, a “little church.” (Concepts 2013, 11)

Family policy in Russia prefers traditional family with a marriage between two heterosexual individuals. Other unions, including common law marriages and single motherhood are considered to be inferior: “Compared to year 1990 the number of registered common-law marriages has decreased to nearly a third by year 2000. Young couples increasingly refuse to officially marry” (The Conception of the Demographic Policy of Russia Until 2015 cited in Isola 2011, 19). The choice of non-neutral language such as “refuse to officially marry” expresses the normative position of the legislators (Isola 2011, 19). Legislation on family policy also employs vocabulary of the Orthodox Church (Isola 2011, 27).

Nevertheless, while the government’s policy stresses the importance of family values, it does not postulate that it is the responsibility of the government and society as a whole. Instead, the individual is ultimately and exclusively responsible, for child-rearing and for their own self. (Isola 2011, 27). The sources of and solutions for family problems reside within the family. (Isola 2011, 27). This position of the government is consistent with a politics of morality discourse that stresses the responsibility of an individual for social sins.
Politics of Morality and Protection of Children

Persecution of Homosexuality in Russia

The moral debate surrounding the protection of family values manifested itself in the persecution of social groups that allegedly represent a threat to family values and infringe upon the purity of children. Persecution of homosexuality on the legislative level is one of such cases. Many government officials became crusaders for the protection of family values and children from the perceived threat of homosexuality. Deputy Olga Batalina contended that “[e]rasing the differences between genders, of traditional family values—is a serious destructive blow for any society, its moral values, leading to demographic catastrophe” (Rossiyskaya moral' 2014). Russia adopted the stance of prohibiting the “sin,” but not the “sinner.” According to this policy, “being lesbian, gay, bisexual, transgender or queer is not banned and LGBT citizens enjoy all the same rights and protections as heterosexual citizens, provided they do not transgress societal norms in public” (Wilkinson 2013, 5).

While homosexuality was de-criminalized in 1993, in 2013 the Duma adopted the law against the “propaganda of non-traditional sexual relationships” (Federal Law of June 29, 2013 N 135 -FZ). Propaganda is loosely defined as:

distribution of information that is aimed at the formation among minors of nontraditional sexual attitudes, attractiveness of non-traditional sexual relations, misperceptions of the social equivalence of traditional and non-traditional sexual relations, or enforcing information about non-traditional sexual relations that evokes interest to such relations. (Federal Law of June 29, 2013 N 135 -FZ)

The lawmakers explicitly state that the main purpose of the law is to protect children from the propaganda of homosexuality. The discourse is structured as a politics of
morality discourse. The lawmakers emphasize the purity of children and the value of heterosexual relationships as well as identifying threats in society that can challenge these values.

References to children’s purity in discussion of anti-gay legislation is ubiquitous. Dmitry Kozak, the Russian deputy prime minister overseeing the Olympics in 2014 commented: “Please, do not touch the kids” (Lally 2014). The desire to protect children from sex has also appeared on the political agenda: “I believe that we should not tell children that there is sex” (Gasparyan 2014).

The road to the development of protection of children laws in 2013 was paved by President Dmitri Medvedev who put the question of protection of children in the center of his attention, emphasizing the importance of children more than any president before him. In 2009, he expressed his desire to protect children from violent crimes (Medvedev urges action 2011). In 2009, Medvedev signed laws on social support of orphaned children and changed the law on the guarantees of the rights of the child (President Rossii, Dokumenty 2009). In 2011, Medvedev also called for stricter punishment for people who commit crimes against children younger than 14 (Sokolova and Tkach 2011). The president’s initiative is the fourth one during that Duma tenure.

When amendments to the Federal law “On Protection of Children from Information Harmful to Their Health and Development” were included, stipulating protection from information on non-traditional relationships, they were almost unanimously adopted by the Duma (Stenogramma June 11, 2013). It is explicitly stated in the Federal law that the aim of the amendments to article 5 of the Federal law is to protect children “from information that promotes negation of traditional family values” (Federal
Law of June 29, 2013 N 135 -FZ). This focus to protect children from harmful interests is still on the agenda of some members of the Duma. Elena Mizulina, for example, decided to protect children from profanity as well. Mizulina suggested blocking websites and forums where profanities are used.

Protection of children from sex education

In 2005, a member of both the Moscow City Duma and the Healthcare Committee initiated a program of abstinence in Moscow. Her campaign contended that safe sex does not exist and claimed that condoms have very limited protection against sexually transmitted diseases. Billboards of this campaign contained the following slogans: “The true feeling and faithfulness to your loved one is the protection against AIDS;” “Safe sex’ does not exist”; and “[A condom] protects…but does not guarantee safety!” Earlier, in 2004, Stebenkova contended that “[t]here is a capture of our market by the international sex industry” (Emelyanenko 2004). Stebenkova urged to instill control over sex content in media:

I never was afraid and I am still not afraid to be a hypocrite. There are universally recognized moral values. They are pillars of society for centuries. All attempts to revise them in any direction of tightening or decadency (the latter we are currently undergoing) are doomed. (Emelyanenko 2004)

Stebenkova expressed what emerged as consensus among policy makers and in society regarding protection of children, particularly from sexual depravity: “One cannot experiment on children” (Kostinskiy 2007).

Some legislators seek to protect children and teenagers from any kind of information with sexual content. Mariya Maksakova, a member of the State Duma and one of the authors of the law states the following regarding the new law: “It concerns the
priority of information with sexual content over other values: shared humanistic, family and cultural. We would like for the information that prioritizes sexual content not to be in such free access for teenagers” (Nedelya 2014).

*Juvenile justice*

Politics of morality in Russia, with its goal to resurrect traditional family values, shape juvenile justice policies in the Russian Federation as well. Politics of morality also seek to protect children from any immoral influences. Yet the Russian Federation rejects international juvenile justice legislation. Russia ratified the European Convention on Children’s Rights; however, both policy makers and the Orthodox Church opposed its implementation because they found recommended interventions threatening to family values. The Concept of Family Policy drafted to last until 2025 vehemently opposed the priority of children’s rights as opposed to the rights of the parents citing UN legislation including the UN Convention on the Rights of the Child (Concept 2013, 25).

*The Russian Orthodox Church*

The Russian Federation conceptualizes itself as morally superior compared to other states in the Western World and as a defender of traditional values concerning family, purity of marriage, and claims the practice of an authentic Christianity (Korejba 2014). In light of this moral distinction, the Russian Federation condemns European homosexuality. During the 45th UN Commission on Population and Development in April 2012, the delegation representing Russia defended family values and opposed clauses supporting rights of sexual minorities (Rossiya i ryad 2012). This position was buttressed by Alexey Komov, who represents the Russian Orthodox Church’s
Commission on the Family and Motherhood and the World Congress of Families in Russia, stating:

For the majority of Russians, family, motherhood and fatherhood are immutable values. One of the priority goals of the analytical center “Family Politics of the Russian Federation” is to make the voice of the Russian society in protection of family and morality to be heard on the international level. We hope that our work will help to return to the true understanding of fundamental norms of international law, where natural family and its rights take central place. Without participation of representatives from Russia, it is hardly possible to overcome international influence of the supporters of radical ideas, destroying family and society. (Rossiya i ryad 2012)

Komov contended that, in the international arena, Russia is the last bastion of moral values [nравственных ценностей] (Rossiya-Posledniy Bastion 2013). Russia disputes the support of gay rights by international bodies. Komov complained that the UN and other international bodies force non-Western countries, including Russia, to interpret international law in such a way as to legalize gay parades and gay marriage, as well as the rights of gay parents. However, Komov claims neither the United Nations, nor any other international organization, stipulates such protection of gay rights (Rossiya-Posledniy Bastion 2013).

3 Sex Education: Policy Continuity

**Sex Education in the Soviet Union**

With the policy of Glasnost adopted, the realities of Soviet life became more transparent. The state of affairs related to sex and sexuality in the Soviet Union was not an exception. Famously, on July 17, 1986, during the Leningrad-Boston TV bridge, when an American woman brought up a question regarding sex in the Soviet Union, a Russian
counterpart revealed that sex in the Soviet Union did not exist (Riabova and Riabov 2002). Subsequently, the phrase became an anecdote. It very aptly captures policy shortcomings towards sex, sexuality, and sex education in the Soviet Union. The sexual revolution did not reach the USSR either in the 1960s or in the 1970s when it emerged in the West. Soviet citizens in the 1980s were still uninformed about sex education, contraception, and were ashamed to discuss sex. These attitudes towards sex were shaped and reinforced in the country by a conservative politics of morality.

Sex education is a part of the international consensus on HIV/AIDS; however, all current attempts to implement it in schools in the Russian Federation were thwarted by policy makers. Sex education policy is part of the response to the HIV/AIDS epidemic that has been most noticeably affected by the attitudes that emerged in the Soviet Union towards sex and sexuality and the politics of morality. Below, I outline sex education policies in the Soviet Union and the Russian Federation, show their continuity, and influence on morality politics and their development. Since the questions of sex education are closely tied to the women’s issues and the policies of family planning as well as social and health policy, I will also examine these policies to the extent that they help us to understand the policies and attitudes towards sex education.

Questions regarding family planning and attitudes towards sex and contraception are explained in the literature, primarily, by the utilitarian demands of the Soviet State (Lapidus 1978). Gail Lapidus, for example, argues that the revision in family planning policy and attitudes towards abortion can be mainly explained by declining birthrates (Lapidus 1978, 112). Abortions were made illegal in 1936 in an attempt to address the question of declining population growth (Lapidus 1978, 113). However, I show that
morality politics were one of the decisive factors in regulating the sex sphere in the
Soviet Union. Attitudes towards sex education, sexuality, and contraception in the Soviet
Union and the Russian Federation can be understood only in the historical context of
morality politics.

1920s

An historical investigation of sex education in Soviet Russia sets the background for the current debates that the Russian Federation is facing regarding sex education and its policies on HIV/AIDS. The question about the nature of sex, sexuality, and the attitudes towards sex education emerged in the 1920s, when debates regarding the make-up of the new society were taking place. In tsarist Russia, matters of sex, family, and relationships between sexes were regulated exclusively by the principles of religious morality: for centuries, Russia was an Orthodox state. Yet, with the Socialist Revolution, a religious foundation that organized pre-revolutionary Russian society, crumbled. Following the revolution, new foundations of the society, consistent with Marxist doctrine, explicitly excluded religion.

The re-evaluation of the question of sex education became a by-product of re-examination and re-negotiation of other important questions such as gender equality, the role of women in the Soviet Union, and conceptions of the family. These issues were examined by the state both from ideological and developmental perspectives. However, I will demonstrate that matters related to the family, the woman question, and sex were not regulated primarily by the economic needs of the growing Soviet State, but by the politics of morality as well. First, I will review the emerging debates regarding family matters
and then I will examine these questions through the lens of a politics of morality. Then, I will demonstrate the emergence of morality education that replaced sex education in addition to neglecting contraceptive policies.

