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Wendy K. Mariner

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**LEGAL ISSUES IN HIV/AIDS PREVENTION AND TREATMENT
IN THE RUSSION FEDERATION**

**SUMMARY AND CONCLUSIONS
OF THE
BOSTON UNIVERSITY HIV/AIDS PROJECT
USAID - BOSTON UNIVERSITY COOPERATIVE AGREEMENT FOR
TECHNICAL ASSISTANCE IN RUSSIAN HEALTH LEGISLATION AND REGULATION**

Wendy K. Mariner
Professor of Health Law
Boston University School of Public Health
Boston, Massachusetts
United States of America

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INTRODUCTION

The Russia Federation faces an urgent need to control the spread of HIV. Although infection has been concentrated primarily among high risk groups so far, the risk that it will spread rapidly throughout the general population is growing daily. Controlling the HIV epidemic requires leadership and strategies that are somewhat different from traditional infectious disease control models because there is no vaccine yet available to prevent disease and people spread infection by engaging in activities that are hidden from public view and not susceptible to simple prohibitions.

Boston University conducted several studies as part of USAID's HIV/AIDS Strategy to assist the Russian Federation in developing effective responses to the epidemic. The Boston University HIV/AIDS Project investigated Russian Federation law governing HIV/AIDS prevention and treatment programs, identified and analyzed criminal laws that may impede prevention and treatment efforts, and solicited ideas from physicians as to problems and opportunities for investigation and change.

Conclusions drawn from the Boston University HIV/AIDS Project's activities are summarized below in two categories. The first category includes findings and suggestions for improving civil law programs, while the second focuses on criminal and administrative law. More detailed information on each subject can be found in the subject-specific reports submitted earlier by Boston University.

I. USING FEDERAL LAW TO CREATE MORE EFFECTIVE HIV PREVENTION PROGRAMS

The Federal Law on the Prevention in the Russian Federation of Disease Caused by the Human Immunodeficiency Virus (HIV Infection) lays a good foundation for creating prevention and treatment programs in the Russian Federation. The law offers opportunities that have not yet been taken advantage of. Its effectiveness is also hampered by how other laws are applied or perceived and by entrenched practices in medicine and law enforcement, as well as by persistent shortfalls in the financial resources made available for health programs. It is possible to improve prevention by addressing the first two problems even while financial resources remain limited. This could be done most productively in three areas discussed below: public education, HIV testing, and medical education. Success in creatively implementing the law should reduce the pressure for additional resources in the long run.

1. Public Education

Preventing HIV transmission is the best way to bring the epidemic under control and limit its increasingly damaging effects on the country. HIV cannot be transmitted casually, so almost everyone is capable of protecting himself or herself from infection, if they know how and are willing and able to do so.¹ Therefore, it is critically important that everyone in the population clearly understand how HIV is transmitted, how they could be exposed to infection, and what steps they can take to prevent transmission.

Although HIV infection is most prevalent in high risk groups, like drug users, sex workers and men who have sex with men, HIV can infect anyone. It is impossible for an ordinary citizen to identify another person as having HIV infection. To be most effective, therefore, prevention education must reach everyone in the population. While resources are limited, the most cost-effective educational programs should target groups at highest risk of HIV infection in the Russian Federation.

Prevention education must provide information that is explicit, detailed and understandable by people of all educational levels and cultures. Educational programs can and should be provided in many forms, including advertisements on television, radio, and public transportation, brochures in polyclinics, and classes in schools. The most important goal is to reach the intended population so that no one remains ignorant of what he or she can do to protect himself.

Few people have the time, resources or inclination to learn about HIV on their own initiative, so social institutions like government and NGOs must provide the necessary prevention education. The federal government has ample authority under the Federal HIV Law to initiate prevention education activities and to encourage NGOs to do so. Article 4 of the Federal HIV Law mentions “regular information for the public on available means of HIV prevention” as the first type of program or service that federal and Subject governments are responsible for providing.

Unfortunately, prevention programs have received little funding. Consequently, the population in general is likely to have an inadequate appreciation of HIV and how it can be prevented and treated. High risk groups that are most likely to contribute to the spread of disease may remain unaware of how to avoid becoming infected or how to prevent transmitting infection.

