

This paper explores the role that law enforcement and police actions can play as structural deterrents to the conceptualization of drug addiction as a public health issue rather than as a criminal justice concern. Specifically, this paper explores challenges to the development and implementation of the Harm Reduction Model in countries of the former Soviet Union as a component of a larger attempt to grapple with one of the fastest growing HIV/AIDS epidemics in the world. In this region, the HIV/AIDS epidemic is the specific result of injecting drug use (IDU), with as many as 90% of documented HIV/AIDS cases in the Russian Federation in the early years of the 21<sup>st</sup> century associated with IDU (Rhodes et al. 2003). While IDU and associated infectious disease rates in the former Soviet Union (as discussed further below) are elevated relative to rates in many countries, the law enforcement dynamics explored in this paper are relevant for all nations in which IDU is addressed through a framework of criminalization and potential police violence rather than through a framework of social, mental, and health support for the drug user.

The Harm Reduction Model (HRM) described in this paper is an approach to the prevention and treatment of drug use that focuses on limiting negative health consequences of drug use for both drug users and their communities (UNAIDS 2016). While the majority of robust data that link implementation of HRM with reductions in infectious disease transmission result from studies in high income countries, the approaches undertaken in the HRM – specifically, the provision of clean needles and syringes and/or the availability of Opioid Substitution Therapies (OST) - are universally

valid. Overall, in evaluating HRM implementation in low- and moderate-income countries, Des Jarlais (2013) has identified 75 distinct HRM projects in 17 nations,<sup>1</sup> with the focus of these projects divided between those assessing the impact of needle and syringe exchange on reductions in transmission of blood-borne infections (12 projects) and those assessing retention/success rates for individuals receiving methadone or buprenorphine (63 projects).

The fundamental tenets of the HRM for addressing drug use include the beliefs that: (1) the provision of resources and services to IDU should be nonjudgmental and non-coercive; (2) the experience of class, race, gender, poverty, social isolation, discrimination and trauma all affect people's vulnerability to drug use, their ability to cease or reduce use, and their ability change behaviors to minimize self-harm; and (3) drug users should be supported as having agency in their own lives (UNAIDS 2016).<sup>2</sup> While recognizing that adoption of the HRM should not ignore the real harms caused by drug use, implementation of harm reduction policies are grounded in a directive that defines 'success' in terms of maintaining or improving quality of life rather than in requiring the elimination of all drug use. Of significance in evaluation of the HRM regardless of a country's economic status is also recognition that the relationship between an individual drug user and their community is bi-directional. That is, while an individual's actions impact their community in a range of social, financial and legal

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<sup>1</sup> Countries cited include: Afghanistan, Bangladesh, Brazil, China, Georgia (Republic), India, Indonesia, Iran, Kyrgyzstan, Lithuania, Malaysia, Mauritius, Taiwan, Tanzania, Thailand, Ukraine, and Vietnam

<sup>2</sup> Additional information on HRM can be found at [www.harmreduction.org](http://www.harmreduction.org) [accessed 06/17/18]

ways, a community's influence - in terms of laws, enforcement practices and social supports - also shape the safety of an individual's drug injection practices.

Conceptually, one of the more significant impediments to the introduction of harm reduction programs is the challenge these programs pose to social constructs regarding the 'costs' of behavior. That is, in many countries, including the Russian Federation, drug policies are developed and enforced from the vantage of protecting society from behaviors associated with the pursuit of addictive drugs rather than from the vantage of protecting people who use drugs from associated harms. Put plainly, the HRM insists, in contrast, that an individual who injects drugs has as much right to protection from HIV/AIDS, Hepatitis C (HVC), and other blood-borne infections as an individual who does not inject drugs.

