HEALTH PROMOTION IN THE FIELD OF SUBSTANCE MISUSE IN POST-SOVIET RUSSIA

by

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ABSTRACT

This thesis is an investigation into health promotion in post-Soviet Russia in the field of substance misuse defined as the problematic and chaotic as well as recreational use of alcohol, solvents and both prescription and illicit drugs. The thesis outlines and analyses developments in the provision of health promotion in Russia since the collapse of the Soviet Union in 1991 in two areas: institutional shifts in the provision of health promotion (the relative and changing roles of state, non-state and international actors); and changes in content and form of health promotion messages.

The hypothesis that health promotion in the field of substance misuse in post-Soviet Russia remains fixed within a medical model of health is tested through an analysis of the way in which health promotion is developing in two regions – Saratov and Sverdlovsk oblasts. The relative and changing roles of state, non-state and international actors in the development of health promotion interventions, and the way health education materials framed the issue of substance misuse, both illuminated significant barriers to the development of alternative community empowerment approaches and confirmed that the medical model of health is indeed still hegemonic among approaches to health promotion in post-Soviet Russia.

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INTRODUCTION

This thesis is an investigation into health promotion in post-Soviet Russia in the field of substance misuse, defined here as the problematic and chaotic as well as recreational use of alcohol, solvents and both prescription and illicit drugs. The emphasis is on developments in the provision of health promotion in Russia since the collapse of the Soviet Union in 1991 in two areas: institutional shifts in the provision of health promotion (the relative and changing roles of state, non-state and international actors), and the changes in content and form of health promotion messages. The thesis provides an in-depth study of how health promotion in a politically very significant social issue is being constructed. It presents valuable information on how Russia perceives the state of its nation's health while at the same time it evaluates the extent to which health promotion is being shaped by wider ideological changes.

In Soviet times health promotion was the preserve of the state, whose ideology shaped the nature of health education around substance misuse. There was an official denial of any drug or solvent problem prior to the Gorbachev era and figures on the levels of alcohol consumption were suppressed. The official line was to regard addicts as 'deviants' who operated outside 'normal' Soviet society, and their marginality was emphasised in the media and high-profile health education campaigns. However, from the Gorbachev era onwards there has been increasing public awareness and concern about substance misuse, particularly in relation to drugs and young people. Substance misuse has been a growing problem in Russia since the collapse of the Soviet system and the high levels of alcohol consumption have been cited as a significant factor in the country's 'demographic crisis', which has created negative population growth and reduced the life expectancy for men to a low of 57.6 years in 1994 (Leon et al. 1997). The pre-1991 life expectancy for either men or women has still not been regained (UNICEF 2001: 10-11). This 'alcoholisation' of Russian society has also been coupled with a sharp increase in the misuse of both licit and illicit drugs, termed the 'narcotisation' of Russian youth (see Popov and Kondrat'eva 1998). Both of these have been framed as symptomatic of the psychosocial effects of

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Russia's political, economic and social flux, with the attendant increase in poverty and exclusion since the end of the Soviet Union (Shaw et al. 1999).

Before introducing the nature and content of this thesis, it is first necessary to unpack and contextualise some of the terms which have been used. The concept of 'health' is one which is notoriously difficult to define, but some clarification is essential before any understanding of the nature of health promotion is possible. Beliefs and definitions of health and illness are at once individual and social; they are influenced by the prevailing social and medical ideologies and are therefore culturally sensitive (Nettleton 1995: 46). Definitions of health contain within them complex ideas about what it is to be healthy, whose responsibility it is to maintain health and how illness and disease should be interpreted (Jones 1997b: 18). The medical definition of health – the absence of disease or disability – has been rejected here in favour of the more positive World Health Organisation (WHO) definitions of health; as Annandale argues, health and illness are not polar opposites and it possible to be both 'healthy' and 'ill' at the same time (Annandale 1998: 262).

The original WHO definition of health as "a complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity" (WHO 1978: 1), when it was first developed in 1946, was groundbreaking in its holistic emphasis. However, it is an idealistic description that subsequently became viewed as unattainable and so irrelevant to the lives of most individuals (Nutbeam 1986). Therefore, 'health' was reframed by WHO as a 'resource for living' rather than just an object or an end in itself (Jones 1997b: 19). In the Ottawa Charter health was defined more broadly, embedding health in the processes and actions of people's everyday lives: "[Health is] the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and on the other hand, to change or cope with their environment. Health is seen, therefore, as a resource for everyday living; it is a positive concept emphasizing social and personal resources as well as physical capabilities." (WHO 1986). This definition is positive and inclusive because it draws attention not only to individual biology and to medical services, but also to conditions in the wider natural, social, economic and political environments; health is not just about avoiding or delaying death (Jones 1997b: 19). For the purposes of this work it was also deemed most appropriate to use the WHO definition, which applies

as a worldwide standard and has been ratified and accepted as such by both the Soviet and Russian medical and political elites.

The underlying ideology behind the WHO definition of health – as outlined in the Ottawa Charter (1984) – is central to finding a workable definition for health promotion also. In the Ottawa Charter, health promotion was defined as "the process of enabling people to increase control over, and to improve their health." (WHO 1986) This WHO definition therefore roots health promotion in the empowerment of individuals and communities, making it essentially political. The empowerment basis of health promotion can be neatly summarised in the Tones and Tilford formula:

Health Promotion = Health Education X Healthy Public Policy

The balance between health education interventions and healthy public policy initiatives is culturally and politically determined and therefore varies from one country to another. Neither health education nor health promotion are unitary processes with universally accepted philosophies or clear goals, as these are dependent on the practitioner's, or indeed the state's, underlying approach to health improvement (Tones and Tilford 1994: 1). Health education has been defined by Tones and Tilford in relatively broad terms as any activity which provides people with an informed basis for making choices (Tones and Tilford 1994: 1). It is the process by which people work towards increasing their understanding of health issues and their capacity and confidence to try and change their cultural, socioeconomic and physical environment in order to improve their health. Public policy initiatives are considered 'healthy' when they are actively designed to facilitate behavioural and environmental changes which will improve health. Therefore, in this thesis, policy initiatives around substance misuse at both a local and federal level in Russia have been approached in terms of their health promoting capacity.

The central aim of this thesis is to assess whether or not health promotion in the field of substance misuse remains fixed within the medical model of health in post-Soviet Russia. At a global level, the drugs issue, for example, has been linked to 'social exclusion' – it is so widespread that it can no longer be explained as an individual problem (MacGregor 1999: 80-1). However, at a national level, in the West, the

medical approach to substance misuse issues has informed social policy, and so health promotion, in this area (see MacGregor 1999); although alternative approaches – particularly towards providing services for drug users – have come through grassroots and community-based movements (see Lane et al. 2000). State-led health interventions around substance misuse in both the Soviet Union and post-Soviet Russia have been framed similarly within the medical model of health (see Chapter 2); and the capacity for grassroots movements to provide alternative approaches is assessed as a part of this thesis (see Chapter 5). Alternative approaches to health promotion in the field of substance misuse have come also from outside Russia, either through Western aid agencies or international non-government organisations, and the impact of these 'international' interventions is assessed (see Chapter 5). The content and form of health promotion messages is analysed, in addition, as a means of assessing how far they reflect biomedical over societal factors in improving health (see Chapter 6).

This thesis contributes significantly to the field of area studies as it focuses on a neglected aspect of health in Russia. Although there are many epidemiological studies of Russia (e.g. Shkol'nikov et al. 2000) and fundamental academic study has been conducted into drinking in Russia (particularly Simpura and Levin 1997; Zdravomyslova and Chikadze 2000) and drug / solvent misuse (see Omel'chenko 2000); research on public policy generally and health promotion specifically in Russia is extremely limited, which reflects the low status of this field locally (see Tkatchenko et al. 2000). The approach taken in this thesis also builds on previous studies around civil society development in Russia (Bruno 1998; Wedel 1998; Stephenson 2000), but it is the first to concentrate on the development of non-government organisations (NGOs) and community-based programmes around alcohol, drugs and solvent misuse. Previous studies have focussed on the development of NGOs from a political, democracy-building perspective (e.g. Koehler 1999; Hemment 1999); a welfare perspective (e.g. Thomson 2001); or they have concentrated on the development of women's groups in the region (e.g. Kay 2000). This study is unique in its focus on the potential of NGOs to improve health through community empowerment. Critical sociological analyses of the content of health interventions in Russia have centred on HIV/AIDS prevention and sex education more broadly (Williams 1994; 1995; Rivkin-Fish 1999).

The findings of this thesis also contribute to the sociology of health promotion and medicine. They challenge theories around the roots of biomedical dominance in society which have been developed in relation to Western industrial and post-industrial societies (e.g. Hart 1985); but they also question the utility and relevance of community empowerment models, which have been developed for Western liberal-democratic states, to post-socialist states (e.g. Tones and Tilford 1994). The study also contributes to the growing body of work examining the way health issues are constructed within and by societies (see, for example, Waldby (1996) on HIV/AIDS, Waterson (2000) on women and alcohol, and Plant (1999) on drugs).

In view of the current scale of the drug, solvent and alcohol problem in Russia and its complexity, a full survey of all factors affecting substance misuse in the region is well beyond the scope of a PhD thesis. Consequently, this thesis does not aim to answer cultural questions about the level or nature of substance misuse in post-Soviet Russia (for such an analysis of drug use see Omel'chenko 2000; for alcohol use see Simpura and Levin 1997).[1] For the purposes of this work it has not been necessary to quantify the number of drug or solvent users (see Omel'chenko 1999), or problem drinkers in Russia (see Nemtsov 1995; Bobak et al. 1999). Nor has it been necessary to measure the response of different client groups to specific health promotion initiatives in order to determine their efficacy (as in, for example, Stothard and Romanova 1999). Such surveys are of unquestionable value, but this work is not a sociological survey *for* health promotion, but a sociological critique *of* current health promotion initiatives in the field of substance misuse. Equally, some aspects of the interventions encountered have been contextualised in relation to the current Western debates around 'pragmatism' and 'moralism' in health promotion; but this thesis is not a comparative study, and it does not aim to be prescriptive. Substance misuse is an extremely complex socio-cultural issue, and it deserves a suitably complex and multifaceted response; such a detailed study would not be possible within the limitations of a PhD thesis.

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[1] Other contemporary sociological research in this field has concentrated on assessing the level narcotisation more than cultural issues around the context of drug use, see, for example, Popov and Kondrat'eva 1998, Kesel'man 1998, Zhuravleva 2000.

Thesis structure

This work aims to provide the reader with an empirical knowledge of the diversity of contemporary health promotion initiatives, with particular reference to regional variations within Russia, as well as a knowledge of lay and professional attitudes towards substance misuse. The critique aims to demonstrate the effective limitations to the development of different health promotion initiatives in Russia, from a social, political and financial perspective.

Chapter 1 reviews the current Western debates within health promotion in order to develop a comprehensive theoretical framework that informs the whole thesis. The five features of the medical model as outlined by Nettleton are described in detail (Nettleton 1995: 3). They serve as the basic markers for testing the central hypothesis that health promotion in the field of substance misuse remains fixed within the medical model of health in post-Soviet Russia. Empowerment models, as advocated in the Ottawa Charter (WHO 1986), are presented as the alternative to medicalised health promotion so that the potential for their development in post-Soviet Russia may be assessed. The ways in which different approaches to health promotion can contribute to social control and the development of surveillance medicine are highlighted also as contested areas that need to be addressed in a sociological survey of health interventions.

Chapters 2 and 3 serve to contextualise both the theoretical framework developed in Chapter 1 and the empirical findings from the fieldwork (as analysed in Chapters 5 and 6). Chapter 2 outlines the historical legacies of Soviet health promotion generally, but also health education and healthy public policy around substance misuse more specifically. The analysis shows that the impact of Soviet reticence in the discussion of drug use and Gorbachev's disastrous anti-alcohol campaign have had a significant impact on how initiatives and discourses in this field have developed in post-Soviet Russia. Chapter 3 presents an analysis of media discourse around alcohol and drug use throughout the 1990s which shows the ways in which the two issues are treated differently in the print media. Key narratives about young people, drug dealers and the family are identified which both reflect and reinforce the way drugs particularly are framed as a social issue.

Chapter 4 is an introduction to the methodological difficulties and concerns associated with conducting fieldwork in this area of research in post-Soviet Russia as well as an explanation of the full research process: the choice of methods and research regions; the experience of data collection; approaches to data analysis and comparative profiles of the two research regions. The methods used, namely a combination of expert interviews, observation and document analysis, reflect the nature of the information sought and the theoretical framework that underpins the thesis.

Chapters 5 and 6 present the empirical data collected in the two research regions: Saratov and Sverdlovsk oblasts. Chapter 5 uses models developed in Western studies of the 'welfare mix' to map the various actors in the two research regions in order to examine the extent to which the health promotion initiatives encountered may be seen as bottom-up community empowerment initiatives or top-down state led interventions. The difficulties associated with developing community-based programmes and lobbying for political change from a grassroots level are then explored. Chapter 6 is an analysis of the competing discourses within health education interventions in the two research regions and shows how narratives presented in the print media have been used and reinforced in health education materials. These narratives are shown to underpin an individualised and medicalised approach to health education, but an approach which is individualised more through a focus on psychological factors than on biological ones. How far these initiatives may be considered to contribute to either social control or individual / community empowerment is also assessed.

The Conclusion is a summary of the principal findings and their implications for further research and practice. The findings are used to illustrate the practical limitations and barriers to community and individual empowerment in post-Soviet Russia. These findings are then contextualised within global debates around health promotion in the field of substance misuse, and the relative imbalance between interventions around alcohol, drug and solvent misuse are addressed. The Conclusion re-examines the potential for health promotion to become a tool for social control through the expansion of surveillance medicine. The findings show that health promotion in post-Soviet Russia is still a top-down process which focuses on the individual, in spite of the sideways shifts in the form of health education and healthy

public policy around alcohol, drugs and solvent misuse between branches of biomedicine – from a biological to psychological emphasis.

CHAPTER 1: THEORISING HEALTH PROMOTION IN THE POST-SOVIET RUSSIAN CONTEXT

Health promotion is a 'magpie' discipline which incorporates aspects of sociology in its theorisation and practice as well as elements of, amongst others, psychology, educational theory, and medicine (Seedhouse 1996). This thesis is an examination of how health promotion is developing in a specific country and why it is taking certain patterns, forms and working methods. Strictly speaking, therefore, the thesis falls within the realm of the sociology *of* health promotion. The sociology of health promotion is a constituent part of the sociology of health, illness and health care. However, if research into the sociology of health is both 'undertheorized' and 'marginalised' within social theory (Annandale 1998: 3), then the sociology of health promotion has been even less extensively examined (see Caplan and Holland 1990). Nevertheless, within this narrow niche, the sociology of health promotion around substance misuse has been relatively widely debated, although generally in the context of HIV/AIDS prevention. Research into the sociology of health promotion has largely developed in relation to Western industrialised nations, although there is also now a growing body of work around the practice of health promotion in the developing countries of the South. Therefore, in view of these limitations, in order to develop theories relevant to the post-Soviet Russian context, the critical theoretical framework which has informed this thesis is necessarily wide-ranging and draws on many sources, not just those which are strictly within the field of the sociology of health promotion.

The overall aim of this chapter is to explain the critical theoretical framework which has informed the thesis and to isolate the concepts that have been used to explain its key findings. Firstly, the medical model of health is defined and critiqued as an approach to health promotion generally and in the field of substance misuse specifically. Secondly, alternative community based approaches to health promotion are compared and contrasted with the biomedical approach, as the former are currently favoured by national and international actors within the field. Thirdly, social and medical approaches to health promotion are examined in the context of

debates around the nature of risk, rationality and autonomy. The debates around risk, rationality and autonomy and the regulation of individuals and communities by the exercising of power through surveillance are outlined next. The chapter concludes with a discussion of how theories around health promotion, which were developed with Southern or Western countries in mind, can usefully be applied to the post-Soviet Russian situation.

1.1 Critiquing the Medical Model of Health

In this thesis, Nettleton's formulation of the medical model of health as being based on five main assumptions has been accepted. It provides the standard for the analysis of whether the medical model of health remains dominant in health promotion in post-Soviet Russia. The first assumption is that the body and mind can be treated as separate entities (body-mind dualism). The second is that the body is presented as a machine and the doctor a mechanic who fixes malfunctions (the mechanical metaphor); the third is a consequence of the mechanical metaphor, and is the overemphasis on technological interventions (medicine's technological imperative). Fourth, is that biomedical explanations of disease focus on biological factors to the relative neglect of social and psychological factors (reductionism) and fifth, such reductionism is accentuated by the assumption that every disease is caused by a specific identifiable agent (the doctrine of specific aetiology) (Nettleton 1995: 3). A corollary of the reductivist approach is the biomedical claim to scientific neutrality, "that medicine can be rational, objective and value-free, treating each individual according to their need and irrespective of any sense of moral worth" (Annandale 1998:7). It is through the high status afforded to the natural sciences in modern societies that the medical model of health has come to predominance (Naidoo and Wills 1994: 85). This power has grown through professional organisation, i.e. the medical profession limiting and defining who may be involved in different aspects of health care (Nettleton 1995: 31-2). Professional status has also been maintained through an exclusive professional discourse where lay definitions and terms are rejected in favour of a Latin 'standard' vocabulary.

The dominance of the medical model of health has been criticised on many levels; firstly for its objectification of the individual through body-mind dualism and the

mechanical metaphor. As Jewson (1976) argues, the shift from 'bedside' to 'hospital' and then to 'laboratory' medicine has increased biomedical power within society and has gradually removed the 'sick man' from the equation, being replaced by hospital 'cases', and then by laboratory 'cell complexes'. The site of inquiry moved from the whole individual to just the physical body and, as biomedical technology progressed, then shifted to an abstract collection of samples and slides lacking human form (Jewson 1976). Through screening, laboratory medicine, driven by medicine's technological imperative, not only breaks down the site of inquiry from whole bodies to cells, genes, etc., but also removes the strict temporal aspect of illness. Advances in the technology of screening have allowed biomedicine not just to detect disease, but to detect the possibility of disease and so intervene pre-emptively, thus pathologising the essentially 'healthy' who may just demonstrate the potential to develop specific conditions (McKie 1995; Armstrong 1995). The technological imperative in biomedicine, which pathologises essentially healthy states, and the objectification of the individual through body-mind dualism and the mechanical metaphor are central to feminist challenges to the medical model as a form of patriarchal domination (Annandale 1998). This is particularly clear in the way that reproduction, as a natural phenomenon, has become increasingly controlled by a male dominated medical profession, and increasingly pathologised by same in order to justify technological intervention throughout pregnancy and childbirth (Nettleton 1995: 152).

Biomedicine is necessarily disease focussed, but its focus is also narrow in that it looks specifically at the individual body and the biophysical causes of disease. This reductionism may be criticised in that it neglects psychological factors in the development of any disease, but at a less individualised level it also fails to take into account potential social, economic, environmental and political factors, among others. It is these factors which shape the health of nations and individuals most of all, rather than developments in biomedical technology; inequalities in health do not result from inequalities in access to 'advanced' health care (Marmot 1999: 2). The reductionism of the medical model is particularly significant when questioning the doctrine of specific aetiology. Hart (1985) uses the example of tuberculosis to make the point that improvements in medical science do not affect disease rates as much as other events and processes do, as diseases are multifactoral by nature. Hart gives the

example of the decline in the incidence of tuberculosis in the UK, which had been dramatic – due to improvements in sanitation and general living conditions – before the tubercle bacillus was even identified in 1881. After the Second World War, when antibiotic drugs first became available for its treatment, the incidence of tuberculosis had already fallen from an annual level of 4000 cases per million population in the early 1800s to only 500 cases per million in 1947 (Hart 1985: 5).

The reductionism and subsequent individualisation in the medical model in the West has been linked also to the increasingly neoliberal political climate, which grew in strength throughout the 1980s and 1990s. "Medicine presents an image of health which fits with the culture of industrial capitalist societies. The most important parallel is between the ethic of individualism in modern society and the focus of medical treatment on individuals." (Hart 1985: 17) Such a conclusion calls attention to the political aspects of biomedicine, but also questions its claim to scientific neutrality, as "far from being objective and value-free, medicine relies in its operation upon general cultural ideas in society" (Annandale 1998: 7). Waldby (1996: 140) in her examination of HIV/AIDS demonstrates how the disease was constructed and not merely 'discovered':

> "AIDS should not be regarded as a natural event with social consequences. Rather its conditions of emergence *as* a disease – as a describable, coherent entity with a name, an aetiology, a set of calculable symptoms and outcomes, rather than a nameless and random affliction – should be understood as socially located and politically interested. There is no point to which a naturally occurring phenomenon 'AIDS' can be tracked back, prior to its appearance in biomedical discourse".

The political, value-laden aspects of biomedicine are visible in the medicalisation of social issues – social iatrogenesis – and this is viewed by Hart (1985) as a potentially dangerous and limiting expansion of medical power into society. "In the medicalisation of social problems, their political nature is stripped away as they become neutral objects for technical treatment." (Hart 1985: 47) The medical profession by being involved in 'social problems' becomes bound up in the control of different populations through labelling, sectioning, and isolating individuals who

deviate from the norm. However, the power of biomedicine is more fundamental to the control of everyday life as in the medical model, health is viewed as an 'absence of disease' the aim is 'functional fitness', experts not only diagnose illness and disease but also sanction and supervise the withdrawal from active labour. The main functions of health services are thus remedial or curative – to get people back into active labour (Jones 1997b: 30). Thus it can be argued that biomedicine has become part of the surveillance systems of late modern societies that impose norms and punish deviance. Both Foucault and Goffman have pointed to the diagnosis of insanity but also the founding of asylums as evidence of how society, through the extension of the medical profession's power, seeks to medicalise and thereby control behaviours which have come to be labelled 'deviant'. The argument being that insanity was not some objective human condition that was 'discovered', but a subjective human condition which has been recategorised through different historical ages (Goffman 1968; Foucault 1991). The recategorisation of different behaviours has effectively 'created' deviance through discursive shifts (Armstrong 1994: 22). Consequently, in relation to constructing problematic substance misuse, the alcoholic did not exist until classified as such in Bruhl-Cramer's model (Kielhorn 1996) and the drug addict only 'appeared' in the early twentieth century as attention shifted away from alcohol policy to drug policy (McAllister 2000: 16).[1]

Although sometimes viewed as an extension of the medical model (see below), in theory health promotion is a response to the dominance of medical model in health, particularly as it makes no claims to neutrality and should be therefore knowingly political and reflexive (Caplan and Holland 1990). Health promotion to a large extent grew out of critiques of simplistic models of health education which assumed the mere provision of information would lead to behaviour change (Nettleton 1995: 234). As a combination of both health education and healthy public policy, health promotion should also combat the reductionism inherent in the medical model. The conceptualising of health in holistic, broad, positive terms (not just 'the absence of disease') offers resistance to the medical body-mind dualism. The technological imperative and mechanical metaphor are resisted through health promotion's

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[1] It should be born in mind that although the creeping medicalisation of alcoholism and other 'diseases' which are at once social, biological and incurable, has brought it under the remit of biomedicine, it is commonly viewed as 'dirty work' and not welcomed by medical practitioners (see Strong 1980).

emphasis on prevention rather than cure and through the 'empowering' of lay people, by increasing the awareness of health issues, as a challenge to the professionalised narrow focus of the medical model (Tones and Tilford 1994). The birth of health promotion is linked to the Western demographic shift from a communicable to chronic disease burden, and a recognition that the doctrine of specific aetiology simply does not apply to clearly multifactoral diseases. This recognition has given lay perceptions of health and 'alternative therapies' greater status within health promotion, perceptions and therapies, which biomedicine may reject as 'unscientific'.

However, criticisms of the medical model may be also applied to the way health promotion has developed. A key concern is that health promotion by definition combines both individual and structural level initiatives, but in practice it is more likely to target the behaviour of individuals than the behaviour of governments or industry (Hart 1985). "How else can one explain a public health rhetoric which argues that social conditions affect health outcomes and then, in turn, argues that the appropriate solution is to eat better, exercise more, drink less and give up smoking." (McQueen 1989 quoted in Nettleton and Bunton 1995: 44) The critiques of many health education initiatives, particularly in relation to the 'new' problem of HIV/AIDS, have extended this 'victim blaming' criticism from individuals to whole communities through the health education focus on medical 'risk factors', which meant many HIV/AIDS campaigns targeted specific 'risk' groups. These groups were already considered 'other' and 'deviant' within society (particularly sex workers, gay men and injecting drug users – IDUs) and the health education campaigns served to reinforce prejudices against these groups while offering 'normal' society a false sense of security (Patton 1996). These minority groups were targeted as threats to 'normal' society, and they were therefore, by implication, to blame not only for their own infection, but also for the infection of others (Annandale 1998: 8).

Reductivist health promotion strategies are particularly visible in the area of containing and controlling substance misuse, and the inherent tensions between 'behaviour change' and 'structural reform' become clear. Here too health promotion strategies rarely manage to break out of the medical model, which maintains its reductivist focus on individual behaviour, psychology, physiology or genetics outside their environmental context. Medical explanations of substance misuse tend to focus

particularly on the toxicology of illicit drug use, stressing the physiological damage that different substances can do the body (MacGregor 1999: 68), and this is often a central concern for much health education in this field. At its most extreme, biological explanations of problematic substance misuse combine with moral explanations and reject social or economic determinants in explaining societal differences in drug consumption opting instead for a eugenic stance – deviancy being the preserve of the biologically corrupted underclass (MacGregor 1999: 76).

Other criticisms of the medical model are of relevance to substance misuse where it has been framed specifically as a 'disease' rather than socially problematic behaviour. The disease model of addiction includes the development of a very specific set of biological problems often associated with the regular use of certain drugs, chiefly the development of tolerance, withdrawal and craving (Drucker 2000: 29).[2] The treatment of drug addiction and alcoholism as a disease can easily involve body-mind dualism where the primary intervention is seen as detoxification of the patient and psychological support and counselling is deemed to be of secondary importance (MacGregor 1999: 68). The technological imperative whereby pharmaceutical advances in easing the detoxification process and blocking the possible pleasure from drug or alcohol use are at the forefront of modern medicine (MacGregor 1999: 68; Cohen 2000). This also supports the view of the body as a machine in need of 'fixing' (the mechanical metaphor) by blocking out the problematic sections of the brain instead of viewing 'the body' as a sentient patient who chooses to misuse substances for diverse reasons. The brain chemistry involved in the use of the wide range of substances which can be misused, has been explored in all its fascinating complexity (Plant 1999: 170-203). No doubt as a consequence of this, the doctrine of specific aetiology now narrowly focuses much research into drug or alcohol addiction to the search for the gene which is responsible (Vines 1999; Cohen 2000).

The value of the disease model of addiction comes from "having a consistent physiological explanation of what are clearly powerful biological phenomena"

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[2] Physical tolerance to a drug builds so that a higher dose is needed to achieve the same result. Withdrawal is the body's adverse reaction to the absence of a drug to which it has become tolerant; and craving is the psychological awareness of the body's tolerance and so 'need' for the drug (Drucker 2000: 30).

(Drucker 2000: 31), but to view all substance misuse as a 'disorder of neurotransmission' is clearly a form of social iatrogenesis. The disease model fails to adequately represent the full spectrum of drug use patterns (both legal and illegal) and can easily overlook the positive side effects, i.e. potential clinical applications, of different substances that are misused or addictive by labelling them 'pathogenic' (Drucker 2000: 31). However, framing addiction as a disease also gives it a different social meaning. Diseases bring fear of contagion, so that American servicemen returning from the war in Vietnam in the 1970s came home "as carriers of the disease and are afflicting hundreds of communities with the heroin virus." (McCoy 1989 quoted in Plant 1999: 198) The disease model may also act as a way of 'absolving' the individual suffering addiction in the face of moral arguments because it is effectively defined by 'uncontrollable behaviours' (Fitzpatrick 2000: 107).[3] The disease label makes space for the individual to withdraw from normal social roles without being labelled 'deviant' as they have taken on the 'sick role'. Here the 'sick role' refers to the niche provided for the individual to recuperate without the burdens of everyday life. Individuals are given the two 'rights' of exemption from normal social roles and from blame for their ill health, provided they conform to the two 'obligations' – to seek professional help and to comply with the physician's instructions (Annandale 1998: 10).[4] However, failure to conform to the 'sick role' – to seek treatment for the disease of addiction or to 'fail' in maintaining abstinence as the doctor ordered for the addict – is a return to 'deviance' and 'otherness'.

1.2 Community Empowerment as an Alternative Approach

In order to counteract the reductionism, objectification and individualisation of the medical approach to health promotion, alternative models for action have been developed. Medicalised approaches are criticised for being expert led and insensitive to the needs and beliefs of communities – information provision alone is not enough

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[3] Fitzpatrick also argues that a key factor in the growth of the disease model has been the reframing of tobacco use as a form of 'chemical dependency' from its earlier formulation as a 'bad habit'. Fitzpatrick is highly critical of the recent tendency to medicalise all personally or socially undesirable behaviour as addictive and notes: "Whereas the struggle to medicalise alcoholism raged for more than a century, the extension of the disease model of addiction first from alcohol to heroin and tobacco, and then to gambling, shopping and sex has taken place over only a few years." (Fitzpatrick 2000: 108)

[4] The 'sick role' was originally developed by Talcott Parsons (1951), but it is Annandale's interpretation that has been followed here.

and such top-down approaches neglect the specific needs of different communities and the existing social barriers to improving health. For most alternative models, some form of community empowerment and involvement in health interventions is seen as the answer. With a community empowerment approach the health promoter acts as a catalyst or facilitator helping individuals or communities to find the skills and confidence necessary to effect change in their 'social reality' (Naidoo and Wills 1994: 89). The building blocks of this 'empowered community' are 'empowered' individuals, who become so through non-directive, client-centred counselling which aims to increase people's control over their own lives. "Clients are valued as equals who have knowledge, skills and abilities to contribute, and who have an absolute right to control their own health destinies." (Ewles and Simnett 1995: 38) An empowered community actively participates in democracy and in 'empowerment theory' this activity is a prerequisite for the development of healthy public policy (Tones and Tilford 1994: 25).

The community empowerment approach thus emphasises the political nature of health promotion, and one of the health promoter's roles is critical consciousness raising through health education. Critical consciousness raising may be radical or more akin to 'agenda setting', but the tools are largely political, for example lobbying, policy planning and the design, negotiation and implementation of both policy and legislation, and even social revolution, depending on the political drive of the health promoter. Different aspects of critical consciousness raising within health promotion can be inspired by different varieties of anarchy, social democracy, socialism, Marxism and egalitarianism, and may have different bases dependent on their practical emphases, level of radicalism, and the context in which they are advocated (Seedhouse 1996: 90). The common ground is a commitment to putting health issues on the political agenda at all levels and a rejection of the dominance of the biomedical model within health promotion. The rejection of 'victim blaming' and emphasising of socio-economic determinants of health also points to common ground "in a political outlook which begins by acknowledging that people are essentially equal, and can be understood not only as individuals but also as communities" (Seedhouse 1996: 91).

Empowerment theories are in many ways a response to the domination of the medical profession within health promotion, but also to the, clearly flawed, earlier

assumptions about information in itself being an adequate catalyst for behaviour change (Nettleton 1995: 235). However, reports which highlighted the need to take a structural level approach in order to tackle the causes of ill health rooted in inequality (for example Lalonde 1974; Black et al. 1982), were also highly influential in the broadening of health education into health promotion, i.e. shifting the emphasis from the purely individual to include the structural level (Thorogood 1992: 51). As barriers to behaviour change became more apparent, so empowerment theories about facilitating change through political action evolved. Health promotion was recognised as essentially political and WHO set a range of political targets for Health for All 2000 (HFA 2000). For HFA 2000 to be achieved, therefore, it needed not just health education but healthy public policy that was pluralistic; it called for multi-sectoral, multi-level and participative initiatives (Bunton 1992: 131). The official WHO concept of health promotion views health and lifestyle as inextricably linked to socio-economic conditions, although in practice WHO has been criticised for focusing too much on individual and community empowerment without actually challenging the socio-economic context in which people live their lives (Nettleton 1995: 233).

> "It is only since the 1980s that health promotion experts at an international level have systematically developed strategies to share power with lay people through community action, healthy cities projects and health alliances. Such initiatives are underway but it will remain difficult to ensure that lay people's voices and their expressed needs are heard." (Jones 1997b: 30-31)

Health promotion acted as an impetus to the new public health movement to take a more grassroots approach, but as a consequence, health promotion became at risk of being usurped by the professional health care system. Consequently, programmes can often just become a core function of public health units, which are dominated by medical professionals, even when nominally based on a grassroots approach to health promotion (Nettleton 1995: 234). However, while it is important to be aware of who, 'lay' or 'medical professional', is running state health promotion initiatives, it is also necessary to acknowledge the considerable impact non-government organisations (NGOs) have had on health promotion through the development of lobby groups, self-help groups as well as charities which fund research and patient care within their area of interest. NGOs have been particularly successful in providing support for the

chronically ill, and have grown as the burden has shifted from infectious to chronic disease (Richardson 1991).

It has been argued that NGOs have in the past been neglected as sites for health promotion because they belong predominantly to the 'lay system'; they do not seem to have 'health damaging effects'; and because such groups are not always visible to researchers and politicians as they are overshadowed by the larger institutions in society (Trojan et al. 1991: 443-4). Indeed, some argue that the community health movement is largely invisible to state health care structures, this invisibility both protecting and undermining the movement (Watt and Rodmell 1993: 7). However, where the broader definitions of health are accepted, NGOs do not even have to have a specific health focus in order to have secondary or latent functions for health; for example voluntary organisations which work to improve local housing, whilst not focusing on health through their actions, may have a positive impact upon health. Indeed, Trojan (et al.) argue that the voluntary sector is a 'hidden health promotion system' which means that to a large extent promoting health means strengthening community organisations and increasing intersectoral collaboration (Trojan et al. 1991). NGOs generally focus on specific diseases and health issues and are outside the formal health care system; they therefore tend to ignore strict professional and institutional boundaries; organisations press for services to be integrated around the needs of their members, forming new coalitions of interested lay and professional people (Richardson 1991).

Whilst the proliferation of self-help groups throughout the end of the twentieth century may be attributable to an upsurge of interest in lay health, and an antipathy to the professional dominance in health care delivery (Watt and Rodmell 1993), many people actually choose to combine both self-help and professional help (Richardson 1991). Therefore relations between health-related NGOs and the state health care system are not necessarily adversarial; self-help groups often have a dual role, dealing with the social and health needs of their members, but also with the broader policies on, and the delivery of, health care (Richardson 1991: 468). It is through this second role that discriminatory public policy and the dominance of the medical model of health have been challenged, as have societal attitudes towards different conditions and lifestyles. Most recently this has been seen in the self-organisation of the self-

proclaimed (rather than labelled) gay community around HIV/AIDS awareness (Patton 1996), a disease which also gave impetus to the emerging IDU lobby to advocate changes in policy and in medical staff attitudes towards users (Riley and O'Hare 2000).[5]

In challenging biomedicine, it may be argued that the central difficulty for health related NGOs is their positioning in relation to formal health care structures. NGOs need to be 'outside' the system in order to challenge biomedicine – independence fostering imaginative responses to health issues – however, they still need to engage with 'the system' in order to effect change therein (Watt and Rodmell 1993). This neglects the fact that formal structures may seek to 'use' NGOs in order to promote their message among 'hard to access' groups (Beattie 1991), but it also neglects the diversity of different NGOs both in terms of their funding structures and their activities. Being outside the formal health care system (if only nominally) there is no consensus over the most appropriate way of working with specific groups and not all groups actively challenge the hegemony of the medical model, indeed some groups can develop a single factor aetiology for a disease which can narrow their approach (Richardson 1991: 469). A significant example of this in the field of substance misuse is the approach of Alcoholics Anonymous and Narcotics Anonymous (AA and NA), which is very strictly framed within an individualised disease model for addiction. The relations between state and non-state actors need not therefore be seen as 'conflictual', indeed, in some cases it may be viewed as 'consensual' where formal structures seek out NGOs in order to better co-ordinate provision as part of the 'welfare mix' (Beattie 1991).

The success of NGOs in challenging the dominance of the medical model and effecting change from a grassroots level have provided supporters of community empowerment approaches to health promotion a base of evidence with which to support their claims (Watt and Rodmell 1993; Trojan et al. 1991). However, the extent to which this reflects true 'empowerment' is debateable. Those in society with the worst health are still also those with the least power (Nettleton 1995: 238), and

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[5] However, needle exchange for IDUs actually started in Amsterdam in 1984 after the Junkie Union (an IDU self-help group) advocated and initiated the first exchange in order to prevent the spread of hepatitis B among users (Riley and O'Hare 2000: 5).

whilst membership of a self-help group, for example, may be an empowering experience, the 'average' participant tends to be "middle class, educated, elderly, and not from ethnic minorities or rural areas." (Richardson 1991: 471) Another key criticism of community based health promotion is that in empowering the individual to take control over their own health, the responsibility for decision-making shifts from the professional to the layperson, but information and support structures do not. The 'risk' is in this way, individualised (Annandale 1998: 229).[6] The growth in consumerism within health care, the individualisation of risk and the encouragement of community involvement in health promotion can be seen as further evidence of the neo-liberal project and may actually be a symptom of the crisis in the welfare state as explored by Ulrich Beck (see, for example, Beck 1992). In this way community involvement in health promotion may be appropriated by precisely those it seeks to challenge, and so lose its political potential (Nettleton 1995: 239). This is particularly problematic where community development projects are state financed, as there is always the fear of 'biting the hand that feeds them' (Beattie 1991). Related to this is the persistent doubt as to whether local community action can ever achieve more than marginal success in the face of larger social inequalities that reflect policies at a national and even global level (Beattie 1991: 178).

However, the most fundamental critique of community empowerment initiatives is that both biomedical and community-based approaches to health promotion basically adhere to scientifically defined rationality. Both presume that "once socio-structural constraints on people's lives are removed they will be able to make rational healthy choices. However, what is rational and what is healthy is informed by scientific medicine." (Nettleton 1995: 237) Moreover, in practice people are sceptical readers of health information; providing more will not necessarily change this (Jones 1997a: 7). A central question therefore has to be 'do people actually want to be healthy?' People living in socially deprived circumstances might not have health as their first priority and it has to be asked whether these people have the right to live their lives without interference (Jones 1997a: 7). The popularity of extreme sports, excessive drinking and intravenous heroin use is also clear evidence that 'objective health' through 'rational behaviour' is not necessarily everybody's top priority. This is not because

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[6] The concept of 'risk' is explored in detail in the next section.

people are 'fools' who do not understand statistical probabilities, but because perception of risk is culturally constructed (Douglas 1986).