A disproportionate share of funding for HIV/AIDS programs appears to be spent for HIV testing instead of prevention education. As noted in section I.2 below, routine HIV testing creates large expenses without yielding significant benefits. Testing merely determines whether a person is infected with HIV. By itself, testing does nothing to prevent disease or disease transmission. Specific prevention education is necessary to learn how to prevent disease.

¹ There can be transmission through forced contact, like rape, that is not preventable. In the rare cases of transmission from blood transfusions and organ transplants, medical authorities can take effective measures to eliminate infected blood and organs.

However, it is not necessary to test anyone for HIV in order to teach people how to prevent disease. Therefore, testing is not a necessary component of HIV prevention programs.

Prevention education should be the first priority of the HIV/AIDS program. Financial support for unnecessary HIV testing should be shifted to public prevention education programs. This would allow immediate development and implementation of prevention programs without the need for additional funding. Such programs should be supplemented by additional funds as soon as possible.

NGOs that work with populations that are at risk of HIV, especially drug users, sex workers, homeless people, and people discharged from prison, may be well suited to help develop and provide appropriate prevention education programs in formats that these populations understand and find persuasive. Because people at risk for HIV are also at risk for other diseases, HIV prevention education should be coordinated with government authorities and NGOs that work with prison populations and those concerned with tuberculosis and sexually transmitted infections (STIs) prevention and control.

Education programs should also provide information about how the Federal HIV Law protects individuals and the confidentiality of their medical information in order to encourage people to seek appropriate medical care and more specific information. People should be aware that they should not be penalized if they are found to have HIV and that some forms of assistance are available. Educational programs can help the general population to become less fearful of people with HIV and more willing to help prevent the spread of disease. The more people know about HIV, the more likely they are to treat people with HIV like everyone else. This change in public attitudes may also encourage more people at risk of HIV to participate in prevention and treatment programs.

2. HIV Testing

Current approaches to HIV testing could be substantially improved to save money and to ensure compliance with the law. As noted in section I.1 above, vast resources are being spent on HIV testing that has little or no potential for preventing disease or controlling the epidemic. HIV testing for the general population appears to be a waste of scarce resources. Most of this testing could be eliminated and the money spent instead on prevention education programs that are likely to have far more success in reducing the spread of disease.

HIV testing programs should be targeted to individuals who are at risk of HIV infection and need to know their own medical condition. There is evidence that most HIV tests are given to the general population of individuals, including hospital patients, who are not at high risk for HIV infection. This approach, which is not consistent with general practice around the world, unnecessarily increases the cost of identifying people with HIV and misses a large proportion of HIV cases that could benefit from medical attention. The cost is high because millions of HIV tests are performed, but only a tiny number of cases of HIV are found among the general population. People at risk for HIV may not be part of that population tested for several reasons. High risk groups are often marginalized in society, have little access to health care facilities where testing is conducted, or avoid testing for fear of discrimination or criminal prosecution.

Where financial resources are scarce, the most efficient and cost-effective way to detect cases of HIV infection is to offer tests to groups at the highest risk of infection.

High risk groups may be reluctant to participate even in targeted screening programs unless they believe that they have more to gain than to lose from being identified as HIV positive. Currently, there is little benefit to being tested for HIV. Testing is rarely accompanied by useful information about how to interpret either a positive or negative test result. A negative test can be counterproductive if it encourages a person to engage risky behavior in the mistaken belief that he or she is not likely to become infected or to transmit an infection to others. Such behavior can also increase the spread of sexually transmitted diseases (STIs) or blood-borne diseases like hepatitis B. If a person is not taught how to avoid becoming infected in the future, he is no better off than he was without a test.

A person who receives a positive HIV test result faces even worse prospects. He or she may fear being treated as an outcast, fired from his job, abandoned by his family or prosecuted as a criminal and have little hope for a normal life. There are limited supplies of drugs to treat HIV and the drugs are unaffordable to many people. In these circumstances, there is little reason to expect high risk groups to volunteer for testing in which their identities are known. In the absence of effective education programs targeted to such groups, they are not likely to get tested unless they are assured that testing is completely anonymous. Even anonymous testing may prove ineffective unless it is accompanied by extensive counseling about how to obtain treatment and how to prevent transmitting the disease to others. If educational and anonymous testing programs are not available, people who have HIV may remain in ignorance and contribute to the spread of the disease.