Women and the Family Question

After the Bolshevik Revolution, the state was faced with the problem of establishment of new norms and in particular the norms that would address gender inequality. New legal norms regulating political, civic, economic, and family spheres needed to be codified. In the first years of the Soviet Union, the unequal position of the woman in society needed to be addressed to ensure complete political and civil equality of women. The question of sexual liberation was closely linked to the question of the family in policy matters (Lapidus 1978, 82). Write a paragraph about the failure of Bolshevik plan to establish equality.75

The Marxist intellectual tradition viewed family as a social construct, rather than an immutable biological need. The Soviet policy was seeking to implement these ideals into law and practice. The legislation was seeking to alter the role of the family and the woman’s role, attempting to achieve equality. This remaking of the family to suit the new

The Soviet project to establish gender equality failed eventually. Women became part of the work force. However, this did not bring liberation, but further disempowered them by the “double burden” of earning wages and having full responsibility for unpaid domestic labor. In regards to gender equality, Soviet projects had the same effect as observed during the Cuban revolution. Johnetta Cole maintains that in Cuba, despite changes in policy, change in actual practices did not occur because informal norms and practices of the old regime persisted (Cole 1982). This discrepancy between policy outputs (actual policies adopted) and policy outcomes (their effectiveness on the ground) was very evident in the Soviet Union as well.
Soviet ideal led to questions about sexual equality, the place for sex, and the boundaries of sexual promiscuity.

The official policy line was to weaken the traditional family, without encouraging promiscuity (Lapidus 1978, 85). Yet, the question was far from settled among the founders of the Soviet state and women activists of the time. Some advocated a much more radical approach to regulation of the family, gender equality, and views of sexual liberation. Activists like Alexandra Kollontai asked how to reconcile maternity and “free love,” and whether free love was at all possible:

And the question of maternity preys on the mind of the woman who strives for freedom. Is “free love” possible? Can it be realized as a common phenomenon, as the generally accepted norm rather than the individual exception, given the economic structure of our society? (Kollontai 1977, 9)

While Kollontai was trying to define different views of sexual morality and family (Lapidus 1979, 86), these views were not consistent with the larger views of the party (Sypnovich 1993, 289). While there was a grassroots feminist mobilization in the early years of the Soviet Union, which challenged traditional notions of women’s roles in society and of sex and sexuality, it remained marginal; ultimately, more conservative attitudes within the party prevailed (Sypnovich 1993, 289). Efforts of an early feminism to incorporate sexual liberation into the Soviet developmental plan were unsuccessful. A possibility to re-negotiate policies regarding sexuality and sexual liberation existed in the early Soviet society. Yet very different forces won and eventually shaped policy regarding sex and sexual education in Soviet Russia.

Lenin also expressed his concerns regarding sexual liberation. The main fear within official party circles was the association of free love with immoral behavior (Lapidus 1979, 88). In the end, sexuality was subsumed within a larger societal project.
Sexual conservatism prevailed within the party and Aleksandra Kollontai and others were ostracized.

In the mid-1920s, a new strand of thought was developed that prescribed sexual abstinence before marriage, sexual restraint within marriage, monogamy, and reproduction as one of the major obligations to society (Lapidus 1979, 89). Psychiatrist Aron Zalkind published *The Twelve Commandments* that recommended sexual behavior based on the proletariat ethics. While it is not clear whether these commandments directly shaped policies of the Soviet government on sexuality and sex education, policy treatment of these questions by the government were constructed in the wake of these commandments. The idea behind the Commandments was that “the energy of the proletariat should not be deviated to sexual connections, irrelevant for its [proletariat’s] historical role” (Stepanov 2004). Zalkind had a strong influence on education as well and became involved with the newly emerged discipline “pedology,” a new science about children. He also chaired a commission which was supposed to develop the research program of the newly developed discipline.

In the 1920s, research on sex and sexuality continued in Russia. Surveys were conducted and the Soviet Union was scheduled to host the congress of the World Sexual Reform League where it was supposed to participate; however, the congress that was supposed to be held in Moscow never took place (Kon and Riordan 1992, 23).

The Soviet policy regarding the woman question and child rearing demonstrates that the legislation of the 1920s was progressive. However, the notions dictated by the Soviet ideals were difficult to materialize due to socio-economic conditions of the country. What followed were increased divorces, unwanted pregnancies, prostitution, and
sexually transmitted diseases that were all a great cause for concern (Kon 2010, 219). The discourse that emerged in the intellectual Soviet circles demonstrated that the intentions of the early Soviet government were not yet tainted by the newly emerging moral politics of the state. The moral politics of the Soviet government at the time regulating women and reproductive health did not insist on the moral primacy of saving the fetus in abortion decisions is a significant indicator.

This early discourse in the Soviet Union and early policy direction shaped similar policy development on prevention and sex education at later points in time. The initial attempts of sexual openness, like the ones undertaken by Alexandra Kollontai, were replaced by conservative views on family. The family was constructed in moral terms, as a unit in society that needs protection from harmful external influence and interference. This position on the family had ramifications for sex education, eventually placing it in the hands of individual families.

1930-1955

The shift in moral politics of the state is clearly observed in the 1930s. This shift is particularly noticeable in policies regulating sex and sexuality. At the same time a reassessment of family policy was taking place. Changes that occurred under Stalinist regime were those of radical transformation, on the one hand, and of social conservatism, on the other hand (Lapidus 1979, 110). Soviet policy was shifting from efforts to establish gender equality back to exalting traditional family values.

Soviet family policies demonstrate a reproduction of the ideology and politics of the regime. In the 1930s when a demographic situation in the country worsened, the
family again became the focus of Soviet policy. Locating problems solely within the family was accompanied by a decisive denunciation of previous efforts of sex egalitarianism and sexual liberation: “so-called ‘free love’ and all disorderly sex life are bourgeois through and through, and have nothing to do with either socialist principles or the ethics and standards of conduct of the Soviet citizens” (Pravda quoted in Lapidus 1979, 112).

Under the new state ideology, family stability was praised. At the same time, what was perceived as sexual deviance was punished. While some of the factors behind the desire of Stalin’s regime to strengthen the family unit and address the problem of declined fertility in the country were economic, attitudes towards sexuality, sexual behavior, and perceived sexual deviance and policies regulating these areas of life of Soviet citizens cannot be explained by the demands of the industrial state alone. The ban on homosexuality was reinstated in 1941; abortions were outlawed in 1936. At the same time, the forging of a new communist morality was underway. The emerging Victorian politics of the state regulated policy issue areas of sex and sexuality.

The ideology of the state is reflected in the education and sex education research performed under the Stalinist regime. One of the theorists of education, Anton Makarenko, contended in Lectures to Parents (1937) that while family was essential for the education process, “that sex had not achieved as much prominence as in the West because it was treated as a normal part of collective living in the FSU” (Williams 1994, 82). In his letters to parents, Makarenko stated:

And so by developing honesty, industry, sincerity, straightforwardness, habits of cleanliness, of telling the truth, respect for other people - for their experience and for their interests - love of country, devotion to the ideas of the socialist revolution, we are, at the same time, educating the child in sex
relations. Some of these methods are more pertinent than others to sex education but all taken together contribute to your success...to bringing up the future husband or wife. (Makarenko 1937)

Makarenko disagreed that special methods of sex education should be implemented. He found that “[s]ex education should be education for love, the cultivation of deep feeling, which beautifies the whole of life, its strivings and hopes”76 (National Council of American-Soviet Friendship 1961). He continues noting how “[n]o talks with children about the ‘sex’ problem can add anything to the knowledge that will come of itself in good time. But they do cheapen the problem of love, they rob it of that restraint without which love is called license” (Makarenko in Field 2007, 51).

Makarenko believed that sexual education of children would be achieved through moral education within the family. His views on education influenced policy on education for the state. Makarenko’s views on sex education were also a reflection of the general politics of morality at the time. The official ideology reflected Makarenko’s views on education and sex education in particular. These were major reasons why sex education during Stalin’s era were practically non-existent. Morality within society and particularly after World War II took a puritanical turn (Kon and Riordan 1993, 24).

Khrushchev 1955-1964

Morality politics became important during Khrushchev’s tenure. This period is characterized by the adoption of the “Moral Code of the Builder of Communism” in

76 These texts are lectures that were given by Makarenko over the radio in 1937. They were published in the Literaturnaya Gazeta after he died in 1939, and also in the Collected Works of Makarenko, Vol. 4, 1951. These were the first English translations of those lectures.
1961. Behind the emergence of this document is the desire of the official party to legitimize its rule and to control the private lives of citizens, not via imposition of strict legal controls, but through implementation of moral regulations (Field 2007, 12). To achieve this goal, private lives of people were made a public matter.

“The Moral Code of the Builder of Communism” stressed the importance of the “respect in the family” and “concern for upbringing of the children” (the Moral Code 1961). These views on the family came to signify the importance of sexual continence within the framework of Communist morality (Field 2007, 54). Sex education was perceived as the most effective measure to address both immoral sexual behavior and sexually transmitted diseases by health workers. However, sex educators made a link between sexual activity and what it would mean to be a moral citizen. It repudiated those sexual activities which, in accordance with the concept of communist morality, were perceived to be immoral: adultery, premarital sex, and masturbation.

Homosexuality remained one of such subjects explained through moral distinctions of “us, “or the moral Soviet citizens, and the immoral “them,” the Cold War enemy. Homosexuality was explained as both the lack of education and deleterious Western influence (Koptiaeva 1963 in Field 2007, 56).

1980s

It was only until the early 1980s the policy makers in the Soviet Union were able to start thinking about implementing sex education programs. Introduction of rudimentary sex education in schools was the outcome of the contentious debate within the Ministry of Public Health [Narkomzdrav] (Willims 89, 1994). Several pilot projects
were implemented to address the issue of sex education. In 1983, the Education Ministry of the USSR adopted a course in “hygiene and sex education” for 15 year-old students and “ethics and psychology of family life” for 16 and 17 year-old students. However, despite the fact that such programs were introduced, they were sex education programs in name only: “in practice almost nothing of what was taught within the recommended curriculum corresponded to either the principles or the goals of sex education” (Shcheglov 1993, 158 in Kon and Riordan 1993).

While there existed will to introduce sex education, the problem faced by the Education Ministry was a lack of trained sex education experts. Students in medical and education professions did not receive sex education training and did not receive systematic information on the matters of sex and sexuality as well. The Ministry of Health finally decided to correct this problem by instituting the choice to specialize as a “sexo-pathologist” in 1988 and organizing education for this specialization (Prikaz Minzdrava 1988).