1.3 Health Promotion and the Construction and Control of Risk

The concept of 'risk' is central to health promotion practice; the risks and benefits to health of different behaviours and environments are evaluated, represented, and constructed through the course of a health promotion intervention. However, as with biomedicine, risk is not 'scientific', i.e. objectively determined and value free; risks to health or society are not merely 'applied probability'. The invoking of probability when medical professionals explain the likelihood of disease, is instead a symptom of cultural change: "The language of danger, now turned into the language of risk, often makes a spurious claim to be scientific." (Douglas 1992: 14) This is not to argue that there are no 'real' dangers, but that the concept of 'risk' is actually how a society copes with and evaluates different dangers, the evaluation process being inherently political. "Certain dangers are selected out from others for attention by a society and entitled 'risks' for certain reasons that make sense to a particular culture, based on its shared values and concerns." (Lupton 1999: 39) Where something is given 'risk status' it means that its importance to our wellbeing has been recognised. "In some societies at some times, certain phenomena are selected as the focus for anxieties. In other societies and eras, other phenomena become prominent as 'risky'." (Lupton 1999: 13) Thus, risk takes place in specific historical and socio-cultural contexts.[7]

Douglas' theories around the nature of danger and risk are rooted in the contextualisation of so-called 'primitive' beliefs and behaviours around taboo, pollution and purity within 'modern' ritual (Douglas 1966; Douglas 1992). Theoretically 'moderns' are separated from their 'primitive' neighbours because modern dirt avoidance is not related to religious belief but to hygiene and aesthetics; modern rituals are based on superior knowledge of pathogenic organisms (Douglas 1966: 35). The difference between 'primitive', modern and late-modern societies is therefore not in the way danger is managed but in the way that it is labelled. By

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[7] Ulrich Beck must also be credited for raising the awareness of risk as a political issue, however, Beck has approached risk from a different perspective in that 'risk' is accepted as a neutral and objective measure of danger. The core of Beck's argument is that in late-modern societies old questions around the distribution of wealth have been replaced with new questions about the allocation of risks (Beck 1992).

examining the pre-bacteriologist / unscientific past of modern cultures Douglas found that dirt is simply 'matter out of place' and that where there is dirt, there is a classification system. Therefore, highly polished shoes are considered clean, but not when placed on the kitchen table (Bauman 1997: 6). Pollution behaviour and dirt avoidance rituals in all societies seek to maintain order and keep things in place, but also to deal with the anomalous or ambiguous, and the behaviour and ritual may take place on different levels. "Central to Douglas' ideas about the symbolic nature of purity and pollution strategies is her insight that the human, fleshly body is a conceptual microcosm for the body politic (or the community of which it is a part)." (Lupton 1999: 40)

Pollution behaviour and dirt avoidance rituals help to maintain the integrity of spaces which have to be separated, but they also focus attention on the boundary itself. "This boundary line space is a locus for the residuum of social order, a twilight place of outcasts, danger and pollution." (Armstrong 1993: 394) All marginal spaces are defined as dangerous; bodily orifices are marginal as they are the body's borders, the margins and borders of the city are where 'outcasts' are encouraged to reside. The body's excreta are marginal substances and which excreta are classified as polluting and which are considered 'acceptable' is entirely defined by culture. Pollution, danger and the body / social system are examined by Douglas (1966) through the theoretical and actual attitude of Hindus in India towards defecation. Douglas' argument is that the pollution rituals, beliefs and dirt avoidance strategies are not actually about faeces as a pollutant but about maintaining a social structure whereby the only ones who have to deal with it are the untouchables. "It is a symbolic system, based on the image of the body, whose primary concern is the ordering of a social hierarchy." (Douglas 1966: 125)

The importance of maintaining and monitoring both bodily and social boundaries is perhaps most clearly reflected in the discipline of public health (Armstrong 1993). Initially public health efforts concentrated on the need to quarantine. In this system illness somehow resided in places, which had to be kept separate; boundaries between the polluted and the pure were drawn geographically. These were elaborated upon in the next phase of sanitary science, where geographical boundaries were drawn according to soil, climate and buildings, which could either be classified as inherently

illness provoking or beneficial to health. However, the new sanitary science was also the first to look at the body as a new space for hygiene interventions and, more significantly, to mark the boundary between the body and its environment. Hygiene strategies thus began to shift their attention from monitoring movement between geographical locations to the relationship between the body and its geographical context. The hygiene regime which grew out of this concentrated on the monitoring of matter which passed between the two great spaces (body and environment), particularly in its manifestation as dirt. Environmental spaces could be controlled by public health legislation, but personal hygiene was less easily regulated, which is why institutions such as the army and schools became loci for personal hygiene interventions. Attention then shifted to the spaces between bodies, which had the effect of reconfiguring illnesses; for example, the origins of tuberculosis were reconfigured, from poverty and insanitary conditions in the nineteenth century to the bodies of others in the twentieth. The new public health of the late twentieth century then came full circle by looking once more at the environment, but this time looking at the incursion of bodies into nature rather than vice versa; it called for a new ecological approach to health (Armstrong 1993).

However, the boundaries between different spaces is not always clear and cannot always be sufficiently guarded as there are anomalous things which defy clear classification, and these are considered to have no place. This is particularly true of mobile things which are able to transgress boundaries without permission – these things cannot be accommodated, they are ambiguous and it is not enough to move them to another place; they need to be obliterated (Bauman 1997: 6). At one level this can refer to creatures such as cockroaches or flies, but it can also be applied to 'outsider' groups in societies. The 'outsiders' have transgressed social boundaries (taboos) so have marginal status. An example of this is a behaviour classed by a psychiatrist as pathological which may be accepted as 'quirky' by society, but then no longer tolerated once the individual has been placed in a mental hospital – mental illness being stigmatised and 'taboo' (Douglas 1966: 97; Goffman 1968). 'Outsiders' may also have an ambiguous power status being at the same time both abhorred and curiously respected, but they always remain a pollution danger. This is significant because polluting people occupy a special stigmatised position; they are seen as wicked both because they have transgressed cultural norms or taboos but also because

they have placed others in danger by their actions (Lupton 1999: 44). Outsiders are always dangerous and 'risky'.

Apportioning blame to marginal groups within society is then just one small step away, and in health promotion terms this has been most effectively demonstrated with the public health responses to HIV/AIDS. The disease was initially presented as one which affects minority groups, particularly the male homosexual community.[8] Outsiders who 'transgressed boundaries' were targeted particularly harshly, notably male bisexuals and commercial sex workers – both of these groups were monitored and controlled heavily as the main route for HIV/AIDS transmission from 'risk groups' into 'safe' heterosexual society (Annandale 1998: 8). Biomedicine defines the boundaries and "maps the flow of infection from its reservoir in the gay male body through the transmission bodies of bisexual men and heterosexual women to the ultimately 'cultural' body, that of heterosexual masculinity." (Waldby 1996: 20) Where addiction is labelled as a disease and addicts are labelled deviant these groups also become marginalised as 'dangerous' elements which need to be controlled in the same way as people with mental illnesses – the addiction disease replacing rational self-preservation impulses with irrational cravings. Different communities at different times have been targeted as carriers of disease, therefore attempts have always been made to separate, confine, exile or destroy 'outsiders' in order to preserve health by preserving a particular order. "The pursuit of modern purity expressed itself daily in punitive action against dangerous classes; the pursuit of postmodern purity expresses itself daily in punitive action against the residents of mean streets and no-go urban areas, vagabonds and layabouts." (Bauman 1997: 16)

Douglas (1992: 5) contends that there are essentially three modes for apportioning the blame for misfortune within a community, one of which will predominate and influence the structuring of society. The first is moralistic – the individual had broken a taboo, had sinned and so has been punished; following this some purification ritual is called for and in order not to share the same fate the community is exhorted to obey the rules. This is most often associated with 'primitive' religions, where nature is

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[8] Indeed AIDS when first acknowledged as a health issue was called GRID – Gay Related Immune Deficiency (Patton 1996: 118).

made into a sensitive, if sometimes heavy-handed, gauge of morality. However, parallels may be seen in (late-) modern societies where this same strategy is used to avoid the scapegoating of living persons by invoking nature with a verdict of death by human error, natural causes or misadventure (Douglas 1986: 56). Blaming the victim for their misfortune in this way is also effective for silencing indictments of the whole social system, consequently single mothers are often blamed as though they were the sole procreator of their child and addiction is due to flaws in individual genes or personalities. "Thus well-labeled, natural vulnerabilities point to certain classes of people as being likely victims; their state of being "at risk" justifies bringing them under control." (Douglas 1986: 57). This control is even stronger when the blame is taken away from the victims and placed on the shoulders of their families. Hence, for example, an increase in juvenile delinquency is blamed on the increase in working mothers. Such blaming is unarguably political and aims to preserve the *status quo* within societies. The second mode of apportioning blame also aims for this, but instead of blaming 'nature' an external enemy is discerned; an enemy of the community which may be an external enemy or even a traitor-enemy within. Mainstream society must root out the enemy, to inflict communal punishment and to exact compensation (Douglas 1992: 6). However, Douglas also argues that it is more difficult for political leaders to maintain blaming external enemies for all the sufferings of their people because, at some stage, the leader must name the enemy and outline what the leadership propose to do about it (Douglas 1986: 58).

Both the first and second blaming strategies work in different contexts to enhance social cohesion. "Victim blaming facilitates social control; outsider blaming enhances loyalty." (Douglas 1986: 59) This is different to the third mode which blames individual adversaries; the individual has suffered because they were not quick enough or smart enough in looking after their own interests. In this community everyone expects to be beset by rivals and vengeance for misfortune is sought on an individual basis. Members of such a society would not be likely to give credence to either of these stock responses to misfortune, but then in such a society preventing dissent in the community is unimportant (Douglas 1986: 59). Nature has to be free of moral bias, instead its forces are there to be captured and enrolled to the service of individual competitors. The more individualistically competitive a society the more its members will attribute misfortune to an individual's fate from birth, whereas secret

resources and sheer luck may account for the individual's successes. In this way instead of seeking to blame, responsibility is claimed as a way of showing strength, as in the case of political terrorists (Douglas 1986: 62). Consequently therefore, unlike the first two modes, where nature stays whole and steadfast to its loyal followers, here the various decisive elements of nature are fickle.

In contemporary secularised Western societies, risk as a concept has replaced, to a large extent, earlier notions of the causes of misfortune that were rooted in sin and divine retribution. Such 'primitive' notions have now been largely discredited, but the way 'risk' can define taboo and apportion blame works in just the same way. Risk has become a 'new morality,' it is a new way of defining otherness and as such can be used to muster xenophobia but also to control those on the margins of society. Positioning occurs within organisations, social groups and individuals with certain classes of people singled out as being 'at risk' and therefore requiring control to bring them back to conforming to moral values (Lupton 1999: 49). Top-down biomedical interventions serve to reinforce boundaries between 'normal' and 'dangerous' communities through the definition of 'risk groups', as well as the increased monitoring and segregation of these 'outsider' groups by a '*cordon sanitaire*'. The only way to be reintegrated into society is thus to be 'corrected' as an individual, at least to the point where they can 'pass for normal'. Bottom-up approaches, particularly when they come from the marginalised community itself, aim instead to challenge dominant perceptions of themselves as being inherently 'risky', and essentially 'different'. The aim is to break down or at least move the boundaries so that people with ambiguous or 'outsider' status are no longer viewed as taboo, individuals and behaviours are accepted as they are.

1.4 Health Promotion and Social Control

'Risk' as a concept is far from neutral and it is important for this to be recognised as part of health promotion, which is, as shown above, in itself a political project. If 'risks' are social constructs not based on 'objective' statistical reasoning, then different cultural groups within one society will assess the 'riskiness' of different activities in different ways. An acceptance of risk as a construct is the basis for health

promoters to operate 'reflexively', challenging the evidence base for their work, looking at their 'power base' and at who is being blamed for dangers to health and why. Cultural interpretations of relative risks need to be taken into account in health promotion interventions, because 'rationality' is also relative, existing purely in the eye of the beholder. The underlying assumption in most health promotion is that human beings are rational actors who will invariably operate in their own best interests, however, these interests and priorities do not necessarily coincide with the priorities and concerns of the health promoter. Therefore for some mothers living in poverty, smoking is rational behaviour in the context of their daily routines in spite of the health risks about which they are frequently warned. When trapped at home all day with young children and little disposable income, smoking makes sense to these women in that it provides a break so they can replenish their capacity to cope, when a physical break from the full-time caring responsibility is not possible (Graham 1987). Risk taking is thus a subjective process; it is not 'irrational' behaviour, but a matter of preference (Douglas 1992: 103).

The cultural nature of rationality and risk perception is also reflected in the results of research into lay beliefs which have shown, for example, that other people's illness is perceived as being self-inflicted through the neglect of some aspect of approved behaviour (e.g. inadequate hygiene, food, sleep or excessive drinking, smoking, stress); whereas personal illness may be apportioned by the individual concerned to bad luck, family disposition or environmental influence (Thorogood 1992: 49). However, the results of this research also demonstrate how effective much health education has been in raising awareness of 'risk factors'. The internalisation of 'risk factors' by society has been seen by some as the greatest achievement of 'surveillance medicine' (Armstrong 1995). With biomedicine moving out of the hospital and into the community and the object of its study moving from the physical body to the laboratory slide (Jewson 1976), the 'normal' has been pathologised and problematised through surveillance medicine which targets everyone and uses health promotion as a tool. "Surveillance Medicine requires the dissolution of the distinct clinical categories of healthy and ill as it attempts to bring everyone within its network of visibility." (Armstrong 1995: 395) The clinic is no longer just for treatment, but also monitoring, particularly of infants and children who are intensively surveyed. Moreover, it is not just physical development that has been examined, psychological growth has also

been construed as inherently problematic and precariously normal (Armstrong 1995: 396).

Monitoring the precarious health of populations is at the heart of surveillance medicine, and initially, in the early twentieth century, this was achieved through extensive screening programmes. However, population screening still focussed on embodied pathology, whereas the 'risk factor' opened the new space of *potential* pathology (Armstrong 1995: 400). The risk factor is also disembodied, encompassing any state or event from which a probability can be calculated and many risk factors can be identified in extracorporal spaces, particularly that of 'lifestyle' (Armstrong 1995: 402). Thus surveillance medicine was not just about the 'silent' lesions which may be revealed through screening, as a risk factor merely opens up the possibility of future disease; it has no necessary or fixed relationship with future disease. The increasing importance of the 'risk factor' is therefore also a temporal shift, visible in the move from 'acute' to 'chronic' illness as the major concern for health promoters, so a new temporal space was opened up in which risk factors materialised. It has been argued that surveillance medicine is also more invasive than earlier hospital medicine, since it is concerned with the body in its environment, its genetic past, lifestyle, psychology, beliefs and behaviours.

Some contemporary health promotion techniques, which pay close attention to lay views through qualitative interviewing, observation and health diaries, may be seen as facilitating surveillance medicine, because they monitor much more invasively, than earlier basic population screening or advertising campaigns. The use of drinking diaries in alcohol counselling and education, for example, can contribute to the health promoting 'self' (Nettleton and Bunton 1995: 47). Top-down health persuasion tactics, such as large-scale advertising campaigns, remain the most popular health promotion strategy, but only because they are beloved of policy makers; all the evidence suggests that they are in fact remarkably inefficient in influencing health

behaviour (Beattie 1991: 169).[9] It may also be argued that these approaches are easier to challenge, resist or ignore than supporting and caring interventions that set an agenda for our lifestyle (Nettleton and Bunton 1995). The more 'invasive' and individualised strategies, as criticised by Armstrong (1993) and Nettleton and Bunton (1995), are also actively endorsed, particularly personal counselling for health (PCH) strategies which are utilised by many actors in the voluntary sector (such as Relate and MIND) as well as professionals in health and social services. PCH strategies are rooted in psychodynamic, social and post-Freudian 'humanistic' psychology, and are essentially individual, concentrating on 'life-review' – eliciting the personal narrative of the client in order to focus attention on the issues which need to be addressed so that the client may 'move forward'. In spite of its popularity in the West, PCH has been strongly criticised, particularly for its potential for covert invasion of the private domain by policing values, infringing personal rights and facilitating surveillance of the intimate biography (Beattie 1991: 175).[10]

Armstrong accuses health promotion and HFA 2000 of being attempts to involve everyone in the surveillance task, creating the truly panoptic society; disciplinary power being delineated through a new space, not just the body, but the space between the body and its environment (Armstrong 1993). Changes in practice which have challenged the medical model may be seen as actually facilitating greater and more invasive social control, the expansion of medicine into all society and not just the clinic thereby actually increasing the power it exercises through surveillance. This would therefore be equally true of health promotion interventions that were 'top-down' or 'bottom-up'. "Empowering people is not a morally neutral activity; it assumes that raising consciousness and developing advocacy skills are 'good' types of health promotion and that limiting knowledge and choice, imposing solutions and ignoring clients views are 'bad'" (Jones and Cribb 1997: 100). Individuals are

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[9] The alternative to health persuasion tactics is often seen as legislative change for health as most evidence suggests that social inequality is the root of most ill health; along with intersectoral working this is a cornerstone of the WHO's Health for All 2000 (HFA 2000) strategy. Unsurprisingly, legislative change for health or healthy public policy initiatives have not been so enthusiastically endorsed by policy makers, who in the UK have even attempted to suppress such strategies and reports which endorse them (Beattie 1991: 173).

[10] The contribution of psychiatry to surveillance medicine is explored by Castel (1991), who concluded that the natural extreme of risk reduction – the sterilisation of 'risky' individuals – was only morally and politically discredited by the grotesque excesses of Nazism; eugenics would otherwise have had a fine future (Castel 1991: 286).

empowered through education, which is theoretically concerned with enabling autonomy. "To be educated is essentially to be free, in control of one's own life, able to think rationally and logically, and make decisions without coercion or fear." (Weare 1992: 66) However, if increasing the autonomy of the client through education is really the core aim of empowerment, it must be accepted also that the client is free to chose unhealthy behaviour if they wish and not to be persecuted for so doing, provided they are not impinging on the freedom of others.

Consequently, health education to encourage behaviour change, i.e. to encourage people to take on a range of pre-set values, beliefs and habits, should be more accurately characterised as health 'training' (Weare 1992). "The language of autonomy and empowerment falls easily from the lips, but the practice is never easy or comfortable." (Weare 1992: 71) This gap between the theory and practice is a key area for investigation, particularly if claims for or against framing health promotion as social control are to be made. Health promotion only avoids becoming a tool for social control where initiatives are evaluated in terms of real shifts in actual power and not just participation rates. If health promotion is to merely reinforce social norms and extend the surveillance and power of medicine into wider society, the main tool for this is language and this should therefore be a key focus of attention for the sociologist. Relations and structures of power are embedded in the forms of everyday language and thus contribute to the legitimising of existing social relations and hierarchies of authority and control (Deacon et al 1999: 150). Thus the actual language used in health promotion programmes is extremely significant, particularly as it is asserted that many programmes attempt to control the behaviours of certain 'problem' or 'risk' groups, through the promulgation and legitimation of dominant norms and values (Nettleton and Bunton 1996:51). The labelling and subsequent targeting of certain groups in terms of 'risk' can have the effect of pathologising the behaviours of a minority group whilst reaffirming the health beliefs and behaviours of structurally advantaged groups; the 'victim blaming' as outlined by Douglas (1992).

In analysis of health promotion programmes around substance misuse, the language of debates and the construction of definitions of what constitutes a licit or an illicit drug and whether the drug is used, abused or misused, is of prime importance (MacGregor 1999:79). For example, in the West, images of the drug user were challenged with the

advent of HIV/AIDS and the pragmatic responses to the spread of the virus such as needle exchanges. Users were reconceptualised as individuals capable of making rational decisions about their health, whereas previous characterisations had emphasised "their sociopathy, or their psychopathology (as in psychiatric and psychological theories that viewed addiction, dependence or intoxication as interfering with freedom of choice and rational action)." (Stimson and Donoghoe 1996:17) The new harm reduction view, by contrast, helped to depathologise drug use and humanise drug users. "The proposition that 'drug users are people' was reflected in the shift in terminology, away from primary statuses such as 'addict' or 'intravenous drug abuser' to behavioural descriptions such as 'people who inject drugs'." (Stimson and Donoghoe 1996:18) People who misuse alcohol, solvents or illicit drugs are generally seen as valid targets for health promotion interventions. Whether these interventions aim to control, monitor and pathologise these behaviours more efficiently or to reintegrate people into society is the central issue in determining which approach towards health promotion is being used. It is so important because the underlying aims of an intervention show how health promotion is seeking either to further channel power away from lay communities to biomedicine, or away from biomedicine by dispersing it through the community. Awareness of power issues should therefore be central to health promotion interventions so that they may be conducted reflexively.

1.5 Post-Soviet Russia as an 'Atypical Space' for Health Promotion

The above critical theories around the medical model and community participation in health promotion, as well as debates around risk, rationality, autonomy and surveillance medicine have all informed this thesis. However, these theories were developed predominantly with reference to Western industrialised nations, therefore how far these theories may be applied to the specific circumstances in post-Soviet Russia needs to be explored. The cultural, economic and social legacies of seventy years of communism cannot be ignored, and the applicability of theories which link the rise of the medical model of health or surveillance medicine to the rise of capitalism need to be tested. Equally, theories around community empowerment, mobilisation or participation in health promotion may not be appropriate for societies

and communities in a state of flux and which do not have a strong voluntary sector. The difficulties with using the theories discussed for the study of health promotion in Russia are explored below in the four thematic sections as used above – the medical model, community empowerment, risk and surveillance.

The medical model in Russia and the Soviet Union

Biomedicine in the Soviet Union was unquestionably viewed as an absolute and objective science by both practitioners and policy makers. Marxism-Leninism encouraged 'scientific' explanations by its own 'scientific' basis and with this ideological support the medical model thrived; Soviet ideology was in itself, theoretically, essentially rational and scientific – communism in the Soviet Union was in many ways both a modernist and modernising project. The five main features of the medical model may therefore be easily detected in the Soviet health care system, and consequently in Russian health care, although with some key differences. For example, the process of objectification of the patient in the shift from bedside to hospital medicine, as described by Jewson (1976), also occurred in the Soviet Union with rapid urbanisation. However, unlike in the West, the shift in medical gaze was not accompanied by the birth of capitalism, as hospital medicine in Russia did not really come to fruition until the Soviet state started building the extensive health care system (Ryan 1978). It can be argued that the reductionism of the medical model was actually stronger in the Soviet Union than in the UK, and this continues in post-Soviet Russia with the medicalisation of many things beyond the usual scope of health practitioners, e.g. the medicalisation of rest and relaxation through the network of sanatoria (Shapiro 1997). The extent to which the medical model was actually accepted by the Russian lay population is also debatable. Even though biomedicine still exercised the most control over Russian and Soviet bodies through hospital medicine, it has been shown that the medical model remained weak in relation to the Russian population's actual health beliefs and health behaviours (Brown and Rusinova 2001).

The extension of biomedicine into society, social iatrogenesis, was actively encouraged by the Soviet authorities as 'scientific' explanations were sought for all social problems and their symptoms, particularly as biomedical explanations would not point to flaws in Soviet society. The reductionism of the medical model therefore

also fulfilled an ideological role, negating the influence of social factors on a wide range of social problems in order to discourage challenges to the dominant system. In the light of this, Hart's (1985: 17) assertion that the expanding influence of biomedicine is part of a neoliberal project must necessarily be challenged. The medical model cannot be framed as specifically neoliberal in its ideology if it also dominated a communist society. Instead it would be more accurate to classify the medical model, and any health promotion interventions based upon it, as being inherently 'conservative' emanating from "a political philosophy of prudence, utilitarianism, and the preservation of the status quo." (Seedhouse 1996: 88). However, as in post-Soviet Russia, neoliberal policies have been actively encouraged by international organisations such as the IMF through structural adjustment programmes, and as the individualisation of the medical model also fits this ideology, this has not encouraged any challenges to the dominance of biomedicine in framing social issues.

Community-based health promotion in Russia and the Soviet Union

For an alternative approach to health promotion to develop, the flaws in the conservative biomedical approach must not only be recognised, but also acknowledged. This did not happen in the Soviet Union, and assessing the extent to which it has been achieved in post-Soviet Russia is greatly complicated by the basic differences between 'civil society' in the West and 'civil society' in post-Soviet Russia. For example, Tones and Tilford's (1994: 25) prescriptive model for how health promotion should be conducted is simply irrelevant in the Russian context. A prerequisite for empowered individuals and communities to lobby government for change is clearly defined channels for such lobbyists. Such channels in post-Soviet Russia remain opaque and with the decentralisation and fragmentation of the old Soviet system, it is not always clear which bodies actually have the power to effect change, i.e. it is not always clear who needs to be lobbied. In the Soviet Union, the state supposedly catered for all the needs of its citizens, and strict limitations were placed on the development of non-state or non-Party organisations. Where there were gaps in state provision, it was generally the family that filled the gap (Thomson 2001). The lack of 'civil society' in post-Soviet Russia has been addressed by international funding organisations working in the country, but civil society development is framed

predominantly as a political project (i.e. part of the democratisation process) rather than a health project.

When the successes of Western health related NGOs are examined, the potential impact that a deficit of them could have becomes clear. Without NGOs to challenge the dominance of biomedicine and without government will to challenge the reductionism of the medical model, lay voices are unlikely to be heard or even sought. The problems associated with community-based approaches around the reality of practical empowerment are still relevant, but only where health-related NGOs actually exist, otherwise the problems with developing community-based health promotion interventions are more fundamental. The persistent focus on Western societies which have a wide range of health-related NGOs in debates around community-based approaches has also meant there is a lack of models which could be used comparatively in order to look at how community-based health promotion develops in countries outside Western Europe and the United States.

Constructing and controlling risks in Russia and the Soviet Union

Although a lack of organisation may mean a lack of open challenge to biomedicine, research into health beliefs and health practices has demonstrated a level of resistance to biomedicine by Russian lay people (Brown and Rusinova 2001; Gurjeva 2001). On the basis of this it is reasonable to suggest that, as in the UK, Russian lay people perceive risks differently to health professionals. As in the West, it is unlikely that Russians are 'fools' who do not understand probability; the scale of risk, feelings of self-efficacy and whether the risk is considered politically significant would all influence risk perception. Biomedicine is central to the process of health risk construction and has the power to define normality, to advise against polluting actions or agents and to offer purification to the contaminated. Therefore, although biomedicine would appear to have few possible challengers in post-Soviet Russia, by identifying the boundaries within society that mark out the 'polluting' people, it may be possible to find more dissonant voices.

Surveillance medicine in Russia and the Soviet Union

The possible impact of surveillance medicine on a society is reflected in the language used by health promoters to frame the nature of their main concerns, i.e. their

portrayal of risk. The extent to which interventions are 'controlling' is reflected in health education programmes – whether they aim strictly for behaviour change or genuinely for increased autonomy. However, the cultural specifics of Russia's Soviet past must also somehow be acknowledged, as surveillance critiques were not generally applied to Soviet society. Assertions about the diffusion of power through surveillance were a 'given' for Western commentators and taboo for Soviet scholars, and most discussions of social control focussed on political top-down efforts (see, for example, Reddaway 1983). However, control in Soviet society actually very rarely had to be enforced from above; the level of resistance to the state in comparison with the level of resistance in Poland, for example, was low (Sakwa 1998). Kharkhordin (1995) has successfully mapped how surveillance actually shifted from top-down to bottom-up with the increasing 'liberalism' in Soviet society after Stalinism; Soviet citizens monitored their own behaviour and self regulated, generally without the need for state brutality. However, as Kharkhordin asserts, this shift from top-down to bottom-up regulation was not driven by the need for voluntary confession as in the West, but instead by the need to dissimulate, i.e. to maintain separate public and private selves (Kharkhordin 1995). This has probable implications for the development of post-Soviet Russian health promotion, as confessional techniques are central to many bottom-up initiatives, and, in the field of substance misuse, notably movements such as Alcoholics or Narcotics Anonymous.

In discussions of the Soviet regime it was common to cite, perhaps somewhat unreflexively, the 'abuse' of medicine and psychiatry in the control of deviance or dissidence as a top-down method of social control (e.g. Reddaway 1983). It is considered 'abusive' of medicine and psychiatry because in 'totalitarian' regimes, 'deviance' included the voicing of alternative political views. However, with respect to the Soviet victims of persecution, this does effectively frame biomedicine as 'innocent' and 'apolitical' when it has been shown to be essentially political in its facilitation of the defining of deviance in Western industrialised nations. Consequently, in this thesis the concern is not how biomedicine was used to exercise power from above but instead to examine the extent to which it has been used to exercise power from below through health promotion techniques.

Conclusion

In this chapter biomedical claims to scientific neutrality have been challenged and the cultural nature of biomedical claims has been revealed. The medical model has been critiqued as the basis for conducting health promotion in general and in the field of substance misuse more specifically; this has informed how the empirical data in this thesis should be contextualised. The five features of the medical model detailed above (body-mind dualism, the mechanical metaphor, medicine's technological imperative, reductionism and the doctrine of specific aetiology) provide the constant standard for the analysis of whether the medical model of health remains dominant in health promotion in post-Soviet Russia. In the West, community empowerment approaches have been presented as the alternative to health promotion rooted in biomedicine and this acts as the basis for another test to the central hypothesis. It has been argued that community and individual empowerment approaches ideally involve a wide range of actors from different social sectors and the importance of grassroots NGOs has been emphasised. However, in practice there have been significant barriers to the development of health promotion in Western societies in spite of support from the WHO for such initiatives. These debates underpin the assessment of whether community and individual empowerment and intersectoral collaboration have been achieved in post-Soviet Russia in Chapter 5.

'Risks' serve as the basis for most health promotion interventions, and as with biomedicine, the scientific basis of 'risks' has been challenged, 'risk' being the culturally determined assessment of an objective 'danger'. 'Risk groups' have been shown to inhabit the margins of societies and spaces as 'outsiders' – they are portrayed as potential dangers to the main body of society. The extent to which drug alcohol and solvent misusers are presented as marginal and dangerous is explored in the analyses of the Russian print media (Chapter 3) and health education materials (Chapter 6). The positioning of groups and individuals in health education discourses also reflects the extent to which health promotion is a grassroots initiative, as top-down interventions aim to 'correct' the individual, whereas bottom-up initiatives aim to challenge the risk status with which they have been labelled. Debates around the development of 'surveillance medicine' and the disembodied 'risk factor' have also

been used as part of the critical framework, as another means of understanding how health promotion is developing in the field of substance misuse in post-Soviet Russia.

The overall aim of this chapter is to demonstrate the critical theoretical framework which has informed this thesis and to isolate the concepts that have been used to explain its key findings. The potential limitations to this theoretical framework were also outlined in relation to post-Soviet Russia as an 'atypical' space for health promotion interventions. How biomedicine was used in the development of health education and public policy initiatives around substance misuse in the Soviet Union is discussed in the next chapter, which examines the Soviet historical background to contemporary health promotion initiatives.

CHAPTER 2: THE SOVIET HISTORICAL CONTEXT

This chapter outlines the Soviet ideological and institutional legacies which impact upon the development of health promotion initiatives in Russia today, and thus provides the context for understanding both the research questions and findings which are discussed later in this thesis. The aim is to demonstrate how professional biomedical discourses and competing ideological discourses have influenced the development of healthy public policy and health education initiatives. It is argued that although common processes of modernisation ensured that an individualised biomedical approach predominated in the Soviet Union as in the West, there were fundamental differences in the ideological drives underlying these processes. The ways in which alcohol and drug misuse were approached in the Soviet era has had a profound effect on how the issues are currently framed within health promotion initiatives. Therefore the first section deals with the ideological and theoretical grounding of health promotion in the Soviet Union in order to identify the different roots of individualised biomedical dominance. The history of Soviet alcohol and drug policy respectively are then outlined in order to contextualise the current situation.

2.1 The Theoretical Grounding of Soviet Health Promotion

As in the West, the medical model of health predominated within the practice of health promotion in the Soviet Union, and the five key features of the medical model – reductionism, the mechanical metaphor, the doctrine of specific aetiology, the technological imperative and body-mind dualism – as well as elements of social iatrogenesis were all present. However, the rise of the medical model within Soviet society cannot be associated reasonably with the rise of capitalism (see Chapter 1). Consequently the roots of this dominance are sought elsewhere, in Marxism's own technological imperative, and in the refocusing, for ideological reasons, of attention away from societal factors in substance misuse, to individual and micro-environmental factors.

Bolshevism and the Medical Model in Soviet Health Promotion

Health education was seen by the Bolsheviks as central to efforts to control the spread of infectious disease. Health education was similar in form to the agitprop materials

produced for social and political education and it was disseminated in similar ways: through work collectives, educational lectures, posters and other forms of mass propaganda in places of work, rest and residence (Storey 1995). All the materials were produced and the initiatives carried out via the Communist Party of the Soviet Union (CPSU) although health education was kept under the administration of the Ministry of Health and not actually transferred to the main political propaganda organs (Storey 1995). *Doma sanitarnogo prosveshcheniya* [sanitary education buildings] were set up in each region and were charged with improving the information level of citizens on basic personal hygiene, disease transmission and better industrial working practices (Ryan 1978). The basic system of health education units was formalised and centralised through the 1930s and 1940s and, with the exception of the war years, remained virtually unchanged and absolutely centralised until the Gorbachev era of *perestroika*. There were no non-state actors in the field of health promotion, and such initiatives would not have been encouraged or considered necessary.

Health education as practiced throughout the Soviet era relied on the health information model which assumes 'rationality'; health damaging behaviour is viewed as the result of insufficient information. Consequently in order to improve health one merely has to increase knowledge levels about 'risks' or 'lifestyle' and health education need not feed into the public policy process. In this way health education can also maintain a mass nature which was considered important in Marxist-Leninist ideology (Storey 1995). The evaluation of health education interventions thus focussed on whether they had improved the knowledge level of a given population; the impact on actual behaviour was not assessed (Storey 1995). This means of evaluation was in keeping with the Soviet preoccupation with quota fulfilment and the valuing of quantitative output over qualitative. Such measures extended into the health sector which used the same method of resource allocation as was used in other sectors of the economy. The administrative command system evaluated 'production' in terms of quantitative achievements and not qualitative outputs. Consequently health gain and improvements in demographic indicators were not used as measures of success in health care; instead success was measured by the aggregate size of the system and how many patients had been treated (Ryan 1978). This allowed plenty of scope for the 'mechanical metaphor' and the dehumanisation of patients in the

system. Although in combating infectious disease such quantitative measures are perfectly adequate – for example, inoculation rates are a good way of evaluating such medical interventions against infectious diseases (Ewles and Simnett 1995: 38) – they are not sufficient for tackling the chronic diseases which arise with improvements in the general standard of living.[1]

Despite the pride the Soviet authorities had in the universal health care system, it was never adequately funded (Buckley 1993: 114-5). In reality the state budget allocation to health halved between 1950 and 1985, from 10.5 per cent to 4.6 per cent of overall budget expenditure (Williams 1996: 186). Health care was considered a low priority. Moreover within the health care system, preventative medicine and health education themselves were low priority. Most emphasis was placed on the improvement of technological therapeutic health interventions and the physical number of beds and doctors *per capita* (see Buckley 1993: 115). However, the post-Soviet Ministry of Health continued to prioritise investments in medical care services over improvements to basic sanitation or preventive measures (Barr and Field 1996: 308). This is clear evidence that the medical model's 'technological imperative' remained dominant throughout.

For largely ideological reasons the 'doctrine of specific aetiology' and 'reductionism' were key features of the way health problems were framed. Reasons for ill-health, and indeed social problems, could not be sought in the social structure. According to Marxist thinking good health depended on the nature of the social structure; since, officially, this part of the equation had been resolved, the root causes had to lie elsewhere. Most often the reason for illness was given as individual psychology or biology. The treatment of addictions also focussed on the individual, but until the rise of the self-help movement, interventions concentrated on either removing the addict from society through the system of therapy and labour camps (see below) or on treating the physical aspects of detoxification ('body-mind dualism').

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[1] It should be emphasised that many of the improvements in health, particularly the dramatic improvements in life expectancy between 1938-9 and 1958-9 (an increase of 24 years for men and 27 for women) have been wrongly attributed to the expanding health care system alone. In this period the general standard of living improved significantly for most Soviet citizens and it has to be said that following the Civil War, collectivisation, famine and the purges the Soviet Union was starting from a low base – 20 years behind the United States (Shapiro 1997).

The Soviet health care system medicalised many things beyond the 'normal' scope of health practitioners, e.g. the medicalisation of rest and relaxation through the network of sanatoria (Shapiro 1997). Also many 'nervous conditions' were medicalised, which was often comforting for the 'patient' but also demonstrated the clash between lay and professional perceptions of health and illness (Skultans 1999). Marxism-Leninism encouraged 'scientific' explanations by its own 'scientific' basis and, with this ideological support, the medical model thrived and so too did victim blaming.

From Marxism to Conservatism

Early Bolshevik ideology rooted ill-health in society, but it did not do so as a challenge to biomedicine, which was actually embraced for its scientific rationality. . Many social issues such as alcoholism, drug addiction, prostitution and homosexuality were viewed as indicative of the bankruptcy of capitalist society and labelled 'diseases of capitalism'. It was assumed, therefore that these issues would automatically fade away as the Soviet Union approached communism, as they no longer had any basis in a socialist society. However, when these 'diseases of capitalism' were not eradicated soon after the Revolution, rather than examining the potential failures in Soviet society, the Soviet authorities chose to deny the existence of these social issues rather than challenge them directly. The 1920s were characterised by a spirit of experimentation, but during the 1930s "Soviet society returned to many of its pre-revolutionary traditional [conservative] standards for the remaining sixty years of Communist party rule, and many of these norms seem to have survived into the post-Soviet period as well." (Stevenson-Sanjian 1994: 112) At a policy level the focus shifted away from the material conditions, which led to negative social phenomena such as addiction, to outright denial.[2] At a therapeutic level, therefore, the focus also shifted away from the macro-environment to the individual.