Counseling individuals about how to prevent disease and how to obtain treatment for disease is critically important to control the HIV epidemic. Testing offers an opportunity for this type of counseling. Indeed, the educational component is more important than the testing, and there is little point in testing without appropriate counseling. As other countries have learned, effective education and counseling requires extensive explanations of HIV infection and how to prevent its transmission. It is not sufficient to simply tell people they should not use drugs or have unsafe sex, for example. Not everyone can always control the urge to use drugs or have sex. They need to know how to avoid infection even if they use drugs or have sex.

Individuals may be reluctant to participate in programs intended to prevent disease transmission or even seek medical care unless they are confident that they will be protected against involuntary testing. The Federal HIV Law contains several provisions protecting the rights of individuals with HIV, but these rights are not always respected in practice.

The Federal HIV Law prohibits testing anyone for HIV without that person's voluntary consent.² However, it is likely that individuals are tested without their consent in violation of the law. Focus group sessions revealed that some hospitals and polyclinics have a policy of routinely requiring patients—especially surgical patients—to submit to HIV testing. Others may test patients' blood for HIV when other blood tests are being conducted, without the patient's

² Limited exceptions require testing workers who work with the HIV virus or HIV infected patients, as well as testing blood, tissue and organs for donation for transplantation.

knowledge. For example, a 1979 law authorized involuntary STI tests for patients who were reasonably believed to be infected with an STI. Other laws authorized compulsory testing of prisoners, military personnel, drug users, pregnant women, and homosexual men. Although the 1995 Federal HIV Law should have superseded this law and thus no longer permit involuntary HIV testing, some health officials may mistakenly rely on earlier law to require involuntary testing. In addition, local government authorities may impose their own testing requirements in violation of federal law in response to increases in the population of sex workers, migrant and temporary workers and drug users.

Although empirical data on the current practices is limited, there is reason to believe that involuntary testing may be widespread. Historically, the medical profession has routinely conducted many diagnostic tests on patients without explicit prior patient approval, and patients often acquiesce in their physicians' recommendations even when they are uncomfortable doing so. Since testing alone does not decrease HIV transmission, and involuntary testing violates the federal law, steps should be taken to end involuntary testing wherever it occurs. Ideally, a survey of practices could be undertaken to identify where unlawful testing is most frequent so that efforts could be concentrated in those areas. However, in the absence of time or resources to conduct such a survey, the Ministry of Health should issue guidelines for compliance with the Federal HIV Law (accompanied by an explanation of its rationale) to all government authorities and all medical facilities. These guidelines should make clear that HIV testing is a diagnostic tool and not a preventive measure and cannot be performed without an individual's voluntary consent (except where exceptions apply) given after the individual has received adequate counseling about the meaning and consequences of its results. In addition, as noted above in section I.1, public education should include information about the rights of individuals so that patients understand that they are under no obligation to be tested for HIV and need not avoid medical care for fear of being tested for HIV.

3. Medical Education

In the absence of a national prevention education program, physicians are a primary source of information about HIV and HIV prevention. However, few physicians have more than superficial knowledge in these areas. AIDS centers have the advantage of concentrating specialized physicians in one place, but they may not be able to accommodate the need for information and services as the epidemic spreads. Currently, the existence of AIDS centers may create incentives for other physicians to pay little or no attention to HIV issues. Physicians who practice outside the AIDS centers, infectious disease hospitals and dermatology/venereology clinics appear to know little about HIV prevention and treatment beyond testing for HIV. Consequently, individuals who see physicians in regular polyclinics and who need to learn how to protect themselves from HIV infection may not obtain the information they need. As the risk of HIV infection rises, the need for physicians who are not HIV specialists to provide this information will also increase.

There is some evidence that physicians who lack experience with high risk groups are not familiar with ways to encourage patients to prevent HIV transmission. They may also have misperceptions about high risk groups and people with HIV that interferes with their ability to provide appropriate care. NGOs who offer AIDS education complain that few physicians know

how to treat drug users other by telling them to stop using drugs. Educating patients requires establishing a trusting relationship with the patient and taking the time to discuss embarrassing behaviors and give advice in nonjudgmental terms, which may be difficult for physicians who are overworked and unfamiliar with prevention education techniques. Patients may be reluctant to ask important questions, so that it is often incumbent on the physician to find out what the patient needs to know.