Regarding IDU and associated infectious diseases in countries of the former Soviet Union, approximately 25% of global IDU occurs in this region, with approximately 82% of HIV/AIDS cases in this region associated with IDU (Aceijas et al. 2004). With studies suggesting that as few as 35% of people who inject drugs in the Russian Federation have access to clean syringes and sterile needles (Mathers et al. 2008), sharing of injection equipment is likely the most significant route of HIV/AIDS transmission in the region. Within Russian cities, rates of HIV/AIDS prevalence amongst IDU have been documented as ranging from approximately 10% to 65% (Sarang et al. 2007), and have been documented as reaching 90% in cities of the wider former Soviet Union (Kerr 2005). Overall, the HIV/AIDS epidemic in Russia is one of the fastest

growing in the world, with up to 4% of the adult population in specific regions of the Russian Federation testing HIV positive (Kerr 2005). In the Russian city of Togliatti, as example, data from 1998 suggest only two of approximately 90,000 HIV antibody tests conducted that year were HIV positive; in 2000 - 2001, in contrast, 6410 new cases of HIV were registered by the City AIDS Center from approximately 240,000 antibody tests. Of these 6410 new cases, 99% were attributed to IDU (Rhodes et al. 2003). In addition to HIV/AIDS, the use of injecting drugs is associated with diseases including HVC, for which infection rates in some areas of the former Soviet Union are 20 times higher than rates in the general population (Walsh and Maher 2013). Likewise, because use of injecting drugs is significantly associated with prison time in the Central Asian region of the former Soviet Union, with up to 90% of people who inject drugs having a history of current or past incarceration (Walsh and Maher 2013), IDU is also associated with increased rates of infection with multi-drug resistant tuberculosis (MDR-TB).

With these risks as framework, a range of challenges have been documented with the development and implementation of harm reduction policies in the Russian Federation. Specific challenges have included drug policies and police intervention (discussed further below); social stigma and discrimination for IDU, people living with HIV/AIDS, prison inmates and sex workers; poor access for those who need prevention and treatment medications including methadone and buprenorphine, as well as the anti-overdose medication naloxone; and challenges with continuation of services after the completion of internationally-funded harm reduction programs (Sarang et al. 2007). As noted in the introduction to this paper, while Sarang et al. (2007) have focused their

research on the Russian Federation, the challenges they describe to implementation of the HRM for IDU most certainly transcend the boundaries of this region.

Within the Russian Federation, harm reduction programs have focused principally on the provision of clean injection equipment through pharmacies and syringe and needle exchange programs (Sarang et al. 2008). Data from 2007 indicate that while there were 68 specific harm reduction projects then active in the Russian Federation, fewer than 15% of IDU were accessing these programs (Sarang et al. 2008). Whereas multiple reasons likely exist for this low IDU access rate, surveys conducted amongst individuals accessing syringe and needle exchanges and/or pharmacies providing clean injection equipment highlight fears of police interference as a significant contributing factor (Sarang et al. 2008). Police interference in this context has included detention, harassment, assault, arrest, and extortion (Sarang et al. 2008). In Russia, the overall impact of situational factors - including fears of police interference - on health-negative, drug-related behaviors has been documented broadly. As presented by Rhodes et al. (2003) from a survey of 426 IDU in the city of Togliatti, as example, those who acquired injection equipment from pharmacies or syringe and needle exchanges had an approximately 50% lower infection risk from HIV/AIDS than those who acquired injection equipment from friends or street contacts (Rhodes et al. 2003). In the context of infectious disease risk, because aggressive street policing results in a reluctance to store or carry clean injection equipment (as well as a reluctance to seek assistance in the event of witnessed overdose), aggressive street policing appears correlated with an increased likelihood that IDU will engage in higher risk drug-related behaviors.