Marx and Engels did not really address the issue of alcoholism or drug addiction in their writings. It was Engels rather than Marx who explicitly stated that capitalism

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[2] Apart from addiction, other 'deviancies' were also addressed after the Revolution, but then denied and suppressed in the 1930s, including, for example, homosexuality (see Essig 1999; Riordan 1996).

inevitably produces pauperism and with it alcoholism, prostitution, crime and other 'social ills' – though notably not drug addiction (Engels 1892). However, Engels' description of alcohol abuse amongst the masses in <u>The Condition of the Working Class in England</u>, as Levin argues (1997: 64), was not a comprehensive theory of the relationship between alcoholism and capitalism. It was Kautsky in the late nineteenth century, who took this comment and developed the logic that Socialism would therefore cure these social ills as a socialist state would eradicate the root causes of poverty (Levin 1997).[3] Lenin subscribed to this theory of a causal link between capitalism and 'social ills' as hinted at by Engels, and this became the ideological foundation for the official Soviet attitude towards alcoholism, drug use, prostitution, homosexuality and crime.

Before they were in power there is no evidence that the Bolshevik Party had any real interest in alcohol or drug abuse (Kramer 1991; Levin 1997).[4] This is a very interesting omission in the context of the early twentieth century when the temperance movement was a global and highly politicised feature of public debate and temperance groups were some of the most vociferous critics of the hardships which the working classes had to endure. In the early twentieth century there was little public debate in Europe around the dangers of 'drug' use as it was not a particularly visible problem, particularly when compared to alcohol abuse. However, this did change in the 1920s and 1930s when a drugs epidemic swept across Europe and the US (Plant 1999), and included the new Soviet Union (Conroy 1990). The roots of this epidemic are complex and there are both country specific and non-specific factors in its development, but an important historical point is that globally debates around drugs related crime, dealing or trafficking were simply not taking place as at that time there were no illicit drugs; opiates and cannabis, for example, were freely traded through pharmacies (Williamson 1997). Debates around substance misuse at the time centred on alcohol misuse, particularly among the working classes, and though the strongly politicised alcohol question was never central to the Marxist agenda, as it became an urgent issue for public debate, it also became an issue for the Social Democracy movement in Russia (Levin 1997).

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[3] There were other Marxist thinkers who viewed alcoholism as much more complex in its origins, notably Emile Vandervelde (see Levin 1997: 65-7).

After the October Revolution the 'social ills' did not fade away, and by the 1930s it was clear that they could no longer be framed simply as 'remnants of capitalism', so alcoholism and drug use, as sources of ideological embarrassment to the regime, 'disappeared'. Interestingly, however, despite its politicised past, alcoholism was first to be more publicly discussed, just one year after the death of Stalin (Levin 1997). Drug use, by contrast was not openly discussed until the mid 1980s with the rise of Gorbachev and the new openness about previously taboo subjects; a reflection of the fact that while both alcoholism and drug use were considered 'deviant' practices and neither were officially tolerated by the Soviet regime, in practice drug use was considered much more deviant (and dealt with much more severely by the state) than alcoholism (Shelley 1996). The persistence of these deviancies in the Soviet Union could not be explained in terms of social conditions for ideological reasons, so substance misuse was blamed on physiological and psychological factors, in spite of the fact that originally such interpretations had been seen as a "bourgeois focus on heredity and individual flaws and weaknesses" (editor of *Voprosy narkologii* in 1934, quoted in Conroy 1990: 465).

As argued above, the expansion of the medical model cannot be framed as symptomatic of neo-liberalism as it was also a feature of Soviet society, the shift occurred for ideological reasons rooted in conservatism, emanating from "a political philosophy of prudence, utilitarianism, and the preservation of the status quo." (Seedhouse 1996: 88) Under Brezhnev, preservation of the status quo became an art form, and didactic health education suited the maintenance of the Party's ideological monopoly (Richardson 1999). Consequently, although linking ill health to wider socio-economic conditions rather than concentrating on the individual is very much within the Marxian radical political approach, the reality of Soviet health promotion came from a culture of conservatism, which focused on 'lifestyle'. This conservatism forced the suppression of data and statistics on the true scale of drug, alcohol and solvent misuse in the Soviet Union, which in turn severely hindered the development of health education and healthy public policy in these areas.

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[4] Once in power, the Bolshevik Party's position did, however, change over time (see Williams 1991).

2.2 Alcohol in Soviet Public Policy

As argued above, alcoholism was viewed as an essentially 'capitalist' problem, however Stalin reintroduced the state monopoly on alcohol production and sale – the very modernisation of Russia was thus financed by a 'drunken budget'. Subsequent leaders then had to cope with the economic, social and medical impact of a population which drank so much (see below). Despite this, the most significant attempt to tackle the drink problem through public policy and health education initiatives in the Soviet Union was Gorbachev's anti-alcohol campaign. The effects of this campaign proved far reaching; some commentators have even credited this ill-advised campaign with the demise of the Soviet Union (see Aslund 1991). Thus post-Soviet alcohol policy has been shaped inevitably by the effects of this campaign which had a major impact on both the economics and demographics of the newly independent Russian Federation.

Alcohol in the Soviet Union: Revolution to Perestroika

In spite of the prohibition, which ran from 1914 as part of the war effort, the new Soviet leadership inherited an alcohol problem. Initially, the Bolsheviks had positioned themselves as pro-temperance and had spoken out against the Tsarist alcohol monopoly as profiteering out of the misery of the working classes. Lenin could see the hypocrisy in the reinstitution of the alcohol monopoly, but reports were showing that the country was awash with *samogon* (homebrewed vodka). Stalin took an altogether more pragmatic stance; either loans from the West or alcohol revenues were needed to finance industrial development (White 1996; Levin 1997). From 1931 discussion of excessive alcohol consumption and the temperance movement were both silenced and until the 1960s alcohol production and consumption levels were not published and alcohol related social problems, like most other social issues, were not discussed openly in the press (White 1996: 32). When alcoholism came back into the public eye in the 1950s, it was through the 'usual' anti-alcohol propaganda supported by medical data (Levin 1997: 72). In 1966 the Brezhnev leadership introduced a system of fines for public drunkenness and the labour-therapy camps (LTPs) for persistent offenders (White 1996: 59).

More concerted efforts to tackle alcohol consumption in the Soviet Union were not evident until the 1970s, and one of the more comprehensive anti-alcohol campaigns took place in 1972. It concentrated on educational measures and the use of the mass media; the aim was to eradicate drunkenness and it specifically targeted youth (Tarschys 1993: 18). There were also legal measures, such as increased penalties for public drunkenness and a planned reduction in the production of vodka in conjunction with a planned increase in the production of wines and beers in order to compensate. However, levels of alcohol consumption continued to rise (Treml 1987: 2), and in 1979 there were calls to make anti-alcohol propaganda and education more effective and to impose the regulations that were already in place more vigorously, including a reduction in the production of vodka (White 1996: 59). These proved to be empty statements and the production of vodka actually increased in line with demand (White 1996: 60). Further evidence that the leadership lacked a real will to change the situation is provided by the Inter-Ministerial Council on Alcohol Propaganda, 'set up' in 1979 within the Ministry for Public Health but which only ever existed on paper (Tarschys 1993: 18). The rising rates of alcoholism in the Soviet Union were not only testimony to the ineffectiveness of the campaigning, but were also evidence of the leadership's lack of commitment. Brezhnev was personally unable to lead a campaign by example and the Soviet economy was dependent on the revenues raised by alcohol sales. By the early 1980s taxes levied on the sale and production of alcohol accounted for 13-14 per cent of the Soviet state budget, making it the single most important source of state revenues, even though high alcohol consumption levels were causing concern (Treml 1991: 130). This was a paradox that the Soviet leadership was unable to resolve.

It was widely believed that greater labour discipline would improve productivity, and that alcohol had a detrimental effect on labour discipline. However, if the working population all drank less this could seriously unbalance the budget - as Gorbachev found to his cost (Aslund 1991). The anti-alcohol campaigns under Brezhnev all aimed to 'perfect' society, individuals and the economy alike by tackling the problem directly, without necessarily analysing its root causes. Alcoholism, like crime and bureaucracy, was viewed as a hangover from the old capitalist regime, and it was asserted that, as the socialist system was perfected, these would become problems of the past. Consequently it was not deemed necessary to attack the causes of these

problems, this having been achieved in 1917. The Brezhnev leadership did not view any problem as systemic or inevitable, but rather it was viewed as the result of not having applied the correct principles consistently. Therefore the leadership would launch a campaign and give the impression of genuine change through official declarations and regulations. However, all the campaigns served to do was tinker with the existing methods and institutions while the system, the society and the individual remained largely unaffected, as did the root causes of the problem.[5]

By the 1980s many in the CPSU viewed alcoholism as an insurmountable problem (White 1996: 60). Early in 1983 Andropov launched a campaign to strengthen public order and morality (White 1996: 62). This campaign included anti-alcohol measures, which were particularly aimed at reducing the prevalence of drinking in the workplace.[6] Andropov was the first leader to acknowledge that the alcohol problem in the Soviet Union was more than just a 'survival' from the capitalist past, but his alcohol campaign was part of a wider discipline campaign in order to raise economic efficiency, and therefore it was principally industrial workers who were targeted. The aim was to strengthen public order and morality while broadening the terms in which public issues such as alcoholism could be debated (White 1996: 62). This approach towards alcoholism remained unchanged by Gorbachev's anti-alcohol campaign. Nevertheless, before 1985 the main thrust of anti-alcohol education had been aimed at reducing the amount of pure alcohol an individual drank, that is, encouraging the population to drink more moderately and to switch from spirits to wine or beer. Public health education also aimed to create an atmosphere of intolerance towards anti-social behaviour such as drunk driving and drunkenness in the workplace. Changing the population's relationship to alcohol was seen as the key to reducing consumption. The encouragement of such 'cultured' drinking was rejected as a half-measure by the new Gorbachev leadership and instead an all out war against alcohol was launched.

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[5] See Kornai (1992: 396-398) and Schroeder (1979), for a detailed discussion of economic 'reform' campaigns, and Shlapentokh (1989: 18-34), for a discussion of the ideal and the improvement of the average Soviet citizen.

[6] Andropov's campaign did not, however, take such strong action against alcohol consumption. Indeed during his short leadership a new even cheaper brand of vodka appeared which soon became known as 'Andropovka' (see Roxburgh 1991: 27).

Gorbachev's Anti-Alcohol Campaign

The 'Measures to Overcome Drunkenness and Alcoholism' was the first decree of the new Gorbachev leadership, and it looked similar to previous anti-alcohol campaigns in structure, possessing the same classic top-down format, emphasising the role of the CPSU and the importance of Party members leading the rest by example. Party discipline was seen to be as important as labour discipline and this element also made it reminiscent of a Stalinist crusade (Sakwa 1991: 272). The policy tools used were also familiar - decreasing state sales and production, raising prices, controlling the network of state shops which sold alcohol and increasing penalties for drunkenness, *samogon* production and speculation in alcohol. The age limit for purchasing alcohol was increased from 18 to 21 years. The campaign was thus primarily an attack on the supply of alcohol, although there was also a concerted effort to decrease demand and the role of different party organs 'in pursuing anti-alcohol propaganda' was emphasised ("O merakh…" 1985).[7] The main difference between this campaign and previous anti-alcohol measures was that it was actually carried out in earnest: the output of alcoholic beverages was indeed reduced and, for a time, so was consumption (Aslund 1991: 79). A new organisation was formed, the All-Union Voluntary Society for the Struggle for Sobriety (AVSSS). A significant part of the AVSSSs remit was the promotion of a sober way of life through social events, and the dissemination of information on the dangers of alcohol. They had extensive access to the mass media, they were allocated enough resources to commission a large number of posters and they also had their own journal – 'Sobriety and Culture'.

The momentum for Gorbachev's campaign was aided significantly by the fact that it had genuine support within the Politburo.[8] This support was gained largely as a result of greater openness about the Soviet Union's alcohol problem and the results of research into the social and economic cost of alcohol. This coincided with the growth in medical and demographic evidence that linked the Soviet Union's low life expectancy with the population's drinking habits. The social costs of an alcoholic

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[7] Ryzhkov is quoted as saying, "At first I thought they were joking when they said that 'drunkenness would continue so long as there was vodka on the shelves.' Then I realised they were dead serious" (Roxburgh 1991: 28).
[8] The two most active proponents of the campaign were Ligachev and Solomentsev (Chairman of the Party Control Committee). Gorbachev himself also endorsed the measures, but support within the Politburo was by no means unanimous. See Ryzhkov (1992: 94-96).

society were being calculated in the early 1980s and on the eve of Gorbachev's campaign about 4.3 million people were officially classified as chronic alcoholics, as registered by health authorities (Treml 1991: 125). Alcohol abuse was identified as the single most significant cause of marital breakdown and in virtually every investigation into family life it was cited as the most damaging social ill (White 1996: 42). Moreover 'most acts of hooliganism and two-thirds of murders and violent crimes were committed by intoxicated people' (Ivanets and Lukomskaya 1990: 246). Research had also begun to show that the economic costs of high alcohol consumption, through absenteeism, accidents and thefts, far outweighed the revenues raised through taxes on alcohol production and retail. As much as 90 per cent of absenteeism from work was alcohol-related. Productivity on pay day and after weekends was up to 30 per cent lower, and these 'morning after' losses on a Monday were estimated to cost approximately three billion roubles annually (White 1996: 48). Something had to be done to counteract the stagnation in the economy but the anti-alcohol campaign was launched not only in order to improve labour discipline, it also aimed to stop the Soviet, or more specifically Slavic, people from destroying themselves.[9] However, this destruction was feared not only through the immediate health costs of high alcohol consumption levels, it was even argued that the nation's gene pool was at stake (see, for example, "O merakh…" 1985: 1).

The anti-alcohol campaign's momentum was maintained through pressure from extremists who had gained influence within the CPSU. It was generally accepted within the Politburo that the previous anti-alcohol campaigns had simply not been effective, but concerns from the growing informal temperance movement about the damaging effect of alcohol on the nation's health, and birth rate in particular, were being heard on a much higher level. These extremist voices began to direct the campaign after having silenced their opponents, who supported the 'cultured' drinking doctrine – specifically the Soviet Union's chief narcologist Eduard Babayan. Babayan and his associates had been raising the issue of alcoholism in the Soviet Union for many years and they saw public health education as the way forward. The goal of total abstinence was viewed as particularly unrealistic in a country such as the

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[9] It was the Slavic republics in the Soviet Union that had the most serious drink problem, and it was another failure of the campaign that this was not taken into account (Treml 1991: 122-5).

Soviet Union where patterns of heavy drinking were so ingrained in society, especially in the Slavic republics (Treml 1987: 18). In the autumn of 1985, only a few months after the anti-alcohol campaign had been launched, the Ministry of Public Health and Babayan personally were attacked for a lack of consistency in conducting anti-alcohol propaganda ("Uluchshat'…" 1985). Babayan was subsequently removed from his positions of influence within the Ministry, and Fedor Uglov succeeded him as the leading authority on alcohol abuse.

Uglov was a fanatic who had been making his opinions on the dangers of drinking - even in moderation - known for some years, but his views had always been largely discounted as too extreme and naive. After Babayan's removal all debate between the temperance lobby and the supporters of 'cultured' drinking was ended. The overriding position within the Ministry of Public Health and the CPSU became a drive for temperance, and the idea of moderate drinking was widely ridiculed in the media. The temperance lobby had a monopoly on alcohol ideology, and it never ceased in its denunciation of 'cultured' drinking doctrine. There were even attempts at censorship of films or books that portrayed any drinking in a positive light (Roxburgh 1991: 27). The medical establishment retained its traditional attitude towards alcoholism as a moral failure or weakness of character, a view supported by the temperance lobby. The rise of the temperance lobby to supremacy heralded a complete change in the very nature of anti-alcohol propaganda. Previous campaigns had been based on state fiscal interests and 'cultured' drinking doctrine. However, by the end of 1985, the social and health aspects of the Soviet Union's alcohol problem became dominant, thus ensuring that the campaign became more than just an attempt to improve labour discipline and productivity.

Much of the health information published during the campaign was alarmist. Shock tactics were used in order to scare people into a sober way of life. Much attention was paid to the poisonous effects of alcohol on the human organism. This was aimed particularly at men of working age (see Zerenin 1985; Entin 1985), but special attention was also paid to the effect of alcohol on children, who at the age of 11 or 12, it was asserted, could be poisoned by only 100ml of wine (Dmitrieva 1985), and the unborn child (Kiryushchenkov 1986; Kaz'min 1988). In temperance ideology the demographic situation in the Soviet Union was very closely linked to the alcohol

situation and this became the main focus for anti-alcohol propaganda, and less emphasis was placed on the economic costs to society through alcohol abuse amongst the working population.

As demography was the leading consideration in public health education, during Gorbachev's campaign young women became another prime target group. Theories about 'drunken conceptions', 'alcoholic embryopathy'[10] and the damaging effect of alcohol on the reproductive system blamed women who drank for rising rates of 'defective' children being born.[11] It was argued that an unborn child was at risk from alcohol damage to its genes before, during and after conception; consequently, health information in the mass media about the effect of alcohol on a woman's body centred almost exclusively on her reproductive health. It was in these terms that abstinence was advocated for women of childbearing age, and there was even discussion of banning pregnant women from drinking, by making alcohol available only through coupons (Boikova 1986). There was also a lot of emphasis placed on bad mothers being responsible for the drinking and criminality of their offspring and even of their husbands, to the point of women being attacked for allowing their husbands to spend the family budget on drink (Tokareva 1985). Parents who drank were labelled irresponsible, and it was even debated whether alcoholics should be denied the right to have children (Dmitrieva 1985).

Despite the genuine commitment of many activists in the AVSSS, there was a lack of genuine popular support for an extremist campaign for temperance in the Soviet Union. This made prohibitionary policies largely unenforceable, but it also made the general population much less tolerant of the campaign's awkward side effects. As the Soviet population did not unanimously become temperate many sought alternative supplies of alcohol and the production of *samogon* increased dramatically to fill the gap in the market left by the actual reductions in state produced alcoholic drinks. Alcohol based products disappeared from the shops and pharmacies as alcoholics were reduced to drinking antifreeze and eau de cologne, amongst other things, when alcoholic beverages were not available to them. Sugar, jams and sweets also became

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[10] More commonly known as Foetal Alcohol Syndrome in the West.
[11] The term '*nepolnotsennyi*' is often translated as 'disabled', but there is also a sense in which it means 'substandard' or 'inferior'.

scarce as they were used in the production of *samogon*. Purchasing legitimately produced alcoholic drinks was made very difficult for all citizens by the campaign's restrictions on the retail of all alcoholic beverages; queues outside liquor shops were enormous and often became violent. These extra inconveniences to people's everyday lives occurred at the height of the general shortages resulting from the first three years of *perestroika*.

The quality of the illicit vodka was, at best, variable and alcohol poisoning from *samogon* became a serious health concern in the Soviet Union and post-Soviet Russia. Also, as in the United States in the 1920s, moonshine production and supply in the Soviet Union became a mainstay of organised crime. Because Gorbachev's anti-alcohol campaign aimed for absolute sobriety, it targeted moderate as well as heavy drinkers. This perception of all drinking being problem drinking did not strike a chord with the wider Soviet population; people were being severely inconvenienced and sometimes even punished, when they themselves did not misuse alcohol. The victimisation of alcoholics combined with the much stricter penalties for drunkenness also drove alcoholism underground and back into the home. When the campaign was effectively cancelled in October 1988, the damage to the economy, society and many individuals was widespread. It has even been argued that the damage inflicted on the national economy from the loss of government revenues from alcohol production and sales was a critical factor in the collapse of the Soviet Union in 1991, as it effectively bankrupted the country (Aslund 1991: 193).

The Fallout from the Anti-Alcohol Campaign

It is unsurprising that the anti-alcohol campaign was abandoned and it is also unsurprising that alcohol policy in post-Soviet Russia has remained a sensitive issue. In 1992, as part of economic liberalisation, Yeltsin completely deregulated the alcohol market. This has since been recognised as being a serious mistake, and since 1995 the Russian government has been attempting to re-impose the alcohol monopoly (Sakwa 1996: 258). From October 1988 onwards alcohol misuse in the Soviet Union and post-Soviet Russia has been largely neglected in the media and by the government. This is clearly not because Russia's alcohol problem has gone away; there was a sense of 'fatigue' with the subject following the campaign and there was also a renewed sense of fatalism, i.e. a sense that Russia's alcohol problem was indeed

insurmountable. Since Gorbachev's campaign the Ministry of Public Health (which, officially, is now almost entirely responsible for public health education) has not conducted any anti-alcohol education as part of a ministerial directive.[12] There appears to be no significant recognition within the medical community, especially at a ministerial level, of alcohol abuse as a problem that could or should be dealt with (Tillinghast and Tchernjavskii 1996: 474).

The relative importance of non-state actors in health education and healthy public policy around alcohol misuse therefore increased, and in the early 1990s the two major groupings of NGOs to work in this field were the temperance lobby and the self-help movement. The temperance lobby continued in its struggle for sobriety and remained allied, to varying degrees, to the national patriotic movement and a slavophilic agenda, concentrating on Russia's demographic crisis. The mushrooming of the Western influenced and Western funded self-help movement was predominantly based on Alcoholics Anonymous (AA) doctrine (the 12 Step approach) and facilitated by the Gorbachev leadership's activation of social and voluntary groups in order to create an active citizenry (a 'civil society'). The aim of this reactivation was to encourage a multiplicity of ideas and approaches to social problems so that new solutions could be found. As a result of this and greater openness to Western ideas, many self-help groups formed in existing state narcological services: i.e. an existing clinic would set up an AA or Alanon group (for the support of relatives of alcoholics). Alternatively groups were formed outside state structures, frequently in the newly emerging charitable organisations which were involved in related projects (Stivenson 1996: 29-30).

In the late 1980s the temperance lobby became increasingly frustrated with the government's lack of commitment to the campaign. Fired by the initial successes, many now were seeking an all out 'dry law' as well as a complete transformation of AVSSS. There were calls for the society to be completely overhauled, to be converted into a new NGO independent from the CPSU, and for Uglov to be appointed as its new president (Brudny 1991: 165). Uglov argued that the campaign

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[12] In its report on the health of the nation in 1995, the Ministry of Public Health reported on its education work in other fields, particularly smoking, and there have been recent developments in AIDS awareness campaigning, but nothing on alcohol use (see Minzdrav 1996: 145).

had failed not because there was a lack of grassroots support for temperance in Russia but because the campaign was a series of half measures and not a 'dry law' banning the production and retail of alcoholic drinks. In some respects this can be seen as a continuation of the 'conservative' mindset, whereby a problem is not systemic or ideological, but instead the result of a failure to implement the correct principles consistently. Nevertheless, Uglov also revealed the increasingly evident national patriotic bias within the temperance lobby; he argued that the campaign had been sabotaged by a conspiracy between bureaucrats who were only interested in revenues from alcohol and 'ethnic non-Russians' in the mass media who opposed the idea of a sober Russian nation.[13] Uglov's theories were published in the extreme right wing journal *Nash Sovremennik*, which in 1987-1988 led a campaign for a full 'dry law' in Russia.[14] There was a fundamental disagreement between the hardline top-down advocates of a 'dry law' and the advocates of bottom-up temperance as an individual choice; this led to a split in AVSSS in December 1988 when Uglov formed the secessionist 'Union for the Struggle for People's Sobriety' (White 1996: 129). After the bad publicity that had been afforded to AVSSS, its former leadership founded the League of Temperance and Health as a replacement during 1991.

2.3 Drugs and Solvents in Soviet Public Policy

Officially there was no problematic drug use in the Soviet Union; the existence of such phenomena was explained as 'vestiges of the past' or 'remnants of capitalism' which would 'wither away' with the achievement of communism (Kramer 1991: 94). However, the Soviet *militsiya* had been dealing with drug users since the time of Khrushchev (Shelley 1996: 145). The development of a coherent legislative framework for dealing with illicit drug production and sale as well as drug users themselves would also indicate that there was indeed a significant level of drug use in

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[13] In previous works Uglov had openly blamed the Jews for Russia's alcohol problem, (see Brudny 1991: 165), and it has been pointed out that amongst the 'authorities' adduced by Uglov, were the ideologists of the Black Hundred and other parafascist groups, (Laqueur 1989: 171).

[14] However, links between far right organisations and the temperance movements predate Uglov's close working relationship with the editorial board of *Nash Sovremennik*. The Novosibirsk branch of the nationalist *neformaly - Pamyat* ('Rememberance') was formed in 1984 from the remnants of an early Sobriety Society, the founders of which had been inspired by a visit from Uglov (White 1989: 26). By the end of 1986 *Pamyat'* had been driven underground, and in the summer of 1989 it was the biggest political informal group, with between 300 and 500 members, 250 in the Novosibirsk region.

the Soviet Union which was considered problematic, even if it was not as visible there as in the West. The invisibility of drug use in the Soviet Union may have been a reflection of the relatively minor scale of the problem, but censorship also undoubtedly played a part, for example use of the words '*narkoman*' and '*narkomaniya*' was prohibited in the Soviet national press and other publications (Simpura and Levin 1997: 14). Drug use was not combated openly until the Gorbachev era when the extent of the Soviet drug problem was first seriously, if sensationally, discussed in the media. Since that time the issue has attracted more attention from both the media and policy makers, and shifts in attitudes towards drug use and drug users have occurred.

Soviet drugs policy

Drugs were considered a serious problem in urban areas in the 1920s, as a wave of cocaine use swept across Europe, the young Soviet state included (Conroy 1990: 450-63). Other widely misused drugs were morphine (particularly within the medical profession) and cannabis (among residents of Siberia, Southern Russia and Central Asia), and opium for smoking was also widely available in the form of 'Egyptian cigarettes' (Conroy 1990). The sale of products containing morphine and cocaine was, theoretically, controlled by law – sales were restricted to prescription only and were only processed by licensed pharmacies. The misuse of most drugs was not criminal, and the smoking of both opium and cannabis was unregulated (Conroy 1990). However, the first Soviet list of 'controlled substances' was produced in 1924; the non-medical use of opiates and cocaine was outlawed in 1925, and although cannabis remained legal (Conroy 1990: 459-60) further regulation prohibited the free circulation of cannabis and other 'narcotic substances' in 1928 (Kramer 1991: 94). The change in policy also marked the end of 'objective' rather than polemic medical/academic writing on the subject of substance misuse (Conroy 1990).

Drug addiction appeared to decline drastically in the Soviet Union in the 1930s, though it is debatable whether this is due to a genuine decline in incidence and not just underreporting (Conroy 1990: 463). Initiatives in the 1930s sought to impose greater control over the cultivation and supply of cannabis and opium products, and, in the absence of any real data on drug consumption levels, this has been interpreted as evidence of a growing concern about, or even incidence of, drug use in the Soviet

Union (Kramer 1988: 34, 39). Initiatives aimed at controlling the cultivation of illicit drugs were actually in line with international efforts to control and co-ordinate drug supply (see McAllister 2000: 105-133). By the late 1940s there was no new information available on the subject of drug addiction in Soviet society, "the Soviet government had either conquered the problem or suppressed most information on it." (Conroy 1990: 447) After the 'Thaw' a narrowly focussed medical literature did emerge, but the issue was not debated in the wider press and the first sociological surveys were not produced until the late 1970s, and not published until the Gorbachev era (Buckley 1993).

A more significant indicator of a potentially growing drug problem in the Soviet Union were shifts in policy around drugs education and the treatment of active drug users. For example, although drug use was not criminalised in the Russian Republic in 1972, treatment for drug addiction was made compulsory and individuals who failed to stay clean after treatment, or who refused treatment, would be sent for re-education to a therapy and labour camp. A decree on combating drug addiction was issued in 1974 and, in 1975, the Supreme Soviet once again looked at the issue of drug addiction, not because it was becoming a problem, it was argued, but because "this poison must be killed in its infancy" (commentary quoted in Kramer 1991: 95). From 1966, those charged with drug-related crime faced increasingly harsh penalties from the courts, as judges were encouraged to intensify the struggle against drug addiction by combating the supply of drugs to young people (Powell 1973: 36-7). In the Russian Republic, however, the actual use of illicit drugs was considered only an administrative offence, usually punishable by a fine (Kramer 1989: 27). The drugs laws were changed again in 1992 and drug use was effectively legalised in the Russian Federation and the forced treatment of addicts was outlawed.

It was not really until 1986 that drug use in the Soviet Union was acknowledged by the Soviet authorities, and official sessions devoted to the issue were held in the Supreme Soviet, etc. (Kramer 1988: 35). Official policy towards drug use appeared to move towards decriminalisation; the MVD stopped instituting criminal proceedings against individuals found to be in possession of small quantities of drugs or who voluntarily handed themselves in to the authorities (Kramer 1988: 37). The decriminalisation debate was led by a number of Soviet specialists who had been

arguing that drug abuse was a medical not a legal, problem and should be treated as such, i.e. the need for proper rehabilitation services should be emphasised over punishment facilities (Kramer 1988: 37). This is a key example of social iatrogenesis; the medical lobby was pushing to get a social problem recognised as a medical one on both humanitarian and efficiency grounds, promoting improved treatment technologies as the solution to a complex issue. Hence instead of incarceration in corrective labour camps, the Soviet Supreme Court instructed the courts to "consider" compulsory treatment for drug addicts who refused voluntary treatment in therapy and labour camps (Kramer 1988: 37). The authority to exclude both drug addicts and alcoholics from society was subtly shifting away from the *militsiya* towards health services throughout the 1980s and 1990s. Even voluntary drug addicted patients still had to register with the police (Kramer 1991: 108), so they maintained their role in society as "social workers with sticks" (Shelley 1996). But the authority over the therapy and labour camps for drug users was transferred from the MVD to the Ministry of Health, along with the network of 'sobering up' stations.

The hidden sociological research

Although the official silence only really affected the dissemination of information about drug use in the Soviet Union, this also necessarily hampered the development of sociological research in the field. It was acknowledged that keeping silent about drugs in society was not healthy but ministers still advocated limits to public discussion in order to avoid stimulating an unhealthy curiosity and interest in the subject (Kramer 1988: 30). The Republican Komsomol and the MVD in Georgia set up a commission to investigate the extent of use and to make proposals to combat drug use. The project ran initially from 1967-1974, and it was the only sociological research into drug use in the Soviet Union at that time (Gabiani 1990: 42).[15] However, the findings were only made public under *glasnost'* (see Gabiani 1987). The Georgia surveys showed that whilst most drug users [*potrebiteli narkotikov*] were male, urban and under the age of 35, over time more women appeared to be becoming involved in drug use, users were getting younger, but also better educated, more affluent and they were increasingly likely to be raised in families with both parents

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[15] It needs to be acknowledged that Georgia was a republic with a distinct identity and culture – therefore it cannot be assumed that the findings of these surveys also reflect the situation in Soviet Russia.

present (Gabiani 1987; Gabiani 1992).[16] While in the 1970s users were initiated into drugs while in prison, in the 1980s they were more likely to be introduced to drugs through their peers – friends and family members (Gabiani 1987).

> "The social causes that drive Western young people into a drugged haze do not exist in the Soviet Union. If, over there, inability to find work or the hopelessness or excesses of life force young people to seek escape from reality, in our case we have to seek the roots elsewhere."
> (*Moskovskaya pravda* 11/6/86, quoted in Kramer 1988: 32)

The above quote sums up the Soviet attitude towards drug use in the Soviet Union; the problem there was portrayed as being essentially different to the Western experience. The Georgia surveys, and much research published in the print media under *glasnost'*, appear to show a different pattern of problematic opiate use in the Soviet Union to the situation in the West where opiate addiction was framed as a problem of an impoverished and excluded urban 'underclass'. By contrast, drug use in the Soviet Union appeared, at least initially, to affect the so-called 'golden youth' who were privileged and educated. However, this may actually reflect a mutual misunderstanding of the drug situation in the West as much as in the East. A closer examination of the Georgian survey findings reveal patterns of drug use which are actually very similar to that of, for example, the US. Although popular perceptions in the US see drugs as a problem of urban (usually black) 'underclasses', there is actually just as much drug use among young people from 'elite' (usually white) families – it is just that the 'War on Drugs' is being fought unevenly and urban 'underclass' users are more frequently caught (Human Rights Watch 2000). Every society develops its own narratives for describing and explaining different social phenomena, but emphasising the essential 'difference' of the Soviet Union was also a part of the ideological discourse. Powell (1973) contended that drug use in the Soviet Union was a problem for the children of the elite and was symptomatic of modernisation and the anomie it causes; "the very fact of progress and change in the Communist world has probably helped to bring about greater use of drugs." (Powell

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[16] There were also concerns that this pattern of 'elite' youth drug use was being followed across Eastern Europe (see Powell 1973: 34).

1973: 33) By the end of the 1980s drug use appeared to be, albeit to different degrees, evident in all social groups and educational levels (Kramer 1991: 98; Shchadilova 1989: 44).

Framing and coping with drug use and drug users in the Soviet Union

The central problem with both journalistic and scholarly work on drug use in the Soviet Union was the "considerable terminological carelessness" (Powell 1973: 32). These difficulties relate to the classification of both drugs and their users; in the literature there was no clear differentiation between drug use, misuse, abuse, addiction or dependence (Kramer 1988: 30). Terminology around both drug and solvent misuse was equally problematic and definitions, where supplied at all, were highly normative. For example, the chief narcologist Babayan described '*narkomaniya*' as "the state induced by the use of narcotic substances" which were classified as such by law; '*toksikomaniya*' was defined as the "'damage to health' induced by the non-medical use of a substance" which was not yet "juridically recognised as being narcotic" (quoted in Kramer 1988: 30). Terms were used interchangeably so that no differentiation was made between people who had experimented with drugs, had used drugs recreationally or had suffered dependency or problematic/chaotic use (Kramer 1988; Powell 1973). Similarly there was no distinction made between illicit drugs in terms of their effects or dependence potential (Powell 1973: 32). Even in scholarly writing drug use was, and continues to be, described in moralistic and highly emotive terms. Drug use has been described as 'infectious evil' (Gabiani 1987: 48), a 'national catastrophe' (Popov and Kondrat'eva 1998: 65), and in both the press and official health education materials drugs were commonly referred to as "white death" [*belaya smert'*] (see Gul'dan et al 1989: 70).

The difficulties around classifying different types of licit and illicit drug use made the collection and analysis of statistics very difficult even without restrictions on their publication. However, it is still reasonable to assert that "drug use and misuse [was] far less widespread in Eastern Europe than in the West, and they [had] not yet begun to rival alcoholism as a social problem." (Powell 1973: 32) Drug users were then relatively rare in the Soviet Union so did not warrant their own specialised services. Where they existed, facilities for drug users were usually subsumed under institutions dealing with either alcoholism or mental health (Kramer 1988: 35). This was

commonly cited as problematic because drug addicts were seen as needing specialist services (Buckley 1993: 85). Drug users/addicts were portrayed in the media during the Gorbachev era as tragic dying teenagers, which was in sharp contrast to the presentation of youth as the joyful builders of communism that youth had been previously (see Pilkington 1998). Alternatively users were portrayed as socially dangerous parasites who should be segregated and punished for the protection of 'normal' society (Buckley 1993: 83). Media coverage of the treatment facilities such as therapy and labour camps and narcology wards emphasised the dehumanising treatment of patients and gradually drug addiction came to be viewed more as an illness than a crime, a view which was reflected in the relaxation of drugs laws in 1992 which decriminalised use and possession for personal consumption.

With the acknowledgement of a drug problem in the Soviet Union also came calls for improved anti-drug measures and various explanations of how such a social issue could have occurred. The Soviet media and professional medical discourses tended to look towards a cluster of personal factors in explaining drug use in the Soviet Union – boredom, curiosity, escapism, hedonism and peer pressure (Kramer 1988: 32). "Such 'shortcomings' in the family as divorce, excessive drinking by parents, the absence of warm and loving bonds among family members are all seen as driving youths to seek solace in drugs." (Kramer 1988: 32) Some Soviet specialists pointed to the moral vacuum in society which had proved such fertile ground for drug addiction (Kramer 1988: 33). Certain ethnic groups from Central Asia were also seen as vulnerable, but as a historical legacy, the use of cannabis and opium being seen as embedded in their traditional culture instead of the alcohol use. Other factors cited were the anti-alcohol campaign forcing drinkers to look for a substitute for vodka (though there is no evidence to support this, see Kramer 1988: 32) but also the Afghan War veterans bringing back their drug problem from the front line and 'infecting' their home territories (Shelley 1996).[17]

The calls for drugs education in the Gorbachev era concentrated on the need to warn people of the dangers of drug use, particularly as drug treatment specialists

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[17] There were parallel discourses in the US around drug use amongst Vietnam War Veterans (see Plant 1999: 117).

emphasised the dangers of one-off experimental use (Kramer 1988: 32). Clearly there was a dearth of information programmes until the late Soviet period, but these education programmes were 'heavy-handed' and 'overly didactic' (Kramer 1988: 39). Sensationalist documentaries were produced, the horrors of drug addiction were serialised in the print media and an informational pamphlet was produced for distribution in Soviet schools which warned that there were "terrible consequences for a moment of intoxication" (pamphlet cover reproduced in Kramer 1988: 39). The *militsiya* were also involved in drugs education providing citizens with the opportunity to learn first hand about the dangers of drugs, however this was not successful in attracting Soviet youth (Shelley 1996: 146). Contemporary sociological research was critical of these approaches and scare tactics, questioning their efficacy in changing the attitudes and behaviour of young people who do not think in terms of long term health consequences (Gul'dan et al. 1989). However, there was also significant resistance to the conducting of drugs education for young people; there was a fear that it would encourage curiosity about drugs from a ministerial level down but also that it was not a serious enough problem to warrant such attention (Powell 1973: 39; Kramer 1988: 39). This in itself shows that the Soviet propaganda asserting that the country had no drug problem had been highly effective.

Conclusion

Individualised biomedicine was as much a feature of Soviet health promotion as it was of Western health promotion, although its ideological roots were different. The early post-Revolutionary focus was on the potential impact of socio-economic factors on health. The focus shifted from societal influences on health – particularly in the field of substance misuse – to the microenvironment (the family) and individual personality. Despite the fall of the CPSU, which lay at the heart of the Soviet ideological project, the focus on the individual in health promotion interventions has survived into the post-Soviet period. The reasons why the medical model has retained its hegemonic position in the framing of substance misuse issues are explored in Chapters 5 and 6. The impact of other legacies associated with the particularities of Soviet biomedicine are also discussed. The continuing influence of valuing quantitative over qualitative evaluation of interventions is covered in Chapter 5. The

impact of the continuing value placed on 'rational' and 'scientific' explanations for substance misuse is explored in Chapter 6.