Some physicians in the Focus Groups conducted for Boston University who see HIV patients had apparently learned these counseling techniques, and they were quite positive about their experiences. They were also more knowledgeable about the disease than physicians who do not typically see patients with HIV and less likely to view high risk groups as difficult patients. This is consistent with the evolution of physician attitudes in other countries, where physicians became more receptive to patients at risk for HIV and more effective in their prevention efforts when they learned more about HIV.

Physicians are likely to be open to education and training in HIV prevention and sensitivity to high risk group concerns. Such training may also improve treatment of patients with HIV. As physicians become familiar with high risk group behavior, they may become more willing to trust patients to follow the somewhat complicated drug regimen for HIV treatment and provide treatment to a larger proportion of the population. Although the drug supply is limited and the drugs expensive, more patients could benefit from the drugs that are available. Moreover, it is possible that drugs may become less expensive and more easily available in the future.

Physicians in general are ordinarily eager to learn more about medicine and how to help their patients. There are many ways to educate physicians and medical education should take advantage of as many as possible, beginning with the university medical curriculum for training medical students. Physicians already in practice may prefer specific HIV educational conferences and workshops or practice guidelines developed by those with expertise and perhaps disseminated by the Ministry of Health. Not all physicians who need to learn about HIV may seek out specific information, for lack of time or interest. It may be possible to reach such physicians by including presentations on HIV prevention and treatment in educational programs directed at other topics.

Medical education programs should include basic information about the etiology of HIV, transmission of infection, methods of preventing infection, progression of disease, and treatment for HIV, opportunistic infections, and related complications, and how to discuss these topics with patients effectively. Medical education programs should also explain the laws governing HIV that affect physicians and their patients, and, equally important, how these laws help prevent disease by protecting individuals.

In addition, medical education should include training in the use of universal precautions to prevent HIV infection in medical facilities. Universal precautions also can prevent the spread of other infections, including hepatitis B, and should replace the practice of testing patients for HIV in hospitals. Medical facilities should provide the same training to non-physician personnel so that the precautions become standard practice throughout the country.

Physicians may be the only source of HIV prevention information for many people for some time to come. Therefore, it is essential that physicians be knowledgeable about HIV prevention. It is important that people who may be unwilling to go to specialized clinics learn about HIV prevention from the physicians that they do see. Physicians can be a catalyst for changing public opinion. Properly informed, they can make a substantial contribution to preventing the spread of HIV.

II. CRIMINAL LAWS THAT DISCOURAGE HIV PREVENTION

Criminal laws intended to deter one kind of harm sometimes have the paradoxical effect of increasing other kinds of harm. This is particularly true of criminal laws prohibiting intimate personal behaviors that occur in private, like sex and drug use. Criminal prohibitions rarely outweigh human desires, addictions or compulsions—personal or financial—to engage in sex or use drugs. All countries face problems of balancing the effects of specific laws on public health and safety.

Several criminal and administrative laws in the Russian Federation have the potential for unintentionally increasing the risk of transmission of HIV and other STIs without achieving their public health or safety goals. These include laws concerning narcotics, HIV and STI transmission, residency, and prostitution.

1. Harm Reduction Programs

The Federal Law on Drugs and Psychotropic Substances (Narcotics Law) is intended to stop or reduce the use of dangerous, addictive drugs in the Russian Federation. Article 46 of the Narcotics Law is intended to prevent encouragement of drug use by prohibiting “propaganda aimed at spreading information about ways, methods of exploitation, production and use” of illegal drugs. However, there is anecdotal evidence that some people interpret this provision to prohibit even advice given by a physician to a drug user on how to avoid HIV infection when using drugs. This interpretation may lead physicians and other health professionals to avoid participating in so-called “harm reduction” efforts that teach drug users to prevent HIV transmission by sterilizing equipment, drugs, and additives. It is not clear how widespread this interpretation is. Several physicians in the Focus Groups conducted for Boston University reported that they did not consider this type of patient education to be propaganda in violation of the law.

The text of Article 46 does not explicitly prohibit harm reduction information. The term “propaganda” is not defined and there is no list of prohibited activities or information beyond the general description. Therefore, there may be no reason to for anyone to fear prosecution under this law. If, as it appears however, people perceive the law as threatening them with prosecution, then they are unlikely to provide harm reduction information. Therefore, the law should be clarified to assure the public, especially physicians and workers in narcology clinics, that it is lawful to provide information to drug users on how to prevent becoming infected with HIV.