Sex Education in the Russian Federation

The 1990s in Russia was a period of large scale reforms. The debates on the implementation of sex education were taking place at the time of Russia’s entry into the Council of Europe and adoption of legislation that would bring the country into compliance with the norms of international law. Initially, sex education reforms were supported by the Duma and the Ministry of Education, as well as by public opinion. The initiative to implement sex education in schools in the mid-1990s by the Ministry of Education was the only time when these reforms were supported by the state. Surveys
reflected that the majority of the Russian population, including educators, also agreed that sex education in schools was necessary (Kon 2010, 518). However, surveys also revealed that there was no consistency across respondents regarding the content of such sex education programs. Sociologist Igor Kon, contended that to implement sex education, input from sex education specialists was necessary and it was absent in Russia at the time (Kon 2010). The initiative to implement sex education programs was also supported by the Family Planning association created in Russia in 1991.

It was the Ministry of Education and medics who eventually initiated the implementation of sex education programs in 1997. In the Duma, the initiative to implement sex education was supported by a prominent member, Ekaterina Lahova, who became an advocate of the project of sex education in schools and of modern contraception (Kvitkovskaya 2003). The project of sex education was established within a larger program, “Children of Russia.” When the Ministry of Education created an expert committee in 1994 to implement education programs in the country, domestic expertise was not established and the Ministry of Education decided to use foreign experience. It was decided that the pharmacological company “Organon” would provide expertise for sex education programs. It offered the Russian Federation the use of its school education program pro bono. The organization only offered Russia technical expertise. The Russian Federation then turned to the UN for financial assistance and received funding (Kon 2010, 521). Although sex education programs were created by the domestic experts soon they were pejoratively named a “UNESCO project,” stressing a negative Western character and influence over the content of these programs. Igor Kon contends that this association of sex education programs and lack of their adaptation to
the Russian context led to the rejection of these programs and sex education entirely. Anti-Western discourse only exacerbated the situation. However, while the rejection of sex education in schools was indeed a part of the anti-Western discourse in the Russian Federation, it did not emerge as a response to these programs. Rather, these programs were not consistent with the already existing politics of morality in the Russian Federation.

The government initially decided to create a planned parenthood center focused on reproductive health and delegated this task to the Ministry of Health to fulfill in 1998-2000 (Government Decree from September 19, 1997 N 1207). UNESCO-sponsored sex education projects caused a backlash throughout society and the media. In its report to UNESCO in 1998 the Russian Ministry of Health stated that the implementation of the project of sex education was being delayed in the Russian Federation; however, it was not being completely terminated (Yearly report for 1998 of the Ministry of Health). It was mentioned in the report that it was recommended to rename the project; new titles would exclude evocations of sexual education and would stress “reproductive health” [reproduktivnoye zdrovye shkol’nikov] or “healthy life style” [vospitaniye zdrovogo obraza zhizni detey i podrostkov] instead. This decision was made by the Ministry of Health in accordance with the decision of the Duma.\textsuperscript{77} The official document cited inconsistencies between sex education programs and the tradition of “sexual moral

\textsuperscript{77} Officially the work on the project was suspended by the directive of the Ministry of Education of Russian from April 22, 1997 N 781 in accordance with the decision of the State Duma from March 10, 1997.
education” [polovoye vospitaniye] in the Russian Federation. Most of the health specialists were also against sex education citing the danger of “an undesirable interest in sex among teenagers” (Group Aims 1997). Psychiatrists particularly opposed sex education for the fear that it might lead to “psychological pathologies and spur drug addiction and alcoholism” (Group Aims 1997). The Planned Parenthood Center was soon terminated and authors of the project “Planned Parenthood” [planirovaniye sem’yi] were called to the prosecutor’s office for explanations; however, the charges were never brought up (Bitva 2006).

In the Duma, the bill on reproductive rights of the citizens was being prepared. The Duma member Ekaterina Lahova, the head of the President’s Advisory Committee on Women, Family and Demographics had initiated the bill. However, with the change of the leadership in the Committee on Women, Family and Demographics, the law on reproductive rights was stalled. The bill caused much debate. The paramount concern in the Duma was that “politics of family planning—is the politics of moral disinhibition of our children” [politika rastleniya nashikh detey] and decline in population as a result of family planning was listed as a secondary concern (Stenogrammy, February 5, 1998). The initiator of the bill tried to appeal to the rational aspects of the law on family planning, such as decreases in maternal mortality and in child pathology (Rodionova). However, the program of “Planned Parenthood” was portrayed in the Duma as a direct threat to children (Krivelskaya 1997). It was particularly problematic that the program was included under the umbrella of a larger presidential program “Children of Russia”

78 The resolution of the Ministry of Health from May 27, 1997 N 6/1.
79 Minister of Health Degree from January 8, 1998 N1.
along with such programs as “Orphan children” and “Children with disabilities”. Aspects of the “Planned parenthood” program were also included into a federal program “Safe motherhood” [Bezopasnoye materinstvo].\textsuperscript{80} This was often a point of reference for policy-makers: the argument was that instead of funding those more important programs, the funding was directed to the “moral disinhibition” of “our children” (Krivelskaya 1997).

In 1999, a medical journal published an open letter to the Minister of Education, Philippov, against sex education (Otkrytoye Pis’mo 1999). The letter was signed by leading scientists and members of the Orthodox Church. The letter stated that the scientists were against the discipline of “valeology” [valeologiya] taught at schools that, according to the authors, not only promoted a healthy lifestyle, but introduced Western models of sex education in Russian schools (Otkrytoye Pismo 1999). After the failure of the first attempt to implement sex education programs, they were largely abandoned. Sex education as a separate subject is absent from school curricula; the questions of reproductive health are discussed within different disciplines such as biology and basics of life safety courses.

Following this unsuccessful attempt to implement sex education in schools, other attempts by the state were stymied. The 1990s and the early 2000s can be characterized by the forging of a new identity of the Russian state and re-emergence of conservative ideology. This time it was influenced by the Orthodox Church that found its place into Russian politics. The analysis of minutes from the Duma meeting and the survey of the media reveals that a discussion of sex education is absent from the public sphere. A

\textsuperscript{80} Government Directive from October 14, 1994 N 1173 “About the Federal Programme “Safe motherhood.”
comprehensive program of reproductive health in the Russian Federation is also absent (Shabunova 2005, 75).

By the end of the first decade of 2000s, politics of morality and reification of traditional values started to play a prominent role in defining policy. The discussion of sex education at the end of this decade is firmly framed by the politics of morality discourse. The international community continuously urged Russia to adopt sex education in schools. However, despite the fact that Russia adopted international legislation encouraging sex education, these laws were interpreted by the Duma to omit sex education.

In 2006, the Russian Federation ratified the European Social Charter that guarantees, among other rights, a “right to protection of health.” In the European Union interpretation of this document the implementation of sex education in schools is stipulated (European Social Charter (revised). Conclusions, 2005: 339). Nonetheless, during the process of ratification of the charter, the head of the Russian Orthodox Church and representatives of the United Russia party met to discuss the charter. Patriarch Kirill expressed deep concerns over the possibility of the implementation of sexual education and juvenile justice, but the representatives of United Russia reassured him that such interpretation of the Charter would not be implemented (Lipich 2009).

In 2009, the Moscow City Duma adopted a law on HIV/AIDS prevention. One of the more important measures, which this new law stipulated, included propaganda regarding family values, such as chastity before marriage and faithfulness in marriage (Gorbacheva 2009). The progressive newspaper, Novaya Gazeta, contended that all of
these values are good as aspirational, however hardly feasible in practice (Gorbacheva 2009).

In April 2013, the State Duma ratified implementing the optional protocol outlined by the Convention on the Rights of the Child that addresses issues of child trafficking, child prostitution, and child pornography as well as the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse. The interpretations of these conventions in Europe stipulate mandatory implementation of sex education in an attempt to protect children from sexual violence. However, in Russia, these conventions are interpreted differently. Resistance to the programs comes from high-ranked government officials. Pavel Astakhov, the Children's Rights Commissioner for the President of the Russian Federation, commented that adoption of these documents might lead some to believe that sex education is a part of these conventions. However, Astakhov warns that early sex education has its own hidden dangers:

I want to draw your attention that incorrect [nekorrektnoye] interpretation and use in educational practice of the mentioned provision of the Convention without accounting for Russian cultural, educational and family values and traditions can harm children’s development, negatively reflect on moral and psychological health of growing generation, facilitate widening of the involvement of the minors into different forms of sexual exploitation. (Astakhov 2013)

In another instance Pavel Astakhov contended that the best moral education [polovoye vospitaniye] is found in Russian literature: “[i]t is imperative to read more to children: there is everything – about love and about relationships between sexes. The school should provide chastity in moral education, in the spirit of understanding of family values” (P. Astakhov: Luchsheye). He sent letters to the Minister of Education and ombudsmen in the regions warning against implementation of sex education in schools. Astakhov contended that sex education “deprave[s] a child” and “does not prepare him to
any kind of life” (Rossiya 2013). He stressed the necessity of abstinence and suggested that sex education must be banned legislatively (Astakhov predlozhil 2013).

Religious organizations were also in opposition to the signing of the treaties by the Russian Federation (Yelizova). However, the population in Russia, according to surveys, is not as adamant about ideas of planned parenthood as policy-makers. According to the surveys, 77 percent of Russians supported ideas of family planning (Levada-tsentr survey 2013). Therefore, resistance to implementation of sex education in schools cannot be explained by public resistance to sex education in the Russian Federation.

The Morality Education Tradition

The moral education tradition remains an important aspect of the Russian education tradition. The research of the role of the moral education for child development remains one of the important aspects of research agenda in child education. While the Orthodox Church is concerned with morality education, support for morality education stems not only from the Church. The analysis of research on moral education reveals two trends in the literature. On the one hand, the literature advocates continuing morality education in schools (Divnogortseva 2007). On the other hand, it rejects sex education in schools entirely, relegating it to the realm of the family.
Religious literature on the dangers of sex education makes many spurious claims on dangerous consequences of sex education. Some claims are directly associated with the HIV/AIDS epidemic, for example, that condoms do not provide effective protection against HIV infection (Medvedeva and Shishova 2004, 36; Tsareva 2007).

While the Orthodox Church allegedly represents society as a whole and should serve as a platform to view individuals as being equal, publications informed by religious sentiment strongly reflect othering of individuals with HIV/AIDS and homosexuals. One part of sex education programs is teaching society about the acceptance of people with HIV/AIDS and about the fact that HIV/AIDS is not a death sentence. Some studies, nevertheless, maintain that creating a positive image of people with HIV/AIDS is inappropriate (Medvedeva and Shishova 2004, 33).