The Soviet legacy to contemporary health promotion is visible in the lack of alcohol policy aimed at improving health following Gorbachev's disastrous anti-alcohol campaign. The end of the campaign also seriously weakened the temperance movement, which left the third sector in the field of substance misuse dominated by self-help groups and NGOs working in the field of drug use. The unpopularity of the anti-alcohol campaign was reflected in Yeltsin's populist move to completely deregulate the alcohol market. This was also considered a disastrous move, and attempts at re-regulation started almost immediately. As is explored in the next chapter, revenues from alcohol production and sale are still a key source of budgetary finance and central to alcohol policy making. In the field of substance misuse the focus of concern shifted away from alcohol misuse to the misuse of illicit drugs, which appeared to be a new phenomenon – real coverage of the issue having only begun in the mid 1980s. Sociological research produced and made public at that time laid the foundations for future research concerns in this area, namely the decreasing age of drug users; the increasing number of female drug users and, in contrast to what was perceived to be the situation in the West, the increasing number of 'golden youth' involved in drug use. How this shift was reflected in the print media through the 1990s is explored in the next chapter and as a result of the shift in focus from alcohol to drugs, the empirical chapters (Chapters 5 and 6) necessarily focus primarily on health promotion around drug use.

CHAPTER 3: THE RUSSIAN PRINT MEDIA ON SUBSTANCE MISUSE THROUGHOUT THE 1990s

 This chapter is an analysis of ways in which alcohol, drug and solvent misuse as problems were framed in the print media throughout the 1990s, with particular reference to the development of public policy around substance misuse. Discourse analysis of the print media is a useful tool for unpacking public debate as newspapers are one means of disseminating new ideas into the public arena – by translating theoretical ideology into populist idiom (see Howorth 1995). Rising costs in the production of print media in Russia since the collapse of the Soviet Union and the loss of heavy state subsidies have drastically reduced newspaper circulations, and this has greatly enhanced the relative importance of television, which has become the focus of political power struggles (Wedgwood Benn 1996: 473). However, this does not mean that the print media in Russia is now without influence in shaping discourses around different issues or that it no longer reflects and constructs the social norms and values of the society in which it is embedded. For these reasons analysing print media discourse in Russia is still a 'valid' exercise, and in assessing the extent to which health messages have been dominated by a biomedical approach it has proved an invaluable tool. Some measure of the continuing influence of the print media may also be seen in the information source overlap between the media and health education materials.[1]

This chapter begins with an introduction to the sources and how they were accessed and approached. The shifting emphasis between the coverage of alcohol, drug and solvent misuse is then examined as this has contributed to perceptions about the relative severity and seriousness of different forms of substance misuse. Such perceptions potentially dictate the relative levels of financing different health interventions are likely to receive. The interaction between media discourse and the policy making process in relation to drug and alcohol use is explored next as a way of showing how key narratives have been articulated and now shape both popular discourse and the legislative process. The chapter concludes with an analysis of the

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[1] For example a poster produced in Nizhnii Tagil (shown in Figure 6.1), shares the same image of a woman as was used to illustrate an article on drugs in *Rabotnitsa* (pictured in Berezina 1994: 17).

main trends in the media discourse, with a view to assessing the extent to which professional biomedical discourses have remained hegemonic in setting the framework for debates around substance misuse.

3.1 Doing Media Discourse Analysis

The discourse analysis presented below aimed to examine a range of different types of print media in terms of their target audience, and this is how the analysis was initially approached. Broad similarities in the discourses presented in the family/women's magazines, the lay health publications and the national newspapers were uncovered, however, and thus separate analyses of these groups of publications have not been presented here. The 'different' discourse was found in the youth magazines. Analyses of the professional media discourses were incorporated into the historical sections above [2.2 and 2.3] as they may be seen as reflecting 'official' approaches to substance misuse issues. The publications consulted by category were:

Family or women's magazines (*Krest'yanka*, *Rabotnitsa*, *Sem'ya i shkola*)

Lay health publications (*Argumenty i fakty "Zdorov'e"*, *Zdorov'e*)

National newspapers (*Segodnya*, *Nezavisimaya gazeta*, *Izvestiya*, *Komsomol'skaya pravda*, *Argumenty i fakty*)

Youth magazines (*Dilizhans*, *Ptyuch*, *Om*)

Professional health publications (*Meditsinskaya gazeta*, *Zdravookhranenie Rossiiskoi Federatsii*)

Professional educational publications (*Vospitanie shkol'nikov*, *Narodnoe obrazovanie*)

With the exception of some youth magazines which were accessed through colleagues and whilst in Russia,[2] print media was easily accessed in the UK in both hard copy and electronic form. Where possible, publications were analysed from the formal end of the Soviet regime in 1991, so that changes in the language or coverage of substance misuse issues could be charted, however, a content analysis using statistics collected from electronic databases was actually found to demonstrate shifts more effectively

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[2] Special thanks here go to Hilary Pilkington, Moya Flynn and Cordula Gdaniec for their assistance.

(see below). Available editions of the magazines and newspapers, were read for references to different forms of substance misuse from the end of 1991, or from the year the publications entered the market, to the end of the fieldwork year in December 2000, or until they ceased publication. Changes in legislation published in *Rossiiskaya gazeta* as well as legal documents collected in the field were also analysed. Some regional newspapers were accessed during the fieldwork period, though the sample was not considered great enough to inform this analysis.

Of the 'national' newspapers, the weekly tabloid *Argumenty i fakty* was the only one which was found to have a real presence in the research regions (with a region-specific supplement) during the fieldwork period.[3] *Komsomol'skaya pravda*, however, was highly influential even if it was 'invisible' as it was a common source of news for local journalists. *Komsomol'skaya pravda* was a Soviet newspaper, which traditionally targeted youth and, due to its style of reporting, has remained a popular youth paper (Tartakovskaya 2000). *Izvestiya* was also a former Soviet paper, but it has little youth appeal and remains rather conservative although it is independent of the state and relies on advertising to survive (Wedgwood Benn 1996: 473). *Segodnya* and *Nezavisimaya gazeta* were both centrist 'post-Soviet' newspapers and like *Izvestiya*, both would be considered 'broadsheets' in the UK. *Nezavisimaya gazeta* is part of Berezovsky's media empire which included *Ogonek* and *Kommersant"* along with ORT and TV-6 television channels (Fossato and Kachkaeva 2000). *Segodnya* seemed to carry more features on social issues than its competitors and was considered the most liberal Russian national newspaper until it was declared unprofitable early in 2001 and closed down. Another useful resource for the print media was the Current Digest of Soviet and Post-Soviet Press – an English language press digest, which drew attention to some articles from other national Russian newspapers, but clearly could not be used alone as the editors had different selection criteria to the researcher.

As magazines, *Sem'ya i shkola*, *Krest'yanka* and *Rabotnitsa* all have very similar histories and target readerships, indeed all were housed in the same editorial building

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[3] Wedgwood Benn argues that not even the most popular newspaper is capable of winning a truly nationwide mass circulation for financial reasons, although a survey conducted in the mid 1990s found that *Argumenty i fakty* was still read by one Russian in four (Wedgwood Benn 1996: 475).

in Moscow – along with *Zdorov'e*. All of these magazines are well established and have been published since Soviet times, although they have changed significantly both in appearance and in ideological content; none are as politicised as they were in the Soviet era. Now these magazines aim to fill the same position in the market as magazines such as Family Circle or Woman's Weekly do in the UK; they predominantly target women with families. During the fieldwork it was noted that supplies of these magazines to the provinces were not always reliable, but they were generally available, though not necessarily 'on time'. A major constraint to circulation was clearly their relatively high cost, but the actual readership of print media is higher than circulation figures suggest as publications are frequently passed around through social networks (Wedgwood Benn 1996).

The problems with accessing different Russian youth magazines in the UK and also the problems associated with the life span of new youth publications meant that this aspect of the study was somewhat limited. This was unfortunate as youth media provided the primary alternative to the 'main' discourse. *Dilizhans* was a magazine which had a very limited shelf life; it was published only 1996-1997. It is hard to classify in relation to British youth market niches, although in terms of which bands were featured it appeared to be very much a 'heavy metal' magazine aimed predominantly at male youth. *Ptyuch* and *Om* are relatively successful magazines that have been running since the mid-1990s and both were found to be available in the research regions and widely read. Editions were shared through social networks. In terms of fashion, lifestyle and music, *Ptyuch* is comparable in content and 'quality' with British magazines such as The Face, iD or Mixmag. *Om* would appear from its fashion coverage to be more of a men's magazine, comparable with British magazines such as 'GQ'. However, the vast majority of readers would not be able to afford the featured clothing and would not necessarily have access to the 'hip' club scene portrayed. In this sense, as in the UK, these magazines mould rather than reflect cultural tastes and affiliations.

Vospitanie shkol'nikov and *Narodnoe obrazovanie* were both produced by the Federal Ministry of Education, and *Meditsinskaya gazeta* and *Zdravookhranenie Rossiiskoi Federatsii* were both produced by the Federal Ministry of Health. All these journals published ministerial directives and programmes as well as relevant changes in

legislation and the latest in pedagogic and medical research respectively. *Meditsinskaya gazeta* is a biweekly newspaper aimed at all medical staff, i.e. not just clinicians, and covers pertinent current affairs and union news as well as policy and research developments. Interviews conducted in state health care organisations also showed that it is distributed throughout the federal health care system, and may therefore be seen as potentially very widely read.

3.2 The Shifting Emphasis: Drugs Versus Alcohol

Irrespective of the actual scale and parameters of a particular social issue, if it is considered unusual, and therefore shocking, it is more likely to receive attention in the media and it is more likely to be framed as an urgent issue. Consequently, for example, in Western societies drug use, which is perceived as 'deviant' behaviour – receives more media coverage than tobacco or alcohol consumption, which is considered 'normal'. It was believed that the same was true of Russia as in the course of the discourse analysis the number of articles on drug use appeared to increase year on year, whereas the number of articles on alcohol misuse seemed relatively stable and solvent misuse remained largely invisible. In order to show this shifting coverage of substance misuse issues, a small-scale content analysis was undertaken.

The sample newspapers used in the content analysis were *Segodnya*, *Nezavisimaya gazeta* and *Izvestiya*. These three newspaper titles were chosen as they had been included in the discourse analysis and were considered 'representative' of the Russian print media, and they were all available in electronic form for the years 1996 to 2000 (inclusive). The titles selected were also *de jure* national rather than regional and, as argued above, represented differing political standpoints. While the use of electronic databases for content analysis does have the benefit of added 'objectivity', the analysis was constrained by the limitations of finding articles using keywords. It was not possible to control for articles which would not generally have been included in the discourse analysis, such as those which featured, for example, an alcoholic burglar but which were not focussed on alcoholism *per se*. However, some sensationalist coverage of individuals' drug or alcohol problems, which would have inflated figures

disproportionately, was avoided by including only 'broadsheets' in the sample.[4] The two search terms used were '*narkoman**' (to cover both 'drug addict' and 'drug addiction') and '*alkogoli**' (to cover both 'alcoholic' and 'alcoholism'). A search for '*toksikoman**' (to cover both 'solvent addict' and 'solvent addiction') was also conducted and it revealed a virtual absence of the topic in the selected media.[5] The terms used focus on addiction rather than use, but this was deemed necessary in order for the results to be comparable (see Diagrams 3.1 and 3.2 below). A number of other search terms were later included in order to assess the validity of the original findings (see, for example, Diagram 3.3 below). Figures on the frequency of articles about 'drugs' or 'alcohol' themselves were not counted as they would undoubtedly include articles pertaining to trade in these commodities and not just their consumption.

The results clearly show that articles featuring drug addicts and addiction (Diagram 3.1) are significantly more common than articles featuring alcoholics and alcoholism (Diagram 3.2). Also, as hypothesised, alcoholism as the 'traditional' problem has had relatively stable coverage over time whereas the 'new' problem of drug addiction has increased over time as the Russian drug problem itself, and awareness of it, has increased.[6] Searches which included the colloquial term '*alkash*' for alcoholic and '*p'yanstvo*' meaning drunkenness (Diagram 3.3) showed that even when articles featuring alcohol abuse and not just addiction are factored in, the total number of articles is still significantly smaller than the total number of articles featuring just drug addiction / addicts. However, the use of colloquial terms was also shown to be quite widespread in the media, and this might be taken as evidence that alcohol misuse was less medicalised as an issue and considered less deviant – the widespread use of colloquial descriptors making alcohol use more everyday and 'acceptable'. The other notable feature of all three graphs was that all substance misuse (alcohol or drugs) appeared to fall off in 1999 and then increase again in 2000. The second war in Chechnya did start at the end of 1999, but breaking down the results into monthly

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[4] For example, *Komsomol'skaya pravda* ran a large number of articles on revelations about different Russian rock stars being drug addicts, notably Zemfira (Brodzkii 2001). This was not considered 'newsworthy' by the broadsheets which were selected for the content analysis.

[5] The total number of articles in the three newspapers surveyed which featured solvent addiction / addicts were: 1996 = 7; 1997 = 12; 1998 = 19; 1999 = 6; 2000 = 3.

[6] This shift was also visible in the range of health promotion interventions around drug use, as opposed to alcohol use, which were encountered during the fieldwork. See Chapter 6.

as opposed to annual figures did not show a correlation between a drop in coverage of drugs issues and rising coverage of the war in Chechnya.

Diagram 3.1: Articles on Drug Addiction / Addicts
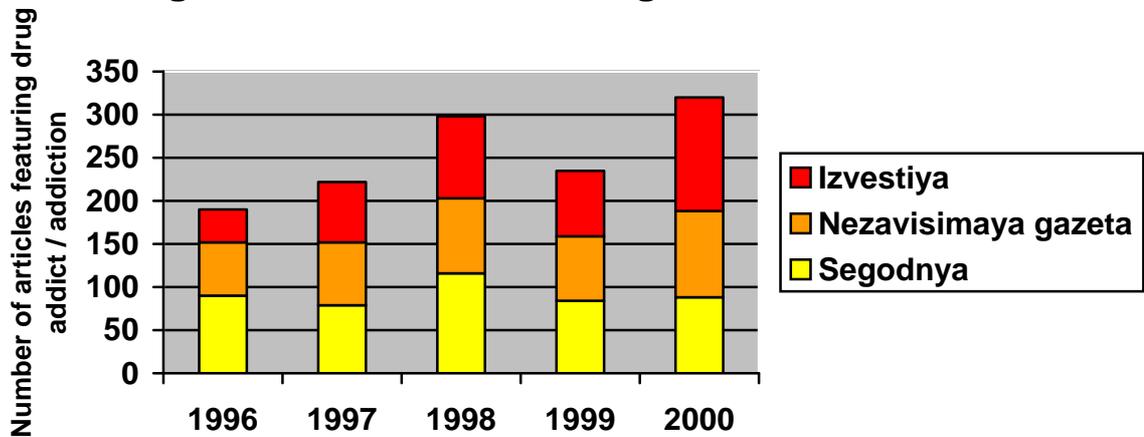
Diagram 3.3: Articles on Alcohol Addiction and Drunkenness
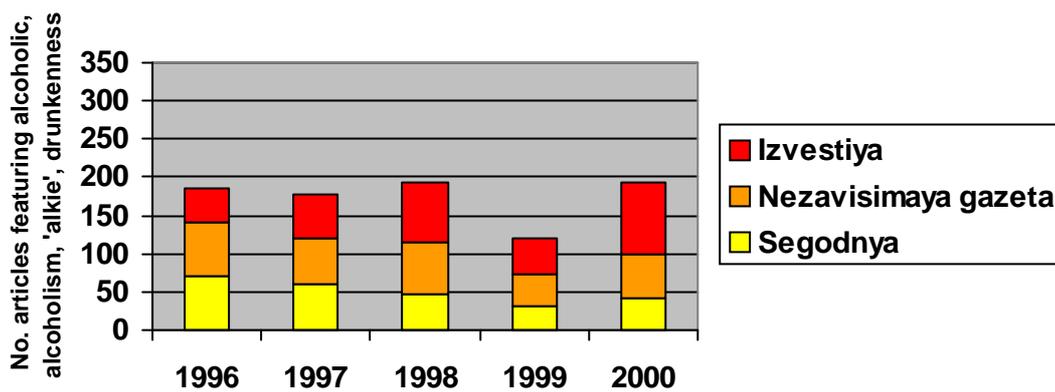
Diagram 3.2: Articles on Alcoholism / Alcoholics
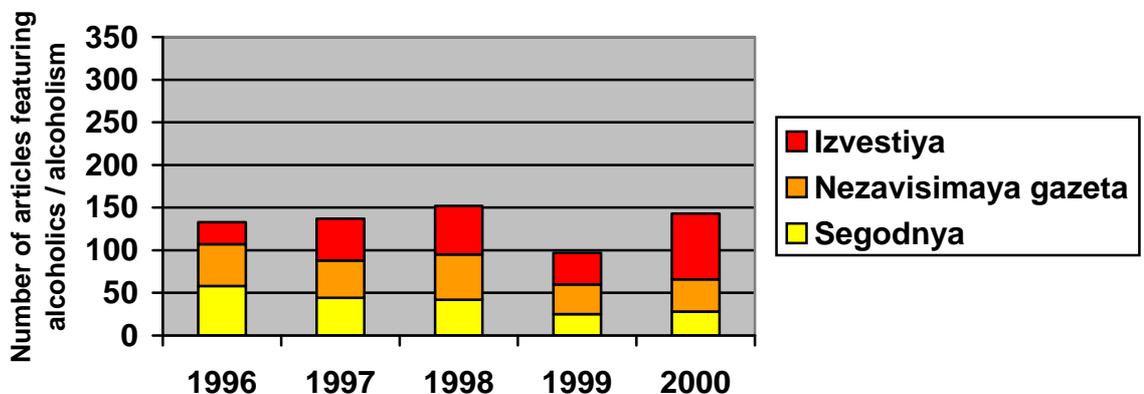
Also a 'control' was carried out for the coverage of HIV/AIDS over the same period and this showed a straightforward steady increase in the number of articles (see Diagram 3.4). Therefore it is evidently much easier to form conclusions about why there is an increase in press coverage of certain issues than why certain items – particularly social problems which are not going to change dramatically overnight – fall out of the news. The shifts in coverage showing how, relative to alcohol use, drug use as a new pressing social issue was a 'sexy' news topic.

Diagram 3.4: Articles on HIV/AIDS
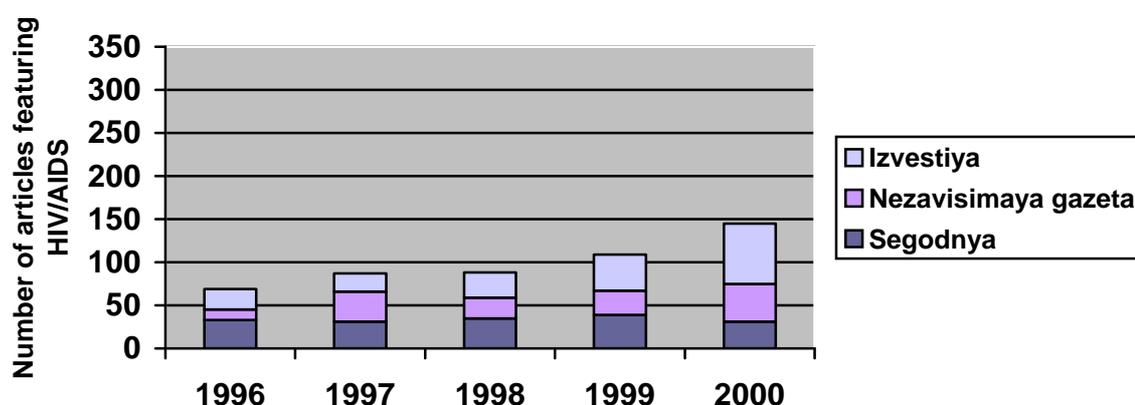
3.3 Tracing Changes in Public Policy in Post-Soviet Russia

Discourse analysis approaches language not as a straightforward reflection of society, but as a means of actively constructing and ordering our social reality (Tonkiss 1998). The media constructs reality in a powerful way as it influences how all media consumers, including policy makers, frame different issues: "the mass media have become the major public spaces where images are massaged, policies promoted, events made sense of and issues debated." (Deacon et al. 1999: 1) This section therefore aims to examine developments in public policy and contextualise them within print media debates. Firstly, the extent to which the debate around the deregulation of the alcohol market and subsequent attempts at re-regulation was led by fiscal or health concerns is contextualised in this way. Next the debates around the 1998 Russian drugs law are explored through an analysis of the competing discourses in the youth press and national newspapers. The coverage of accusations against the media for 'propagandising' drug addiction was also examined as this had been outlawed by the new legislation. This section concludes with an examination of how

'health' issues have been reframed as 'security' issues in both policy and the print media.

Regulating alcohol in post-Soviet Russia

The Russian alcohol market was officially deregulated by Yeltsin in May 1992, putting an end to the state monopoly, which had to a large extent financed the Soviet economy. However, calls for the reintroduction of a state monopoly started soon after and moves to reinstate it were introduced in June 1993 by presidential decree. Excise duty stamps were introduced in April 1994 as a move against 'fake' vodka and tax evasion, the coverage of this legislation reflected an acceptance of the Russian Federal budget being reliant on revenues from alcohol sales – the paradoxical health implications of this were of secondary importance (Arifdzhanov 1994). Yeltsin once again declared the alcohol industry a state monopoly on 13 January 1998, but this did not become an urgent policy matter until the end of September 1998, when the alcohol monopoly was made central to anti-crisis measures following the collapse of the rouble and the Russian banking system. This is when the real shift occurred in the way alcohol policy was framed. The creation of an alcohol monopoly enjoyed cross-party support, even becoming a central feature of the Russian Communist Party (CPRF) economic programme in the 2000 presidential elections. However, it actually took eight years from the initial deregulation to effectively bring the alcohol market back under the control of the state. Rosspirtprom (the state alcohol monopoly) was created on 23 May 2000.

Alcohol policy was thus driven by short term fiscal rather than health concerns. Initially moves to reinstate the alcohol monopoly were presented as also having positive health benefits; through the greater regulation of alcohol imports, it was hoped that a monopoly would stem the flow of poisonous 'fake' vodka. However, these health concerns were presented more as happy by-products of the law despite the alcohol monopoly debate coinciding with the publication of a number of reports on the demographic impact of Russia's increasing alcohol consumption. The negative social consequences of relying on a 'drunken budget', which had been at the forefront of Gorbachev's anti-alcohol campaign, were rejected. Alcohol regulation has become a key fiscal issue and there has been alarmingly little debate on the historical paradox this policy created in the Soviet Union. In the Soviet era it was recognised that, for

the good of the nation, it was necessary for the state to reduce alcohol consumption, but such a reduction would inevitably lead to a potentially crippling shortfall in budgetary revenues. None of the fiscal approaches to alcohol policy touch on issues of increasing or decreasing alcohol consumption and its potential effect.

Propagandising drugs and the parallel youth press discourse

Parallel to the liberalisation of the alcohol market, in 1992 Russia adopted new, very liberal drugs laws, effectively decriminalising drug use. This was not 'legalisation', but it was no longer an offence to be caught with drugs in your system or on your person – under specified amounts, e.g. one matchbox of cannabis leaves or less, it was treated as being for personal consumption. The new legislation was widely criticised in the media; it was argued that such liberalism could only be afforded by 'stable' countries. It was also suggested that it sent out the wrong message to young people as the state was effectively condoning drug use. Subsequent policy changes have been progressively more restrictive and in 1996 new legislation criminalised all drug possession, although not use. At this time drug use was becoming increasingly politicised and in the run-up to the second round of the presidential elections in July 1996 the leader of the CPRF, Gennadii Zyuganov, accused the editor of *Izvestiya*, as well as the editors of *Moskovskii komsomolets* and *Obshchaya gazeta*, of "propagandising immorality and drug addiction, contempt for the elderly, [and] nurturing hordes of hooligans [*khunveibiny*]" (quoted in Chugaev 1996). Charges of propagandising drug use have been made in earnest and since the introduction of the 1998 Drugs Law,[7] propagandising drugs has also been made a criminal offence (see Chapter 5). In the 1998 Drugs Law the youth and other media were called upon to lead the fight against drugs and the struggle against the 'pro-drugs' movement. Although the sample of magazines surveyed here was small, it was clear that the youth media had already taken on this 'educational' role, though the stance in '*Ptyuch*' and '*Om*' primarily drew on harm reducing strategies from Western Europe rather than defending a strong moral anti-drugs position.

The response in the youth press to the 1996 change in drugs laws was broadly negative, and the editorship appeared to take a pragmatic stance. In August 1996 and

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[7] Federal'nyi zakon "O narkoticheskikh sredstvakh i psikhotropnikh veshchestvakh" 1998

June 1997 '*Ptyuch*' published guides to the drugs legislation as it stood then, which provided legal and medical advice to people who chose to take drugs (Zharkov 1996; Babayan 1997). Writers in '*Ptyuch*' have consistently argued that drug use is a matter of personal choice, "to allow a person to rot in jail for using drugs is more undemocratic than to allow him to use them" (Zharkov 1996), but that people should be enabled to make informed choices. In keeping with this approach '*Ptyuch*' also ran a positive interview with two Moscow outreach workers on the MSF harm reduction project (Radov 1998), and reproduced UK harm reduction materials about 'Ecstasy' in Russian ("Pravda…" 1996; "Rastavlyaya…" 1997). '*Dilizhans*' also aimed to provide drugs information so that readers could make an informed choice about whether or not they would use different substances (Milovidova 1996). However, it is not clear what the information sources for this article were, indeed, it would be reasonable to assert that the journalist relied on her own personal, and imperfect, knowledge.[8] However here, as in various '*Ptyuch*' articles, the Netherlands were presented as being a 'Mecca' of civilised drugs policy (Milovidova 1996; Zharkov 1996; Babayan 1997; Radov 1998).

In both '*Dilizhans*' and '*Ptyuch*' in 1996 'Western' patterns of drug use were both condoned and glamorised, and this is in stark contrast to how the Russian experience of drug use was portrayed as bleak and hopeless addiction. There was no real discussion of a Russian recreational drugs scene, but much was made of experimental drug use in 1960s America. '*Ptyuch*' featured the continued serialisation of "Flashbacks" by Timothy Leary, a character who also featured as a hippie role model in a '*Dilizhans*' article (Liri 1996; Sedov 1996). Both articles offer an uncritical view of Leary's development of a new spirituality based on the use of hallucinogens in 1960s America. The 'glamour' in these articles, however, comes less from Leary's own 'hippie' credentials than his connection with beatniks, namely Jack Kerouac, Allen Ginsburg and William Burroughs. Burroughs in particular is held up in many articles as a positive representation of literary creativity and the 'bohemian' lifestyle

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[8] This would explain some of the more unexpected assertions in the article, for example that cannabis is considered to be a 'psychedelic' drug and that Ecstasy is "consumed as part of an alcoholic cocktail", that it had been "legalised" and was "freely available in many clubs and discos" (Milovidova 1996). It is especially important to note that the mixing of Ecstasy and alcohol carries significant health risks as both substances dehydrate the body.

of which drugs are an essential part (Sedov 1996; Liri 1996; Volchek 2000).[9] This glorification of 1960s subculture is contrasted with the hopeless situation of (generally female) Russian drug addicts. For example, '*Dilizhans*' contains articles about two Russian women who are addicted to '*vint*' and the dangers of having a drug addict as a partner (Petrova 1996; Guseeva 1996) and *Ptyuch* ran an autobiographical piece written by a (female) former heroin addict ("Ispoved'…" 2000).

The special 'drugs' edition of '*Dilizhans*' (#10:1996) gave no sense of a Russian recreational drug scene, and from the limited survey of '*Ptyuch*' that was possible, the same seems equally true. In '*Ptyuch*' articles about drug use in Russia relate either to how 'draconian' the Russian laws are (Zharkov 1996; Babayan 1997) or they concentrate on the tragedy of drug addiction for Russian youth (Radov 1998; "Ispoved'…" 2000). In both magazines the positive portrayals of recreational use are reserved for 'Western' drug users. All three publications surveyed could be viewed as condoning drug use to some extent – even if the glamorisation is of drug use in the West – for more conservative observers any positive coverage is always perceived as encouraging drug use even if it is not direct pro-drugs propaganda.

The securitisation debate

Another visible aspect of the Russian print media discourse was that it unquestioningly accepted the securitisation of drug use as an issue. Securitisation reframes drug use as a national security issue rather than a social issue and focuses attention on the ability of drug consumption and drug trade to destabilise regions, populations and even armies. The end of the Cold War has reshaped the field of international relations and now so-called 'soft' security issues (such as drugs, organised crime and even HIV) have become more prominent topics in this field. Similarly security services have expanded their remit to include the control of drug use and supply.

The new drugs law of 1998 was symptomatic of the way in which elites were reframing drugs as a security issue and the same security debates echo in an

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[9] It is interesting that Russian youth magazines have adopted the 'beat generation' as the artistic spokespeople for drug culture and not Russian 'druggie' authors such as Bulgakov, Agaev, Akhmedova or, contemporarily, Pelevin.

influential report presented in the same year (significantly) by the Foreign and Defence Policy Council. "Drug Addiction in Russia – A Threat to the Nation" [*Narkomaniya v Rossii: ugroza natsii*] was summarised in *Rossiiskaya gazeta* (Rossiiskaya gazeta 1998). In the report it was argued that a third of the country's 'new generation' was under the threat of drug addiction which questioned both the physical and moral health of the future – the number of drug and solvent users topping 10 million by their estimates. The report also contained all the common narratives which had been put forward in the print media and which were also found in the health education materials (see Chapter 6). Drug traders were portrayed as extremely powerful in their ability to get schoolchildren addicted to drugs by positioning themselves within educational facilities and giving away one dose of 'narcotics' free. The young people then take the drug and are instantly addicted thereby becoming 'trapped' by the 'pusher'. The mortality of drug users is emphasised through the commonly cited statistic that 'very few chronic addicts live to 30'.

Both the unique severity of Russia's drug problem and the absolute acceptance of the 'gateway theory' are emphasised through the narrative of the speed at which Russian drug users move from 'soft' to 'hard' drugs. Russia was also found to be special in that the drug problem is one of 'elite' youth, this also framed drug use as a security issue because "in this way the degradation process of a significant part of those, who may become the new state elite has started" (Rossiiskaya gazeta 1998). Drugs are even more clearly framed as a security issue in the discussion and description of the drug market in Russia. The foreign origins of different drugs are emphasised, for example, in the report it was stated that most 'ecstasy' production in Poland, The Netherlands and Germany is specifically for the Russian market. All the drugs traders in the report are given specific foreign ethnic identities, for example it is stated that "in and around Moscow Azerbaijanis control practically 100 percent of the heroin and methadone trade, but also a significant segment of the marijuana market." (Rossiiskaya gazeta 1998) The ethnic homogeneity of drug gangs is emphasised and the groups are described as coming from Tajikistan, Kazakstan, Georgia and Azerbaijan. Moreover it is argued that in the capital there are foreign communities who deal in drugs, namely the Afghan, Chinese, Vietnamese and Nigerian communities. The source of Russia's drug problem has been pushed beyond the

country's borders: the drug dealers are foreign, the drugs are foreign and Russia is under siege.

However, the securitisation of drug and alcohol use by young people has occurred also in relation to the biannual draft and the continuing concern with drug use in the army.[10] Concerns about the 'quality' of new conscripts in relation to rising incidence of drug addiction, alcoholism and HIV/AIDS were frequently raised in the press, particularly in relation to wider demographic debates (e.g. Khamraev 1997; Litovkin 1998; Chuikov 1999). The problem of substance misuse in the army was also often highlighted by shocking instances of young soldiers killing their comrades or civilians while intoxicated. For example, on 10 October 1996 two new conscripts shot three fellow conscripts and their officer, "in cold blood" (Builo 1996). According to the coverage in *Izvestiya* (Litovkin 1996; Litovkin and Reznik 1996), The two conscripts had been caught sniffing paint whilst on duty earlier in the day and this was considered the most likely 'motivation' for the killings, particularly as the one who actually pulled the trigger was clearly a 'drug addict', the evidence for this being that: "In his letters home there is a request to [his] parents (they are both entrepreneurs) 'to send "medicine", because [my] ears really hurt.'" (Litovkin 1996). This is not the only tragedy in the army which has been linked to 'drug addiction', the potential influence of bullying being explicitly rejected as a motive in the killings in favour of substance misuse (e.g. Litovkin and Reznik 1996; Urigashvili 1997).

3.4 Key Features of the Discourse

This analysis is an examination of how medicalised the print media discourse was and the ways in which professional medical discourses around substance misuse were rejected or embraced. This has been done through an analysis of the perceived causes of addiction, how substance misuse related to other social issues and finally how addiction as a problem could be resolved.[11] To add coherence to the thesis as a whole, where possible, illustrative points from articles which relate to the two

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[10] Drug use in the army is not, however, a 'new' concern, and it was the spur to much early Soviet research into drug issues (see Kalachev 1989 and Kramer 1991: 95).
[11] In Russian print media coverage of substance misuse through the 1990s it also would have been possible to look at how different social groups were constructed specifically in terms of race / ethnicity, gender, class or age. The construction of racial and gender difference through this issue was particularly striking, but was not deemed relevant to the central research question.

research regions (Saratov and Sverdlovsk oblasts) have been used, although these regions did not feature more prominently than other oblasts in the coverage.

Explaining Addiction

Explanations of why Russians, as opposed to other nationalities, drink so much and why increasing numbers of contemporary youth are so attracted to drug use were central to the print media discourse around substance misuse, particularly in the late 1990s. These debates are significant in terms of whether biomedical explanations of addiction were reinforced or challenged by the mass media, through their analysis of both biophysical and socio-economic determinants. Biophysical explanations concentrated on individual genetics or individual psychological predisposition to addiction. Socio-economic determinants were generally more vague, linking increasing substance misuse with the transition in general rather than specific aspects of it, particularly in the mid 1990s when the drugs issue was becoming more apparent, "medics consider the socio-economic crisis, which has gripped the whole territory of the former USSR to be the main reason for the growth in the number of drug addiction patients." (Fedorov 1994) Where more specific socio-economic determinants were cited, it was usually seen as a particular feature of the economic environment of the specific town or city which had recently been struck by a wave of drug addiction. In this way increasing drug use could be explained as being the result of deprivation in the area, or conversely as a result of the town's relative affluence. Hence in Sosnovoborsk (Krasnoyarsk oblast) the drug problem was because the town's only factory closed and more specifically, the local teachers went on strike over wage arrears leaving the young people too much free time (Tarasov 1996). Whereas in Verkhnyaya Salda (Sverdlovsk oblast) the startling rise in intravenous drug use was associated with the success of the local titanium factory which provided young people with excessive disposable incomes (Karmaza 1997).

In Naberezhnye Chelny (Tartarstan) the drug problem was also presented as being rooted specifically in the biggest local employer – the KamAZ lorry factory, but the socio-economic factors were seen as creating the necessary domestic environment for cultivating drug addiction, the current (HIV+) drug addicts being the children of the original KamAZ workers. "Many of these children were born in hostels and due to the triple shifts of their parents they did not know what domestic upbringing was. The

street provided them with activities and interests. The subsequent long crisis at KamAZ, unemployment and the loss of the last social values intensified the situation." (Bronshtein 2000) This example demonstrates an overlapping of the specifics of the immediate geographical location as one factor and flawed individual upbringing as another. The importance of the latter as an explanation for increasing substance misuse in Russia came across most strongly in the women's magazines. Absent fathers in Kaliningrad contributed to the problems there (Berezina 1994), whereas Moskalenko in many articles focused on the specifics of alcoholic families, and looked at how passing on the alcoholic legacy to children can be avoided (Moskalenko 1992; Moskalenko 1991b; Moskalenko 1994). The focus on upbringing is very much rooted in the psychotherapeutic tradition and biomedicine; the formal medical and academic training of the experts quoted in the articles is highlighted as they are introduced, for example the narcologists Bryun (Domashenko 1993) and Ibragimova (Tret'yakova 1996) and Moskalenko herself.

The perceived importance of the micro-environment is made explicit in stories where its influence is not immediately apparent, for example the story of a fifteen year old alcoholic, "Sasha's family is impossible to call deprived in any traditional sense of the word. The parents were never drunkards, indifferent to the fate of their son." The 'usual' micro-environmental factors are therefore absent, however the parental contribution is still decisive as they trade in vodka, providing the boy with easy access to alcohol. Finally, it is asserted that Sasha clearly must have had an "internal, hidden "bug", a predisposition towards alcoholism…" (Domashenko 1993). Such predispositions – either organic or genetic were a distinct biomedical feature of the media discourse, for example, the predisposition resulting from parental alcoholism was framed as neither psychological nor environmental in its origins, instead it was entirely biophysical and thus measurable (see Moskalenko 1991a). The argument that addicts are born not made looked into the organic roots of the 'brain damage' which caused the psychological predisposition. "People are born equal [*ravnopravnymi*], but they always have different strengths [*ravnosil'ny*]. Drugs attract people with psychological abnormalities, the infantile, idlers, poseurs and also the excessively curious." (Buyanov 1998) The genetics argument reached its extreme in debates around the Russian nation's particular weakness for alcohol (Baimukhametov 1998; Sidorov 1998). Cultural and historical norms were not entirely ignored in these

analyses of 'national characteristics', but such norms were dismissed in more 'scientific' studies which argued that, for example, the Russian population like the Japanese population apparently has a high proportion of people who lack one of the enzymes necessary for the digestion of alcohol; this seriously decreases alcohol tolerance and increases the damage that alcohol can do to the body (Bateneva 1999b).[12]

It is reasonable to suggest that such extreme biomedical explanations dominated the debate because of the information sources used. The handful of journalists who consistently kept substance misuse issues in the public eye (particularly Valentina Moskalenko, who wrote extensively for a number of women's magazines, the Izvestiya health correspondent Tat'yana Bateneva and the Segodnya correspondent Marina Latysheva) most often sought professional medical comment on the latest statistics or reports to be released. Moskalenko describes herself as both a psychotherapist (Moskalenko 1994), and a doctor of medicine [*doktor meditsinskikh nauk*] (Moskalenko 1991b). Bateneva clearly had a good working relationship with the Moscow-based NGO "No to Alcohol and Drugs Addiction" (NAN Moscow), which began as a treatment centre and is very much an organisation of medical professionals (Richardson 1999). NAN Moscow, or specifically its director Oleg Zykov was frequently used as the expert opinion for Bateneva's reports, so these reports reflected NAN Moscow's therapeutic concerns and 12 Step approach (for example Bateneva 1997a; 1997b; 1998a; 1998b; 2000c).