Some people object to providing harm reduction information because they believe that such activities send a message that drug use is acceptable. Other countries' experience with harm reduction programs provides considerable evidence that telling drug users how to avoid getting and transmitting HIV does not encourage them to use drugs, but does help prevent the spread of disease. Private counseling by a physician does not send any public signal to the general public. Drug users who receive this information can avoid HIV infection themselves or prevent infecting their sexual partners. Although it is often called harm reduction information when provided to drug users, advice on how to prevent disease is better understood as one piece of the information that should be provided as part of the larger public prevention education effort. Harm reduction programs also offer an opportunity for health professionals to gain the trust of drug users and encourage them to enter drug treatment programs or attempt to stop using drugs on their own.

Stopping drug use is a laudable goal. However, drug use appears to be on the rise in the Russian Federation, in spite of severe criminal laws prohibiting it. Since drug users are a significant source of HIV transmission, prevention efforts cannot be effective unless drug users participate in controlling the epidemic. Harm reduction information is analogous to condom distribution. It is understood that public support for condom use does not mean that the public encourages promiscuous sexual activity. Rather it recognizes the reality that some people will have sex anyway and if they do, they should be able to protect themselves from infectious disease. Everyone is better off when disease is prevented. This was the rationale for giving condoms to soldiers in the world wars and it worked to reduce the incidence of sexually transmitted diseases (STIs). When soldiers were only warned not to visit prostitutes and not given condoms, the rates of STIs soared and tens of thousands of soldiers were unable to participate in active service. When they were warned not to visit prostitutes and given condoms for cases in which they could not resist, there was no adverse effect on the ranks of healthy, active soldiers.

Harm reduction efforts could be encouraged by simply issuing guidelines for interpreting Article 46 of the Narcotics Law that make clear that the law does not prohibit providing harm reduction information. However, in light of the need to reduce HIV infection among drug users, harm reduction programs should not only be permitted, but also encouraged. Guidelines clarifying the law and encouraging harm reduction could be targeted, at least initially, to specialists in narcology who are most likely to see drug users. Such specialists should be well qualified to explain how to reduce the risk of HIV infection while at the same time discouraging continued drug use. However, not all drug users who could benefit from harm reduction efforts may see narcology specialists. Therefore, special programs outside the clinics should be developed to reach more drug users. Needle exchange programs are more visible than physician-patient discussions inside a clinic. However, if they are located in places that drug users already populate, as they should be, then their presence may improve the local situation.

2. HIV and STI Transmission

People may fear diagnoses with HIV or even a sexually transmitted diseases (STI) because of the history of paternalistic STI treatment in the Soviet era, including required treatment in specialized clinics for long periods of time, informing the patient's employer, and

stigmatization. Patients with HIV are highly susceptible to STIs, and patients with an STI are at risk to get HIV infection. Therefore, both treatment and prevention efforts for HIV and other STIs should be coordinated. Similarly, laws that affect individuals with STIs also affect those with HIV and should be evaluated together.

Two Articles in the Criminal Code may discourage high risk groups from seeking diagnosis or treatment for HIV or STIs. Article 121 makes it a crime for anyone over the age of 16 years to “knowingly infect” another person with a venereal disease. A former law (former article 115, no longer in effect) also made it a crime to “intentionally endanger” another person with the risk of venereal disease. In theory, current Article 121 is less onerous because it requires actual infection, whereas the former article 115 also prohibited merely exposing someone else to infection. However, in practice, there may be little difference between the two. The behavior that merely exposes a person to an STI (unprotected sexual acts, sharing drug paraphernalia) is the same behavior that can transmit an STI to that person. It is impossible to determine in advance whether a particular act will actually infect the other person. A person can never know whether they are violating Article 121 until after the fact. Therefore, people who are aware of the criminal prohibition against actual infection may recognize that they are vulnerable to prosecution with each act of exposure. If, as is equally likely, the general public is not aware of the technical difference in the laws, then people with an STI may believe that they are subject to criminal prosecution if they are discovered to have had sex with another (uninfected) person or to engage in any other act that might transmit infection. Indeed, a physician in the focus groups conducted for the Boston University HIV Project reported his belief that people could be prosecuted merely for exposing another person to an STI. Thus, the well intentioned change in the law (eliminating article 115) may have made no practical difference in people’s perceptions of the law or the law’s practical effect on people’s behavior.