Scientific Publications

The Russian Academy of Education continues active research on the benefits of morality education. A number of scientific publications criticize any attempts to incorporate Western-style sex education into education. They maintain that sexual culture in Russia historically was absent and therefore they perceive Western notions of “safe sex” as harmful for Russia (Strakhov 2008). Moral education is perceived as an important factor in the education system as a whole. Lack of moral education is allegedly a source

81 Some contend that sex education leads not only to increased abortions and rates of HIV/AIDS, but to cancer, impotency, high rates of rape, increase in the rates of homosexuality, drug addiction in children and teenagers, high rates of children out of wedlock, a decrease in birthrates, high rates of neuro-psychological diseases, and high rates of sexual abuse (Medvedeva and Shishova 2004).
of many ills for children and teenagers. Some claim that absence of morality education can lead to deviant behaviors in teenagers (Zhiginas, Grebennikova and Zvereva, 2014).

Conclusion

This section demonstrates that the Russian Federation has a tradition of morality education—vospitaniye—which began in the early Soviet Union. This tradition delegates discussion of “safe sex” practices to the nuclear family and excludes these matters from public school and other discussions. This section also shows that vospitaniye was defended in the Duma through politics of morality arguments. Protection of children was invoked as the main argument to reject other practices of sex education. Discussions in the Duma of other social policies also reveal that one of major arguments in their support is an appeal to the protection of children and traditional family values.

4 Contraception Policies and Prevention of HIV/AIDS

International legislation stipulates that both primary and secondary methods of prevention should be implemented in response to the HIV/AIDS epidemic. Primary prevention of HIV/AIDS is regulated through the existing regime of prevention of sexually transmitted diseases that falls into several policy areas. While overlapping, they have distinctive objects of regulation: family planning, reproductive health, women’s health, and prevention of sexually transmitted diseases. Contraception, prevention, and treatment of STDs are discussed in policy documents within these issue areas. In the Russian Federation, primary prevention of HIV/AIDS is nearly absent. To understand the origins of the state’s policies and government’s stance on the prevention of HIV, I
examine policies within the abovementioned issue areas, draw on a range of federal legislation and legislative initiatives of the Ministry of Health and the Ministry of Education, and other sources of legislative initiatives. I show that prevention politics both in the Soviet Union and in the Russian Federation were shaped by politics of morality.

The fastest growing HIV/AIDS epidemic in Eastern Europe is not the only outcome of the policy regulations in the Soviet Union and in the Russian Federation. Lack of contraception and outdated ideas and beliefs regarding family planning are reflected in the prevalence of abortions as a method of contraception that emerged in the Soviet Union. This trend persisted in the Russian Federation and is characterized by high levels of abortion even with increased knowledge and accessibility of contraception among the population (Karpov and Kaariainen 2005). The Soviet Union was by far an outlier in the levels of abortions in the world (Popov 1991). The country has had the highest rates of abortion than any other country since at least the mid-1950s (Remennick 1993, 45). These high rates of abortion also correlate with low rates of using contraceptives. While high rates of abortion are caused by many factors, the most influential ones are a near absence of family planning methods and restricted availability of services and contraception (Popov 1991, 376). After the fall of the Soviet Union, Russia was less successful than other states, like Ukraine and Belarus, for example, in decreasing rates of abortions (Denisov, Sakevich and Jasioniene 2012)

While abortion and family planning policy changed throughout the Soviet Regime, the general attitudes towards matters of sex, sexuality, and contraception remained intact. This cluster of policies regulating reproductive health is very closely linked. I will examine general changes in these policies during the Soviet Union and
particularly, I will examine the issue of contraception. These particular policies became consequential in the 1990s and 2000s when the HIV/AIDS epidemic and prevention of sexual transmission of HIV/AIDS became an urgent matter in the Russian Federation.

\textit{Policies during the Soviet Union}

\textit{Abortion and Contraception policies}

In the aftermath of the October 1917 Revolution, social policies were reconstructed in accordance with the newly adopted socialist ideals of the reconstructed state. The makers of the Soviet Union were seeking to achieve equality and emancipate women. These ideas found their expression in legislation regulating marriage, divorce, and abortion. From 1917 to 1920, abortions in the Soviet Union were still illegal as in Czarist Russia; however, Lenin “advocated legalization of abortion and the dissemination of contraceptive information.” He contended that ‘one of the basic rights of women was that of deciding whether her child should be born” (Lenin Volume 19, 206-207 in David 1970, 44). In 1920, abortion was legalized by a joint degree of Commissariats of Health and Justice (David 1970, 44). During the period from 1920 to 1936 the Soviet Union was the only country in the world which offered abortions free of charge and at the request of a woman (David 1970). The legalization of abortion was not, however, matched by adequate policies of contraception, family planning, and sex education; consequently, abortion emerged as the dominant form of contraception.

The legalization of abortions led to a dramatic increase in abortion rates. Some statistics demonstrate that by 1934 the number of legal abortions reached 700,000 a year while the number of births was at 3 million a year; the number of abortions exceeded the
number of births in some city centers (David 1970, 45). Subsequently, the 1935 decree made abortion during the first pregnancy illegal and set a six month interval between abortions. In 1936, abortions were outlawed entirely. According to the new legislation, physicians performing abortions could be imprisoned for up to two years. The criminalization of abortions inevitably led to a rising rate of illegal abortions and increased maternal mortality rates in the country. The campaign to criminalize abortion was aided by the emerging moral discourse surrounding the control of deviance and family planning. The emerging Soviet politics of morality and conservative discourse on matters of family planning escalated in 1934. Around this time, the campaign against sexual promiscuity, bigamy, and adultery was initiated in Russia (David 1970, 45).

Only after Stalin’s death in 1955 did the restrictions on abortions finally lift and a decree similar to the one in 1920 was passed stipulating that abortions were legal in the Soviet Union if performed by a qualified medical personal (David 1970, 46). The literature indicates that there might be several reasons to change the position on abortions in 1955. First, criminalization of abortion, absence of contraception, and sex education led to disproportionate increases in the number of illegal abortions; second, the idea of a woman choosing whether to keep the child was consistent with Leninist doctrine to which the country turned against after Stalin’s death (Heer 1965). However, even when the medical establishment recognized that an illegal abortion problem existed and regarded the ban on abortions as detrimental to women’s health, it largely employed a discourse of blame to explain why abortion was prevalent. Doctors attributing blame to individuals rather than socio-economic conditions is consistent with the influence of morality politics setting the framework for policy-making at the time.
Despite the problem of induced abortions, questions of contraception were removed from policy consideration during nearly the entire existence of the Soviet Union. The state chose to regulate abortion rather than to be implicated in matters of sex education and provisions for contraception. The provisions for contraception were addressed only insofar as it helped to resolve the problem of disproportionately high levels of abortions; otherwise, discussion of contraception was taboo (Heer 1965, 539).

While an array of contraceptive methods was available to women in maternity centers, such as condoms, diaphragms, and cervical caps, there is no reliable data on accessibility of contraceptive devices for women at the time. Statistical evidence regarding the scale of the accessibility of contraception varies greatly. Researchers find that anywhere between 40 percent to 52 percent of women practiced various methods of contraception, with condom use (20%) the most prevalent (Chernetskiy survey 1961 cited in David 1970, 52). In a letter from the Soviet Minister of Public Health to the Literaturnaya Gazeta in 1968, Dr. Boris Petrovsky indicated that the ministry intended to make contraception more affordable by manufacturing intrauterine devices, preferring this to the use of contraceptive pills (cited in David 1970, 46).

Discussion of contraception and family planning in the Soviet Union was closely linked to discussion of the emancipation of women (the woman question). Some of the conditions related to family planning and women’s health were recognized during Brezhnev’s era, while some were “whitewashed by ideology or not even mentioned” (Buckley 1992, 202). In 1966 and 1968, more contraception was promised and the question was briefly discussed in newspapers. Then again, the question of contraception received attention in the 1970s when the discussion of female roles and prostitution
emerged. Only when Glasnost was adopted in 1988 as a tool of Perestroika, some of topics related to sex life, family planning, and contraception could be discussed more openly; however, such discussions often lacked analytic rigor (Buckley 1992, 208).

The outcomes of family planning policies, attitudes regarding sex and sex education, and everything that dysfunctional regarding these policies and attitudes could be clearly observed during the formative years of the Soviet Union and immediately after its disintegration. The years of Gorbachev’s Glasnost made possible many inquiries into the political past, facts, policies, and statistics. In 1988, statistics on abortion in the Soviet Union were disclosed for the first time in 60 years when *The Population of the USSR* was published (Remennick 1993, 47). These data drew a deplorable picture of reproductive health, women’s health, and contraception in the Soviet Union. The data demonstrated that rates of induced abortion in the USSR were higher than in any other country in the world (Popov 1991).

The observations regarding induced abortion rates in the USSR and union republics are two-fold. First, comparison with European states based on UN calculations demonstrates that the rates of abortions were disproportionately higher in the Soviet Union (33 times greater than in Great Britain and 12 times the rate in Hungary) (Popov 1991, 373). The Soviet Union was an outlier for rates of abortions, as long as the mid-1950s. Second, comparisons of rates of abortions demonstrate that with exclusion of Ukraine, the rates of abortion in the RSFSR\(^\text{82}\) itself (the current day Russian Federation) was higher than in other union republics (Popov 1991, 371).

---

\(^{82}\text{RSFSR- Russian Soviet Federative Socialist Republic.}\)
The socio-cultural phenomenon of induced abortion as a widespread method of contraception points to the unavailability of modern methods of contraception and the state of policy regulations of family planning. By the last years of the Soviet Union’s existence, 70 percent of female patients in RSFSR’s health centers were not informed about methods of contraception (Ovcharov et. al 1987 cited in Popov 1991, 373). Moreover, the selection of contraceptive methods, 90 percent of the time, was determined by the unavailability of contraception (Popov 1991). Only about 20 percent of the estimated need for contraceptives of any kind was met in the Soviet Union in the mid-1980s (Remennick 1993, 54).

Despite the fact that contraception was, at least in principle, present in the Soviet Union in policy provisions, knowledge about family planning and contraception, as well as sex education, were absent. The need for contraception and sex education were understood only by a small group of medical professionals and scholars; however, this view that there was a need for sex education did not translate directly into policy initiatives.

Some of the most popular women’s magazines published letters from anguished readers reflecting the dire situations regarding contraceptives, condoms in particular. These letters drew a rather accurate picture on the issue of contraception: “In Ufa they [contraceptives, condoms] cannot be bought, not even the most basic ones. Not in one chemist’s! There aren’t enough in Moscow to go there for them … some people are recommending using children’s balloons instead of condoms” (Buckley 1992, 209).