However, although biomedical explanations dominated media discourse, other factors were not entirely neglected, particularly in relation to Russia's increasing drug problem. As demonstrated above, socio-economic explanations were also apparent, although they were rooted very much in the local rather than national environment. National factors in alcohol problems were linked with genetic debates, but the increase in drug addiction was specifically associated with the increase in drug supply from the south, thus drug supply may be regarded as a more universal factor in explaining Russia's drug problem: "it was noted that population migration from

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[12] Such national genetic traits have apparently come to light recently as the Soviet drunken budget forced Russians to consume more and more alcohol (Bateneva 1999b). This is what Zdravomyslova and Chikadze (2000) characterised as discourse on *Soviet heavy drinking* (2000: 37).

Central Asia and the Caucasus has resulted in a sharp rise in illegal drug trading in the region." (Zuikov 1995) Russia as a country is constructed as besieged by dealers and drug users through the vulnerable and permeable southern border, which law enforcement agencies do not have the resources to patrol (Shinkarev 1998; Builo 1994). Drug using migrants from Ukraine also bring with them HIV/AIDS and import new injecting practices which increase the risk of HIV transmission (Karmaza 1997). With this explanation, the roots of the drug problem were invariably placed beyond Russia's borders, the body politic falling victim to external pathogens. To a lesser extent this also featured in the discourse around alcohol where the large numbers of fatal alcohol poisonings from 'fake' vodka, illegally imported from the Caucasus and East Asia, provided evidence that a state alcohol monopoly needed to be reintroduced (Kantor 1993; Babenko 1997). Pushing the problem beyond Russia's borders is clearly a distinct feature of the 'securitisation' of social problems.

"Plagues of the Twentieth Century"

The differences in the way alcohol and drug addiction were framed in the media discourse was made most clear through an analysis of the other social issues with which they were associated. For drugs this was most often HIV/AIDS, either related to intravenous drug use or commercial sex work undertaken ostensibly in order to finance a drug 'habit' (see, for example, Leskov and Orekhova 1997). Both HIV/AIDS and drug addiction have been sensationally referred to in the press as plagues of the twentieth century (for example, Karmaza 1997; Dobrynina 1998).[13] Drug users, or addicts [*narkomany*] as they are more commonly referred to in the media, are presented as the core 'risk group' for HIV infection; drugs and AIDS being like "twin brothers" (Dobrynina 1998). As problematic drug use received more media attention through the 1990s, the link between drug addiction and HIV transmission has been reinforced. Articles about drug use usually mention HIV/AIDS, and coverage of HIV/AIDS issues reinforce the link further. For example, in an article examining the HIV/AIDS problem in Russian jails the disease is linked to sex between men in prisons, but the 'infectors' are framed as drug users because: "the deadly virus is already well established among drug addicts, who sooner or later all

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[13] This is particularly notable in relation to HIV/AIDS. Williams (1995: 125) has examined how the mass media framed the issue of HIV/AIDS by its use of sensationalist and emotionally charged headlines in coverage throughout the 1980s and early 1990s.

end up in prison" (Latysheva 1998). In relation to HIV/AIDS, drug users are presented as dangerous infecting agents who need to be under "strict medical control", particularly if they are also sex workers (Leskov and Orekhova 1997). Drug users who have contracted HIV were not represented as victims of misfortune; they were presented as moral bankrupts who were also a dangerous conduit for HIV/AIDS into 'normal' society: "Drug addicts became the real reason for the [HIV] epidemic" (Nosova 1999; see also Williams 1995: 121-139).

Drug use has been very strongly linked into biomedical concerns with epidemiology; the need to apportion blame but also monitor and exclude diseased bodies from society. Specialist facilities for the containment of HIV+ drug users in Kaliningrad are praised and put forward as one reason (along with harm reduction initiatives) why the region has stabilised its HIV infection rate while Moscow city's rate is still rocketing (Leskov 1999). The discourse was also found to be medically biased in its focus on demographic concerns, particularly the impact of drug use and HIV/AIDS on the younger generation (Rybak 1994). Many of these demographic fears related not just to depopulation and youth mortality however. The potential effects on the nation's gene pool was also, once again, cause for concern. Articles which linked both alcohol and drug misuse to other social concerns related mainly to the deteriorating health status of Russian youth and such coverage often coincided with the autumn or spring drafts. Again, emphasis was placed on biomedical factors around substance misuse, such as the cost of testing all conscripts for "the tendency towards alcohol and drug use" as each test cost \$2.50 (Litovkin 1998). Over successive drafts, the coverage has concentrated more on the number of HIV+ and/or drug using new conscripts than the number who show signs of having an alcohol problem (see, for example, Chuikov 1999).

By contrast, in the print media discourse, alcohol misuse alone was most often associated with homelessness; directly through the homelessness of adults as a result of their alcohol problems or indirectly through coverage of homeless children abandoned by their alcoholic parents (e.g. Osheverova 1993). Another factor in 'creating' homeless children is abuse, and again this is linked into the drunkenness of a child's guardians, the abuse often taking place when the adults are under the influence of alcohol (for example, Averbukh 1998). The link between homelessness

and alcohol misuse was also made in coverage of the changes in the laws regulating the treatment of alcoholics, as these included both the right to treatment and anonymity. This was criticised because it provided vagrants with a way of abusing the system (Zheludok 1994), which rooted problematic alcohol use more in the social than the medical sphere. However, whereas HIV/AIDS was framed as the disease of drug addicts, homeless alcoholics were presented as contagens for tuberculosis (TB), and again the need to section and control this population was emphasised (see Rostova 1999).

What is to be Done? Substance Misuse Prevention and Cure

As argued above, the expert opinions given in print media coverage of substance misuse was generally that of a medical professional. This is one reason why the media discourse focussed so heavily on biomedical explanations of addiction throughout the 1990s, but it may also partially account for the predominance of biomedical solutions to the issue. Failures in the system for dealing with alcoholics are highlighted (Filippov 1997; Bateneva 1997c), as are weaknesses in the health care system in relation to treatment for drug addicts. The statistic that only 5-6% of drug addicts in Russia are ever cured was commonly cited in the press and used by narcologists in interviews with the media (see, for example, Rossiiskaya gazeta 1998).[14] There was also extensive coverage of the latest Russian research into 'curing' addicts, which included detoxification achieved by superheating patients to 44°C, a temperature previously believed lethal (Bateneva 2000a), and cryogenic neurosurgery to remove the centres in the brain responsible for heroin addiction. Details of the procedure were juxtaposed with statistics showing the size of the drugs 'epidemic' in Russia (Bateneva 1999b).

Bateneva (1999b) clearly presents surgery as a solution to the grave problems Russia was facing with its increasing drug habit – the most medical solution to a problem which is at least partially social. The need for more money to be pumped into narcological services so that more drug addicts could be treated was emphasised as much as the need for more resources to be allocated to the fight against international

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[14] As with other commonly cited statistics around drug use it was not possible to find a provenance for the assertion. One academic also claimed that only 3-8% of alcoholics can be cured, and that women alcoholics never can be (Bateneva 1997c), Again no reference was made to the source of this information.

drug smuggling (see, for example Verda 1997). It was only towards the end of the 1990s that calls for better funding specifically of prevention were made and space was given to organisations and programmes which sought to actually prevent addiction (for example, Rossiiskaya gazeta 1998; Bateneva 2000b).

Conclusion

It is clear from the analysis that alcohol and drugs are presented in the print media as distinct types of social problems, and drug use is the more serious of the two. Solvent misuse is largely absent from discussions of substance misuse although it is a feature of Russian society. Alcohol misuse, understandably, is presented as the more 'normal' social problem, and coverage of alcohol as an issue did not reflect the securitisation and medicalisation of the discourse as starkly as the coverage of drug misuse. The medicalisation of the issue presents the roots of problem drug use as being in the family; however, the supply of drugs is necessary to activate these predispositions. The two strands in the discourse are therefore not mutually exclusive; instead they reinforced each other and presented the same narratives of youth as innocent and passive victims of the drugs trade.

These common narratives are shown to be hegemonic in Russian society – they have also been incorporated into drugs education materials (see Chapter 6). The roots of these narratives cannot be objectively determined, but the print media reflects and concurrently reinforces social norms and values around substance misuse. In this way the print media discourse impacts upon the development of health promotion initiatives as it shapes the way in which the misuse of alcohol, solvents and drugs are perceived – in moralist and biomedical terms. The print media directed at youth did present an alternative, subordinate conceptualisation of drug misuse issues as personal choice, and this may well reflect a different youth attitude towards drugs. However, this alternative youth discourse is swamped by the dominant, hegemonic discourse as reflected in the newspapers, women's magazines, professional publications and even legislation. In this way, it could be argued that youth voices do not have great power to influence how the majority define what is 'normal' and what is 'deviant'.

CHAPTER 4: INTRODUCTION TO THE FIELDWORK SITES AND METHODOLOGICAL ISSUES

This chapter is an account of qualitative data collection and analysis as an evolutionary and exploratory process. During the fieldwork the methods and even the nature of the data sought evolved and changed in focus as access to information was facilitated or denied. Key actors and decision makers could be identified and effectively accessed only in the field and it is only with hindsight that order can be imposed on the process of data collection; the actual process was more intuitive than that described below.

Empirical data were collected in the course of three trips to the fieldwork sites (Saratov and Sverdlovsk oblasts) in 2000, following one short pilot trip in 1999. This chapter introduces the two research sites and examines the methods of data collection used in the field. The first section reviews how the research process developed from data sources and collection methods to analysis. Secondly the process of selecting and accessing the two regions is discussed, and the oblasts are then profiled in order to contextualise Saratov and Sverdlovsk in terms of their relative political and socio-economic status within the Russian Federation. The chapter concludes with an examination of the ethical considerations inherent in such research and a discussion of how gaps in the data were overcome.

4.1 Methodological Approach

There are difficulties specific to collecting data in the post-Soviet space, which have been discussed by scholars previously (for example Pilkington 1994; Thomson 2001). Such difficulties centre on the position of the Western researcher in Russia as 'outsider', but also on both the real and perceived power of the researcher. Being an outsider both hinders and facilitates the data collection process in ways which are discussed in detail below, and can significantly impact upon the respondents' willingness to trust the foreign researcher. Choosing appropriate locations and identifying suitable methodologies to ensure good quality data can be accessed are all

complicated by the 'insider' / 'outsider' relationship inherent in such cross-cultural research.

However, the researcher's previous experience of data collection in Russia (see Richardson 1999) and extensive reading in this area ensured an awareness of these difficulties so that issues of 'impartiality', and 'power' could be addressed through the choice of methods and approach to data collection and analysis. This, combined with continuous reflection on the research process, enabled the researcher to work flexibly in the field and made it easier to adapt methodologies during the research process to improve access to potential respondents. This, combined with a strong awareness of the sensitivity of much data collected and a clear commitment to respecting respondents' confidentiality, ensured many of the pitfalls associated with cross-cultural research were avoided. This section reviews the decisions made about the data collection and analysis process. Firstly, the reasons why qualitative data collection methods were selected over quantitative methods are given; this is followed by a detailed account of how the rich mesh of data were collected through a combination of expert interviews, observation and document analysis. This is followed by an exploration of how this data was then analysed.

Selecting qualitative approaches

Official state statistics and surveys have been used to good effect in looking at the epidemiology of drug and alcohol misuse (e.g. Leon et al. 1997, Simpura and Levin 1997). However, such statistics are potentially as problematic as any other morbidity statistics in that definitions of 'addiction' or 'dependence' are affected by cultural factors, diagnosis problems and reporting (both over- and under-). It should also be emphasised that addiction rates are not an accurate representation of usage figures. However, as this research is an examination of the development of health promotion initiatives, and not their impact, where such data have been used they serve only an illustrative purpose. Both qualitative empirical data and official statistics can be successfully used to evaluate health promotion initiatives (Scott 1998), but in order to examine the factors which led to the development of such initiatives and the philosophies behind them only qualitative approaches provide the necessary detail.

The data might have been collected through well-designed surveys, but as this research was highly exploratory it would not have been possible to develop a sampling frame for the respondent group until the 'map' had been developed at the end of the research process. This is largely due to the way in which respondents were located through 'snowballing' contacts, i.e. following up on references to other organisations and individuals mentioned by interviewees. Also, difficulties in locating and accessing health promotion initiatives could not have guaranteed a good enough response rate for a questionnaire survey to be 'significant'. Therefore, as a reflection of the nature of the research question and the exploratory nature of the research, rich detail was prioritised over quantification of initiatives or their efficacy. The spontaneity of such 'sampling' through ongoing data analysis – following up on leads from earlier interviews – is also in many ways consistent with sampling strategies employed in 'active' interviews (Holstein and Gubrium 1995: 74).

Interviews with actors at different levels were supplemented by observation and document analysis, which provided a multi-level mesh of data. The richness of the data allowed for some cross-checking in order to enhance 'validity', but the 'honesty' of respondents was not tested. For this research it was more important to look at how organisations chose to present themselves than to examine any differences in the 'reality' or effectiveness of their practice. As a cross-national work, notions of universal truths have been rejected, as such a 'universal truth' would inevitably be based upon West European concepts of how health promotion 'should' work; specific local, personal and community forms of truth are acknowledged and results are 'validated' in these terms (Kvale 1995).

Choice of methods

A range of different methods were employed in order to overcome some of the barriers to data collection (see below), but also in order to improve the richness of the data and the researcher's own understanding of the situation. Data were gathered through a combination of expert interviews, observation and document analysis.

Expert interviews

Due to the nature of the research question, interviews were primarily with 'experts', an 'expert' was defined as anyone who worked in the field of health promotion – even

if they did not have the power to influence or change policy or practice. Interviews were conducted with a range of experts in thirty-four organisations in the two research regions throughout 1999 and 2000 (see Appendix 1). Contacts with people working in the field were made during the pilot trip to the regions, and these contacts were followed up during the major period of data collection in 2000. Problems with identifying the relevant decision makers and the need for recommendations from other influential actors when trying to arrange interviews meant that 'snowballing' these contacts was the most effective method of gaining access.

However, towards the end of the fieldwork period in both regions 'cold calling' was resorted to in order to try and access more elusive decision makers. In some more extreme cases where telephones were proving unreliable (particularly in the smaller towns) cold calling even extended to simply turning up on the doorstep of target organisations and requesting an interview face to face (this happened in both Engel's and Nizhnii Tagil). Whilst this was not an ideal way of securing an interview – as there was no guarantee the relevant person would be either at work or available – it actually proved to be a successful tactic. Addresses and contact numbers for cold calling were accessed largely through directories, which are published by regional NGO support organisations and structures (Dissanayake, Geller and Zyrina 1999; Mezhvedomstvennaya… 2000). Whilst these directories could be criticised for not being accurate reflections of the size of the voluntary sector in the region (many of the 'NGOs' listed were actually local government departments or had already closed) they still proved useful resources for finding health promotion programmes in the regions. In Sverdlovsk oblast a directory of different local government departments was also found, though cold calling the bureaucracy proved futile.

Interviews were semi-structured or conversational. There were a set number of questions all of which needed responses so that the interview data was comparable, but the order in which these questions were asked or answered was not significant. Questions were therefore used as a prompt for the researcher rather than a guide for the whole interview. The questions fell into three categories – structure, approach and networks. Structural questions around personnel, official status, funding and decision making were to aid the mapping process. Structural questions about the organisation's activities and questions about the organisation's approach explored the

organisation's conceptualisation of health promotion, best practice and substance misuse. Networking questions about collaboration with other organisations also aided the mapping process and often illuminated ideological issues, but these questions also facilitated snowballing more contacts – when 'new' organisations were mentioned a recommendation was also requested and was usually granted.

Most interviews were taped; only one interviewee refused permission to tape the interview. However, technical difficulties with tape recording equipment or high levels of background noise meant that in some instances it was not possible to produce transcripts and instead the data comes from field notes. This was possible because even when interviews were taped successfully, extensive notes were taken and written up as soon as possible after the meeting to record not only the responses but also the interview context and the researcher's own impressions.

Structured interviewing was avoided because better data were generated when interviewees were 'allowed' to talk freely about substance misuse and how they conceptualised it and users (for example, were the client group drug users, drug abusers, drug addicts, chemically dependent, junkies, etc?). A principal aim of the research was indeed analysing the language interviewers used and what they perceived to be the root causes of substance misuse issues, as a way of assessing the underlying ideology of their organisations. Semi-structured interviewing was also more effective in accessing different narratives in that the respondent was 'allowed' to answer questions from different perspectives or personal vantage-points such as head of NGO, professional psychotherapist and mother of heroin addict (more than one respondent did actually fulfil all of these roles). Such competing narratives often appeared contradictory, however, rather than 'invalidating' the interview this was actually taken as a reflection of the complexity of the issues being discussed and the respondents' relationship with them.

In state administrative structures the interviews were generally more formal, semi-structured interviews. They rarely contained the kind of dialogue that evolved in interviews in the health and voluntary sector organisations. Where conversational interviews became more general dialogue it was not considered a failure in the research process. Respondents were often keen to discuss comparable interventions

in the UK, and this proved fruitful for contextualising and clarifying the organisation's activities. Indeed such diversions were also a useful way of accessing different narratives around the issue of substance misuse and did not 'taint' the Russian data any more than the researcher's Western status. For a Westerner in the Russian provinces being inconspicuous is not possible, so the researcher could not ever be accepted as neutral. Irrespective of how questions were framed, responses were inevitably constructed in relation to the audience: the female, Western interviewer. It would also have been awkward and almost rude not to give an opinion when asked; such an attempt at objectivity would have disrupted the interview process. It is ethically contentious to assume an impartial attitude when in practice the researcher is knowingly working within a particular framework, or believes one approach to be more acceptable than another.

By being a Western outsider, class issues between interviewer and interviewee were not significant – whereas doing similar work in the UK the researcher would have been largely identifiable as a middle class 'southerner', in Russia the only identifiable point from accent was that the researcher was a foreigner. This was in many ways a liberating experience and almost certainly made interviewing and observational work with outreach workers easier than it would have been in the UK. Western status aided access, especially in more remote towns, as it made the researcher 'exotic' – many of the interviewees, particularly in smaller towns, had never met a UK citizen before so natural human curiosity made the experts much keener on being interviewed. In the smaller towns when initial contact was made with interviewees there was also sometimes a genuine sense that the interviewee felt flattered by the interest being shown in them and their work, particularly as few researchers from East or West, had managed to get out of the regional centres. However, Western status also meant that the interviewees often had unrealistic expectations of how they could be aided by the researcher. Often when access to a respondent had been achieved by snowballing contacts through a Western funding body the researcher was seen as having some influence over the decision making processes around giving grants (see 'Ethics' below).

Gender also affected the dynamic of interviews in that the researcher being a young female seemed generally to make her appear less threatening. Many of the

interviewees were also young women. Male interviewees were in the minority and generally held positions of greater power or authority, more women worked 'on the ground'. On the occasions where a friendship developed from the research process, 'data collection' happened over a much longer period of time, in a variety of settings and clearly moved away from an interview format to a dialogue format. Although this sort of dialogue based research is used more consciously in some approaches to educational research, this method of data collection had a similar impact. The dialogues effected similar changes in the awareness of language, practices and beliefs as the respondent-friend learnt more of the nature of the ongoing research. The interviewer is not a neutral actor in the research process and through putting questions and leading the interview-dialogue the interviewer forces the respondent to reflect upon their feelings, beliefs and actions. All interviews are interactional events and "respondents are not so much repositories of knowledge – treasuries of information awaiting excavation – as they are constructors of knowledge in collaboration with interviewers." (Holstein and Gubrium 1995: 4)

Observation

The main observation work was done at rallies and 'events' which targeted youth. Some were specific to HIV awareness / prevention (in Saratov and Ekaterinburg) and one was an anti-drugs, anti-alcohol and anti-promiscuity event organised by the regional Unification Church movement (Pervoural'sk). It was also possible to sit in on training sessions for both teachers and outreach workers (Saratov, Ekaterinburg and Balakovo) and project planning meetings (Saratov, Ekaterinburg). Observation at public events was relatively easy as the researcher was just one in the crowd. Training sessions were also easily observed, having been invited to attend by the trainers, the researcher was just another person taking notes in the audience. Such observations were useful as they enabled the researcher to see theory in practice and to get more of a feel for the 'reality' of the ways in which organisations worked, which was not always possible from one interview. Unfortunately such observational work was not possible with all the organisations that were interviewed for a number of different reasons around access, timing and time constraints.

Observation at planning meetings did not allow the researcher the same anonymity. However, the role of the researcher was not always made clear – particularly in

relation to her independence – and so it was generally assumed that the researcher worked for the organisations which had invited her, whatever was said by way of introduction. This generally had the effect of giving the researcher an elevated status, and often created the illusion of close contact with funding bodies. As attending planning meetings was also one of the most successful ways of making contact with possible respondents this no doubt facilitated access; mere presence at such meetings conferred a certain 'official' status. However, planning meetings were most informative in mapping networks, as they were a physical representation of which organisations actively worked together.

As the thesis covers the ways in which health promotion was developing it was not actually necessary to come into contact with the target audiences for different programmes. However, having contact with users was considered desirable in order to better understand the issues around substance misuse. The people actually involved in substance misuse were the ultimate 'experts' and therefore it was considered important to recognise the validity of their narratives and their competence in contextualising the issues around substance misuse and to access and hear their voices if only in an informal way. Accessing alcohol users in Russia in an informal way was not difficult, as there is little social stigma around the use of alcohol. Problem alcohol users were also easily accessed through self-help groups, although the nature of such groups meant that the participants generally subscribed to specific theories and concepts about substance misuse. Some recreational users of drugs other than heroin were found through networks of Russian friends, and sometimes by chance, but the main observational work around drug use was with problem heroin users.

As drug and solvent misuse are more 'underground' activities and the using groups are more marginalised, access was more difficult than for problem alcohol users. Access to drug users was made possible through an opportunity to go on outreach to IDUs / CSWs on a harm reduction programme. This was extremely informative as it was a rare opportunity to actually meet with this client group in their environment and on more equal terms; having an outreach worker as a guide gave the researcher as outsider credibility and almost instant trust. However, on a personal level this contact was emotionally very hard, as an inescapable observation was how fragile the lives of

the drug users appeared. Such 'emotional hardship' is a common part of qualitative data collection in certain realms, but it can actually serve to give the researcher valuable life experience which academic environments often lack (Punch 1993; Merridale 2000). Similar emotions were aroused when meeting young solvent abusers, mainly 'street children', who were accessed through contacts in the prison service in Ekaterinburg. However, as the research location was a detention centre for juvenile offenders, the dynamic was very different and there was no opportunity to talk to the children 'off the record', in these circumstances the children were understandably not keen to talk about any personal experience of different substance misuse.

Documents

The documents collected were mainly health education pamphlets and leaflets distributed by state and non-state organisations. These were generally given to the researcher either to copy or to keep. Any pamphlets handed out at rallies and 'events' were also collected, as were relevant flyers being distributed on the street or available through some bars and cafes. Some press releases were also distributed at meetings and a couple of grant applications from relevant NGOs were made available in electronic form. These applications were in English, and were given as an aid to the research, but also so that they could be 'proof read' by a native English speaker. This was one form of reciprocity with organisations which had taken part in the research (see 'Commitments…' below). Relevant posters and banners were also deemed significant and were photographed for convenience and the location of these larger documents was described in field notes. Where photography was not possible, the text was accurately copied in field notes, with full descriptions of any images, logos, fonts and colours used, as well as details of where the poster / banner / hoarding was seen.

Health education / promotion programme outlines were also available, though not always for copying, as in some cases it was very important to the authors that their 'copyright' on the ideas in the programmes was protected. Consequently these programmes were analysed in the field and usually within strict time constraints, whereas copies of other programmes were made available for more leisurely analysis back in the UK. The 'copyright' of all the authors of all programmes have been

respected and have been fully acknowledged and referenced in the analysis. All the programme outlines were extremely valuable resources for examining the theories which underpinned different organisations' work, particularly as they were generally outlines of what they would be doing if they had the funds, and were therefore not tailored to the criteria of specific funding bodies, unlike grant applications. These programmes were not generally operational at the time of interview and they are therefore not reflections of the 'true' situation on the ground. However, like all the other collected documents, they are 'valid' in that they are further representations of the organisations and useful as they reflect the way in which the organisations wish themselves to be seen and how they frame the issues around substance misuse. As with the interview data, documents were taken as further narratives – as 'a' truth rather than 'the' truth (Atkinson and Coffey 1997:47, quoted in Silverman 2000:128).

Approaching the data

Although the analysis of some documents was possible before the fieldwork began, it was rethought and refined throughout and after the periods of data collection. Analysis of other data started in the field and informed how the research developed, which Kvale has argued is essential to the process of qualitative research (see Kvale 1996). The process of analysing interview, document and observational data in the field highlighted certain patterns from an early stage and informed which people and organisations needed to be contacted; this intermediary analysis also developed the style of interviewing. Theoretical frameworks and assumptions were challenged in the field based on background reading in health promotion and social policy, but as the research went on it became increasingly clear that Western theories and models for explaining how programmes develop would need to be adapted in order to be applied to the specifics of the Russian situation.

Interview tapes were not fully transcribed; only the salient points were transcribed directly into English by the researcher. It was not usually appropriate to transcribe the full interviews as they were most often a conversational dialogue which often wandered off 'the point'. Only the most formal interviews took under an hour and many interviews were much 'baggier' and involved a lot of social dialogue and basic human interaction over a whole afternoon. As asserted above, this is not considered a failure in the research process, the aims of the interview were still fulfilled – all the

questions were answered, and data was better situated within a local context. Interview tapes were analysed with care and listened to in full, but as only key sections were transcribed the interview data kept at least some of their original form of evolving conversation (Kvale 1996: 280). Finally, relevant interview data – either from transcripts or from field notes – were all in the same word processed format, which was then closely analysed by hand using a colour coding system to mark out different themes.

Unpublished materials such as grant applications, press releases and unpublished health promotion / education programme outlines were treated as complementary to other data and used to triangulate the findings from both interviews and observation. As far as possible information from grant applications has been kept anonymous as it is in many ways sensitive, however, this was not deemed necessary for press releases, as they are already in the public sphere and do not by their nature disclose sensitive information about the organisation. Details from unpublished programme outlines have been fully referenced in order to respect the author's 'copyright' (see 'Documents' above).

The content of published materials was analysed for direct meaning, that is what actual information is provided by the leaflets and who is the target audience, but also for the source of the information used. This was applied to legal documents, pamphlets, leaflets, posters and print media. Published documents were also read critically to draw out subtexts so that parallels and influences through the use of common language and 'borrowed' images became clear. The use of specific terms or language was held to be significant as indicating possible national or international networking or influence, but also as signifiers of philosophical or ideological allegiance. The latter also became clear through the way different structures framed substance misuse issues, and their concepts and philosophies of best practice. However, it is important to emphasise that care was taken when approaching the 'meanings' of published documents, as it was acknowledged that they might not be reaching their target audiences, i.e. that laws may not be enforced, programmes may not be put into action and pamphlets or posters may not be distributed. In some cases it was possible to 'verify' the significance of documents through observation, but not always.

Observational data were recorded in the form of field notes which were written up as soon as possible after the event in order to preserve not just what was said by respondents, but also impressions about the way events, meetings or outreach were structured and who else was present. These field notes could then be analysed in the same way as interview based data and unpublished documents. Data collection through observation was not a large part of the research process, but it did inform the research and help to contextualise and 'verify' findings. The main problem with this area of data analysis related to the observational work with problem heroin users and 'street children'. Reliving the feelings of powerlessness, anger and pity made it hard to step back from the data in order to analyse the issues they helped to illuminate.

4.2 Choosing the Locations

In the research no attempt has been made to present the analysis of the situation in Sverdlovsk and Saratov oblasts as fully representative case studies, particularly as regional differences in health care policy, administration and practice are key features of health promotion throughout post-Soviet Russia (Field 1997). Nor are the results a definitive guide to initiatives in the two regions as health promotion programmes are in a constant state of flux due to the short-term nature of some programmes or changes in funding levels. Instead the results are temporally specific snapshots of the ways in which health promotion initiatives around substance misuse were developing in the two regions, in response to global, national and regional processes, which have been analysed elsewhere in this work. Their relevance is in highlighting the issues as they are faced at a regional level and in showing the range of responses that such processes elicit. This section provides an overview of the problems encountered in selecting and accessing the two fieldwork sites which were eventually used.

Comparative value versus established contacts

The choice of the two regions was largely determined by the research questions, but prior knowledge and existing institutional contacts were also major factors. Fortunately, for this research Saratov and Sverdlovsk oblasts offered an extremely interesting contrast. As the influence of Western funding bodies on the development

of health promotion in Russia was a central research question, it was important to find regions that had internationally funded programmes. At the beginning of the research process, in 1998, there was little Western funding and few international partnerships in the field of health promotion outside Moscow or Saint Petersburg. However, whilst no individual Russian region could be considered representative of the whole Federation, the standard of living and wealth in the two capitals are much higher than any other region. Therefore it was felt that collecting data on projects and programmes in Moscow or Saint Petersburg would not provide a picture that would necessarily have meaning for any other regions.

Through contacts in the UK it was established that there were health promotion programmes in the field of substance misuse located in Ekaterinburg and Saratov. It was also established that the Urals region was a priority target for DfID British-Russian Partnerships (then the Know-How Fund) and Saratov was a target region for USAID projects. It was apparent that this would provide a useful contrast as it might shed light on how global politics affect decision making at a micro-level. It was hoped that any differences in the impact of different ideological approaches to health promotion at a global level would also be thrown into relief. However, as became clear during the pilot trip to the two regions in May/June 1999, doing social research in Russia is often hampered by bureaucracy. Having good contacts in different regions and organisations is of prime importance for ensuring access, therefore, and personal contacts in the regions were also very important factors in choosing locations for reasons of pragmatism.

Sverdlovsk became a research location through an established contact with VSO Eastern Europe (formally East European Partnership), for whom the Urals region is a priority area. Like British-Russian Partnerships, VSO is primarily funded through DfID. At the planning stage Perm' had been the initial fieldwork region in the Urals, but en route to Perm' during the pilot trip, it was discovered that the contact project there had folded. However, new projects were being developed in Ekaterinburg. Having links with VSO also provided the opportunity to see how British health promotion experts working as volunteers within the state health care system operated in the Russian environment. Indeed, this micro-level impact of Western theories and attitudes illuminated many of the issues that were visible at a macro-level. The main

period of data collection in Sverdlovsk oblast was from February to April 2000, with one follow up trip for the month of September 2000.

On the basis of other research being conducted in CREES, Saratov was seen as relatively well developed in terms of grassroots initiatives so it was hoped that a good range of interventions would be identified.[1] The main period of data collection in Saratov oblast was May to August 2000. In spite of this region being the focus of other empirical studies in related fields, a lack of previous detailed empirical work specifically on health promotion in any region of Russia made it impossible to choose fieldwork locations on the basis of programmes which would have provided useful comparisons. The decision to choose Saratov and Sverdlovsk oblasts was thus made largely on the basis of pragmatism and the hypotheses about international funding bodies.

Regional profiles

It is important to contextualise the fieldwork both in terms of the two regions' socio-economic status, but also in terms of the contemporaneous political situation, particularly as the fieldwork was conducted in an election year and a year which saw much change in regional politics in the Russian Federation. It was an election year at a presidential, oblast and municipal level in both regions, Also, in that year a new federal level of administration was created by President Vladimir Putin, as he began the process of reversing the uneven regional devolution that had occurred early in the Yeltsin era.   It is still too early to judge the 'success' of this attempt at recentralisation, but the presidential representatives in all areas have been engaged in a power struggle with the local leaders (see IEWS 2000e). Russia is not one homogenous unit and policy and legal frameworks vary from region to region. From Moscow's standpoint it is argued that the new level of the presidential administration is designed to rein in on regional corruption and unconstitutional legislation, to bring more uniformity across the Federation (Slider 2001: 167). For the governors it is

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[1] Two fellow PhD students had also chosen Saratov oblast as a fieldwork location. This made it an attractive proposition in that it offered the opportunity to compare and transfer knowledge and experience in the field. One colleague, Dr Kate Thomson, also passed on a regional anti-drugs newspaper called 'Navigator', which she encountered during fieldwork.

another stage in a series of developments which have undermined the considerable power that they were invited to take by Yeltsin when the Soviet Union collapsed.

Both governors (Dmitrii Ayatskov in Saratov and Eduard Rossel' in Sverdlovsk) had generally good relations with Moscow in the Yel'tsin era, but neither have managed to maintain the same level of closeness with the Putin administration. Both governors were initially appointed by Yeltsin, as were many others, and given extensive powers in order to keep anti-reform politicians out of power (Sakwa 1996).[2] Both governors were then democratically re-elected, but both have lost the power to appoint city mayors, who are now popularly elected, and consequently they both have ongoing power struggles over decision making and resources at a municipal level (Slider 1997).[3] Rossel''s relations with Putin's regional representative, Petr Latyshev, has been hostile and acrimonious from the beginning, whilst it would seem that Ayatskov has managed to win round Sergei Kirienko, Putin's representative in the Volga region.

Sverdlovsk oblast

Sverdlovsk oblast is the biggest region in the Urals Federal District, and the region's governor has been central to political developments in the area. When Yeltsin told regional leaders to take as much power as they could handle (Slider 1997: 253), Rossel' took plenty, and was even, briefly, the head of a Urals Republic – one of the most serious regional independence movements in post-Soviet Russia (Sakwa 1996: 95). As Sverdlovsk oblast was a key economic region in Russia, Rossel' was able to negotiate a treaty with Moscow which ensured the region greater autonomy. It is an independent region with a clear identity and Ekaterinburg genuinely feels like a regional capital and not a provincial town. Sverdlovsk oblast consists of 73 municipal districts containing 47 cities, 99 towns and 1886 villages; by population size it ranks fifth amongst the 89 subjects of the Russian Federation although some proud locals claim third or fourth place (figures from RACC 1999a). The oblast is 2000km to the east of Moscow and is 2 hours ahead of the capital (GMT+5). It is right on the border of Europe and Asia as the Ural Mountains run down its Western side and much of the

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[2] Ayatskov was appointed in 1996 and won the Gubernatorial elections later that year; Rossel' was appointed in 1991, removed from office in 1993, but then elected back into power in 1995.
[3] In spite of these broad similarities, the governors operate in very different circumstances and consequently have developed dissimilar leadership styles – Rossel' has been categorised as a more 'democratic' leader whereas Ayatskov may be viewed as more 'authoritarian' (see Gel'man 2000).

eastern side is Taiga. Key social and economic data for the oblast are shown in Table 4a.

Table 4a: Social and Economic Indicators for Saratov and Sverdlovsk Oblasts

	Saratov oblast	Sverdlovsk oblast
Area (km²)	100,200	194,800
Population	2,709,000 [Saratov 871,600] [Balakovo 207,400] [Engel's 189,800]	4,602,600 [Ekaterinburg 1,264,100] [Nizhnii Tagil 390,500] [Pervoural'sk 135,400]
Urban population as % total oblast population	72.94	86.90
Registered unemployed (as % working aged population)	142,300 (8.90)	318,400 (11.49)
Average nominal monthly wage (roubles)	1,066.40	1,328.50
Average price for 'basket of goods' (roubles)	515.80	556.60
Foreign investment (US$)	5,711,000	166,940,000

Source: Goskomstat (2000) <u>Regiony Rossii: statisticheskii sbornik</u>, [Online] URL: http://www.info.gks.ru/scripts/1cinet.exe?R44 [4 March 2002]
Figures are all for 1999.

The oblast has very little agriculture, which contributes to shortages of fresh food in some smaller towns in the winter. Sverdlovsk oblast's economic wealth comes from its rich mineral resources, which are also Ekaterinburg's raison d'être. The city was founded by Peter the Great in 1723, after mineral reserves were discovered, and was named after his wife, Ekaterina I. In the Soviet era these resources continued to be exploited and after the Second World War, when many munitions factories had been moved to the Urals from Western Russia, away from advancing German troops, the region became a centre for the military industrial complex (MIC). However, there is now significant unemployment (both registered and hidden) in the region, as the MIC, mining and other heavy industries have suffered greatly in the ongoing transition (Shaw 1999: 205). On the other hand, there have been some extremely successful MIC conversions in the region, for example, one factory which mainly produced triggers for nuclear weapons, is now (under license from Philips) Russia's biggest compact disk producer (Cooper 2000: 153). As the region has such great mineral wealth the mining of precious metals has continued, and new sources have been found. For example, in 2000 an area near Nizhnii Tagil was found to be rich in very

high quality palladium. However, finding the money to invest in its extraction is difficult in this case due to the bureaucratic barriers to foreign investment (IEWS 2000b).

Nevertheless, generally the region has proved to be successful in attracting foreign investment, and Ekaterinburg is where many big Western corporations have their 'second' offices outside Moscow (e.g. Pepsi-Cola, Siemens, Rank Xerox). Both the US and the UK have consulates in Ekaterinburg, and the European Bank for Reconstruction and Development also has offices there. The city boasts branches of Western clothing chains (Benetton, Sisley and Hugo Boss) as well as an 'International Business Center' (with five star luxury hotel) built two years ago by US investors. The city even has a very high quality sushi restaurant, and there are many foreigners and Russians who can afford to frequent it.

Overall Sverdlovsk oblast is one of the net donor regions in the Russian Federation, even though the region is a net importer of fuel and food (Easter 1997: 618). However, although it is capable of attracting good quality FDI and international contracts, the third of the workforce who work in the public sector face wage arrears, and welfare benefits are most often paid in non-cash goods (Dissanayake, Geller and Zyrina 1999: 5). Arrears and very low pay in the public sector, particularly outside Ekaterinburg, show that money is not 'trickling across' from private to public sectors, and the oblast had to adopt a deficit budget for 2000 (IEWS 2000a). Nearly all foreign investment and money in the region goes into Ekaterinburg, which is relatively prosperous; it has levels of organised crime to prove it. However, very little money leaves the capital for the oblast's other districts. There are great inequalities between the wealth and opportunities available in the regional centre and the smaller towns such as Nizhnii Tagil and Pervoural'sk; even though the latter is so close to Ekaterinburg that many people are able to commute.