More important, there is an obvious way to avoid prosecution under the laws, and that is to avoid learning whether one has an STI. Article 121 requires that the accused person “knowingly infect” another person; that is, the accused must have knowledge of his or her own infection in order to deliberately infect another person. This creates a powerful incentive for people to avoid testing and diagnosis. People who do not know that they have an STI suffer needless illness and are more likely to unwittingly transmit the infection to others. Thus, these laws may increase the spread of the diseases they were intended to stop. In addition, people may avoid health care for other conditions in order to avoid detection with an STI. The health care system then loses an opportunity to educate them about preventing STIs and treating other conditions.

The same problem arises under Article 122 of the Criminal Code, which applies to HIV infection. Article 122(1) makes it a crime to intentionally expose another person to HIV infection, regardless of whether the other person becomes infected. Article 122(2) makes it a crime to intentionally infect another person with HIV. It appears that the lawmakers considered HIV to be more dangerous than an STI; so merely exposing another person to HIV is a crime, whereas merely exposing another person to an STI is not. However, as explained above, there may be no practical difference between making exposure a crime and not making it a crime. These provisions create an incentive to avoid being tested for HIV so that one cannot be responsible for knowing one’s HIV status or intentionally exposing another person to HIV. Sex workers are

likely to be particularly discouraged from learning their HIV status; a sex worker who knows she is HIV positive could be considered to violate Article 122(1) with every unprotected encounter.

Laws like these are often symbolic of public outrage at people who recklessly endanger others by refusing to take precautions against transmitting disease. However, they are very difficult to enforce. The dangerous activity takes place out of public view. Victims may not be able to identify the source of their infection or may not seek help from the police. Successful prosecutions require proof of knowledge and intent on the part of the accused. Laws that cannot be enforced are unlikely to achieve their goals. Given the continuing increase in the incidence of HIV and STIs, it is unlikely that these laws have reduced the spread of disease. On the contrary, they may drive disease further underground and increase its devastation.

Article 45 of the Administrative Code, which prohibits people infected with STIs from concealing their disease or the identities of their sexual contacts, may compound the problem of public reluctance to get tested for HIV and STIs. The negligible financial penalty (amounting to less than US\$2.00) is unlikely to encourage people to disclose their own status or outweigh any fear of prosecution for transmitting disease to other people. In theory, the Federal HIV Law prohibits involuntary HIV testing, so that public health authorities must rely on people voluntarily coming forward to disclose their contacts. However, since people with HIV often have other STIs, they may be reluctant to get tested for STIs for fear of identifying themselves as HIV positive. It should be noted that a similar provision in the former criminal code that prohibited avoiding treatment for venereal disease was eliminated, as part of a shift from treating STIs more like health problems than crimes.

Other countries have implemented successful contact-tracing programs that help reduce HIV incidence by guaranteeing the confidentiality of any person who discloses his infection and his sexual contacts' identities. Public health officials can then offer assistance to the contacts without revealing the identity of the original "index case." The Russian Federation should consider establishing a more effective contact-tracing program that does not obligate any person to disclose his infection, but instead encourages everyone to provide information to enable public health officials to provide help to contacts. This may require repealing Article 45 of the Administrative Code and assuring the public that every person tested will remain anonymous in all contact-tracing efforts.

Ideally, one would like to know how many people are actually afraid to seek medical care for fear of being prosecuted because of having HIV and possibly transmitting it to others. One would also like to know how many individuals have been successfully prosecuted under these laws and whether such prosecutions have succeeded in reducing the spread of disease transmission. Such data could be collected as part of a larger survey of high risk populations. However, even in the absence of such data, the clear incentives created by such laws for people to avoid medical care and the minimal probability of enforcing such laws argue strongly in favor of their repeal. Repeal should be accompanied by widespread public advertising, especially among high risk populations, in order to encourage them to seek medical care and prevention education.

Repealing these laws would not endanger the population because they are not really necessary to protect against disease. Most people can protect themselves from infection by taking precautions and avoiding risky behaviors. Public education is the best way to ensure that all people know how to protect themselves. Most people can refuse to participate in unprotected sex or drug use. Of course, victims of rape cannot protect themselves, but rape is already a crime, and the HIV and STI laws are not likely to deter rapists any further. People who become infected from blood transfusions and organ transplants are not protected by these laws, but by effective blood and organ screening programs. Thus, there are better ways to protect the general population than these laws offer.