As a result of the Soviet policies on abortion, contraception, family planning, and sex education, the Ministry of Health and the country as a whole were facing an
HIV/AIDS epidemic in a society that was entirely uninformed about prevention of sexually transmitted diseases and contraception. While statistical evidence on the use of contraception in the country was available for the Ministry of Health, it failed to implement aggressive policies to remedy the situation and subsequently failed to address the HIV/AIDS epidemic. On the one hand, this inertia was a result of the path dependence of decision-making in the Ministry of Health. On the other hand, policies that were implemented demonstrate the influence of conservative morality on the policy-making process and individual policy-makers in particular. Another outcome of a reliance on preventive and family approaches is the exacerbation of the situation surrounding the epidemic of sexually transmitted diseases. Beginning in 1989, the rates of STDs became a serious concern for the country.

*The Current Policies of the Russian Federation*

In the Russian Federation, this extraordinarily high rate of abortion persists. High abortion rates in the Soviet Union is a behavioral outcome that reveals a deeply engrained acceptance of abortion by society. An opinion survey conducted in 1998 shows that the acceptance of abortion in Russia is disproportionately higher than in other European states (see Table 8).

*Table 8 Opinions about Abortion in Russia and Selected Post-Communist and Western Societies. ISSP Religion II Data, 1998 (Percentage)*

<table>
<thead>
<tr>
<th>Do you personally think that it is wrong for a woman to have an abortion…?</th>
<th>Always</th>
<th>Almost</th>
<th>Sometimes</th>
<th>Not</th>
<th>Always</th>
<th>Almost</th>
<th>Sometimes</th>
<th>Not</th>
</tr>
</thead>
<tbody>
<tr>
<td>if there is a strong chance of a serious defect in the baby?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>if the family has a very low income and cannot afford any more children?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Such persistence of using abortion as a method of contraception in the Russian Federation can be explained by the fact that the state either failed to develop adequate availability to contraception and sex education policies in the first place, or that those policies were largely ineffective. I argue that the former is true: sex education, contraception, and policies on the prevention of sexually transmitted diseases were neglected by the state.

According to experts studying contraception and family planning methods, individual socio-economic factors are less salient determining factors compared to structural factors; state politics in family planning and sex education are among the most important determining factors (Troitskaya, et al. 2010).

Policy-makers continue to avoid public discussions of contraception, sexual health, and prevention of sexually transmitted diseases. For instance, to address the demographic problem the government enacted “The Concepts of Demographic politics of The Russian Federation to 2025.” While the document seeks to address the problems of induced abortions, low fertility rates, and declined population growth, and terminology such as “unwanted pregnancy” and “abortion” do appear in the text of the document, the

<table>
<thead>
<tr>
<th></th>
<th>always</th>
<th>at all</th>
<th>always</th>
<th>at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Russia</td>
<td>5.8</td>
<td>4.2</td>
<td>9.7</td>
<td>80.3</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>12.3</td>
<td>7.4</td>
<td>11.4</td>
<td>68.9</td>
</tr>
<tr>
<td>Latvia</td>
<td>11.8</td>
<td>7.3</td>
<td>14.7</td>
<td>66.2</td>
</tr>
<tr>
<td>Poland</td>
<td>30.7</td>
<td>10.0</td>
<td>18.8</td>
<td>40.4</td>
</tr>
<tr>
<td>East Germany</td>
<td>9.3</td>
<td>9.2</td>
<td>16.8</td>
<td>64.7</td>
</tr>
</tbody>
</table>

Source: Karpov and Kaariainen 2005, 24
term “contraception” is never mentioned (Troitskaya, et al. 2010, 298). These concepts of contraception did not appear in the regional documents addressing the demographic problem either. Not including information about contraception in the documents demonstrates that the government does not consider contraception as one of its priorities even when it was discussed as important to the questions of family planning and demographic politics.

In 2006, the president made an address to the Federal Assembly indicating that he was concerned with the demographic situation and that measures to address it should be undertaken (Annual Address 2006). However, even then, when the plan of action was developed to be implemented in 2006-2010 to address the problem of abortions, the document did not include provisions regarding prevention of unwanted pregnancies, including use of condoms.

Prior to analyzing policies on prevention, it is fair to say that the implementation of preventive policies remains a matter of concern. Information on condom distribution and availability is rather limited. One report monitoring the HIV/AIDS epidemic reveals that during the time period from 1992-1994, condoms were available at a low cost in drug stores, yet they were not in high demand among youth. Commercial kiosks were also selling condoms, but for rather high prices. However, the report does not find availability of condoms satisfactory. By 1998, condoms were not available at night or on holidays. They were also costly and not affordable for low-income populations.

The Russian Federation was faced with the need to construct a new set of policies which could address the problems of a growing STD epidemic, improving women’s health, and addressing an emerging HIV/AIDS epidemic. Public health specialists admit
that the set of policies existing in the Soviet Union were not adequate to address any of the current threats (Rakhmatulina and Vasilyeva 2010, 22). They recognize that policies have to be changed to address changing present day socio-economic conditions.

**Prevention of Sexually Transmitted Diseases**

Right after the revolution, in 1918, when there was no clear policy direction regarding family planning and concurrent experimentation with sexuality in society, The Soviet government identified a necessity to control the sexual lives of Soviet citizens in the early years of the Soviet state. In 1918, the spread of venereal diseases resembled an epidemic (Hoffmann 2003, 95). To address the problem of venereal diseases, the Commissariat of Health established a network of venereal disease clinics [venerologicheskiy dispenser] and an educational campaign was launched to prevent the spread of disease. The medical community viewed the sexually transmitted diseases problem as primarily a public health issue (Hoffmanns 2003, 96). However, the position of the government came to view the problem of sexually transmitted diseases and the problem of prevention as a normative problem and subsequent regulation was consistent with the moral discourse adopted in the late 1920s and early 1930s. From the position of addressing the problem of sexually transmitted diseases as a health problem involving medical discussion, the government not only stymied open discussion of sexual health and sexual behavior by the medical community, but undertook a coercive approach towards the problem of the spread of sexually transmitted diseases (Hoffmann 2003, 97). The set of norms regulating prevention of sexually transmitted diseases was coordinated then in accordance with the emerging puritanical politics of morality discourse. The
policy solution was changed from the approaches advocated by the medical community “to educate the public about the dangers of venereal disease” (Hoffmann 2002, 96) to impose norms of puritanical morality that confined sexual acts to marriage exclusively and for the purposes of procreation. Abstinence became a predominant preventive measure that was supposed to resolve the epidemic of sexually transmitted diseases.

The policy towards family also changed in the 1930s. Hoffmann rightly contends that while there was a sentiment in society for a stronger family ideal, it did not define Soviet family policy: [S]oviet Leaders were not guided by public opinion (Hoffmann 2003, 97). Hoffmann contends that family policies were defined entirely by the instrumental considerations of the state and its demographic concerns during the interwar period. He maintains that this policy shift towards strengthening family values can be observed in other European states as well at the time (Hoffmann 2003).

While the desire to strengthen the family as a policy is partially guided by the instrumental norms and demographic concerns of the state, the norms of sexual behavior, sex education, and prevention of sexually transmitted diseases became regulated by normative considerations. The extent of the regulation of individual sexual lives during Stalinist era cannot be explained entirely by the instrumental considerations of strengthening family, which Hoffman concludes by comparing Russian family policies to comparable policies in Europe. In Europe, family policies did not lead to pervasive control of the private sexual lives of individuals. The politics of regulation of sexual behavior are consistent with the government’s morality politics: the government pursues the policy to clean cities of “social anomalies” (Hoffmann 2003, 109). Homosexuality is portrayed as bourgeois, counterrevolutionary, and inconsistent with the image of moral
citizens (Hoffmann 2003, 109). The discourse of blame characteristic to morality politics was also applied towards homosexuals. Homosexuals were blamed for the defilement of young people. Political efforts to strengthening the family was also a vehicle to instill the norms of propriety in social and sexual relations. Hoffman contends that it “offered a normative model of monogamous heterosexual relationships which fit their notions of how society was to be organized” (Hoffmann 2003, 108).

5 Conclusion

Contrary to the recommendations of the WHO and other international organizations stipulating that sex education, comprehensive condom programs, and policies of abstinence (the ABC approach) are most effective, the Russian Federation failed to implement sex education and comprehensive prevention of the sexual transmission of HIV/AIDS. The WHO argues that these methods alone would not be successful in prevention of sexual transmission of HIV/AIDS. While resistance to sex education and contraception, including widespread condom distribution and availability, are not unique to the Russian Federation, I examined domestic political factors specific to the Russian Federation in order to explain this resistance.

Applying a politics of morality frame provides an alternative explanation to the view that Russian policies regarding public health stemmed largely from a distaste for Western approaches and interventions. Therefore, policy decisions emphasized vospitaniye and not sex education, following the themes of a politics of morality, rather than policies designed to treat public health issues.
CHAPTER 5 CONCLUSION

In this dissertation, I study Russia's deviation from the international norms in state response to the HIV/AIDS epidemic: the Russian Federation is an outlier case of state response as it has not implemented international interventions. In particular, I address the following questions: (1) Why does policy diffusion in Russia not occur? (2) Which domestic factors preclude policy diffusion and shaped policy response? In my analysis, I consider a conceptualization of state response as consisting of state will, policy outputs, and policy outcomes. All three of these components are important for understanding state response: state will indicates state's recognition of the problem at hand, policy outputs determine the consistency and discrepancy with the international standards, and policy outcomes ascertain the effectiveness of the response. In the Russian Federation, the state will to address the epidemic is largely absent, and under such an absence of state will, I examine domestic institutions that shape policy outputs in the HIV/AIDS epidemic.

1 Summary of the Dissertation

Summary of Chapter 1

In Chapter 1, I state the main research question addressed in this dissertation—what is the explanation for a lack of policy diffusion in Russia’s response to the HIV/AIDS epidemic and which domestic factors structure the country’s policy response—and present my proposed explanations regarding Russia's deviant response to the epidemic, accompanied with a review of literature.
Although HIV/AIDS is currently incurable, available interventions are effective in preventing the spread of this disease. Transmission of the disease can be stopped or significantly diminished, both within the vulnerable subgroups of the population (high risk populations) and from these groups into the general public (Bertrand 2004, 113). With the development of effective HIV/AIDS treatment, understanding routes of transmission and effective preventive interventions an international regime on HIV/AIDS emerged to be adopted by states facing the HIV/AIDS epidemic. International regimes are generally regarded as an exogenous factor or an intervening variable in policy diffusion, and political science literature suggests that in many policy areas states adopt similar approaches. However, a substantial critique of international regime literature maintains that regime literature does not take into account the effect of domestic factors on policy diffusion (Bennett, 1991: 226), which I demonstrate here is one important factor explaining Russia's deviation from international norms.