Of issue, as well, in the Russian Federation is a disconnect between Federal legal reforms that may support the HRM and local or regional street police practices that are still strongly influenced by Soviet-era policies that either explicitly or implicitly rely on social behavioral control. As example, because needle and syringe exchange programs typically require the one-for-one exchange of used injecting equipment for clean replacements, IDU accessing exchange programs are required to travel to exchange sites with drug paraphernalia on their person (Sarang et al. 2008). Although it is Federal law in Russia that regulates the amount of injectable drugs that can be legally carried, local police can charge possession based on the cumulative *trace* mass of narcotics an individual may be carrying across multiple used syringes (Rhodes et al. 2003). Thus, as explained by an 18- year old male interviewed by Sarang et al. (2008) “*I would not risk, say, to fetch 200 syringes, especially used ones, through all of the city; [in contrast], I could fetch back, let us say 200 new syringes. That is completely different. There you can explain it somehow. And if you get caught by police with a pack of used syringes it means narcological dispenser, that is guaranteed. That means registration [as a drug user].*” Of note here is the recognition that the Soviet-era approach to public health that focused predominantly on registration and surveillance of drug addicts appears to remain a thread woven through practice and perception of addiction ‘treatment’. In this context, registration and surveillance as drug users are associated with social stigmatization as well as with potential costs to employment, residency and citizenship (Rhodes et al. 2003).

The relationship between police presence and higher risk injection practices has been documented in countries beyond Russia, as well. In China, as example, although it is legal to purchase and possess drug injection paraphernalia, it is illegal to use syringes and needles to inject drugs (Hammett et al. 2005), a seeming contradiction that highlights the challenge faced by law enforcement in balancing a public health mandate with laws that continue to regard drug use as a behavior that requires punishment and moral rehabilitation. Likewise, a study conducted in Mexico observed that although the purchase and possession of syringes is legal, police harassment of those possessing syringes result in significant syringe sharing (Pollini et al. 2008). Studies conducted in the United States have also documented relationships between fears of interaction with police and engagement in health-negative behaviors including syringe sharing, syringe re-use, poor personal hygiene associated with injecting drugs, and injecting drugs of uncertain purity (Cooper et al. 2005; Pollini et al. 2008; Beletsky et al. 2015).

Of significance in these studies are observations that demographic factors - including race, ethnicity, gender, social class and homelessness - all contribute to the frequency and extend with which law enforcement interacts with IDU and, in turn, creates barriers to safe injection practices. In an examination of police violence in New York City, Cooper et al. (2004) document that police activities associated with drug crackdowns include threats and/or use of excessive physical force; psychological aggression including intimidation and use of slurs based on race, ethnicity, gender, sexual orientation, and class; sexual violence including inappropriate contact and threats and perpetration of coerced sex; and neglect in terms of failure to respond to citizen need or

inappropriate response to those needs. Importantly, from this study, while a higher percentage of IDU versus non-users (65% versus 45%) reported witnessing or directly experiencing excessive police violence, a consistent percentage of both groups (approximately 65%) reported that they had been stopped by police and that fears of “unnecessary violence or life disruption” resulted from these interactions (Cooper et al. 2004). These data highlight the culture of fear that can be associated with police interactions, a culture that can, in turn, result in both IDU being unable to practice harm reduction through safe injection behaviors, and the creation of negative psychological health within the communities in which IDU are enmeshed.

An important challenge in the adoption and advocacy of the HRM - in the Russian Federation as well as elsewhere - is therefore likely in resolving the tension between the human desire to attribute social blame and the ability to place social discomforts associated with a set of behaviors within the appropriate context of structural power imbalances. Put simply, although it may be their reality, it is not the addict's *fault* that they experience more police violence than non-drug users. While the addiction behavior may arise with the addict, the violence that they (and their community) experience as the result of that addiction originates, at least in part, with the magnification of underlying cultural biases that can accompany law enforcement. As noted by Rhodes et al (2006) in interviews with Russian police, so long as IDU are viewed as “potential criminals” who deserve pre-emptive arrest, it will be a challenge to contextualize IDU and addiction as the public health concerns they are, warranting the nonjudgmental and non-coercive provision of harm reduction services.