In voting patterns Sverdlovsk is one of the most 'centrist' regions in the Russian Federation. The CPRF does not have a strong following and the population was generally very supportive of their most famous son Boris Yeltsin, and have proven

themselves to be supportive of his chosen successor – Vladimir Putin.[4] However, perhaps electoral results and voting patterns are misleading as they mask the massive political apathy in the region and the general conservatism of the regime there. The turn out for the Federal Duma elections in Sverdlovsk oblast were some of the lowest in the Russian Federation, and, as a protest against dirty campaigning, "none of the above" was by far the most popular choice in two districts (IEWS 1999a). In many respects, as elsewhere in the Federation, the oblast is still operating as it did throughout the Soviet era and below the absolute tip of all the administrative structures the personnel remains completely unchanged in person, theory or practice. Also, as became evident during the fieldwork, the print media of the oblast is largely controlled by either the local mayor or the governor, and political spats are most often played out there. Radio and television journalism is, however, more independent.[5]

Saratov oblast

Saratov oblast consists of 30 administrative districts, 12 towns, 30 "workers settlements" and about 2000 other smaller settlements (RACC 1999b) and is about half the size of Sverdlovsk oblast (see Table 4a). The Volga flows through the middle of Saratov oblast, which is located in the south of Russia and which has a now international border with Kazakstan. Saratov city is older than Ekaterinburg, it was founded in 1590 as a fortress city to protect the valuable Volga trade route, but it was also a closed city until 1991. Saratov oblast remains an important centre for the military – particularly in the field of biological and chemical warfare. Saratov, Engel's and Balakovo are the oblast's main industrial centres, and although the machine tool industry is a significant part of the economy, the region does not rely on heavy industry. Saratov oblast has not been as successful as Sverdlovsk oblast in attracting FDI, indeed the whole of the Volga Region (Saratov, Samara, Ul'yanovsk, Volgograd, Penza and Astrakhan' oblasts with the republics of Tatarstan and Kalmykia) is finding it difficult to find the capital necessary for restructuring (Shaw 1999: 200). However, the oblast became a net donor region in 2000.

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[4] The results of the 1999 Duma elections in Sverdlovsk oblast showed that 'Unity' (the party of power) secured 25.41% of the vote, the pro-reform 'Union of Rightist Forces' secured 12.68% and the Communist Party came in third place with 11.87% (IEWS 1999b).
[5] This is not an uncommon feature of regional media (see Slider 2001: 165).

Significant oil and gas reserves in the region show great potential as a source of both international and Russian revenue, and governor Ayatskov is keen to find the investment to exploit these reserves to their full potential (IEWS 2000c). Otherwise, the regional economy includes light industry and food processing, and agriculture is much more significant here than in Sverdlovsk oblast. The main areas of agriculture are animal husbandry and the production of grain, sunflower seeds and sugar beet and the oblast is Russia's second biggest wheat producer (RACC 1999b). In Balakovo chemicals and energy are the main industries, and the town boasts a hydroelectric power station as well as a four-reactor nuclear power plant, which the authorities are under national and international pressure to close due to its troubled safety record (Bellona 1999). With the history of both biological and chemical weapons production (a chemical weapons arsenal is located in the village of Gornyi) a large nuclear power plant as well as the extraction and processing of oil and gas reserves the oblast has great potential for ecological disasters. Water quality in the Volga is already cause for some concern (Shaw 1999: 200), though the locals still enjoy the crayfish that grow there.

Unlike Sverdlovsk, throughout much of the 1990s, Saratov oblast was a Communist Party stronghold, part of the 'Red Belt' of agricultural regions. Ayatskov was one of the pro-reform governors appointed by Yeltsin to keep some control over the regions. Ayatskov may be characterised as pragmatic, pro-economic reform and obsequiously pro-Yeltsin. Saratov was the first oblast in the Russian Federation to pass laws allowing the purchase and sale of agricultural land, and was renowned also for its infamously short-lived legalisation of prostitution (see Kislov and Orlenko 1998). The land reforms eroded the power base of the Communists and the nationalists, and land sales have proved an important source of income for the regional economy (The Territories… 1999: 215). The Gubernatorial elections were held in 2000, but were not without controversy. Following the Communists decisive victory in the Federal Duma elections, Ayatskov removed his only real opponent from the gubernatorial election by not allowing him to register; the Communist candidate was accused of fraud (IEWS 2000b).

Ayatskov was re-elected by a clear majority, but not only was his campaign deemed the 'dirtiest' so far, but there were also widespread allegations of vote rigging (IEWS

2000b). Thereafter the governor's position has remained very weak as his popular mandate is questionable and financially the oblast is still in difficulty. Wage arrears remain a serious problem for public sector workers and budgetary problems throughout the summer of 2000 meant that most areas were without gas, hot water or both for most of the season. Even Balakovo suffered in this energy crisis, the irony of which was not lost on local residents. The crisis was caused by the administration running out of funds for the payment of such services, and is a reflection both of the changing attitude of energy providers to long-term debt, and the governor's priorities. The oblast budget still managed to find the resources in order to fund, for example, an international scouting Jamboree at Kirienko's behest, because, as Ayatskov said at the time, "now Kirienko is ours" (IEWS 2000e).

Negotiating problems in the field

Due to bureaucratic difficulties with visa registration, there was less time available for data collection in Ekaterinburg than in Saratov, so trips out to other cities in Sverdlovsk oblast at that time were not possible. The data collection in Ekaterinburg also coincided with the presidential and local elections and as a consequence many civil servants were too busy to be interviewed and the regional civil service appeared to be in flux until after the elections, when positions would once again be legitimised. It was interesting to note how politicised health campaigning became during the elections, but clearly this could not be viewed as necessarily representative of the usual situation in the region. Therefore in order to balance the data between the two regions, a second, shorter trip to Sverdlovsk oblast was made, allowing research in the smaller towns of Nizhnii Tagil and Pervoural'sk to be carried out. This extra time also made possible some follow-up interviews which could explore the 'normal' level of politicisation of substance misuse issues when elections were not underway. However, in spite of this second trip to Sverdlovsk, the data for Saratov are richer and more detailed. This is a reflection of the ease with which the researcher was able to gain access to respondents in Saratov, which may reflect a cultural difference between the two regions, but it is more likely to be a demonstration of the importance of personal contacts in gaining access to different levels of the administration.[6]

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[6] The relative ease in gaining access to decision makers in Saratov oblast when compared with the difficulties in Sverdlovsk was due to one person, Irina Klimchuk, with whom a friendship was struck up during the pilot study, and to whom the researcher will be eternally grateful.

4.3 Reflecting on the Research Process

Commitments, ethics and sensitivity

With any form of cross-national research a certain comparative element is implicit (Thomson 2001) and it was challenging to try and overcome personal West European ideas of best practice in the field. Although it was never a part of the research question, it was hard not to estimate the efficacy of different programmes based on the West European experience of doing health promotion around substance misuse. Not doing mental evaluations of programmes should have been important in terms of keeping the research process focussed – measuring the efficacy of interventions was not relevant or meaningful in the context of this research. When asked directly by organisations for an opinion of their work, however, an answer was usually avoided. This was not an attempt at 'impartiality', but a way of avoiding potential conflicts.

The researcher's position was knowingly subjective; when dialogue developed during an interview the researcher was happy to disclose the theoretical frameworks which informed her work and the setting of the research questions. This openness avoided one of the ethical dilemmas which was identified before departure, namely how to avoid being seen to condone the extremist politics of some actors in the field. However, how far this openness was 'real' or constructed by the researcher after the event is a cause for concern, mainly because, in the vast majority of cases, the researcher and the respondent were operating with completely different approaches to the issue. With most of the health promotion initiatives encountered, the personal perception of the researcher was that programmes individualised what should be conceptualised as a social problem. Such 'victim blaming' is not generally acceptable in current health promotion discourse in Western Europe.

It was hard to tread the fine line between cultural sensitivity and respect for minority groups. The language used was in many ways problematic; interviewees often talked about specific client groups (notably IDUs and CSWs) using derogatory terms. Attitudes expressed during interview – such as 'all Roma or Tadjiks are drug pushers' – were also difficult to let go unchallenged. However, in the research, whilst not

seeking to condone such attitudes or the use of abusive language when referring to a specific client group, these attitudes and this language need to be recognised as a culturally specific part of the current discourse. Many of the interviewees who used racial stereotypes, for example, drew this information from media coverage of the issue. They rarely reflected deeply held xenophobic convictions. Consequently, because such attitudes and the use of derogatory terms could be judged unduly harshly by Western readers, as far as possible respondents have not been quoted directly, even though most were happy to go on record. Individuals have not been named in the analysis, instead interview data have been taken as representing the discourses within different organisations. This was also the most straightforward way of representing the interview data in the text as often multiple interviews had been conducted over time and with different representatives of the same organisation.

Reciprocity was an equally important issue in the research process. Although very careful to point out that as a mere PhD student, not much by way of exchange could be offered other than possible contacts, information on how health promotion is developing in the UK and the researcher's abilities as a native English speaker, this was not always understood. Some organisations accepted offers to help with grant applications, but as the researcher's status with Western funding bodies was often misconstrued this did sometimes cause problems. Although the confusion was generally based on the researcher's Western status, having friends working in or for funding bodies in both regions did not help to challenge this impression even though the researcher had no influence over them in their work and would not look to influence them. This was one of the downsides to snowballing contacts and accessing organisations through planning meetings.

Where offers of providing information were accepted, notes of what information was requested and in what format were made in the field notes. Generally where it was possible to send articles electronically such tasks were completed efficiently, often even while the fieldwork was still underway. However, where trips to specialist medical libraries had to be made (usually for information on new pharmaceuticals or techniques requested by narcologists) or articles supplied in hard copy this took much longer to achieve. Once back in the UK the researcher is no longer solely immersed in the research process and other demands on time seem to warrant more urgent

attention. Consequently reciprocal commitments were not always fulfilled promptly, indeed, some were forgotten until the data analysis stage when it was necessary to return to the field notes. A certain amount of time for fulfilling commitments was set aside on return to the UK; as most requests for information were on developing peer education programmes it was only one or two days work. The real difficulty came during the writing up period; old requests which had been forgotten but emerged during data analysis combined with new e-mail requests for help with grant applications and information, and finding time was no longer so easy, but the commitment remained.

One last ethical issue, which was completely unanticipated prior to the fieldwork, was how or whether corruption and organised crime involvement in different NGOs should be approached. Evidence of the misuse of funds was encountered occasionally in locally managed, but internationally funded projects, however, this has not been covered in the analysis as irregular accounting procedures did not have a direct bearing on the central research questions. The involvement of organised crime structures in the voluntary sector produced major ethical problems that are not easily resolved. On the one hand NGOs which are registered do have a level of legitimacy, however, it was felt that including NGOs with clear links to organised crime, in research on the development of health promotion in Russia would give unwarranted legitimacy to NGOs with a questionable provenance. The issue of coping with organised crime in data collection was particularly relevant to one NGO which, it was decided, would not be approached for interview. It was a more conventional NGO which was subject to a hostile take over by businessmen who had close links to organised crime and who changed the primary tool of this NGO in the 'war on drugs' to violence – either against the 'pushers' or the users. Another NGO with links to organised crime was actually interviewed, though by accident. The interview was very brief, the questions were subject to self-censorship, for example, no questions about funding were asked, and contrary to normal practice no contact details were left with the respondents. The value of the data collected at this interview was unquestionably compromised and it could be argued that the attempt to avoid future contact with this organisation displayed a lack of respect for the respondents. Both of these points are accepted, but in the interests of personal safety there was no other realistic course of action.

Conclusion

The field work produced a lot of high quality data, the strength of which lies in its rich detail. The combination of a range of data collection techniques – interview, observation as well as document analysis – made possible data triangulation – findings could be checked and 'verified'. The richness of the data also meant that highly detailed accounts of the process of health promotion development were produced. The detail also contributes to the work of other scholars who have conducted research in Saratov and Sverdlovsk oblasts to provide fuller pictures of these regions, which are, in comparison with Moscow and St Petersburg, relatively under researched. The value here comes particularly from the analysis of the situation in the smaller towns outside the regional capitals.

The main difficulty with access was in relation to local level education departments in both Saratov and Sverdlovsk. In spite of the researcher's frequent attempts to conduct interviews within local education departments, there was no engagement from education services with the process of data collection, which was indicative of these structures' lack of activities in health promotion around substance misuse in either research region. In Ekaterinburg it was possible to take a more 'grassroots' approach and talk to the directors of some schools, which provided valuable insight into how local education policy around substance misuse issues was (or was not) enacted. Information on state education attitudes towards health education in schools at the federal level was also accessed through published resources – journals for the teaching profession, which include ministerial directives, (*Vospitanie shkol'nikov* and *Narodnoe obrazovanie*), the teaching union's newspaper (*Uchitel'skaya gazeta*) and through articles in the national press. Combined with interview data from both regions and information gathered at a grassroots level in Ekaterinburg, it was clear that, unlike other services, the education departments did not generally consider health education to be within their remit.

CHAPTER 5: MAPPING HEALTH PROMOTION IN POST-SOVIET RUSSIA

The aim of this chapter is to identify the actors involved in health promotion in the two research regions and isolate factors at play in encouraging or hindering empowerment, intersectoral working and political lobbying for policy change. This is not an exhaustive list of all the possible actors working in health promotion in the field of substance misuse in both research regions, nor could it be. The flux of organisations, projects and programmes setting up and closing down, proved to be a distinctive feature of the situation in both regions. The first section of this empirical chapter, therefore, presents the research findings as a snapshot of the situation in the year 2000 and shows how the range of non-state actors was examined by categories. The second section is a more detailed analysis of the different non-state actors involved in the field of substance misuse, as community and individual empowerment approaches ideally involve a wide range of actors from different social sectors and great emphasis is placed on the importance of grassroots NGOs. In the third section the relative contribution of health promotion initiatives from state organs is examined. How local, national and international factors have impacted upon the development of health promotion in the two research regions is assessed in the fourth section, and the chapter concludes with an examination of issues around the development of healthy public policy through political lobbying in post-Soviet Russia.

5.1 Explaining the Mapping Process

Mapping the actors involved in health promotion is necessary since the ideals of health promotion, as laid down in the Ottawa Charter (WHO 1986), stress the importance of community involvement, at all stages of the process. The community is emphasised as central to problem definition, planning and action to solve problems, and in the establishing of structures to ensure that solutions are sustained. This can act as a counterbalance to biomedical dominance and social iatrogenesis, but community mobilisation is not purely ideological; experience of community mobilisation has shown that behaviour change is more likely to be successfully

achieved and maintained when the people it affects are indeed involved in initiating and promoting this change (Nutbeam and Harris 1999:37). Therefore, health promotion initiatives should, theoretically, also encourage processes that build community capacity. However, achieving such change inevitably involves shifts in power relationships and resources in society and this is where the problems lie (Nutbeam and Harris 1999:36). Mapping the actors involved in health promotion around substance misuse in relation to established structures can act as a visual representation of whether intersectoral working and the empowerment of community and self-help groups is being achieved.

Diagrams 5.1 and 5.2 were developed by the researcher on the basis of interviews, observation and documents in order to map the connections between different actors in the research regions. Diagram 5.1 shows the network of actors and programmes encountered during fieldwork in Saratov oblast; Diagram 5.2 represents the situation in Sverdlovsk oblast. Different classifications of actors are marked in different colours: red indicates a "pure" non-government organisation (NGO), yellow a Western funding body, green an international non-government organisation (INGO), blue is a state sector organisation and purple denotes a quasi-non-government organisation (QuaNGO).[1] Arrows denote the flow of money, the relative thickness of the arrow showing the relative size of the grant, and dashed lines denote an advisory role. Dotted lines have been used with organisations that were brought into projects at a later date, normal lines indicate practical collaboration on the project or with other organisations. Boxes within boxes show that the relevant NGOs are operating from within another organisation, the reasons for this are explored below. Where boxes are shown 'floating' it is because they are as yet un-networked with other actors in this field of work.

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[1] Although it is understood that the term 'quango' (quasi-autonomous non-governmental organisation) has particular negative connotations in the UK, a similar acronym has been used here as it most accurately describes these organisations' relative position in relation to the state and differentiates them from "pure" NGOs.

Living Thought

Chance

Shidlko Foundation (Ekaterinburg)

Mothers against Drugs (Nizhnii Tagil)

Municipal Youth Affairs Committee Nizhnii Tagil

"I, you, he, she"

Oblast Sanitary Epidemiological Services

Oblast Narcological Hospital

Oblast Preventive Medicine Centre

New Time

Oblast AIDS Prevention Centre

Médecins sans Frontières (Moscow)

NEEDLE EXCHANGE PROJECT

International Family Health

Youth against Drugs (Ekaterinburg)

Mothers against Drugs (Ekaterinburg)

"Holis"

Pervoural'sk against Drugs

"Outpost"

Municipal Narcological Clinic

Psychiatry Union

"Sotsium" Pervoural'sk

Municipal Youth Committee Pervoural'sk

The Federation

"Rubicon"

Diagram 5.2 SVERDLOVSK OBLAST 2000

Pervoural'sk

Diagram 5.1: SARATOV OBLAST 2000

Youth against Drugs

Balakovo Department for HIV Infected

Balakovo City Narcological Clinic

Balakovo Medical Prevention Centre

Parents against Drugs

Engel's City Narcological Clinic

Centre for International Understanding

Oblast AIDS Prevention Centre

HIV Fund

Needle exchange programme

Harm reduction programme

"Sotsium" Engel's

Soros Open Society Institute

Sotsium-Narkorisk Programme

Eurasia Fund

"Rostok" Schools-based prevention project

Balakovo City Administration

"Harmony" Centre

Youth Initiative

NAN Saratov

Outreach team

NA, AA, Alanon

UNAIDS

AIDSMARK (USAID)

Extreme-Sotsium

Population Services International

ADVISORS:

"Return" Foundation (St Petersburg)

Médecins sans Frontières (Moscow)

Society of Temperance and Health

RCCYCSS

Evers' (1995) model for mapping the welfare mix in service provision in Western societies (see Diagram 5.3), has been adapted and used here for categorising the range of actors involved in health promotion around substance misuse encountered in the two research regions. This approach has been found to be the most suitable for describing the nature and relative positioning of the range of actors involved in promoting health around substance misuse, particularly as the boundaries between different social sectors in both research regions were found to be quite blurred. Evers (1993; 1995) formulates the 'third sector' as an intermediary realm, a tension field pulled between three poles – the state (first) sector, the market (second sector) and the private sphere (the family). Service providers within the intermediary realm may be pulled towards any one of these poles, and even fall within their sphere of influence; alternatively, actors can be caught between two poles or find all three have an equal attraction. This way of conceptualising the third sector aims to demonstrate that whilst developments and strategies in the intermediary realm do exert some influence on other realms, they are also exposed to strong influences from their environment (Evers 1995: 161).

Diagram 5.3: Evers' Conceptualisation of the Intermediary Realm (as depicted visually by Koehler 1999)
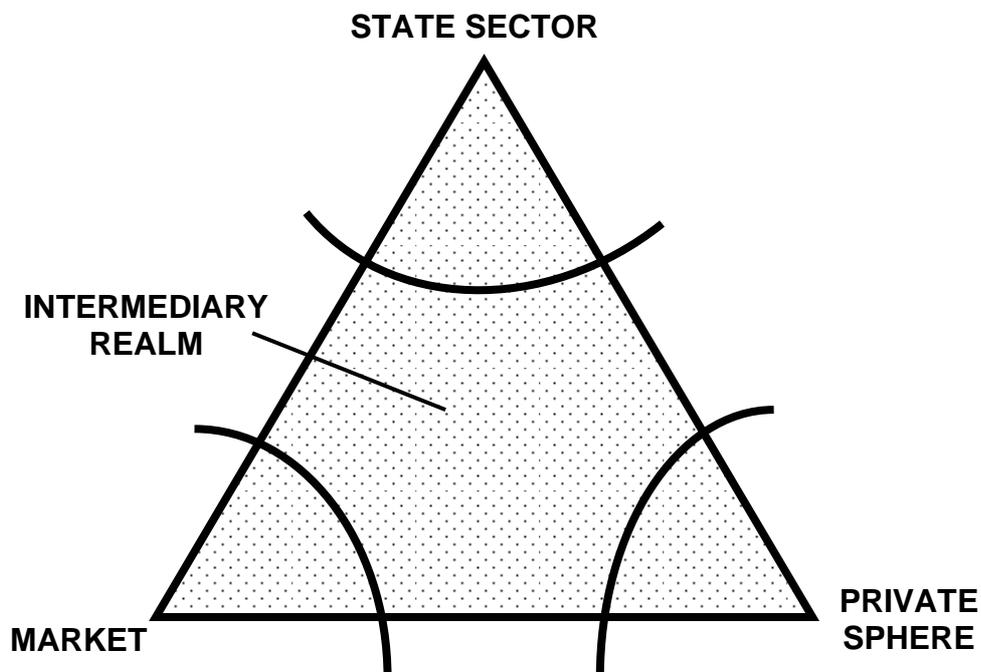
However, the environment in which post-Soviet Russian NGOs operate is not influenced in the same way as the environment surrounding Western systems of welfare provision. Russia is a country in social, political and economic flux which has inherited different structures and systems to those in the West, and these have been subject to strong international influences since 1991. Evers' conceptualisation has been successfully applied to other non-welfare areas in the post-Soviet context, specifically to youth NGOs in Belarus (Koehler 1999) and although the political and economic climates in Belarus and Russia differ significantly, the same adaptations need to be made. In Evers' conceptualisation, the market is a factor in welfare service provision through the privatisation of care (Evers 1995). This is generally of less relevance for health promotion service provision and in Russia as in Belarus the market is not sufficiently large to influence the third sector as a whole, even though the market in Russia is significantly stronger than it is in Belarus. The market does not influence the development or direction of NGOs in Russia because there is little engagement between them and business as yet. Therefore in Diagram 5.4 (see below page 119), which represents the intermediary realm in post-Soviet Russia, the market, as one corner of the tension field, has been replaced by the considerably more influential international funding bodies. Also, as in Belarus, the state's sphere of influence was found to be larger than that of the international funding bodies or the private sphere (see also Koehler 1999: 42).

The polyvalent nature of the activities of different organisations in both the research regions, from the provision of therapeutic services to the publishing of leaflets, means alternative categorisations of actors in terms of organisation activities or membership was not appropriate. Evers' identification of 'hybrid' organisations and the identification of quasi-non-governmental organisations (QuaNGOs) as well as truly independent "pure" NGOs in the field means that the intermediary realm conceptualisation also allows for the representation of organisations which may otherwise not be deemed part of the 'voluntary' sector. For example, health related NGOs have been categorised as having 'independent beginnings', 'self-governing structures', 'independence from other bodies', 'surpluses not distributed for profit' and 'worthwhile purposes, increased morality' (Anderson and Heritage 1996: 176). With the possible exception of the last criterion, all of the other common features of a 'voluntary organisation' would serve to exclude most of the NGOs encountered in the

fieldwork, particularly as few had 'independent beginnings' and many were very much dependent on other bodies.

Table 5a: Non-Government Actors in the Field of Substance Misuse in the Research Regions

Sverdlovsk oblast	QuaNGOs	"Pure" NGOs	International Actors
Ekaterinburg	Outpost Holis (plus Mothers against Drugs; Youth against Drugs)	New Time Rubicon Living Thought Chance NA / AA Groups [City without Drugs] [Shichko Foundation]	Know How Fund The Federation VSO MSF
Nizhnii Tagil		"I, You, He, She" Mothers against Drugs	
Pervoural'sk	Sotsium	Psychiatry Union Pervoural'sk against Drugs [City without Drugs]	
Saratov oblast			
Saratov	RCCYCSS	HIV Fund[2] Youth against Drugs Parents against Drugs STH City without Drugs Extreme Sotsium	Eurasia Fund PSI MSF
Balakovo	Harmony (plus NAN-Saratov)		
Engel's	Sotsium		

Table 5a lists the range of non-government actors active in the two research regions; the organisations listed in round brackets are the alternative hybrid identities of what was at that time essentially the same organisation. An organisation was categorised as a hybrid identity and not an independent entity where the location, personnel and leadership of the registered "pure" NGO was exactly the same as that of the QuaNGO from which it evolved. The QuaNGOs were categorised as such if their legal status

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[2] The full name for the HIV Fund is the "Saratov Oblast Social Fund for the Rehabilitation and Habilitation of Drug Dependent and HIV Positive People".

was officially as a 'state foundation' [*gosudarstvennoe uchrezhdenie*] or where they were officially a part of the state structures, but maintained an independent identity. For both types of QuaNGO the state budget was a significant source of finance for their work. The "pure" NGOs were both non-state and non-commercial actors and most were also officially registered as such, with the exception of the NA and AA groups encountered. Not all of the "pure" NGOs had independent beginnings (notably the Society for Temperance and Health) and many operated from within established state structures or other bodies, as discussed in detail below.

The international actors are both INGOs, such as Population Services International (PSI) and Voluntary Services Overseas (VSO), and overseas government agencies, such as the UK government's Know How Fund (KHF) and the US government financed Eurasia Fund. The Federation was found to be an international religious organisation, although its official status was as an interregional non-commercial NGO.[3] Organisations shown in square brackets were not actually interviewed during the fieldwork period, City without Drugs in Ekaterinburg and in Pervoural'sk were not approached for safety reasons, which are detailed below, and the Shichko Foundation could not be accessed in time. The two books written by the head of the Ekaterinburg Shichko Foundation, however, have been used as they may be considered an accurate representation of his approach to substance misuse issues (see Druzhinin 1998; Druzhinin 2000). The government organisations accessed included the preventive medicine centres which were still operating in each of the towns including the oblast level centres.[4] Other organisations accessed within state health care structures included specialist narcological hospitals in Ekaterinburg and Pervoural'sk as well as AIDS Centres in Saratov and Ekaterinburg. Outside the formal health care structures regional Youth Affairs Committees were accessed in Saratov, Pervoural'sk and Nizhnii Tagil. The interview process has been detailed in Chapter 4, and in order to preserve the anonymity of respondents, but retain the meaningfulness of the information gathered at interviews, data have been referenced by organisation and date only.[5]

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[3] The full name for the Federation is "The Federation of Families for Unification and Peace in the Whole World"

[4] For brevity these have been referred to in the text using abbreviations: municipal preventive medicine centres (MPMC) and oblast preventive medicine centres (OPMC).

[5] A full list of the organisations interviewed during fieldwork is given in Appendix 1.

All of the listed organisations were found to be active in health promotion around substance misuse, though it was not the core function of all actors involved. KHF and Eurasia Fund had both financed health promotion interventions around substance misuse (a needle exchange programme and a schools based health education programme respectively) but were not direct participants in the schemes. All of the QuaNGOs are rooted in providing psychological support services for young people and have become specialists in substance misuse more recently as the problem has become more urgent. 'Chance' is primarily an advocacy service for young people; the Psychiatry Union is involved in all aspects of mental health and not just addiction and 'Living Thought' is a broad community development organisation that had only one drug related programme. The HIV Fund and PSI were involved only with drug use as it related to HIV transmission, the HIV Fund primarily provided support services for HIV+ individuals and 'high risk groups'; PSI and The Federation were more involved in sex education, though from opposing ideological positions. The different actors having various backgrounds and core activities meant that in health promotion terms the organisations had different 'functions' in relation to individual and community empowerment, i.e. in encouraging people to take control over their lives.

Anderson and Heritage (1996) list the functions of 'voluntary organisations' as service provision, political lobbying, education and information, community development and self-help. None of the above organisations fulfilled all of these functions, though most were service providers. That may be seen as a response to gaps in state provision, particularly in relation to the counselling and rehabilitation of drug users. Sometimes organisations were able to offer a wide range of services, but others were more limited in what they could offer either by time, finances or the desire to concentrate on one core service. One of the most common services provided was counselling or support for individuals or families suffering as a result of substance misuse. Many of these organisations also functioned as self-help groups. However, in theory self-help should be a bottom up development – people pulling together for mutual aid (see Myers and Marsden 1996), but most of the self-help groups encountered in the research regions were instead instigated and coordinated from above by medical professionals working in the field. All of the QuaNGOs

asserted in interviews that they were involved in political lobbying of the local administration, particularly in raising awareness of substance misuse issues in order to secure more finance from state budgets for the services they were providing. However, "pure" NGOs also acted as political lobbyists in order to promote changes in how services were funded and provided or to promote attitudinal changes in how different clients were treated within state structures (see section 5.2 below). Most organisations also provided education and information for their members, but some also sought to inform and educate non-members, usually young people in education establishments, but often also parents, teachers, health professionals and journalists. Community development was the explicit function of only one NGO – 'Living Thought' (Living Thought 2000: INT).

The mapping process has been aided and informed by Evers' approach to mapping the new 'welfare mix' in Western societies. However, here the mapping of actors in the field of health promotion around substance misuse is not merely a descriptive analysis of the empirical findings. The relative position of actors in relation to the state has been used in conjunction with interview data in order to assess the potential for community empowerment in the two research regions. Within health promotion literature advocating the community empowerment approach, the importance of collaborations for health between a range of actors is emphasised, so that interventions are not just *for* people, but *with* them (see for example Trojan et al 1991; Richardson 1991; Myers and Marsden 1996; Anderson and Heritage 1996). "The responsibility for health promotion has to be shared among many agencies: community groups, as well as formal institutions." Indeed, "if the idea of community participation is to be put into practice as a basic principle of health promotion, community groups and similar social networks are a central setting and an important resource in the process of enabling people to increase control over and to improve their health." (Trojan et al. 1991: 461) In this way, mapping the relative position of actors is essential for mapping community empowerment.

5.2 Mapping the Organisations

The range of actors listed above and the different services they offer (and functions they fulfil) would indicate that the intermediary realm in Russia is indeed evolving as a space that enables gaps in state provision to be filled and groups of concerned citizens to come together to lobby for change. However, the fluidity of the intermediary realm in Russia and the fuzziness of the boundaries between organisations needs to be examined in detail in order to reveal the real capacity for individual and community involvement in health promotion. Consequently the nature of the QuaNGOs is explored first, particularly in relation to their striking success in the field in terms of attracting funding and attention to substance misuse issues. Next the QuaNGOs' hybrid identities are analysed: the reasons why they have developed and the actual and potential problems these parallel identities can create. Finally issues around the development of "pure" NGOs looks at the main problems organisations face when trying to conduct individual and community empowerment for health.

The Growth of the QuaNGO

Diagram 5.4 shows the relative position of the different QuaNGOs encountered in relation to the state, international funding bodies and the informal realm. The QuaNGOs were located within the intermediary realm, but due to their status as state foundations they were also very much within the state's sphere of influence. Some QuaNGOs, were pulled more towards international funding bodies, as these were the main alternative to the local government budget as a source of funding for their activities [1].[6] The exceptions to this were the Saratov Regional Centre for Child and Youth Complex Social Services (RCCYCSS) and the Nizhnii Tagil Municipal Youth Committee, included here for reasons listed below, as these actors did not actively pursue international funding [4]. Sotsium (Pervoural'sk) had only just grown out of the informal realm, so has been shown here as pulled towards that pole [2]. Harmony's alternative NGO identity, NAN (Saratov), is also marked on to demonstrate the difficulty in mapping the position of hybrid organisations [3].

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[6] The figures shown in square brackets relate to those in Diagram 5.4 overleaf.

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Diagram 5.4: The Intermediary Realm in Russia (adapted from Koehler 1999:42)
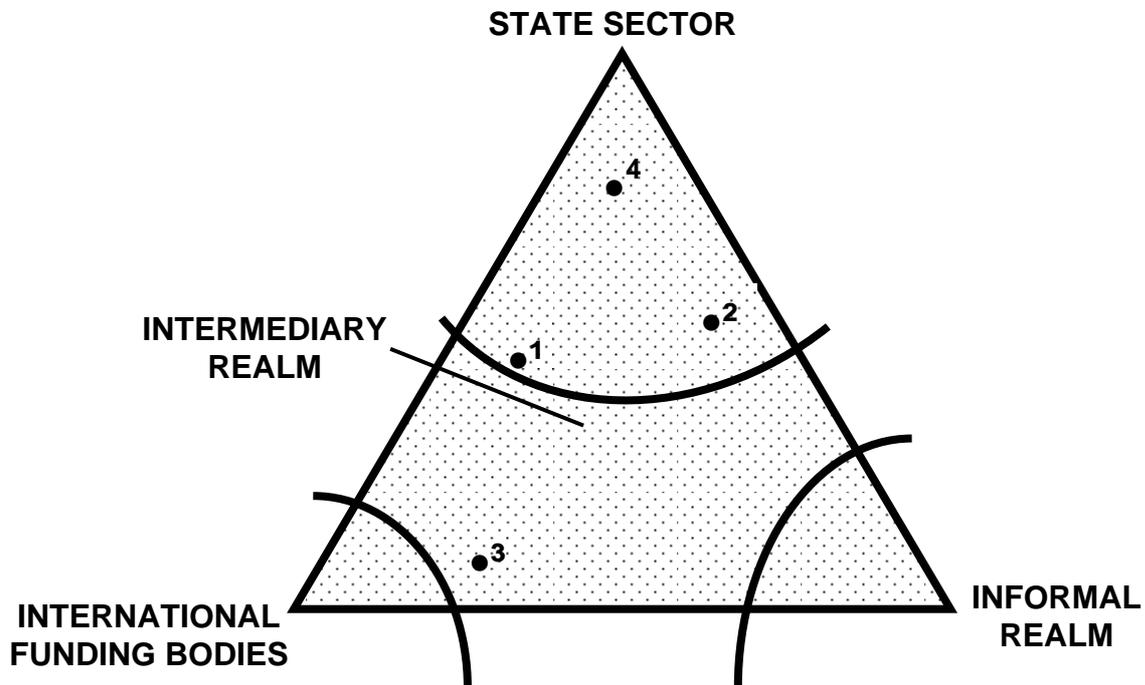
1 – QuaNGOs such as Outpost; Holis; Harmony; Sotsium (Engel's)
2 – The 'grassroots' QuaNGO – Sotsium (Pervoural'sk)
3 – The alternative identity of Harmony – NAN (Saratov)
4 – The Nizhnii Tagil Municipal Youth Affairs Committee and the Saratov RCCYCSS

Although they were all at least part funded through the local administration budget, the QuaNGOs maintained a very independent identity, as though they were NGOs, and they were often accepted as such by international funding organisations for grant distribution purposes. The more established QuaNGOs (namely Outpost, Holis, Sotsium (Engel's), Harmony) were all successful in attracting a wide range of finance for different activities. International donors which aimed to fund only non-state actors for civil society development purposes (notably USAID) were able to support QuaNGOs through their non-governmental, 'hybrid' identities (Harmony 2000: INT). The legal status of the QuaNGOs as state foundations also allowed for commercial activities (provided this was not the main activity in which they were involved) and some of the QuaNGOs encountered raised revenues by charging for some services (Holis 2000: INT). The QuaNGOs were much more flexible in how they could access funds, not just from international donors but also from the state. For example, Holis requested that it be moved from being under the jurisdiction of the oblast youth affairs

committee to the oblast ministry of education so that it could be allocated more money from the budget (Holis 2000: INT). All of the QuaNGOs encountered were expanding rather than contracting, and it was observed during interviews that all but Holis were in the process of refurbishing their premises, so temporarily operating from a building site.

QuaNGOs are automatically in a materially stronger position than the "pure" NGOs. As QuaNGOs are nominally set up by local administrations they do not face the same bureaucratic problems with registration, and the local administration provides facilities – offices with telephone line – which is a significant barrier to development for the "pure" NGOs (Rubicon 2000: INT). Full-time QuaNGO staff are also waged, although they face the same problems of wage arrears as other public sector workers. Theoretically, as 'insiders' in the local administration, they were also in a stronger position to influence policy decisions and were more likely to be consulted during the policy making process (Holis 2000: INT; Harmony 2000: INT).

The QuaNGOs encountered were well established in the Russian context of third sector development – Holis was founded in 1990, Outpost in 1992, Sotsium (Engel's) in 1993, Harmony in 1994 and the RCCYCSS in 1996. The youngest QuaNGO encountered was Sotsium (Pervoural'sk), and this organisation provides the most interesting manifestation of the strengths of not being a "pure" NGO.[7] Sotsium (Pervoural'sk) is literally a grassroots QuaNGO that was set up through the municipal youth committee after a group of concerned mothers had lobbied long and hard for the administration to do something more proactive in the fight against drugs. These women did not see any value in becoming an NGO themselves; they sought to become a state foundation with the stability and resources this status confers (Sotsium (Pervoural'sk) 2000: INT). At the time of interview Sotsium (Pervoural'sk) was still very young (only 3 months old), but had already become networked with other QuaNGOs in the oblast, namely Holis and Outpost, which had been running training courses (Sotsium (Pervoural'sk) 2000: INT).

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[7] Organisations which share the same name (such as 'Sotsium') are not necessarily linked, see below.

The Nizhnii Tagil Municipal Youth Affairs Committee could also have been classed as a QuaNGO for the purpose of mapping the actors in health promotion around substance misuse. Although it is clearly a branch of the local administration, in practice it operated in a very similar way to a QuaNGO. The Committee building houses all of Nizhnii Tagil's youth related NGOs – from sports associations to support groups for young drug users, and this has strongly facilitated intersectoral working on projects. The Committee was also extremely well networked both regionally and nationally with QuaNGOs, NGOs and INGOs in the field of health education. However, the activities in this area also seemed to revolve entirely around the head of the Social and Psychological Support Service within the Committee. Theoretically, therefore, this networking and collaboration might only last as long as they do in that position. A similar situation was encountered during the pilot trip in a Saratov regional youth committee in 1999, which had an anti-drugs programme only as long as they had one particularly energetic employee. The employee left in order to start a "pure" NGO (Extreme Sotsium) with two other activists, having found the restrictions of regional politics frustrating (Extreme Sotsium 2000: INT). However, the work of Extreme Sotsium became intertwined with the work of PSI as this person was in effect headhunted by PSI after the success of some of Extreme Sotsium's activities (PSI 2000: INT). At the time of interview in May 2000, Extreme Sotsium, at least temporarily, had suspended its activities while the founders were engaged in other projects (Extreme Sotsium 2000: INT). The flux in the third sector was thus partially associated with shifts in personnel.

The Hybrid Organisations

In the Russian context the physical mapping of organisations in the intermediary realm are further complicated by some QuaNGOs' multiple identities, the two best examples of which in the two fieldwork regions were Harmony in Balakovo and Holis in Ekaterinburg (see Diagrams 5.1 and 5.2). Evers' model of welfare provision covers the polyvalent nature of some welfare NGOs in the West (Evers 1993; 1995); however, the West European examples do not seem as 'schizophrenic' as the Russian hybrid organisations. Both Harmony and Holis have 'branches' which are registered under different names and with different legal statuses, but which also share the same staff and premises. Holis runs many of its activities through sister organisations registered as NGOs, namely 'Mothers against Drugs' (Ekaterinburg) and 'Youth

against Drugs' (Ekaterinburg). Harmony is also concurrently the Saratov regional filial of the Moscow based charity 'No to Alcoholism and Drug Addiction' (NAN-Saratov) and is registered as such.