It is puzzling as to why states refuse to implement internationally-recommended policies and approaches that are successfully adopted by other states to address similar problems, particularly when alternative viable domestically-generated policy solutions are not available. Russia is such a case, where despite a growing drug addiction-driven epidemic, the state does not implement preventive measures that are admitted into policy by other states that face similar intravenous drug-driven epidemics. By providing descriptive statistics of state response, I show that even though many states in Europe and in post-Soviet spaces adopted harm reduction approaches to prevent both sexual and intravenous transmission of HIV/AIDS, Russian policies explicitly prohibit the use of harm reduction for intravenous transmission of HIV/AIDS and adopt approaches
inconsistent with the international norm for preventing the sexual transmission of HIV/AIDS. To move towards a comprehensive theory of state response to the HIV/AIDS epidemic, in addition to state-level factors, I examine the role of domestic factors in shaping policy response.

To explain Russia’s outlier case, I argue that in the response to the epidemic, lack of intentionality on the part of the state resulted in HIV/AIDS policy being made not by the central authority of institutions specifically created to address HIV/AIDS, as happens in many other states, but rather through agencies that embodied institutional legacies of the previous historical period. In this regard, by examining the role of medical epistemic community and politics of morality, I demonstrate that informal institutional legacies of the Soviet Union are a decisive factor in shaping policies of response to the HIV/AIDS epidemic. The state does not consider the epidemic one of its more important political issues, does not create central institutions to shape the response, and does not articulate or communicate the urgency to respond to the epidemic to state agencies and to the public.

In my analysis of state response to the HIV/AIDS epidemic in the Russian Federation, I segregate state response into three main components: state will, policy outputs, and policy outcomes. Using the AIDS Program Effort Index, a qualitative measure of state support for HIV/AIDS programs, I demonstrate that state will in Russia is absent. Then, I examine domestic factors that account for the absence of policy diffusion, and show that the medical community and morality politics preclude the adoption of internationally recommended approaches into domestic policy because of the theoretical view of drug addiction in the medical community and the inconsistency between prevention of sexual transmission and the idea of protecting the morally “pure.”
Summary of Chapter 2

In Chapter 2, I examine the international regime of HIV/AIDS. I identify three areas of the international consensus on HIV/AIDS and, within them, interventions that are recommended by international organizations—UNAIDS and the WHO—for a successful response to the HIV/AIDS epidemic. I demonstrate that the international consensus specifies how states should frame the epidemic in public discourse and which treatment and prevention interventions they should implement. I further contend that harm reduction interventions, particularly in cases of intravenous drug addiction-driven HIV/AIDS epidemics, are considered an important intervention. Then, I analyze state responses to the HIV/AIDS epidemic in the Commonwealth of Independent States and Eastern European states, and conclude that the Russian Federation is an outlier case of state response. While it has one of the highest growing HIV/AIDS epidemics, I show that Russia has very low political will to address the epidemic and does not implement key preventive interventions. In particular, Russia has poor compliance with the harm reduction norm of international consensus—it does not implement either opioid substitution therapy, nor needle and syringe exchange and sterilization programs. It also does not address the prevention of the sexual transmission of HIV/AIDS.

Summary of Chapter 3

In Chapter 3, I establish that drug addiction treatment and prevention came to play an important role in response to the drug addiction-driven HIV/AIDS epidemic in Russia. I contend that the Russian medical community blocks the inclusion of harm reduction approaches into the treatment and prevention of drug addiction. I show that the medical
community not only excludes harm reduction from clinical practices, but also influences the policy-making process to exclude these interventions at the level of policy outputs. I also demonstrate that the treatment and prevention of drug addiction as well as the role of medical community in the policy-making process are institutional legacies of a previous historical period.

Second, I establish that the policy-making process and policies of the Soviet Union and of the Russian Federation were constructed under the influence of the medical epistemic community of psychiatry and narcology.

I contend that narcology, a medical subspecialty that addresses problems of addiction, rejects harm reduction on theoretical grounds. This theoretical position is rooted in the historical development of this discipline. Narcology was part of a broader field—psychiatry—until the 1980s, and is now defined by the theoretical assumptions of psychiatry. Particularities of institutional and theoretical development of these fields allowed for their influence on the policy-making process.

To demonstrate the relevance of the theoretical position of psychiatry and narcology on the treatment and prevention of drug addiction in the HIV/AIDS epidemic, I trace the historical development of these fields. I analyze theoretical beliefs about the nature of drug addiction and harm reduction through careful analysis of anthropological analysis, publications in scientific journals, textbooks of psychiatry and narcology, and interviews with prominent narcologists and psychiatrists.

I establish that the theoretical views of these disciplines are not compatible with the acceptance of harm reduction approaches as a preventive measure. Principles of harm reduction contradict views of many specialists who consider addiction as “curable,” at
least in the earlier stages of its development. Harm reduction is consistent with the
premise that addiction is a chronic condition, and instead of curing it, the medical
profession should manage its side-effects—including preventing contraction of blood-
borne diseases transmitted through unsterilized needles and syringes, such as HIV/AIDS,
hepatitis B, and hepatitis C.

Institutional characteristics of these medical fields and their relations to the state
explain why these theoretical views persisted overtime. One theoretical school of thought
came to dominate psychiatry and became a foundation of the Moscow school of
psychiatry. This school controlled academic development in the field and publications in
its scientific journals—open discussion of harm reduction and reexamination of scientific
foundations of psychiatry did not occur, even in post-Soviet Russia. The opportunity to
challenge the prevailing theoretical position regarding the usefulness of harm reduction in
treating drug addiction was also absent.

I show that these theoretical positions of psychiatry and narcology found its way
into policy, as well. I show that psychiatrists and narcologists had a prominent position in
the Ministry of Health—several psychiatrists served as Heads of the Ministry.
Narcologists collaborated with the Ministry of Education in drafting legislation to
introduce drug prevention in educational institutions. Finally, narcologists served in
governmental agencies that enacted drug legislation and other initiatives. When the
HIV/AIDS epidemic emerged in Russia, narcologists and psychiatrists also actively
advocated against harm reduction approaches with the hope that methadone would not be
allowed into the treatment of addiction.
In the HIV/AIDS epidemic, there was no directive from the state to prioritize HIV/AIDS, and the influence of drug addiction specialists within policy-making institutions was not challenged. As a result, narcologists only narrowly addressed drug addiction prevention through traditional approaches within the state system of clinics, which existed prior to the HIV/AIDS epidemic. Narcologists, as a medical specialty, did not have training, initiative, or directive from supervising agencies to accept and implement harm reduction.

Summary of Chapter 4

In Chapter 4, I show that preventing the sexual transmission of HIV/AIDS is neglected by the state. Policies that constitute sexual prevention of HIV/AIDS are regulated by a combination of family planning, contraception, women’s health, and prevention of sexually transmitted diseases policies. I show that these policies in Russia are an institutional legacy of the Soviet Union. I also demonstrate that these policies were initially shaped by conservative morality politics in the Soviet Union and that politics of morality persists to influence policy-making within this issue area in the Russian Federation.

First, I explain how morality politics discourse came into prominence in the Soviet Union. I show that morality politics became an important part of the state discourse as tool to justify shortcomings of the socialist project. As the state was not able to rid society of behaviors for which Western states were chastised, it used categories of morally “pure” us and immoral “others” to explain this inability of the Soviet state to transform or re-educate society. A category of morally “pure” in the politics of morality
discourse included families, mothers, and children. The role of the state within the framework of this discourse became to protect the morally “pure” from the immoral “others.” Another aspect of the politics of morality became attribution of blame to immoral “others” for social sins. The state used politics of morality discourse to legitimize its social policies.

Conservative morality in the Soviet Union transformed sex education into what became known as morality education, or *vospitaniye*, which underscores abstinence rather than teaches safe sex practices. The tradition of *vospitaniye* continues in the post-Soviet space.

Politics of morality became formalized in the Soviet Union with the adoption of the Moral Code of the Builders of Communism (1961). In the post-Soviet space, invocation of politics of morality arguments by policy-makers persisted. By analyzing Russia’s legislation and the official discourse on family planning, contraception, sex education, and prevention of HIV/AIDS, I demonstrate 1) the continuity of morality politics in the Russian Federation; 2) the influence of politics of morality on the policy-making process; and 2) the continuity of policies regulating family planning, women’s health, and contraception.

2 Implications for Future Research

Russia’s response to the HIV/AIDS epidemic provides several insights into understanding and a more systematic treatment of state response to the HIV/AIDS epidemic. First, this analysis demonstrates that separating state response to the HIV/AIDS epidemic into its components—state will, policy outputs, and policy
outcomes—is a useful analytical tool. Causal factors behind each of its components are distinct. I show that reducing state response to explanations of political will or conflating political will with policy outputs is misleading in the analysis. Second, this dissertation delineates the role of path dependent factors in policy diffusion and policy-making at the domestic level. I show that with the absence of state will, as in the Russian Federation, there might not be sufficient incentives to disrupt path-dependent policies that preclude effective response to the epidemic.

**Political Will to Address the HIV/AIDS Epidemic**

The Russian case further corroborates findings of the literature on state response to the HIV/AIDS epidemic that state will is an important prerequisite of a successful response. The Russian government did not make the HIV/AIDS epidemic its priority and did not incorporate it into state discourse at the national level. Also, the government did not recognize the HIV/AIDS epidemic as an important public health issue. Presence of political will would make institutional cooperation and coordination in response more likely. However, it does not guarantee that recommended interventions would be put in place, nor does it guarantee incorporation of international norms into policy. State will is an insufficient but necessary condition in a successful response. Analyses of domestic factors help to explain why international HIV/AIDS norms are adopted, partially adopted, or rejected within the framework of state response.

My analysis of Kravtsov’s (2015) work on Russia’s response to the HIV/AIDS epidemic further demonstrates the importance of segregating state response into political will and policy outputs and accounting for the role of domestic factors in policy
diffusion. Kravtsov argues that, in Russia, the norm of the international consensus on HIV/AIDS is partially implemented because it is inconsistent with a state’s newly constructed identity as a sovereign democracy as well as with the state’s social purpose. In his analysis, it appears that the state possesses political will to respond to the epidemic, but it implements only those norms that are consistent with its identity and social purpose. However, if political will examined separately, we notice that there has been very little discussion of HIV/AIDS at the governmental level since the beginning of the epidemic. If we accept that state will is not present in Russia’s response, as other research demonstrates (See Bor 2007), we have to examine other factors that played a role in diffusion, adoption, and implementation of international norms.

**Absence of State Will in Russia: Future Research**

In this work, I do not examine what caused the absence of political will in Russia’s response to the HIV/AIDS epidemic but rather explain how policy develops when political will is absent. However, an inquiry into factors that create political will to respond to the epidemic is also important for future investigation.

Research into African states’ responses to the HIV/AIDS epidemic demonstrates that a number factors might cause absence of political will. They range from ideational factors, such as nationalistic pride, to rational factors, such as, for example, a desire to preserve the tourist industry that might become disadvantaged if the epidemic is acknowledged. For example, Kenya, Tanzania, and Zimbabwe—countries with high HIV/AIDS prevalence rates—did not publicize the scale of their epidemics so as to not interfere with their tourist industries (Engel, 2006: 297). Other factors include political
regime, civil society, and patterns of centralization of power. When power is highly centralized in a democracy, it is more challenging for civil society to exert pressure on the central government to generate a response to the epidemic (Lieberman 2009).