3. Residency Permits

Article 178 of the Administrative Code requires registration of residents who intend to stay in the Russian Federation longer than a certain period of time. In addition, Moscow, which has a large population at risk for HIV, has a city ordinance that requires citizens of the Commonwealth of Independent States (CIS) to register with the police department. People who are not registered are subject to monetary fines, but there is no authorization for deporting them. The registration systems interact with the medical care system in ways that discourage HIV prevention.

The registration system has not prevented large numbers of people from coming to the Russian Federation, and to Moscow in particular, without registering. Some may arrive voluntarily without any permit. Others may have their permits confiscated by unscrupulous businessmen or pimps in order to force them to work as prostitutes or in factories or other places in conditions of servitude. Those without permits remain hidden from authorities. This clandestine existence makes these populations more vulnerable to HIV and STIs because they are more likely to associate with high risk groups and be exposed to infection, voluntarily or involuntarily, and they are less likely to have access to medical care. It is all the more important, then, to make sure that they can protect themselves from HIV and that they are well-informed about how to prevent HIV transmission to others.

It is possible that some authorities may demand permits of people who are not required to have them. If so, then this misinterpretation or misapplication of the law should be corrected so that people are not unnecessarily discouraged from obtaining needed care.

Public education programs should help disseminate information to unregistered individuals. However, they also need medical care and advice. As long as patients are required to register or present a passport or other identity document as a condition of receiving medical care, those without permits are likely to be unwilling to seek medical care. People in the shadow of the law are not likely to be motivated by criminal prohibitions against HIV transmission, when they face more severe penalties—disruption or end of their livelihood—from other laws.

The Russian Federation should consider creating confidential walk-in clinics in locations with high concentrations of undocumented individuals to provide care, at least for HIV and STIs, without requiring valid registration or permits. This would allow undocumented individuals to receive needed services and prevention education, without fear of being reported to the police.

These confidential clinics should be independent of the regular system of health facilities and should be allowed to keep their own local records confidential without any link to other official records. HIV and STI care can be provided effectively without the need for linking to an official medical record that would entail registration and without reporting the patients' identities or location to any government authorities. Clinics could report anonymous data on the incidence and prevalence of infections in order to improve the quality of national health statistics and assist in planning prevention and treatment programs for the future.

Confidential clinics that protect their patients' identities are likely to attract individuals who would not otherwise seek care—the very people who may need it most. These confidential clinics should be able to charge fees to patients for medical services and medications in order to pay their expenses. This would have the advantage of reaching high risk populations without incurring additional expense to the regular health care system.

Offering confidential HIV and STI services to undocumented persons is analogous to the practice, authorized by law in other countries, of providing medical treatment for STIs to adolescents without the consent of their parents. This exception to the general rule that parents must consent to medical treatment for their children has proved both necessary and effective to encourage adolescents to obtain necessary care that they would not seek if they had to tell their parents.

4. Sex Workers

Sex workers are at high risk for HIV and STI infection themselves and also may transmit HIV and STIs to a wide variety of individuals in the population. Clients who contract HIV from a sex worker may, knowingly or unknowingly, transmit the infection to spouses and other sex partners wherever they live or travel. Thus, it is critical to reduce HIV infection among sex workers and to ensure that take precautions to prevent spread of the disease.

Reducing HIV among sex workers is essential because sex work is not likely to be halted or even significantly decreased in the foreseeable future. Apart from the impossibility of eradicating the “world's oldest profession,” there are substantial economic incentives to earn money by selling sex in the Russian Federation. At the same time, there is no generally applicable law that prohibits a woman or a man from having sex with another person in exchange for money (or other valuable goods or services). The criminal law rightly focuses on protecting women and children from being forced into commercial sex work (prostitution) without their consent. Thus, the criminal law does not provide any deterrence against people engaging in sex work using their own bodies. Even countries that make prostitution a crime have not eliminated prostitution.

Sex work, and therefore HIV transmission, is not limited to prostitutes. Many people who exchange sex for money do not consider themselves to be prostitutes because they do sex work only occasionally to obtain money or drugs. Therefore, effective HIV prevention and control programs must include all sex workers, both commercial prostitutes and occasional sex workers.