In some respects these different identities reflect the polyvalent nature of these organisations' work with different groups. Holis' original identity (and still its core activity) was a confidential telephone hotline for young people whereas 'Mothers against Drugs' (Ekaterinburg) is a support group for the families of drug users; and 'Youth against Drugs' (Ekaterinburg) targets youth with health education. Harmony is a psychological support service for young people, which runs courses in 'practical psychology' and runs a schools based health education programme; NAN-Saratov is an organisation which works with the counselling and rehabilitation of drug users and runs harm reduction programmes and has an outreach team. The different identities therefore coincided with different services that the organisations provided in the community. Polyvalence was common among actors, but it was only as an organisation or programme grew in size that it developed separate identities for different services. In some respects this serves to clarify boundaries, but the fact that the actors were essentially the same in terms of personnel meant that power was not being shifted down to the service users, in the way their names (Mothers against Drugs, Youth against Drugs) might imply.

Polyvalence within a given organisation did not generally cause tensions between staff members except in drugs education, where there are wide philosophical differences between moralist and pragmatist approaches. Both approaches do coexist in Western countries, but in Harmony, for example, they were found to be coexisting within a single organisation. The polyvalent activities of Harmony are demonstrated in Diagram 5.1. The 'Rostok' programme followed a similar psycho-social approach to drug use prevention as used in the 'practical psychology club' for young people, and it was funded mostly by the municipal authorities through the Balakovo Youth Affairs Committee (Harmony 2000: INT). The 'Rostok' programme is essentially 'moralist' in its approach as it views all substance misuse as 'wrong'. This is encapsulated in one of the programme's anticipated results: "To broaden children's and teenagers' means of interaction with the world around them and to form the conviction that alcohol and drugs should be excluded from their lives." (Profilaktika

alkogolizma i narkomaniya Balakovo: Harmony 2000: 8)[8] By contrast, Harmony's alternative identity, NAN (Saratov), was 'pragmatist' in that it included an outreach team and was active in a regional harm reduction project distributing clean injecting equipment and information on safer injecting to active IDUs.   When a single organisation has different programmes from differing philosophical bases running concurrently and all sides are pushing their approach as being 'right' the tension can be great and extremely divisive; in Harmony the tension and mutual distrust between outreach workers (pragmatists) and psychotherapists (moralists) was palpable.

In Holis there did not appear to be such great divisions along philosophical lines, no doubt because all the projects and programmes were devised and developed by the organisation's president. In Holis the tensions were around balancing schools based educational work, which was funded by the local administration, with the more profitable rehabilitation of drug users, which was self-financing. As Evers (1993; 1995) has argued, organisations can become 'hybrids' by relying simultaneously on market, state and community based resources and by having to counterbalance for-profit and a diversity of non-profit rationales. Multiple identities are also one way of maximising an organisation's access to finance, particularly from some international funding bodies, which is one reason why Harmony had NAN (Saratov) as a hybrid identity. In Russia the profits are in the rehabilitation of drug users, but these services need to be balanced against the demands of other sources of finance as well as the organisation's membership.   Many organisations rely simultaneously on many different sources of finance from the state, political parties and, more rarely, business donors as well as the international funds.   This can encourage polyvalence and provide the incentive to develop hybrid identities. All donors influence the way in which organisations and their programmes are developing in the field of health promotion, particularly in relation to community empowerment. Different agencies fund different programmes for different reasons and hybrid identities allow the predominantly state resourced QuaNGOs more flexibility in the way they access funding and develop services.

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[8] Unpublished health education sources are listed in Appendix 2.

"Pure" Non-Governmental Organisations

The following section is necessarily not a full survey of all the remaining substance misuse related NGOs in the two fieldwork regions. Some, such as 'Youth against Drugs' (Saratov) and Extreme-Sotsium had effectively ceased to operate and some, such as Chance in Ekaterinburg, had moved away from health promotion into other fields. Many other organisations were more concerned with treatment programmes, than with health education or healthy public policy, for example the Psychiatry Union and the Shichko Foundation (Ekaterinburg).[9] Whilst the notion of a "pure" NGO is in many ways a misnomer in any society, in the two fieldwork regions the term was highly inaccurate as so many of the organisations had sought 'protection' from a range of state and non-state organisations. This was not a merger, they had not become hybrid organisations. Moving closer to other organisations, however, was one of few enabling strategies for NGOs looking to actually enact different aspects of health promotion around substance misuse. Western grants were viewed as desirable, but they do not necessarily afford the same stability as co-operation with a Russian organisation.

'Gimme Shelter'

There was one NGO in each region which specifically targeted drug users for HIV risk reduction as part of their work (New Time in Ekaterinburg and the HIV Fund in Saratov) and at the time of fieldwork both were housed by the respective oblast AIDS Prevention Centres. HIV Prevention Centres are part of the state health care system, but they are federally funded as HIV is considered an 'especially dangerous infectious disease'. New Time's founder works in the Sverdlovsk oblast AIDS Prevention centre, and this is the main reason why the organisations *de facto* share a roof, although New Time is actually registered at the founder's home address. The HIV Fund was invited to move into the Saratov oblast AIDS Prevention Centre to do pre-test counselling and to run an HIV confidential hotline, which had sadly been disconnected as they could not pay the line rental. This situation is considered beneficial on many levels, primarily because it broadens the range of services which

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[9] The fluidity of the intermediary realm and hence the difficulties of the mapping process were amply demonstrated by the directories of NGOs produced by the NGO networking organisations (Dissanayake, Geller and Zyrina 1999; Mezhvedomstvennaya… 2000). Whilst they were still useful resources, it was clear that the situation in both regions had morphed significantly in the short time since they had been written.

can be offered to patients, but also because it provides the HIV Fund with premises, and the HIV Prevention Centre with an associated NGO through which they can be included on internationally funded programmes (HIV Fund 2000: INT). It was through the HIV Fund that the AIDS Prevention Centre was included on the large-scale harm reduction programme which was ongoing at the time of data collection (see Diagram 5.1).

However, "pure" NGOs did not just co-operate with established state structures. The growing drug problem had become a hot political issue in both regions, particularly in the run-up to elections, but this only appeared to impact significantly on third sector activities in Ekaterinburg, where the blurring of anti-drug NGOs with political parties was a significant feature of the situation. As the main period of fieldwork in Sverdlovsk oblast took place during local and national elections this politicisation of the drug problem in Ekaterinburg may have been temporary. However, six months after the elections it was found that the two NGOs that had been donated facilities by political parties were still being supported by them. 'Living Thought' had been allowed to use the offices of a local Communist Party faction, although the leadership of 'Living Thought' claimed no political allegiance to the Communists. The impact of this co-operation could not really be assessed however as 'Living Thought' had yet to access sufficient resources to enact their experimental community-development programmes.

Rubicon was a similarly small NGO which was given shelter by a more established political party – "Our Home – Our City", the party of Ekaterinburg Mayor Chernetsky. Prior to this co-operation Rubicon was very much a one-person organisation, and it operated without offices or a telephone. Both of these had been provided through "Our Home – Our City" and this had allowed for some expansion. Rubicon's main way of working was by giving a series of Saturday morning lectures to volunteer teachers and concerned parents to empower and enable them to tackle drugs education in schools. Co-operating with "Our Home – Our City" allowed Rubicon to distribute information packs, though the logos of both Rubicon and "Our Home – Our City" appeared on the letterhead (see, for example Rubikon (with Nash Dom – Nash Gorod) Ekaterinburg: Rubikon 2000). A party representative did also come along to the lecture just before the elections to encourage participants when

voting to remember who took the drug situation in the city most seriously (Rubicon 2000: OBS).

The importance of having a 'roof' was also demonstrated by a more sinister development in the politicisation of drugs education in Sverdlovsk oblast, which seemed to follow a speech by Governor Rossel' calling for civic help in the war against drugs as the police could no longer cope.[10] "City without Drugs" (CwD) in Ekaterinburg originally worked in kindergartens and with youth groups trying to provide children with healthy alternatives to drug use through sport. This led to one high profile sailing regatta, which received a large amount of media publicity locally. However, it was not until after CwD (Ekaterinburg) was subject to a hostile take-over by a local criminal organisation that it gained notoriety in both the national and even international media for its vigilantism and hard line against drugs and drug users.[11] Initially, the new incarnation of CwD (Ekaterinburg) rose to Rossel's call by setting up a telephone hotline so that local residents could report drug dealers operating in their area. The reported dealers were then often beaten up and as a group dealers became genuinely afraid of CwD (Ekaterinburg). CwD (Ekaterinburg) were also involved in a rally held in the 'Gypsy Quarter' of Ekaterinburg in order to intimidate the Roma population living there, CwD (Ekaterinburg) argued that the Roma were the main suppliers of drugs to the city's youth.

The criminal organisation active in the later CwD (Ekaterinburg) was also linked (by personnel) to a new political movement, the Uralmash Social-Political Union (UPSU), whose leader, Aleksandr Khabarov, was a candidate in local elections to the Federal Duma. The original founders of CwD (Ekaterinburg) felt that their organisation had

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[10] Due to the nature of the information in this section on CwD (Ekaterinburg), most was provided off-the-record by respondents in different organisations active in Sverdlovsk oblast, however information from published media sources has been referenced in full. Due to the links with organised crime, the later incarnation of CwD (Ekaterinburg), CwD (Pervoural'sk) and CwD (Perm') were not approached for interview, although a brief interview with CwD (Saratov) was conducted, as the researcher initially did not realise it was affiliated to CwD (Ekaterinburg). The data from this interview was limited as many questions, particularly around the funding of activities, seemed unwelcome.

[11] For Russian press coverage see, for example, Avdeev 1999; Skaibeda 1999; Varsegov 2001. UPSU and CwD (Ekaterinburg) have been the subject of articles in The Sunday Times (Franchetti 2001) and Der Speigel (Shedrova 2001) and a documentary on BBC Radio 4 (Whewell 2000). All this coverage has detailed the extremely brutal treatment of drug users, and the links between UPSU, CwD (Ekaterinburg) and organised criminal groups. However, the story of how a genuine community development programme was hijacked by criminals does not seem to have been covered in local, national or international media.

been taken over so that it could be used to create good publicity for UPSU in the run up to the elections. The hard line on drug dealing was certainly popular, though it did not secure the UPSU candidate's election to the Federal Duma, and 'none of the above' secured many more votes. From March 2000 CwD (Ekaterinburg) became involved in the forced treatment of drug users instead. As an election vehicle CwD (Ekaterinburg) thus seems to have proved unsuccessful, but it has since actually expanded throughout the RF. There is now a filial in Saratov, and they were looking to set up a treatment centre in Saratov oblast along the same lines as the one in Ekaterinburg – combining a tough regime with physical exercise and Orthodox prayer (CwD (Saratov) 2000: INT). There were also filial organisations in Perm' and Pervoural'sk, which were running the 'shop-a-dealer' hotlines. The speed at which CwD has expanded and networked is alarming; for example arguably the biggest drugs related NGO in Russia, NAN, has taken over five years to develop filial organisations in provincial regions.[12] The influence of organised crime on the voluntary sector was most extreme in the case of CwD, but many other NGOs in the field complained of criminal interference in their activities. Often the interest from criminal groups, which were potentially involved in drugs trading, was explained by respondents working in NGOs as being symptomatic of the effectiveness of their anti-drugs work – it was a sign that the dealers were worried they would lose their clients.

It would seem that NGOs often find it easiest to function if they are provided with a "roof" for their operations. This is not just because it increases the potential for finding finance, and aids passage through the bureaucracy, but also because it provides protection from unsolicited interest. The "roof" can be provided by a Western funding partner or grant, but as shown above, it is more usually a state sector organisation or, in Ekaterinburg, a political party. However, the impact of organised crime is a serious issue for the development of the voluntary sector in Russia for many of the same reasons that it is a serious issue for the development of democratic government and the market economy. In terms of the potential for community development and community empowerment, the micro level impact of such

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[12] The President of NAN, Oleg Zykov, hoped the organisation would expand into the regions back in 1997 (Zykov 1997: INT); NAN (Saratov) was founded in 1999 and at time of writing there were approximately fifty filial NANs registered, or in the process of registering, including one in Ekaterinburg. For more information on the background and activities of NAN and Russia's self-help movement see Richardson 1999 and the NAN website http://www.nan.ru.

influences could be catastrophic. In the case of CwD (Ekaterinburg), a genuine grassroots organisation with an army of committed young unpaid volunteers was effectively hijacked. The interview with an original CwD (Ekaterinburg) founder was disturbing not just because of the personal stress and ill health that the take-over had caused for this individual and their family (who had been threatened), but also because of the disillusion with the whole idea of community involvement it had planted.

The Society for Temperance and Health – a born again NGO

Of the NGOs and QuaNGOs encountered, only the Society for Temperance and Health (STH) viewed official involvement with state structures as problematic. While other organisations even saw a state "roof" as desirable, the oppositional nature of the STH meant they actively avoided integration. This is particularly important in historical terms as the STHs are former QuaNGOs, in that they grew out of the AVSSS set up by the Soviet state during Gorbachev's anti-alcohol campaign. The temperance movement is not homogenous, but political lobbying is central to its activities. The importance of the STH in Saratov should not be underestimated; it was not on the margins and participated in roundtables on co-ordinating anti-alcohol and anti-drug efforts. This needs to be emphasised as in other parts of Russia (and the world) temperance movements can be highly marginal. The organisation's history as a QuaNGO meant that the STH (Saratov) inherited the buildings and other resources which they were allocated in the late Soviet era.[13] Although the STH (Saratov) had to engage in a protracted fight with the Mayor of Saratov, it has kept its building in a sought after central location. They won by staging high profile demonstrations accusing Mayor Arsenenko of putting personal profit above the health of Saratov's youth (STH (Saratov) 2000: INT).

Another Soviet legacy is that the STH in Saratov still has access to facilities for the production and dissemination of educational materials. Due to financial constraints however, the STH is now confined to producing only the monthly free newspaper "In Opposition" (*Vopreki*). However, the influence of the society's history as a Soviet

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[13] The Moscow central League of Temperance and Health has only just lost the fine and centrally located building they were allocated in 1985.

organ is more fundamental. As shown in Chapter 2, the AVSSS was born out of national patriotic oppositional *neformaly* groups.[14] As the title of the Saratov STH newspaper would suggest, the post-Soviet temperance movement has returned to its roots. Many of the articles in "In Opposition" are highly critical of local, regional and national power structures and policy, and many of the opinions expressed are national-patriotic in sentiment. However, the degree to which different temperance societies are allied to the national-patriotic movement varies. In 1990, when the temperance movement in the Soviet Union split into more moderate and radical wings, the individual societies decided for themselves with whom they would ally – radical Uglov in Leningrad or moderate Astafiev in Moscow. Although the Saratov branch of the AVSSS agreed with most of Uglov's theses, it was felt they could not join him as he was too much of a "chauvinist", i.e. he only cared about the health of ethnic Russians (*russkie*) and not all Russian citizens (*rossiiskie*) (STH (Saratov) 2000: INT). Therefore, whilst this 'branch' of the temperance movement was still networked with like organisations in Russia, it actually chose to remain independent.

What's in a name?

Unlike the names 'City without Drugs' or 'Society for Temperance and Health', which did seem to indicate the organisation was networked with organisations that had common practices and philosophies, other names such as 'Mothers against Drugs'; 'Youth against Drugs' and 'Sotsium' did not necessarily indicate any commonalties.[15] As a name, 'Mothers against Drugs' was by far the most popular, though all the current and former 'Mothers against Drugs' NGOs were individual and were in no way networked and nor did they share similar histories. 'Mothers against Drugs' (Nizhnii Tagil) as a support group for the families of drug users grew out of the organisation 'I, You, He, She' which specialises in the treatment and rehabilitation of drug users. The founder of 'I, You, He, She' delegated the running of this organisation to a colleague in order to concentrate on building up 'Mothers against Drugs' (Nizhnii Tagil) (Mothers against Drugs (Nizhnii Tagil) 2000: INT). The

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[14] '*Neformaly*' means "unofficial" organisations and refers to a number of social and political movements that evolved in the USSR in the 1970s and 1980s. They were "unofficial" because they were outside Communist Party structures and control.

[15] Organisations called 'Sotsium' were encountered in Saratov, Engel's, Pervoural'sk and Perm. The name derives from the Latin '*Socium*' meaning joint, common or associated. The name therefore refers more to their role in 'civil society' than specific drug or alcohol related activities.

driving force behind their activities was the pain of dealing with a problem drug user in the family, whereas 'Mothers against Drugs' (Ekaterinburg) and 'Parents against Drugs' (formerly 'Mothers against Drugs') in Saratov were founded by professional narcologists and psychologists as support groups for patients and their families.

'Youth against Drugs' (Ekaterinburg) is an NGO, which specialises in schools based anti-drugs education developed from a form of psychological training. In spite of its name it was founded and is led by adult professionals. 'Youth against Drugs' (Ekaterinburg) also had a filial organisation in Pervoural'sk, but this organisation is now a separate entity called 'Pervoural'sk against Drugs'. 'Pervoural'sk against Drugs' continues to work along similar programme lines as their ex-parent organisation, but now have more independence to apply for grants to develop their training capacities (Pervoural'sk against Drugs 2000: INT). 'Youth against Drugs' (Saratov) was, by contrast, a genuinely youth led and youth developed initiative which set out to challenge accepted norms around drug use in order to make young people (mainly higher education students) think about whether drug use was something they really wanted to do (Youth against Drugs (Saratov) 2000: INT). However, the leaders of this organic peer education project were all final year students in higher education, and when they finished their courses the project folded.

The Religious Organisations

In Sverdlovsk oblast, religious organisations also appeared to be significant actors in substance misuse related health work though there were no religious organisations visibly involved in drug, alcohol or solvent misuse work in Saratov oblast. In Ekaterinburg and the surrounding area a US evangelical Christian organisation was involved with the rehabilitation of drug users and the local Church of Jesus Christ and the Latter-day Saints (Mormons) had developed an anti-drug puppet theatre production to tour local schools and children's establishments. The Mormon puppet theatre production was the only drugs education that respondents in the youth detention centre could remember having received.[16] However, the most active religious organisation in the field was the Unification Church (Moonies) through its

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[16] A youth detention centre in Ekaterinburg was visited in order to access the voices of homeless youth, as 'street children' had been observed by the researcher actively engaged in solvent misuse in different parts of the city.

NGO 'The Federation' which was visible throughout the Urals region.[17] For example, 'The Federation's' newspaper, "The Urals Herald" (*Ural'skii vestnik*), which targets young people with information and news about moral propriety and the importance of the family, was found to be available from young activists on the street in both Ekaterinburg and Perm'.

'The Federation's' main work in health promotion was organising anti-drug rallies and concerts in partnership with local administrative structures (usually municipal level Youth Affairs or Education Committees). As a consequence of working in partnership with local administrations, the rallies were positively endorsed by local political elites. Indeed accruing legitimacy through political channels appeared to be very important; the collection of the official signature and stamp from the partner in the local administration was essential.[18] The impressive document, which bore all the stamps, showed that 'The Federation' was indeed active throughout the Urals region, reaching out to many of the smallest towns. However, the religious organisations encountered in Sverdlovsk oblast did not appear to be networked in with other organisations active in the field of health promotion, even though 'The Federation' was, theoretically, in itself a network of groups. Rubicon had previously worked with 'The Federation' on initiatives, but then moved away from the group because they were a "cult". The split was a difficult one and the respondent from Rubicon asserted that it had taken a long time for Rubicon to actually break free (Rubicon 2000: INT). Representatives from 'The Federation' had also been on Holis training courses, but when organising their festivals and activities they only ever worked in conjunction with local administrations as this was most effective (The Federation 2000: INT).

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[17] Whilst current laws on the registration of religious groups in Russia may well have made it difficult for the Unification Church to operate more directly, operating through front organisations, which are not necessarily directly related to the religion but espouse some ideal with which non-church members may agree, is a common practice within Unification Church movements (Benner 1999).

[18] Personal observation at rallies. The Unification Church has also vigorously pursued legitimacy from political structures in the US and Korea by making donations to evangelical and political conservative organisations (Benner 1999).

5.3 Explaining Health Sector Dominance

Health promotion is a project which necessarily includes a wide range of both state and non-state actors. In Russia there are state actors that have been officially charged with the task of improving the health of the population through education. As discussed in Chapter 2, generally this has not been seen as the task of the official education system, but rather the health care system. The main state actors in health promotion are thus, theoretically, the preventive medicine centres. However, with substance misuse, the work of the state narcological system and the AIDS prevention centres is also significant. The narcological system has been shown to be home to the self-help movement in Russia (Richardson 1999), and the AIDS prevention centres have been significant actors in the Western funded harm reduction initiatives (see Diagrams 5.1 and 5.2).

Mapping actors in the state health care system

The financing of health care has been increasingly decentralised in post-Soviet Russia since the 1992 health funding reforms, which passed the state funding of health care to oblast and municipal level (Stephenson et al. 1998: 6). The impact of this on the preventive medicine system is shown in Diagram 5.5. Other reforms to the preventive medicine system in Russia have been made throughout the 1990s as part of a WHO led initiative to rationalise and update provision. The sanitary instruction buildings (*doma sanitarnogo prosveshcheniya*) became preventive medicine centres (*tsentry meditsinskoi profilaktiki*) and were merged with the physical therapy clinics (*vrachebno-fizkul'turnye dispansery*). However, this concentration of resources and state driven 'symbiosis' has not had so much of an impact as the decentralisation of financing such services. This decentralisation has made the preventive medicine centres subject to the oblast or municipal authorities in terms of both their funding and activities, and where health promotion services have been deemed low priority, many units have been closed down. This is particularly true of health promotion units based within hospitals and polyclinics in rural districts as these institutions manage their own budgets and are not bound to maintain all services; when cuts need to be made prevention work is considered low priority compared with acute therapeutic services (Sverdlovsk OPMC 2000: INT).

Diagram 5.5: The State Health Promotion System

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                  ┌─────────────────────┐
                  │  MINISTRY OF HEALTH │
                  └─────────────────────┘
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          ┌──────────────────────────────┐
          │  STATE CENTRE FOR PUBLIC      │
          │  HEALTH PROBLEMS              │
          │  (PREVENTIVE MEDICINE         │
          │  DEPARTMENT)                  │
          └──────────────────────────────┘
                             ▲
                             │
               ┌──────────────────┐
               │  OBLAST          │
               │  PREVENTIVE      │◄──────┐
               │  MEDICINE        │◄────┐ │
               │  CENTRE          │◄──┐ │ │
               └──────────────────┘   │ │ │
                        ▲             │ │ │
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               ┌──────────────────┐   │ │ │
               │  MUNICIPAL       │   │ │ │
               │  PREVENTIVE      │   │ │ │
               │  MEDICINE        │   │ │ │
               │  CENTRE          │   │ │ │
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                    ┌──────────────────┐ │ │
                    │  PREVENTIVE      │ │ │
                    │  MEDICINE        │─┘ │
                    │  DEPARTMENT      │   │
                    │  (IN HOSPITAL)   │   │
                    └──────────────────┘   │
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                         ┌──────────────────┐
                         │  PREVENTIVE      │
                         │  MEDICINE        │──┘
                         │  SURGERY         │
                         │  (IN POLYCLINIC) │
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                              ┌──────────────────┐
                              │  SANITARY        │
                              │  INSTRUCTOR      │
                              │  (IN VILLAGE     │
                              │  SURGERY)        │
                              └──────────────────┘
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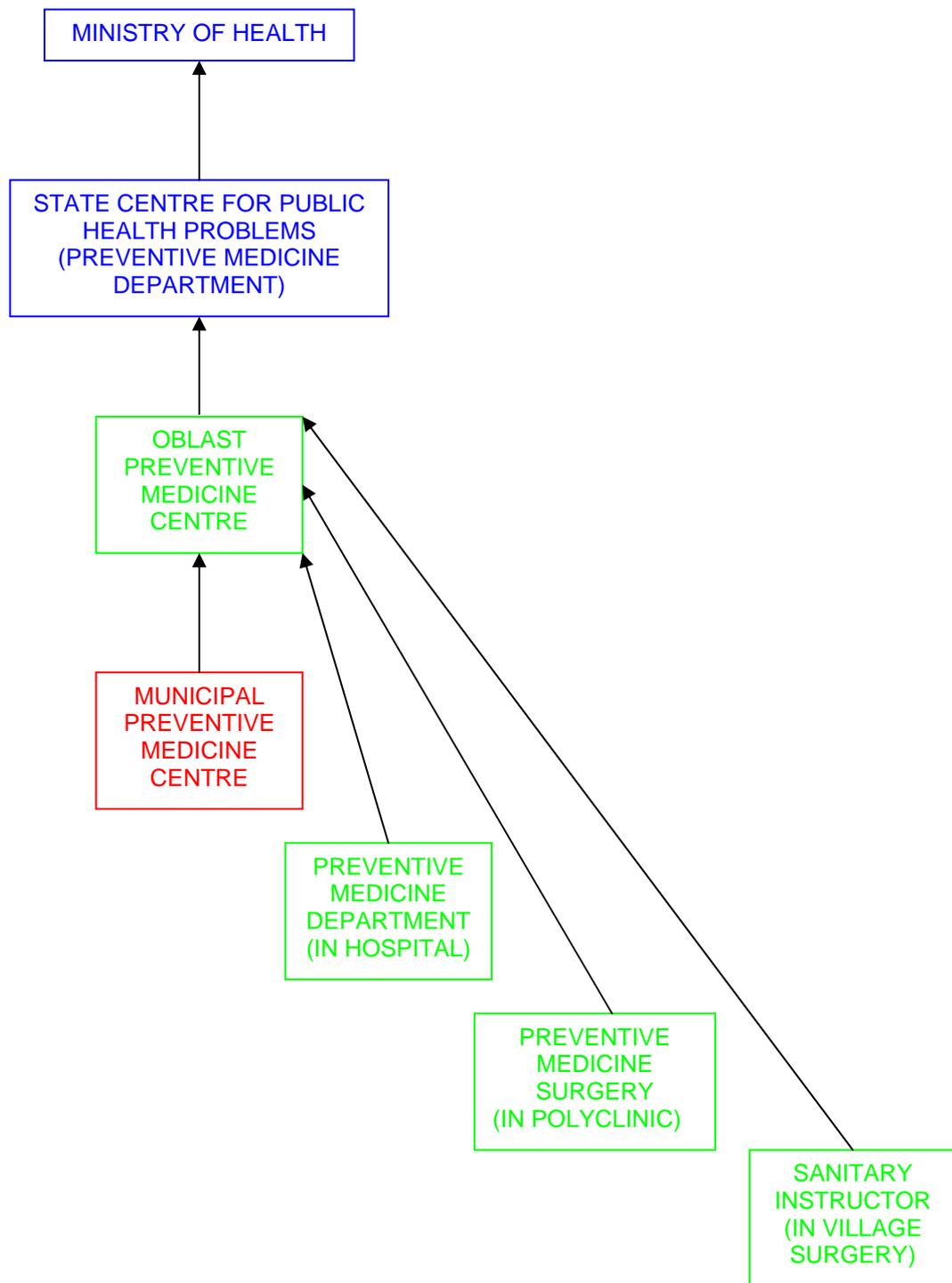
Diagram 5.5 shows how the state health promotion system is structured in both Saratov and Sverdlovsk oblasts. The different colours reflect the different sources of

state funding for the health promotion work. Those in blue are funded from the federal budget, those in green are funded from the oblast health department budget and those in red are funded by the municipal health department budget. The vertical positioning of the text boxes show the relative geographical size of the unit's field of activity, from federal level at the top through oblast and then municipal levels down to small town and rural provisions which are generally small departments within larger health organisations. The arrows indicate the flow of quantitative information on health promotion work that has been carried out by the unit over the past quarter / year. The information flow shows the influence of the old hierarchical system, all the units must in effect report to central authorities in Moscow, and their activities are subject to ministerial directives, even though the Federal Ministry of Health does not directly finance their activities. Ministerial directives theoretically have to be followed, but as funding was not controlled by the centre, resources for the completion of directives could not be guaranteed. Therefore the most important source of directives were actually the local power structures (Sverdlovsk OPMC 2000: INT; Saratov OPMC 1999: INT). The monthly, quarterly and annual reports on activities prepared by all the centres are therefore copied to both 'authorities' – the federal Ministry of Health via the oblast centre and their local source of funding, the oblast or municipal health department (Sverdlovsk OPMC 2000: INT).

These reports in themselves reflect the Soviet way of measuring success – they are entirely quantitative in nature (how many lectures given, leaflets distributed / published, etc.) and non-reflexive, i.e. there is seemingly no attempt to evaluate the impact of any interventions – quality is not of relevance in this form of evaluation. As in education and welfare, it is the state institutions which seem to bear the imprint of Soviet administration most strongly (Thomson 2001). However, this does not mean that practitioners in these state units were unaware of the necessity to engage in qualitative evaluation. The best funded unit found in the fieldwork (the Sverdlovsk OPMC) did aim to involve target audiences in developing new materials, and was looking to develop ways of measuring the psychological impact of materials, but in the municipal centres visited this was not financially feasible (Balakovo MPMC 2000: INT; Engel's MPMC 2000: INT; Nizhnii Tagil MPMC 2000: INT). One respondent from the Balakovo MPMC was acutely aware of the limitations of not only such

evaluation but also the primary methods of working (giving lectures to young people). However, the respondent also pointed out that to develop other programmes would inevitably require extra funds, if only to produce leaflets for dissemination in the training of volunteers.

The same difficulties were not faced by the AIDS prevention centres (*tsentry za bor'by protiv SPIDa*), which are similarly organised geographically, i.e. there is an oblast centre and municipal centres in the larger population centres and clinics (*dispansery*) in smaller towns. The system is similarly hierarchical and the oblast centres are responsible to a Federal Centre in Moscow, but significantly, the whole system is paid for directly out of the federal budget because AIDS is considered an 'especially dangerous disease' and thus too high a priority to be decentralised. The AIDS prevention centres therefore enjoy a 'special' status within health care. However, in spite of the name, the AIDS prevention centres until very recently have acted more as monitoring stations, conducting routine and elective HIV testing and collecting epidemiological statistics in order to trace infection routes and monitor the spread of HIV/AIDS through the population (see Williams 1995). Where AIDS prevention centres have been involved in health education work it is usually in giving lectures on the dangers of HIV/AIDS at the invitation of other organisations. They have been more significant as sites for needle exchanges in the harm reduction programmes, as the AIDS prevention centres theoretically have all the protocols and equipment in place for the safe disposal of potentially infected materials.

The state narcological services were also involved in the Western funded harm reduction programmes as sites for needle exchanges (in Engel's and Balakovo) and as influential project partners (in Ekaterinburg).[19] However, in terms of health promotion through empowerment, the most important role the state narcological services played was as a base for the self-help movement, namely AA/NA groups. AA groups were better established in both regions than NA groups and organisers put this down to the youth of the drug addicts compared with the alcoholics (AA/NA (Ekaterinburg) 2000: INT; Harmony 2000: INT). As outlined above, the QuaNGOs

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[19] The chief narcologist of Ekaterinburg city appeared to be a highly influential and powerful man who had strong links with local power structures. He was the only doctor encountered during the fieldwork who had both a chauffeur and bodyguard.

were also homes for groups following the 12 Step methodology, but the AA/NA groups based within narcological services had greater access to potential members who were new to the system. AA/NA organisers in Ekaterinburg, for example, were allowed access to the wards where, unlike the therapeutic services offered by the QuaNGOs, in-patient treatment was often mandatory rather than purely elective. On the whole, however, the self-help groups in Saratov and Sverdlovsk oblasts seemed more integrated with QuaNGOS and NGOs than with state health care services. This was different to the findings from Moscow in 1997, which showed much greater interaction between the self-help movement and state health care structures which blurred the line between state and non-state actors (Richardson 1999: 27).

Surviving the Russian health care crisis

The state preventive medicine system may be seen as highly traditional in its approach, particularly to health education. The basis of their work, as reflected in the quantitative reports they need to produce, is giving lectures to encourage behaviour change; setting up press conferences as well as producing and distributing leaflets and posters, the philosophy behind which is discussed in Chapter 6. However, through the 1990s the services which the preventive medicine centres have generally been able to provide have been constrained severely by their access to adequate funding. The decentralisation of the system and differences in funding levels (and the reliability of the source of finance) has led predictably to quite wide variations across Russia in the way state health promotion services can operate. In both regions preventive medicine centres, departments and surgeries had been closed down due to short-term financial considerations. For example, Saratov now has no MPMC, although Balakovo and Engel's both do – they are supported out of their respective municipal budgets. Saratov OPMC was still in existence during the fieldwork period, but it was chronically underfunded and has had problems with attracting and retaining staff. Similar staffing problems were felt at the MPMC in Ekaterinburg – one reason being that their wages were lower and less regular than those of the staff in the Sverdlovsk OPMC (Ekaterinburg MPMC 2000: INT).

The Sverdlovsk OPMC was visibly the best resourced of the preventive medicine centres visited during the fieldwork (Sverdlovsk OPMC 2000: OBS). Indeed as a unit it had a reputation for being highly innovative in the materials it produced (Saratov

OPMC 1999: INT). The Sverdlovsk OPMC had a video-editing suite and produced short, high quality health education television advertisements (*klipy*), but it was not always possible to convince the now private television companies to run them. The Sverdlovsk OPMCs approach to health education was that it had more in common with advertising than with medicine, and consequently many of the staff actually had a background in journalism and marketing rather than formal medical training (Sverdlovsk OPMC 1999: INT). They were the only organisation encountered that carried out focus group work with target audiences in order to assess the efficacy of their work (Sverdlovsk OPMC 2000: INT and OBS). Such imagination and abilities were not lacking in other preventive medicine centres, but adequate resources were. Respondents complained that they knew their materials were out of date – some around substance misuse dated back to Gorbachev's anti-alcohol campaign – but they could not afford to develop or buy new materials (Balakovo MPMC 2000: INT).

From this it is clear that the changes in the way health promotion services are funded has also had an impact on the ability of centres to access health educational materials. Previously, materials were developed at a national, republican or oblast level and then disseminated (free of charge) to the smaller units. Currently, any materials developed at a 'higher' level have to be bought by smaller units. Consequently other units are aware, for example, that Sverdlovsk OPMC produces high quality health education videos, but they cannot actually access these materials. Therefore smaller units are accessing and developing materials in different ways, without necessarily respecting national or international copyright. Smaller units have also economised by using human resources more intensively by doing more health education lectures direct to the target audience (as opposed to training lay or other professional people to do this work, which usually necessitates the dissemination of teaching materials). Press conferences were also listed as a cheap way of disseminating information, but it was not always easy to get the journalists to attend, particularly in winter (Saratov OPMC 1999: INT). Other ways of economising included organising poster competitions in schools, making hand-drawn posters and stencilling 'posters' onto municipal walls by bus and tram stops, as observed in Ekaterinburg. Although state health promotion services in Sverdlovsk oblast appeared to be on average better supported and funded by local administrations than those in Saratov oblast, in both regions, centres had had

to diversify their sources of income and develop innovative ways of providing health education with very limited monetary resources.

Some centres did look to work in partnership with well-financed NGOs or international actors, though at the time of the fieldwork only the Sverdlovsk OPMC had managed to get involved in a well financed programme – the KHF funded needle exchange project. The preventive medicine system therefore appears to have kept itself afloat through the crisis in Russian health care in much the same way as the rest of the system has. In all of the preventive medicine centres visited, a range of for-profit services were on offer. These ranged from health checks (Nizhnii Tagil MPMC) to psychotherapy (Sverdlovsk OPMC) and courses in food hygiene (Saratov OPMC). This was not deemed unusual by staff at the centres, possibly because Russians are used to paying for health care. Payments for services are a common feature of the contemporary health system in Russia, as they were in the Soviet Union. Although nominally free to all, in reality adequate health care could only be accessed through connections or 'bribes' to supplement doctors' extremely low wages (Shapiro 1997: 171). These 'bribes' have now become institutionalised as payment for services and most state facilities have price lists for services on display and they reflect general market principles of supply, demand and the customer's ability to pay. The provision of treatment services to problem drug and alcohol users is a good example of this; it is generally cheaper to be treated for alcohol addiction than it is for drug addiction, although there is often very little actual difference in the detoxification or therapeutic process (VSO2 2000: INT). The provision of 'for-profit' services by the preventive medicine centres was then consistent within the context of a health care system which is *de facto* no longer free or universal.

The marginalisation of preventive medicine?
The preventive medicine structures tend to be overlooked as actors in the field of health promotion. For example, they are not routinely included in health interventions led by international actors. Balakovo MPMC was included in the USAID/Soros funded harm reduction project in Saratov oblast as a site for one of the needle exchanges. However, this was as a result of its convenient central location and medically trained staff rather than as a way of including state health promotion structures. The KHF funded needle-exchange project in Sverdlovsk only included the

OPMC in the later stages of implementation, after many requests (Sverdlovsk OPMC 2000: INT). Inclusion in a large Western funded project has clear financial benefits, but it also confers greater status on the participating organisations. The 'marginalisation' of state health promotion structures in different projects is not necessarily a reflection that international organisations do not want to work with these state structures. Their exclusion of the preventive medicine centres in project development is, rather, a reflection of the way state health promotion structures have been marginalised more generally in federal, oblast and municipal programmes. In both regions the 'state foundations' which are largely post-Soviet phenomena separate from the state health care system, were central to health promotion initiatives in the field of substance misuse.

Although the state health care system has been marginalised in health promotion through the rise of the QuaNGO rooted in therapeutic psychology, this does not mean necessarily that the medical model has been marginalised. Professional medical opinion still shapes the way substance misuse as an issue is approached, as therapeutic psychology services are rooted in biomedical sciences. The QuaNGOs were run by medical personnel who also organised the self-help groups. Many of the respondents from both QuaNGOs and "pure" NGOs had begun their activities in the field of substance misuse as 'lay activists'. However, since getting involved, they had either qualified as psychologists or were in the process of becoming qualified (for example, HIV Fund 2000: INT; Harmony 2000: INT; New Time 2000:INT). Indeed, when other organisations assessed the work of their peers, the professional status of the key activists was deemed to be very important (HIV Fund 2000: INT). One reason for this would be the dominance of the medical model in society which means that potential sponsors are more likely to trust medically qualified people to carry out health interventions. Having a recognised qualification is thereby deemed more important than having direct or practical experience of problematic substance misuse.