In Russia, a variation of denialism might help explain absence of state will. The Soviet Union has a long history of denialism of major catastrophes as well as socio-economic problems. With a relative short period of democratic opening and openness, after several days of silence, the government admitted to the Chernobyl accident in 1986. It was unprecedented that Gorbachev gave a speech on television where he stated that the affects of the Chernobyl catastrophe were devastating (Yergin and Gustafson 1993, 24). However, this period, when state leaders were pressured to admit and act on societal problems, was short-lived. Towards the end of Yeltsin’s tenure, while there was a lot of discontent in the society regarding social and economic policies, there was less and less admission of the existent of problems.

A second factor that might explain an absence of state will in the HIV/AIDS epidemic in Russia applies to all states and therefore cannot serve as a leading explanation. Since the demographic consequences of the HIV/AIDS epidemic are delayed in time, the epidemic might not be perceived as an imminent danger by the government. There is a significant lag time of 5 to 10 years between the incidence of infection and actual symptoms of the disease. Particularly, if prevalence rates of the disease—the actual number of people who are infected—are low, governments might not perceive the long-term consequences of the disease as significant.

The Russian Federation responds fairly well to some epidemics, like the tobacco use epidemic, for example, and implements interventions recommended by the WHO
The government also admits that tobacco use is a significant public health problem. However, political will to address epidemics, like tuberculosis and HIV/AIDS, is not present. Causes behind this variation of political will in response to epidemics within the same state deserves further investigation.

*Medical Epistemic Community*

The Russian case of state response to the HIV/AIDS epidemic demonstrates that an expert medical community and its connection to the policy-making process, under certain conditions, plays an important role in a response. While Russia’s narcological community is somewhat unique, medical and other epistemic communities were demonstrated to have played a role in policy diffusion in other geographic regions and other issue areas, as well. Kurt Weyland highlights that, prior to the adoption of social security and public health reforms in Latin America, expert communities lobbied international organizations, such as the IMF, for conditionality loans and were the ones to initially promote reforms. In some cases, although it might appear that the reforms were imposed by the IMF, the primary initiative was frequently undertaken by domestic communities of experts (Weyland 2006, 14). In the HIV/AIDS epidemic response, in-depth case study analyses might reveal an exact causal path in norm diffusion and establish the role of epistemic communities more systematically.

The study of Russia’s response to the HIV/AIDS epidemic and inferences from policy diffusion literature lead me to conclude that expert communities matter in state response to the HIV/AIDS epidemic in key ways. While state will determines whether resources would be aggregated for a response and whether the state would respond
promptly, expert communities have leverage to suggest, promote, or oppose programs of response. Domestic expert communities are often the first to examine a range of possible response strategies and experiences of other states and their approaches; they also pressure policy-makers to implement favored strategies or reject policies not consistent with their theoretical outlooks.

Expert communities vary in the leverage that they have on the policy-making process. I have demonstrated that, in the Russian Federation’s response to HIV/AIDS, the medical community of narcology experts had a significant influence on policy-making, while the HIV/AIDS community of infectious diseases specialists did not, and, therefore, narcologists’ resistance to harm reduction approaches prevailed. This can be explained through the difference in the level of influence on the policy-making process that these communities had prior to the epidemic.

The extent to which an expert community in support of an international norm can compensate for a weak or an absent state will in state response to epidemics merits further investigation. It is not clear whether adoption of an international norm would be more likely if an expert community would be in support of internationally-recommended norms and would advocate for its implementation. Research on Russia’s response demonstrates that the presence of an expert community, one that was antagonistic to the international harm reduction norms with strong links to the policy-making process, lead to a rejection of the international norm.

Two scenarios could be investigated further with regards to the influence of epistemic community on state response to epidemics. What would state response look like if state will is absent, but the epistemic community supports international norms and
has a strong influence on the policy-making process? A second question—what would happen in a state response when state will is present, but the medical community opposes international norms and has a strong influence on the policy-making process?

In Russia’s response to the HIV/AIDS epidemic, it is unclear whether—with the emergence of political will—we would observe adoption of the international norm on harm reduction. Evidence from the healthcare reform analysis in Russia demonstrates that even though the norm might be adopted at the policy level, resistance from the epistemic community might jeopardize its implementation. Russia’s experience with healthcare reform attests to the importance of healthcare providers in the effectiveness of the reform (Holom 2015). Providers implement actual policies on the ground and play a key role in policy outcomes. Healthcare providers therefore have power to subvert policies that are imposed from above when they disagree with the directives. Michel Rivkin-Fish, for example, demonstrates that health care providers in post-Soviet Russia resisted, through their practice, the course of healthcare liberalization (Rivkin-Fish 2005). Drawing on this evidence, I further argue that narcologists, who oppose the principles of harm reduction, would resist an implementation of these interventions in their practice, even if these norms are admitted into policy.

*Path Dependency of Domestic Institutions*

A legitimate question arises about variation in state responses to the HIV/AIDS epidemic across post-Soviet states, despite the presence of very similar institutional legacies and policy-making processes. While I do not seek to provide a full explanation for this variation, my examination of the Russian case suggests that in order to account
for the variation, both political will as well as the role of informal institutional legacies should be examined. Patterns of state response in these countries are very different.

Most countries in the Commonwealth of Independent States (CIS) faced the start of the HIV/AIDS epidemic 15 years later than the beginning of the world pandemic. In most of these countries, the HIV/AIDS epidemics is driven by intravenous drug use. In many states the response is sluggish; nevertheless, it is better than in the Russian Federation. This is particularly significant for understanding state response since Russia has a better technical capacity than, for example, many Central Asian states to devise and implement prevention and treatment programs. While countries in the post-Soviet space and the Russian Federation share a common set of institutions that have influenced their response, many of these states have markedly distinct features that have made drawing generalizations from the Russian case to other former Soviet states difficult.

Central Asian countries—Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan—all face an HIV/AIDS epidemic that is driven by intravenous drug use. Easy access to heroin is one of the driving forces behind the epidemic. Nevertheless, the scale of the epidemic that these countries face is not as severe as it is in Russia. These countries inherited public health institutions from the Soviet Union, particularly the Semashko healthcare system model. In HIV/AIDS prevention, most of these states adopted harm reduction strategies into their HIV/AIDS policy response. Given the institutional similarity of these states to the Russian Federation, we would expect a similar response to the HIV/AIDS epidemic among these states. How could these differences be explained?
I used two variables to explain why Russian policy looks different from other states’—medical epistemic community and politics of morality. I also demonstrated that state will in response to the epidemic was absent. Observations of state response to the HIV/AIDS epidemic in these states demonstrates that state will to respond to the epidemic in these countries was present. While I cannot assess the position of the medical community on harm reduction in these countries, there were no major impediments to implementing sexual transmission of HIV/AIDS prevention as Muslim leaders of Central Asian states were not opposed to condom distribution (Twigg 2006, 89).

The medical communities and politics of morality did not have such a significant influence on the policy-making process in other post-Soviet states as they did in the Russian Federation. I suggest that there are two possible explanations for this: first, the medical epistemic community, by losing its connection with the Moscow school, adopted new theoretical ideas about harm reduction; second, since political will was present in many post-Soviet states, it aided in the adoption and implementation of the international norms on response to HIV/AIDS.

The psychiatric and narcological community in the Soviet Union was dominated by the Moscow school of psychiatry, which provided guidelines about treatment of addiction. Other psychiatry schools, such as the ones in Ukraine, Kazan’, and St. Petersburg, although they supported alternative theoretical views, did not have substantial influence on the policy-making process. However, in the post-Soviet space, regional schools of psychiatry were free of the central Moscow influence and were able to articulate their positions regarding harm reduction policies.
Another factor that might have contributed to the adoption of international norm is the presence of stronger political will or “political commitment factor” to respond to the epidemic. The AIDS Program Effort Index, developed by UNAIDS, USAID, WHO, and the POLICY Project, demonstrates that the political support of the Russian Federation for the HIV/AIDS response is the lowest in the region, with a score of 21 in 2003 and 20 in 2000 (Bor 2007, 1588). However, the regional average political will score was 50 in 2003 (Bor 2007, 1588). At the same time, the average global political support for HIV/AIDS programs has a score of 73 (USAID, et al. 2003). These data demonstrate that there is a significant variation among states in the region in their political support for HIV/AIDS programs, which might explain better support of international norms.

3 Russia’s Response to the HIV/AIDS in Comparative Perspective

Russia’s response to the HIV/AIDS epidemic was compared to the responses of countries with a similar level of economic development—Brazil, India, and China (Gomez 2009)—and to South Africa (Kravtsov 2015), a country that, like Russia, did not recognize or respond to the HIV/AIDS epidemic. This research mostly analyzes whether the state provides resources to address the epidemic (Gomez 2009). However, Russia’s response differs not only in allocation of resources, but in following the norm of the international consensus. Comparison of Russia’s response to country cases where the HIV/AIDS epidemic is also driven by intravenous drug use and are at a similar level of

83 Countries’ efforts are ranked on the scale of 100.
84 Kazakhstan has a score of 63, Ukraine—61, and Belarus—55.
economic development would further establish whether policy-making in Russia is affected by proposed variables. China, Nepal, Thailand, and Vietnam are among countries with similar intravenous drug use-driven HIV/AIDS epidemics. China is a country with a similar level of economic development, an intravenous drug addiction-driven HIV/AIDS epidemic, and a highly centralized decision-making process. China, however, has introduced methadone programs as well as needle and syringe exchanges. Comparing Russia’s and China’s approaches helps to address one of the counter-arguments of why Russia resists harm reduction. It could be argued that the reason behind the rejection of harm reduction approaches is its incompatibility with the prohibitionist approach to drug use, both on supply and demand sides. However, China’s case demonstrates that this is not necessarily true. While China implements a prohibitionist approach towards controlling both supply and demand, it also embraced methadone and needle and syringe exchange programs (Choi and David 2007, 142). In 2005, there were at least 128 methadone clinics in China, and the government pledged in 2004 to establish a thousand during the next five years (Choi and David 2007, 142). There are problems with implementation of needle and syringe programs because of the resistance from law enforcement at the local level. However, China’s response to the HIV/AIDS epidemic also demonstrates that the domestic norm on drug control, as some believe (Lieberman 2009), does not always supersede the norm on harm reduction interventions and exclude them from implementation.
Since all three factors—state will, shift in the medical epistemic community, and politics of morality—matter in addressing prevention, there is little evidence that the situation surrounding the HIV/AIDS epidemic would shift in the near future, since there are no signs that the factors that might affect political will would change. An authoritarian political regime without an independent media and with a weak civil society makes public scrutiny of policy approaches to the HIV/AIDS epidemic non-existent, and pressure from civil society for a change in policy direction is nearly impossible.