Sex workers can be taught how to prevent HIV infection and how to prevent infecting their clients through targeted prevention education programs. Until such programs begin to reach large numbers of sex workers, physicians are likely to be the best source of educating sex workers who seek medical care for STIs or reproductive concerns. Sex workers who want medical care, especially for STIs or HIV, may seek it from physicians who promise not to report either the patient's identity or disease to public health authorities or police. Such physicians may charge high fees that sex workers must pay out-of-pocket. Many sex workers are undocumented persons who avoid regular government medical facilities for fear of discovery. Managers or pimps may discourage their sex workers from having any contact with regular government health facilities. Some brothel-keepers move frequently in order to avoid being prosecuted under Article 241 of the Criminal Code, which prohibits having a permanent place of business for a brothel for prostitution. Their peripatetic existence makes it difficult, if not impossible, for public health authorities and personal physicians to keep track of individuals and their health status. For sex workers, confidential clinics, discussed in section II.3 above, offer an attractive alternative to government facilities and may provide better care for their needs. They can also provide essential prevention education.

Sex workers are vulnerable to arrest by police on minor charges such as minor hooliganism (Administrative Code, Article 158), which gives police broad discretion to detain individuals for "humiliating solicitation to people and other activities that violate public peace and order." They are also vulnerable to arrest for lacking residency permits. Such arrests may invite corruption if sex workers find they can buy their way out of an arrest by paying off the police. They may also discourage sex workers from putting any faith in the law to protect them, so that they are skeptical even about physicians' sincere promises of confidentiality and help. There is no reason to use the law to discourage sex workers from preventing disease.

Although several of the laws discussed above create incentives for sex workers to avoid medical care and detection, it is not clear how many sex workers or undocumented persons actually do so. Therefore, any research conducted with these populations should include a component (which may be a single question in a survey instrument) that measures whether and to what extent the law deters them from seeing medical care. The results can be used to locate confidential clinics where they would do the most good and to inform future legal reform.

CONCLUSIONS

Law should make it possible for Russians to protect themselves from HIV infection and for health professionals to help patients. The Russian Federation has a good legal foundation for public health programs to reduce the spread of HIV. Law is not self-executing, however. It takes national leadership to initiate the kind of programs that can control the HIV epidemic.

Most countries that have brought HIV under control have done so by the exercise of strong political leadership in support of public health goals, including effective efforts at prevention. This sometimes means adopting nontraditional measures that might be distasteful to some segments of the population but have proved necessary to prevent far more illness and expense. For example, the conservative United States Surgeon General C. Everett Koop, who

objected to homosexuality, prostitution, and abortion on religious and moral grounds, initiated a campaign to promote explicit HIV prevention education, including the use of condoms, because he found that the epidemic could not be stopped without such measures and concluded that it was more important to protect the population's health than to yield to objections by individuals not affected by the epidemic. Countries like South Africa that have not taken a strong stand to control HIV have seen their populations devastated by the disease.

The Russian Federation can begin to take control of the epidemic by shifting its programmatic and financial priorities from testing people for HIV to providing accurate information about how to prevent HIV infection—to the public at large and to high risk groups and the medical profession in particular. Russians must have the information as well as the motivation to protect themselves. Only effective education programs can achieve these goals. In the absence of effective national prevention education, physicians may be the only reliable source of information on how to prevent and treat HIV infection. Therefore, physicians should be the focus of targeted educational efforts that help them help their patients.

The Ministry of Health can demonstrate effective leadership by replacing routine HIV testing with these educational programs. The most effective first step would be to issue guidelines encouraging physicians to provide harm reduction information to drug users and assuring physicians that they will not be subject to prosecution for advising their patients how to avoid HIV infection. Another step would be to create confidential clinics to accommodate undocumented individuals, including sex workers, who need HIV and STI services and information without fear of legal repercussions.

Protecting the public from infectious disease is more often achieved—with fewer resources—by providing health information and services to those infected or at risk than by turning them into criminals. The criminal laws discussed above are not likely to be effective in preventing disease transmission and may undermine other well intended health programs. These laws can deter people at risk of HIV infection from learning how to prevent disease, seeking medical care, getting tested for infections, and helping public health officials with contact tracing. They may also limit opportunities for physicians to provide prevention information. Laws that use physicians as the source of information for criminal prosecutions and administrative penalties undermine the trust necessary to the physician-patient relationship and convert physicians into agents of police enforcement. Controlling the HIV epidemic requires removing counterproductive criminal law deterrents to care and replacing them with effective education and treatment measures.

Relevant Boston University HIV/AIDS Project Documents

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