## References

Aceijas, C. Stimson, G.V., Hickman, M. and Rhodes, T. 2004. Global overview of injecting drug use and HIV infection among injecting drug users. *AIDS*. 18: 2295–2303.

Beletsky, L., Cochrane, J. Sawyer, A.L., Serio-Chapman, C., Smelyanskaya, M., Han, J., Robinowitz, N. and Sherman, S.G. 2015. Police Encounters Among Needle Exchange Clients in Baltimore: Drug Law Enforcement as a Structural Determinant of Health. *American Journal of Public Health*. 105(9): 1872-1879.

Cooper, H., Moore, L., Gruskin, S. and Krieger, N. 2004. Characterizing Perceived Police Violence: Implications for Public Health. *American Journal of Public Health*. 94(7): 1109-1118.

Cooper, H., Moore, L., Gruskin, S. and Krieger, N. 2005. The impact of a police drug crackdown on drug injectors' ability to practice harm reduction: A qualitative study. *Social Science & Medicine*. 61: 673–684.

DesJarlais, D. 2013. Systematic review research on needle/syringe programs and opiate substitution programs in low- and middle-income countries. *J Food Drug Anal*. 21(4): S59–S61.

Hammett, T.M., Bartlett, N.A., Chen, Y., Ngu, D., Cuong, D.D., Phuong, N.M., Tho, N.H., Van, L.K., Liu, W., Donghu, M., Shaomi, X., Chen, H., Quyen, H.N., Broadhead, R.S., and Des Jarlais, D.C. 2005. Law enforcement influences on HIV prevention for injection drug users: Observations from a cross-border project in China and Vietnam. *International Journal of Drug Policy*. 16: 235–245.

Kerr, C. 2005. Injection drug use fuels HIV/AIDS epidemic across Eurasia. *The Lancet*. 5:539.

Mathers, B.M., Degenhardt, L., Phillips, B., Wiessing, L., Hickman, M., Strathdee, S.A., Wodak, A., Panda, S., Tyndall, M., and Toufik, A. 2008. Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *Lancet*. 372(9651):1733–1745.

Pollini, R.A., Brouwer, K.C., Lozada, R.M., Ramos, R., Cruz, M.F., Magis-Rodriguez, C., Case, P., Burris, S., Pu, M., Frost, S.D.W., Palinkas, L.A., Miller, C., and Strathdee, S.A. 2008. Syringe possession arrests are associated with receptive syringe sharing in two Mexico–US border cities. *Addiction*, 103, 101–108.

Rhodes, T., Mikhailova, L., Sarang, A., Lowndes, C.M., Rylkov, A., Khutorskoy, M., and Renton, A. 2003. Situational factors influencing drug injecting, risk reduction and syringe exchange in Togliatti City, Russian Federation: a qualitative study of micro risk environment. *Social Science & Medicine* 57: 39–54.

Rhodes, T., Platt, L., Sarang, A., Vlasov, A., Mikhailova, L. and Monaghan, G. 2006. Street Policing, Injecting Drug Use and Harm Reduction in a Russian City: A Qualitative Study of Police Perspectives. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*. 83(5): 911-925.

Sarang, A., Stuikeyte, R. and Bykov, R. 2007. Implementation of harm reduction in Central and Eastern Europe and Central Asia. *International Journal of Drug Policy*. 18: 129–135.

Sarang, A., Rhodes, T., and Platt, L. 2008. Access to syringes in three Russian cities: Implications for syringe distribution and coverage. *International Journal of Drug Policy*. 19S: S25–S36.

UNAIDS. 2016. Do No Harm: Health, Human Rights and People Who Use Drugs. Joint United Nations Programme on HIV/AIDS. 140pp.

Walsh, N. and L. Maher. 2013. HIV and HCV among people who inject drugs in Central Asia. *Drug and Alcohol Dependence*. 132S: S37- S40.