The next step in research of the HIV/AIDS epidemic is to examine a set of factors that explain state will. A political regime plays a role in how a state responds to the epidemic. In a democracy, like the United States, pressure on the government expedited response to the epidemic. For example, in 1984, the Federal Drug Administration under pressure from civil society was forced to make AZT—an HIV/AIDS drug—available to some patients while it was still undergoing trials (Engel 2006, 133). However, political regime does not explain why political will varies among states with the same regime type. It does not explain why political regime in an authoritarian regime, like Russia, is weak, while political will in other CIS states is stronger.

The Russian drug addiction policy that plays a role in Russia’s rejection of harm reduction is strongly locked-in. The adoption of internationally recognized policy measures appears to be unlikely in the near future. Harm reduction programs might be adopted if the medical epistemic community were to embrace harm reduction approaches. This change might occur with increased openness of the medical community and increased access to foreign scientific knowledge on harm reduction and addiction. Under
the Soviet Union, physicians’ access to research produced outside of the Russian Federation was purposefully limited by the government (Cassileth, Vlassov and Chapman 1995, 1569). Limited access to information was available in some of the libraries of Moscow and St. Petersburg. However, articles on bioethics or patients’ rights were torn out of the Western journals available in central libraries (Cassileth, Vlassov and Chapman 1995, 1572). Currently, even without restriction by the government, access to international research remains very low. My examination of publications in Russian journals on treatment and prevention of drug addiction reveals that research does not systematically examine findings and publications in foreign language journals.

Theoretical approaches of psychiatrists and narcologists towards treatment and prevention of addiction might emerge as a side effect of reform in medical education that was discussed by the Duma (Reforma 2013). Medical education reform is discussed within the broader ongoing reform of the education system and of the Academy of Science. The Ministry of Health discussed introducing mandatory study of English as a part of the medical education curriculum. Knowledge of English would make access to ideas regarding theories of drug addiction as well as a theoretical and practical shift within the medical community on the effectiveness and suitability of harm reduction approaches for treatment of drug addiction and prevention of HIV/AIDS more likely.

Under the current Russian government, there is no evidence that the will to undertake measures to address the epidemic has shifted. The authoritarian regime is firmly in place, the government’s policies are not scrutinized by the media, and pressure from civil society in Russia is weak—thus, it is difficult to perceive shifts in state will to address the epidemic will occur in the near future.


Ball, John C., Alan Ross, and others. 1991. The Effectiveness of Methadone Maintenance Treatment: Patients, Programs, Services, and Outcome. New York: Springer-Verlag.


Eramova, Irina, Srdan Matic, and Monique Munz. 2007. HIV/AIDS Treatment and Care: Clinical Protocols for the WHO European Region. World Health Organization.


“Godovoy otchet za 1998 god Ministerstva obschego i professional’nogo obrazovaniya Rossiyskoy Federatsii pered Fondom OON po narodonaseleniyu, UNESCO po proyektu “Polovoye vospitaniye rossiyskikh shkol’nikov.”


“Kontseptsiya sistemy gosudarstvennykh antinarkoticheskoy politiki v Rossiyskom Federatsii (proyekt ECAD).” *Narkologiya* 2006, 5: 8-10.


“On the introduction of amendments into article 5 of the Federal law “On the protection of children from information liable to be injurious to their health and development” and individual legislative documents of the Russian Federation aimed at protecting children from information promoting the denial of traditional family values.” “Article 6.21. Promoting non-traditional sexual relations to minors.Federal bill of 29/6/2013 N 135-FZ


Thomas, Gary. "A typology for the case study in social science following a review of definition, discourse, and structure." Qualitative inquiry (Sage Publications) 17, no. 6 (2011): 511-521.


APPENDIX A

LIST OF SCIENTIFIC JOURNALS OF NARCOLOGY AND PSYCHIATRY

Accessed in Tsentral’naya nauchnaya meditsinskaya biblioteka Pervogo MGMU im. I.M. Sechenova (TsNMB) Minzdrava RF. [Central Research Medical Library of the First MGMU I.M. Sechenov, Moscow]

Voprosy Narkologii [Questions of Narcology].

1989 (N1, 2, 3, 4)
1990 (N1, 2, 3, 4)
1991 (N1, 2, 3, 4)
1992 (N1, 2, 3)
1993 (N1, 2, 3, 4)
1994 (N1, 2, 3, 4)
1995 (N1, 2, 3, 4)
1996 (N1, 2, 3, 4, additional issue [vneocherednoy nomer])
1997 (N1, 2, 3, 4)
1998 (N1, 2, 3, 4)
1999 (N1, 2, 3, 4)
2000 (N1, 2, 3, 4, 5, 6)
2002 (N1, 2, 3, 4, 5, 6)
2003 (N1, 2, 3, 4, 5, 6)
2004 (N1, 2, 4, 3, 5, 6)
2005 (N1, 2, 3, 4-5, 6)
2006 (N1, 2, 3, 4, 5, 6)
2007 (N1, 2, 3, 4, 5, 6)
2008 (N1, 2, 3, 4, 5, 6)
2009 (N1, 2, 3, 4, 5, 6)
2010 (N1, 2, 3, 4, 5, 6)
2011 (N1, 2, 3, 4, 5, 6)
2012 (N1, 2, 3, 4, 5, 6)
2013 (N1, 2, 3, 4, 5, 6)

Narkologiya. [Narcology]. Established in 2002

2002 (N 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12)
2003 (N 1, 2, 3, 4, 5, 6, 7, 8, 9, 12)
2004 (N1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12)
2005 (N 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12)
2006 ((N 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12)
2007 (N 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12)
2008 (N 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12)
2009 (N 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12)
2010 (N 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12)
2011 (N 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12)
2012 (N 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12)
2013(N 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12)
2014 (N 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12)

Other journals in Russian:

*Epidemiologiya i infektsionniye bolezni* [Epidemiology and Infectious Diseases]

*Novaya Apteka* [New Pharmacy]

*Zhurnal Mikrobiologii.* [Journal of Microbiology]
## APPENDIX B

### LIST OF INTERVIEWS

<table>
<thead>
<tr>
<th>INTERVIEWS WITH NARCOLOGISTS AND PSYCHIATRISTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brun, Evgeniy Alekseyevich</td>
</tr>
<tr>
<td>- Narcologist</td>
</tr>
<tr>
<td>- Doctor of Science</td>
</tr>
<tr>
<td>- Chief Psychiatrist-Narcologist of the</td>
</tr>
<tr>
<td>Ministry of Health in Russian Federation</td>
</tr>
<tr>
<td>- Director of Moscow Research and Clinical</td>
</tr>
<tr>
<td>Center of Narcology</td>
</tr>
<tr>
<td>- Department Chair of narcology</td>
</tr>
<tr>
<td>RMAPO Ministry of Health</td>
</tr>
<tr>
<td>- Member of the Civic Chamber</td>
</tr>
<tr>
<td>Gofman, Aleksandr Genrikhovich</td>
</tr>
<tr>
<td>- Psychiatrist and narcologist</td>
</tr>
<tr>
<td>- Doctor of Science</td>
</tr>
<tr>
<td>- Chair, Department of Psychiatric Disorders,</td>
</tr>
<tr>
<td>Moscow Research Institute of Psychiatry</td>
</tr>
<tr>
<td>- Board member, The Russian Society of</td>
</tr>
<tr>
<td>Psychiatrists</td>
</tr>
<tr>
<td>Krasnov, Valeriy Nikolayevich</td>
</tr>
<tr>
<td>- Psychiatrist</td>
</tr>
<tr>
<td>- Doctor of Science</td>
</tr>
<tr>
<td>- Former Chairman of the Board, the Russian</td>
</tr>
<tr>
<td>Society of Psychiatrists.</td>
</tr>
<tr>
<td>- Director, Moscow Research Institute of</td>
</tr>
<tr>
<td>Psychiatry</td>
</tr>
<tr>
<td>Klimenko, Tatyana Valentinovna</td>
</tr>
<tr>
<td>- Narcologist</td>
</tr>
<tr>
<td>- Doctor of Science</td>
</tr>
<tr>
<td>- Deputy Chief of the Ministry of Health</td>
</tr>
<tr>
<td>- Director, National Narcology Research</td>
</tr>
<tr>
<td>Institute</td>
</tr>
<tr>
<td>Dvoryak, Sergey Vasilyevich</td>
</tr>
<tr>
<td>- Narcologist</td>
</tr>
<tr>
<td>- Candidate of Science</td>
</tr>
<tr>
<td>- Director, the Ukrainian Institute on</td>
</tr>
<tr>
<td>Public Health Policy.</td>
</tr>
<tr>
<td>- Board member, European Association for</td>
</tr>
<tr>
<td>Treatment of Opiate Addiction</td>
</tr>
<tr>
<td>Name</td>
</tr>
<tr>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Kozlov, Aleksandr Aleksandrovich</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Larichev, Vladimir Vladimirovich</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Mendelevich, Vladimir Davydovich</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Sivolap, Yuriy Pavlovich</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Snedkov, Yevgeniy Vladimirovich</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Soshnikov, Sergey Sergeyevich</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Somova, Veronika Mikhaylovna</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Name</td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Lavrov, Pavel Galaktionovich</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Nor, Andrei Aleksandrovich</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Al’tshuler, Boris L’vovich</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Borisova, Elena Viktorovna</td>
</tr>
<tr>
<td>Godlevskiy, Denis</td>
</tr>
<tr>
<td>Golichenko, Mikhail</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Pokrovskiy, Vadim Valentinovich</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Zubov, Valeriy Mikhailovich</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Sarang, Anya</td>
</tr>
<tr>
<td>Potomova, Anna</td>
</tr>
<tr>
<td>Nedzyel’skiy, Nikolai</td>
</tr>
<tr>
<td>Mayanovskiy, Vladimir</td>
</tr>
<tr>
<td>Name</td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
<tr>
<td>Maksimovskaya, Alina</td>
</tr>
<tr>
<td>Malyshev, Maksim</td>
</tr>
<tr>
<td>Krutikov, Dmitriy Leonidovich</td>
</tr>
<tr>
<td>Orlova, Natalya Borisovna</td>
</tr>
<tr>
<td>Sokolov, Mikhail Gerasimovich</td>
</tr>
<tr>
<td>Trofimov, Igor Anatol’yevich</td>
</tr>
<tr>
<td>Gavrishchuk, Denis Vyacheslavovich</td>
</tr>
</tbody>
</table>
| Ban’schikov, Genadiy Trofimovich | Cardiologist  
- Doctor of Science  
- Chief Physician, Vologda Region Department of Health  
- Vologda Regional Hospital N1 |