For those lay people who professionalised, the process was clearly a means to self-empowerment. The direct or practical experience of problematic substance misuse was 'validated' by the addition of a professional qualification and this enabled them to mobilise more effectively as they were taken more seriously. It has also enabled parent groups to offer professional counselling services to drug users and their

families and thus fill some gaps in provision. In this respect professionalisation may be seen as a mobilising factor in the development of some NGOs, even though it does not necessarily support the incorporation of lay opinion into health interventions. There was little evidence in the two research regions that marginalised groups, such as IDU or people living with HIV/AIDS, were mobilising to form their own interest groups to promote their own health. However, there is also little evidence from either region that such groups would be able to avoid significant legal and practical barriers.[20] The prejudice that such marginalised groups face also means that their opinions may not be deemed valid or important by decision makers.

The lack of any self-advocacy amongst drug users has significant implications for the development of harm reduction initiatives in Russia, for example, as a tool for harm reduction in Western Europe and the US, needle exchange and outreach began as non-state grassroots initiatives (Lane et al. 2000). Both Western-led harm reduction projects in the research regions (see Diagrams 5.2 and 5.1) worked largely with state structures and had found it hard to identify NGO partners who were able to do outreach work to access IDUs who were not yet 'in the system'. Instead, both projects made links with the QuaNGOs rooted in youth psychological services, and outreach workers were recruited from young people who had had contact with these psychological services through their drug problem. The lack of any mobilised groups within drug using communities in Sverdlovsk and Saratov oblasts meant that outreach and needle exchange had to be a part of an entirely top down process, from which active IDUs were largely excluded. The lack of an organised voice in either region meant the client group was not actually a partner in either project, but instead were the subjects of health interventions from above.[21]

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[20] In a focus group of IDUs in Balakovo (June 2000) the most common problem they all faced was illegal police activity. The high probability of police interference was cited as the main reason why drug users were unlikely to mobilise.

[21] New Time, although still a very much professional-led organisation, was more of a 'grassroots' initiative in that the mobile needle exchange it started was not initiated or funded by international donors. In terms of third sector development this was an important and difficult feat; the bus was run by volunteers and the money for repairs, sterile injecting equipment and general running costs were raised locally. It gained from the KHF project in that this programme had smoothed the way for such initiatives with the local law enforcement agencies, so New Time only had to come to an agreement with the vigilante group CwD (Ekaterinburg). The 'know-how' was accessed through Médecins sans Frontières (Moscow) and "*Vozvrashchenie*" [Return] (St Petersburg).

Although outreach work is also the most effective way of accessing the widest range of IDUs with an intervention, outreach work in itself can be an empowering thing both for individuals and for marginalised drug using communities (Burrows 2000). In the absence of real interest groups, the outreach workers were the only real link with drug using communities, but those outreach workers interviewed felt that their opinions and input were not taken seriously because the decision makers on the Russian side still viewed them either as 'junkies' or patients in remission. At an intersectoral planning meeting for the KHF project, outreach workers, as representatives of the client group, were notably absent. It could also be argued that the outreach workers were not taken seriously because they were not seen as qualified, they were neither doctors nor psychologists in a highly professionalised and professionalising field. Consequently it is clear that in spite of the marginalisation of state preventive medicine structures in health promotion in the field of substance misuse, interventions are still top-down and professional-led. The shift has not been away from biomedicine, but instead has been towards the greater emphasising of psychological explanations and solutions to problematic substance misuse (see Chapter 6).

5.4 Local, National and International Factors

In social policy theory, the intermediary realm or third sector is deemed an important space for innovation in service provision. NGOs are considered more flexible and are less bound by regulations than state actors so are in a better position to experiment in finding different solutions or approaches to social, educational and welfare issues (Evers 1993). Health promotion theory, like social policy, also looks to non-state actors as the key to developing healthy public policy and health interventions not just *for* people but *with* them (Trojan et al. 1991). The extent to which this is happening in post-Soviet Russia is discussed above, the factors which have shaped the current 'map' of actors are discussed below. The key feature of how the responsibility for health promotion around substance misuse has shifted away from official state organs to quasi-state organs, has not been the result of any single factor. Significant influences on the way health promotion develops can occur at different levels – local, national or international.

Local level factors

Local factors relate largely to the openness of the local administration (at both a city and oblast level) to new ideas, the extent to which they trust, support and encourage non-state organisations and international actors. Although Western funding bodies wield significant power in their ability to influence the direction and development of health promotion initiatives or indeed the non-state organisations themselves, through their position as a key source of funding for such initiatives, even they are entirely subject to local power structures. Therefore the necessity of getting local power structures 'on side' was emphasised in interviews with representatives of Western organisations working in both the research regions. Local power structures include the executive branches of the oblast and municipal level administration, the police and the tax authorities. The inclusion of the tax authorities may seem unusual, but the vagaries of Russian tax law at a local and regional level essentially make it possible to close down any organisation at any time. During the fieldwork period, one Western NGO was subjected to a raid by a local fully-armed tax police unit and subsequently fined a significant amount of money for 'irregularities' in their registration. The tax police brought with them a camera crew from a local television station in order to publicise how foreign 'companies' were defrauding the Russian state.

As was found in the mapping process, many organisations were closely bound into state structures or looking to be; it would seem that it is easier to work with Russian provincial bureaucracy than against it. However, as Stephenson has argued, in many Russian provincial towns, to which foreign grants do not come as often as St Petersburg or Moscow, local authorities can be the main source of funding for projects (Stephenson 2000:289). This was certainly the case in Nizhnii Tagil where all projects revolved around the Municipal Youth Affairs Committee. The smaller towns visited in the fieldwork, such as Nizhnii Tagil, were also of a size which clearly facilitated state-third sector co-operation as everybody seemed to know each other. According to a CAF survey, Russian NGOs put relationships with local authorities above relationships with all other clients and organisations; the NGOs questioned even wanted a strong administration which could consequently support them and end all their troubles (Stephenson 2000:290). Although intersectoral working is a key aim of health promotion, as put forward in HFA 2000, it could potentially curb plurality in

service provision, particularly if local power structures do not encourage third sector development. If NGOs fail to find some degree of independence and establish a support base in the local community first, they risk becoming part of the state machine (Stephenson 2000:290), or being swallowed by their 'partner' organisations.

The reality of state-third sector relations at a local level shows that organisations are either insiders or outsiders and those without good personal contacts with the administration have little protection and little chance of success in securing funding or resources from Russian sources (Thomson 2001:175). Outsider organisations, such as Youth against Drugs (Saratov) or Living Thought in Ekaterinburg, are the ones which fold or have yet to secure funding for their programmes. The necessity of having good contacts is also a severe barrier to the development of a plurality of approaches from a range of organisations, particularly in the smaller towns which generally have just one main 'non-state' actor. In Balakovo, for example, Harmony/NAN (Saratov) reputedly was Balakovo's 'third sector' (Harmony 2000: INT, BMPMC 2000: INT). The answer to such 'stateism' may appear to be the international funding bodies, particularly as the concept of 'civil society' is central to Western aid programmes in Central and Eastern Europe (CEE) (Hann 1996:9). However, as shall be explored below, the organisations that are most successful in working with the state are also the ones most successful in attracting Western funding. Moreover, the underlying ideologies of Western aid programmes actually do little to encourage plurality in service provision.

Local politics can be highly influential if a particular health issue becomes a key political concern. This was demonstrated in Ekaterinburg where, as discussed above, local political parties looked to team up with NGOs working in the field of drugs education. In Saratov, drug use was considered an increasingly important issue, and local politicians went to great lengths to appear at anti-drug rallies etc. (Extreme Sotsium 2000: INT). Shifts in local politics can mean that power structures simply withhold support for programmes or actively oppose them and outlaw them on a regional basis, the best example of this is the Moscow mayor Luzhkov, who unilaterally outlawed the distribution of clean injecting equipment to drug users.

Federal level factors

Federal level factors influencing the development of health promotion programmes include the influence of ministerial decisions and directives, even though these are not always followed at a local level. For example, the Ministry of Education's reluctance to get involved in education around substance misuse (or even admit that there was a growing drug problem among Russia's youth) has undoubtedly contributed to the fact that health education is still not on the curriculum of every school. Health education remains under the remit of health care structures and, at a local level, the departments for youth affairs. In both research regions the health departments were much more deeply involved in developing programmes; the contribution of education departments was in providing or withholding their approval for the use of certain programmes in schools.

Another factor influencing the development of health promotion is the legislative framework in which organisations operate. This includes quite fundamental issues around the legal status of NGOs and the lack of provision for 'charitable status' and tax breaks for 'charitable contributions' from businesses (see Dissanayake et al. 1999). However, another good example is the Federal Law on Narcotic and Psychotropic Substances (8 January 1998 [N3-FZ]) which, theoretically, could have restricted the activities of organisations working in the field of substance misuse.

In this law there are articles that insist on the forced treatment of suspected drug addicts (Article 44) and ban all non-state detoxification and rehabilitation clinics (Article 55). Both have clear implications for NGOs involved in the treatment of people with substance misuse problems. However, it is Article 46 which has the greatest potential to impact on health interventions as it makes the dissemination of information about drugs illegal: "The propagandising of narcotic and psychotropic substances and their chemical components, that is, the activity of individuals or organisations in directing the dissemination of information about the ways and methods of cultivation, manufacture and use of narcotic and psychotropic substances and their chemical components and information about where they may be obtained, but also the production and dissemination of publications, mass media programmes or dissemination in computer networks of the indicated information or perpetration of such actions to those aims is not permitted." This section contravenes the

Constitution of the Russian Federation, as it is effectively censorship.[22] However, this paragraph was intended to disarm the Transnational Radical Party, which advocates the legalisation of cannabis, rather than impinge on health education campaigns. However, making it illegal to publish pamphlets, say anything in the mass media or put anything on the Internet which shows people how to prepare different drugs or how to take drugs, effectively bans all harm reduction materials on safer injecting, for example, as it is considered 'pro-drugs propaganda'.

What is interesting is that in actuality the law has not had that much of an impact on the sorts of programmes, which had developed in the two regions. When asked about the legality of harm reduction publications that different organisations were producing, a common response from state, non-state and international actors was to the effect that 'Moscow is a long way from here'. Provided the leaflets were endorsed by state health care structures locally there appeared to be no problem. It was the classification of methadone as an illegal narcotic substance which was cited as the most significant impact the law had had, as it made harm reduction through maintenance drug programmes impossible. Consequently on a day-to-day level, running harm reduction programmes, which included needle exchange, were most closely regulated not by laws but by protocols. The protocols around sharps disposal were put in place and strictly enforced in both regions by the Sanitary and Epidemiological Services (SES). Many of these protocols seemed unnecessary, but the SES had the power to close down needle exchanges if they were not following set protocols. There did not appear to be any mechanism in the system for such protocols, which were set centrally, to be challenged.[23]

The influences of international actors

Both Western funding bodies and INGOs have been categorised here as international actors influencing the way health promotion is developing in the two research regions,

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[22] Article 29 of the 1993 Constitution of the Russian Federation states:
"(4) Each person has the right freely to seek, receive, pass on, produce and disseminate information by any legal method. The list of information constituting a state secret is determined by federal law.
(5) The freedom of mass information is guaranteed. Censorship is prohibited." (the whole Russian Constitution is reproduced in Sakwa 1996, Appendix 3).
[23] Difficulties in challenging SES protocols have been cited elsewhere as an impediment to health care development (see Stephenson et al. 1998), in relation to palliative care it was also a serious problem (VSO1 1999: INT).

as both were key financiers of drugs related health promotion projects. As shown above, state support for NGOs was significant in terms of improving their resources such as office space, but the amount of budgetary funding that went into NGOs and QuaNGOs was, by comparison, low. Local and federal competitions for grants were also important for different organisations, but more for the prestige and official sanction they provided; the grants in monetary terms were usually meagre. As a consequence, many of the organisations interviewed were actually reliant on Western funding bodies and were surviving from one grant to the next. The potential for private sponsorship from enterprises or individuals in either region was still quite low, though all the NGOs had approached businesses for funding. This could indicate that in future 'the market' may become a significant influence on the 'intermediary realm' in Russia, as it is in the West (see Evers 1993, 1995).

Saratov was a target region for USAID, a fund financed by the US government and controlled in its activities by US Congress. USAID is generally more involved in marketisation and democratisation projects, such as business incubators, public administration reform and developing 'civil society' as a counterbalance to authoritarianism, than with social issues, particularly in its guise of the Eurasia Foundation (Eurasia Foundation 2000). The few USAID social programmes in Saratov were administered mainly through the Eurasia Fund, but also through the Washington based INGO PSI. The Soros Foundation Open Society Institute, the only Western non-governmental fund operating in the field, mainly targeted projects in neighbouring Samara where they had regional offices, but had also been active in Saratov oblast, where its drug related initiatives were co-ordinated with USAID efforts, again largely through PSI. Sverdlovsk was found to be a target region for what was the UK government's Know How Fund (KHF).[24] Initially KHF activities focussed on marketisation and democratisation programmes, the transfer of business know-how and support for legal reform to aid the marketisation process, to 'open up' society and to support the creation of a 'civil society' in Russia. However, through impact evaluation KHF has moved further away from supporting marketisation

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[24] KHF was affiliated to the Foreign and Commonwealth Office but at the time of fieldwork it was being moved into the Department for International Development (DfID).

towards more 'socially orientated' projects targeting those that have been hit hardest by economic reform (DfID 2000).[25]

Officially, Western funding bodies focussed on certain regions because, theoretically, the impact should be greater where resources are concentrated. However, lack of provision was also a significant factor in choosing a region, i.e. no one else was already there so the need was greater (Eurasia Fund 1999: INT; KHF 2000: INT). Both Sverdlovsk and Saratov were important centres for different sectors of the military industrial complex, so geo-politics and security may also have influenced the decisions of Western governments; altruism alone is not usually the sole contributing factor in giving aid (see Wedel 1998).[26] The Western funding bodies did not specifically target health issues, and health promotion initiatives were generally viewed as being 'social projects'. In the field of health promotion, all the funding organisations had the common method of working through local partnership programmes. This would appear to be the standard approach to 'helping' Russia (see Bruno 1998). Such partnership programmes were not necessarily as egalitarian as the term may suggest; in reality there is often little information exchange and the main aim is the provision of 'advice aid', which financially benefits the Western 'experts' much more than their Russian 'partners' (Thomson 2001; Wedel 1998).

VSO, like KHF, was substantially funded through DfID, and as a consequence shared DfIDs target regions in Russia (the Urals, Moscow and St. Petersburg); their overseas development aims were also broadly similar. Although it happened earlier, in VSO, as with KHF, the emphasis has shifted away from providing assistance to marketisation through business related placements or English language training to social development placements in order to lessen the negative impact of transition (VSO 1999). The nature of VSO means that it was individual volunteers who had an impact on health promotion in the field of substance misuse rather than the

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[25] It is claimed that Russia is no longer seen as a 'special' case; programmes primarily target 'the poor' as UK government programmes in the developing world do. Russia is now therefore just another country receiving aid from the UK government – as reflected in the reforming of KHF as the DfID Britain-Russia Development Partnership.
[26] One respondent interviewed in Washington DC in 1999, who co-ordinated USAID funded health projects in Russia, explicitly stated that USAID had chosen the Russian Far East as a target region for geo-political reasons.

organisation itself.[27]   However, VSO also helped to shape the way the third sector was developing regionally as they were known to have good links to funding bodies. Many organisations were therefore keen to take on the additional cost of a volunteer (who would be salaried at the going Russian rate) as a way of gaining a progressive reputation which would then facilitate future applications to funding bodies.   As Wedel has argued, Western funding bodies like to work with partner organisations which have been 'tried and tested' (Wedel 1998:188).

PSI also had close links to international funding bodies, although the organisation worked primarily in the field of promoting safer sexual practices through a social marketing programme; in Saratov PSI was also the co-ordinating body for drugs related projects aimed at HIV control funded by USAID and Soros. As with DfID and VSO, USAID had influenced PSIs target regions and development in Russia. The PSI office in Moscow was the youngest, and was set up purely because USAID said it would be easier for USAID if PSI had offices in the capital (PSI 2000: INT).[28] It was also unusual for PSI to be working in the field of harm reduction for IDU, as an organisation worldwide, it is more often concerned with the reduction of sexually transmitted HIV/AIDS.   However, in Russia the need for such interventions was identified as being urgent and it was also recognised that HIV/AIDS transmission through IDU had become a central concern for the Western funding bodies, which meant PSI could attract more funding. In many respects whilst they have more input into decision making, INGOs are no less beholden to the funding bodies than Russian NGOs and live similarly from one grant to the next, having to adapt accordingly. Both VSO and PSI would have liked to be more independent of the political concerns of DfID and USAID respectively. For example, PSI's difficulties with developing harm reduction pamphlets were closely associated with extreme conservatism in the US Congress (PSI 2000:INT), and VSO would have liked to expand activities beyond DfID's target regions in Russia (VSO 2000: INT).

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[27] During the fieldwork period contact pre-departure, during placement and on return was made with a number of volunteers, but only three could be said to have been truly active in the area of health promotion and substance misuse: VSO1 2000; VSO2 2000 and VSO3 2000.
[28] PSI already had offices in St Petersburg, Saratov and Ekaterinburg.

PSI's difficulties in finding sponsors for harm reduction materials reflect the influence the international funding bodies can have on the way health promotion initiatives develop in post-Soviet Russia. The funding bodies have their own programmes for Russia's development and their own priority areas. These programmes might be restricted by the reality of the social, political and economic circumstances in Russia, but in the field of health promotion around drugs they set the scene. The main priority for both DfID and USAID in relation to substance misuse was to control the spread of HIV through intravenous drug using communities. Domestic politics determine whether this includes needle and syringe exchange; the US Congress will not allow American federal tax revenues to fund needle exchange either at home or abroad.[29] However, USAID was keen to fund schools-based health education programmes from a more moralist 'just say no!' perspective. DfID and Soros embraced the harm reduction approach, including needle exchange, however, this harm reduction was narrowly focussed on IDUs and HIV transmission; there were no harm reduction services for drug users who do not inject. The reasons for Western funding bodies focussing on specific issues are easily understood – they too have limited resources, and want to use them to the greatest effect. However, these projects do not encourage plurality, and as discussed above, where IDUs are excluded from the decision making process, they do not encourage lay participation in health promotion.

Russian organisations looking to get Western funding were generally well informed about which funding bodies fund which programmes, and place bids accordingly, adapting their own organisation's ideology to fit the priorities of the funding bodies. Where NGO status was a requirement, an NGO status was acquired. If intersectoral collaboration was a requirement, it was achieved, though often through established networks. International factors contributed significantly to the shape of the third sector, particularly to the development of hybrid identities and QuaNGOs, the QuaNGOs in the two research regions being the main recipients of Western aid in this field. Other local and federal factors have also contributed to the rise of QuaNGOs as the core providers of health promotion in the field of substance misuse.

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[29] For projects around women's health and family planning US Congress also insists that Russian partner organisations sign a declaration saying they will not advocate abortion (PSI 2000: INT; HIV Fund 2000: INT).

5.5 Promoting Change in the Post-Communist Environment

The mapping process showed that there has been a shift in the kinds of actors engaged in health promotion in the field of substance misuse in Sverdlovsk and Saratov oblasts away from the formal health care structures that dominated throughout the Soviet era (see Chapter 2). The field is now dominated by QuaNGOs rooted in psychological support services, which mushroomed in the late Soviet and early post-Soviet era with the support of local governments. These support services were most often linked to telephone helplines and this kept the organisations informed of changes in the nature of social problems people faced.

There are also a number of "pure" NGOs active in the field, and to a certain extent they have developed as a response to specific needs which were not being met by the formal health care system. The community is thus identifying and responding to the needs that it deems most urgent, and this is consistent with the aims of HFA 2000. However, NGOs were found to be severely constrained financially, and in order to fund their activities they often have to instead follow the agenda and priorities of the funding organisations, be they international aid agencies or local government. The more 'successful' organisations, i.e. the ones with the highest profile, are therefore the ones which are most in tune with the will of the financiers; most often this was found to be the QuaNGOs. Other constraints on the development of NGOs included opaque bureaucracy and in Sverdlovsk oblast, interference from organised crime. Although issues such as increasing drug use and HIV transmission have meant greater political commitment to 'doing something', this does not necessarily mean politicians will push for a wide range of initiatives to spring up from a grassroots level. As Parish (1995) argues, the right social climate is necessary to effect social change and governments are rarely the stimulus for social movements but instead usually react to them.

Intersectoral working

As is clear from Diagrams 5.1 and 5.2 not all of the NGOs active in the region were networked – some actively seek to be independent of others and there is rivalry

between organisations, generally due to competition for scarce funds and personality clashes. Some organisations, such as 'Living Thought', were so young that they were not yet aware of other actors in the field – though they were in favour of cooperation. However, intersectoral working was a reality in both regions; some non-state actors had already forged links with formal health care structures, notably New Time and the HIV Fund sheltering in the respective oblast AIDS prevention centres. As Bruno highlights in her analysis of the patterns of operations for Western funding bodies, one of the main aims for internationally funded projects was invariably intersectoral working (Bruno 1998). This was achieved on the two projects encountered, though the intersectoral working was found generally to be based on established networks. The position of QuaNGOs, for example, facilitated relations with the local departments under whom they worked, most commonly the Youth Affairs Committee.

Bruno (1998) has insisted that intersectoral working in Russia is not 'natural', the post-Soviet society is an 'insider' society and networks with inside information are still the main survival strategy (Bruno 1998:184). Information is seen as being of ultimate importance to the West – the free flow of information is needed to gain access to an impersonal market, whereas for Russians, open information loses its value (Bruno 1998: 183). This pattern could certainly be seen with the NGO networking organisations in both regions. For example, in Sverdlovsk oblast the local NGO networking organisation, 'Free Will', acts as a gatekeeper for access to funding bodies – 'tried and tested' partner NGOs are the most successful. 'Free Will' found the partners for the harm reduction project, and 'New Time', which was considered too young and too small, was not one of them. 'New Time' was reluctantly included on the project a year later when they managed to open a needle exchange six months before the KHF funded project did; 'New Time' was therefore only included as an unwelcome partner in the project because they had become unwelcome 'competition'.

Intersectoral rivalries also play a part in which partners are chosen for the international projects. The amounts of money made available through international projects and the 'perks' of foreign trips means that state structures generally do want to be involved and those that wield the most power locally get in. This may well account for the fact that SES units and AIDS prevention centres were included in the international projects whereas preventive medicine centres were not. However, in the

small towns the limited number of actors meant that organisations had to work together and this was not so badly affected by the issues that Bruno highlights as the partners were all known to each other. It must also be added that the problems associated with intersectoral working have been acknowledged as a practical barrier to health promotion in both East and West Europe. In liberal democracies intersectoral collaboration across different power structures for health has few if any precedents (Parish 1995: 23).

Lobbying for change

The decentralisation of the Russian Federation means that in real terms for local NGOs genuine power lies at the local level. This is reflected in the need for organisations to gain recognition for their programmes at a local level and the importance of successfully bidding for local budgetary funds even when the proposed funding is insufficient and the money is never actually distributed. As argued above, local level structures not only have the power to facilitate programmes and projects they see as desirable, but also to close down organisations of which they disapprove. Getting support from the local administration is therefore central to the success of any organisation, more important even than gaining support at a federal or international level. In these circumstances political lobbying for change by local NGOs at a federal level is unlikely to develop. It is also why the women in Pervoural'sk lobbied the municipal administration to set up Sotsium (Pervoural'sk) as a QuaNGO instead of forming an NGO themselves or looking to their representatives in central government. This is a real example of community-based political lobbying for healthy public policy as well as being a demonstration of the very real limitations to NGO development in Russia.

The importance of the local administration in making or breaking a programme increases the relevance of community-based political lobbying for health and it was found to be a large part of the activities of different organisations. For example, at the time of interview Living Thought was in the process of trying to convince the municipal administration of the importance of community mobilisation for health. Organisations that had established links to the local administration or other state structures also lobbied to get more money from the budget to pay for services or to generally put substance misuse higher on the agenda. Such political lobbying

(consciousness raising) was also seen to be within the international funding bodies' remit. However, in spite of the considerable influence the international actors had on the intermediary realm, they were not themselves open to political lobbying from their 'clients' (i.e. the Russians) only from their 'sponsors' (i.e. the tax paying public at home). Russian organisations put in bids for projects for which they see a need, but Western funding bodies will only finance projects that fit their own programme for Russian development. Consequently, getting funding for opening a needle exchange is currently easier than finding international funding to do health education work around substance misuse in schools (HIV Fund 2000: INT). Although these agendas are not locally defined, the Western funding bodies still expect them to be locally sustained after the project end.

Conclusion: The Reality of Community Empowerment?

Community mobilisation around substance misuse is becoming a real feature of the intermediary realm as Russia's drug problem spreads. Political lobbying for healthy public policy is done at a grassroots level and outside formal health care structures, although the solutions are often sought through improving biomedical services. In this respect community involvement in health promotion has not led to any great challenges to biomedicine, beyond the growth in importance of psychology, thus challenging body-mind dualism. Individuals who mobilise for change also need to professionalise and effectively join the medical establishment. The limits to community empowerment and community mobilisation for health are defined by the limits to third sector development in Russia – neither are actually well supported by local power structures.

Political lobbying is also conducted by international actors who seek to influence policy change through partnership programmes. Western funded health promotion programmes are usually short-lived, and a major aim is that the programmes become self-sufficient; by the end of the project a range of different actors should have been brought together, empowered and educated, and a successful programme would be evidenced in the readiness of other actors to fund the activities. Health related projects are not set up to be sponsored forever by the West: this is the basis of advice-aid. However, without real grassroots support Russian politicians are unlikely to fund

these programmes, particularly 'radical' initiatives such as needle exchanges. The partnership programmes aim to empower through increasing knowledge, however this empowers professionals involved in substance misuse issues rather than lay people; as has been shown above, drug users as a group are excluded or marginalised in the whole development process. The empowerment which has been achieved through health promotion projects funded by international actors is therefore also limited.

In this chapter the financial, political and practical difficulties associated with developing health promotion initiatives in the two research regions have been analysed and the potential for community empowerment assessed. There has been a shift away from hegemonic state structures providing health education for the population, but the alternative non-state or quasi-non-state actors are restricted in their actions by the demands of their funders and the local political situation. These effective limitations to challenges to the medical model from a structural perspective are now explored through the range of health education materials these organisations produced.

CHAPTER 6: HEALTH EDUCATION 2000 IN SARATOV AND SVERDLOVSK OBLASTS

The aim of this chapter is not to evaluate the health education materials and programmes encountered during the fieldwork, but to look at their theoretical underpinning. Not only was it beyond the scope of a PhD thesis to evaluate the full range of interventions – to assess how many people were actually reached by different messages and how these individuals responded to them – but it was also not necessary in order to answer the central research question. In order to establish whether the medical model was the one most influential in the development of health promotion interventions what was required was an analysis of, firstly, the socio-political context of programme development in relation to community empowerment (see Chapter 5), and, secondly, the content of the programmes themselves. The way in which substance misuse as an issue is framed by different agents working in the field, and the extent to which it is 'medicalised', may be seen in the way different population groups are targeted by, and represented within, the specific language and images which are used in printed materials.

The impact of the health education interventions described below was therefore not assessed as part of the research. The analysis that follows is based on what respondents from organisations active in the field of substance misuse purported to do, and is not an investigation of whether different organisations were as active or influential as they may have claimed to be. The way in which organisations presented themselves in interviews and printed materials was a rich source of information about their premises and ideals, and such information is in itself 'valid' for an examination of how discursive frameworks are being constructed in the field of substance misuse in post-Soviet Russia.

6.1 Introduction to the Sources

The main health education materials collected during fieldwork were leaflets, pamphlets, booklets, lecture scripts and schools based programmes, and these are the central data sources in this examination of substance misuse discourses in Russia. It

was felt that 'true' professional discourse around substance misuse would be more accurately reflected in these printed materials which assume a Russian, rather than Western, audience. An interview, by contrast, is very much an interactional event where respondents construct information in collaboration with and in response to the interviewer (Holstein and Gubrium 1995). However, some organisations did not produce or make available printed materials, whereas other organisations produced and made available many resources; this can at least partially be explained by different levels of access to resources organisations had. The nature of the materials also varied greatly, most were leaflets or posters consisting of 1 or 2 photocopied sides of text on an A4 sheet of paper; others were more ambitious pamphlets of a few pages, and there were also four published booklets of thirty pages (Strebizh 1996; Strebizh and Strebizh 1998; Shteinberg 1998; Shteinberg 1999).

The leaflets and pamphlets used here, which are listed in Appendix 2, can be divided into four thematic groups: those targeting youth, those targeting parents, those targeting active drug users and promotional leaflets for organisations and services. There were fourteen sources targeting youth, only two of which were from Saratov oblast and eight of which were from Nizhnii Tagil alone. There were also fourteen sources targeting parents, but only four were from Saratov oblast and three were from Nizhnii Tagil. The four published booklets (two from Sverdlovsk oblast, two from Saratov oblast) all aimed to provide information for parents and those in *loco parentis*, such as teachers, and so are included in this thematic category. Although some leaflets made reference to the misuse of alcohol and / or solvents the primary concern of all leaflets was to provide information about illicit drug use. Of the eight leaflets targeting active drug users in the research regions, five were from Balakovo alone.

It was not always clear how the leaflets, pamphlets and booklets were distributed to their target audiences by the different organisations, but from observational work and interview data it would seem that they were generally distributed to 'captive audiences'. The Rubicon leaflets and handouts were distributed at lectures for parents and youth respectively, Holis and 'Chance' gave their leaflets to parents who came to them seeking information, The Federation gave their leaflets to participants in their marches, and outreach workers distributed the leaflets for active drug users directly to

their clients. It was not so clear how materials produced by state entities (namely those in Nizhnii Tagil) were distributed, though it is likely that they were given out or displayed at the anti-drug rallies which were organised by the local Youth Affairs Committee. As noted above, very few materials were professionally printed glossy brochures (The Federation's two leaflets and the four leaflets produced by the RTsKSODM were all glossy, as was one source produced in Balakovo for active drug users). However, only ten materials out of thirty-six used no colour (on the cover, in the text or printing onto coloured paper) and were just black and white. Most materials also used some visual images (twenty-three out of thirty-six), although the clarity of the images in some materials had been compromised during the photocopying process.

As with the leaflets, the lecture materials are mostly from Ekaterinburg, as Rubicon provided the author with copies of the set scripts for lecturers and enabled the author to attend training sessions for future lecturers on its anti-drugs education programme. Again, these materials can be divided thematically – lecture materials for parents and lecture materials for youth – and are listed in Appendix 1. There is a clear bias in the data from leaflets and lectures as programmes in Sverdlovsk oblast are better represented, however this is, to some extent, balanced by the data on schools based programmes which primarily reflect developments in Saratov oblast. There are two substance misuse prevention programmes recognised by the oblast administration, and both have received funding from USAID, so both were able to produce printed materials to accompany their programmes. The Sotsium Engel's programme has been published in a series of booklets (Bakal et al. 1999a; Bakal et al. 1999b; Shteinberg 1999), and an earlier edition of the handbook for parents and teachers was made available to the author for comparison (Shteinberg 1998). Harmony (Balakovo) also made available a booklet about their 'Rostok' programme for preventing alcoholism and drug addiction as well as other materials such as programme evaluation forms. Two schools based programmes were also encountered in Sverdlovsk oblast, but they were not as formalised. The first was the Holis programme, which was explained in

detail in interview, but was not yet available in a more concrete form.[1] The second was the 'Living Thought' programme which actually encompassed the wider community and not just schools, but at the time of conducting the fieldwork, Living Thought had still not been successful in securing funding, so theirs was still only a programme proposal.[2]

How the Sources Were Approached

The printed materials were analysed initially as part of a group put out by the same organisation, or individually where other texts were not available. This, when used in conjunction with interview data, helped to build a picture of individual organisations' concerns (e.g. preventing drug use or providing support services for drug users). Comparisons across regions and between organisations were then made by analysing the printed materials as part of a thematic group based on their target audiences. It was this second part of the analysis which uncovered the dominant narratives, which were not generally specific to one or another region. The thematic analysis also gave clues as to the dominant actors in each region and even nationally as common information sources could be easily discerned both within and across regions.

Unlike the analysis of discourses presented and perpetuated in the media, which can be conducted by deconstructing the basic news story that is generally quite formulaic (Deacon et al. 1999), the analysis of these heterogeneous printed materials was not so

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[1] No statistics for the programme were collected and one former Holis volunteer suggested that no schools based work was actually done by the organisation. Instead, the respondent asserted, Holis preferred to concentrate on the rehabilitation of drug addicts. This was more lucrative as treatment and rehabilitation was paid for by the families of drug addicts, whereas the schools based work was financed from the oblast education budget, which was not as reliable a source of funding (2000:INT). However, at the time of writing Holis had applied for an EVS volunteer to help set up a peer education programme in local schools (personal communication with EVS co-ordinator).

[2] One of the most significant factors in whether or not an organisation produced any printed materials was its success in securing funding. The primary sponsor of the large number of Nizhnii Tagil materials was the municipal authorities through the Municipal Youth Affairs Committee, the Central Municipal Library or the Municipal Medical Prophylaxis Centre. Judging by the dates it is also clear that the Nizhnii Tagil local government has been funding such health education interventions since at least 1997. This is in direct contrast to all of the other printed materials (bar four leaflets produced with support from the Saratov oblast Ministry for Youth Affairs), which were produced with funding from Western funding bodies, local businesses, local political parties or INGOs. It was successful applications for funding through OSI and PSI which enabled NAN Balakovo to produce so many materials for active drug users. Living Thought, as a relatively new NGO, did not even have access to a photocopier, so the materials they made available were typed carbon copies.

straightforward. The texts were not 'linear' in their narrative presentation and they do not obviously contain competing 'voices', which are a necessary feature of news media in order to maintain journalistic 'objectivity' and which, by their relative positioning in the narrative, can be used to demonstrate dominant and subordinate discourses. These materials were essentially opinion pieces, which aimed to put forward 'generally accepted' and 'correct' views of substance misuse issues. Consequently, whilst the overall structures of the leaflets were analysed as a part of the research process, it was the clear incidences of information source overlap; the use of specific words, phrases and images; and the choice of specific target audiences which have informed the discourse analysis.

In order to add depth to these qualitative findings, a small-scale content analysis of the printed materials was also conducted (of the fourteen sources targeting youth, fourteen sources targeting parents and eight sources targeting active drug users – thirty-six sources in total). Clearly the sample was not large enough for the results to be seen as 'representative' of health education leaflets across Russia, but the analysis was an effective tool for testing findings and hypotheses about the linguistic flexibility of drug related terminology that were uncovered during the discourse analysis. As the sample of printed materials was relatively small, the content analysis was done by hand, and the occurrence of terms for drug addict (*narkoman/-ka/-skii*); drug user (*potrebitel'/u- / potreblyayushchii/u- narkotikov*); drug dependent (*narkozavisimyi*); drug use (*potreblenie/u- / primenenie narkotikov*); drug abuse (*zloupotreblenie narkotikov*); drug addiction (*narkomaniya*); drug dependence (*narkozavisimost' / zavisimost' ot narkotikov*) were counted. Although content analysis is not an 'objective' science (Deacon et al. 1999:115), the counting was conducted thoroughly and consistently so that the process could be seen as 'scientific' in that if the 'experiment' were repeated by another researcher they should achieve similar results. The aim of the content analysis was potentially to aid the illumination of tensions between the connotative and denotative meanings of these basic key words and phrases.[3] This was possible because the relative nuances of meaning between these central words and phrases are significant.

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[3] Whilst recognising the tension between connotative and denotative meanings of these phrases, for the sake of clarity in translations from the original texts the denotative meaning is consistently used.

The findings of the discourse and content analysis of the printed materials described above, have been organised by theme rather than by the geographical region in which they were produced. This is largely due to the homogeneity of the health messages and drug use narratives which was found. Consequently, in this chapter, narratives describing what different organisations accept as being 'the problem' are explored first and competing narratives about 'the cause' of the problem are explored second. The third and fourth sections are explorations of the responses to 'the problem' as it has been accepted, the responses being either short-term interventions such as lectures and leaflets or long-term interventions such as the schools based programmes. Finally, the limitations, which the current discursive formations place on the development of other possible forms of health education, are discussed.

6.2 Bad Habits and Deadly Addictions

This section explores which 'problems' were tackled in the lectures, leaflets and schools-based educational programmes encountered, and how these key issues were framed by different organisations through the narratives they employed. The relative emphasis on interventions around alcohol, solvent or illicit drug use, as reflected in the materials is explored first as the context for the discourse analysis. Next, how conceptualisations of 'risk' are presented in the different interventions is examined through an analysis of the types of behaviour change sought in different interventions as reflected in the printed materials.

Drug and Alcohol Education?

The fieldwork uncovered a huge emphasis on illicit drugs over health education interventions around alcohol use, and a dearth of education around solvent abuse. Of the leaflets targeting youth and parents, all twenty-eight were primarily concerned with drug use, eight also mentioned alcohol use and nine mentioned solvents; the schools based programmes were all specifically anti-drug, although the Saratov programmes also theoretically target alcohol, solvent and tobacco use. This emphasis on anti-drugs education over other health issues can largely be seen as being driven by politics and the media, and for many organisations involved in health promotion the

emphasis was pragmatic. For example, the Federation's main way of working was through anti-drug rallies, although their organisation was also against tobacco, alcohol and sex outside marriage. However, drugs had become their most visible focus as drugs concerned parents and politicians the most (The Federation 2000: INT). Drugs being a political 'hot potato', particularly in Sverdlovsk oblast, meant that organisations that gave an 'anti-drugs' emphasis to broader health programmes were more likely to gain interest and support from local politicians (Living Thought 2000: INT). As discussed in the previous chapter, city and oblast leaders were keen to show they were actively fighting drugs, and in Sverdlovsk oblast the issue was extremely heavily politicised with anti-drug NGOs 'merging' with political parties (see Chapter 5). As is true of elsewhere in Europe, anti-drugs programmes in Russia are more likely to gain political and financial support from local, national and international agencies as drugs are an 'apple-pie' social issue (MacGregor 1999:81, Williamson 1997: 50).[4] In Russia, memories of the disastrous anti-alcohol campaign under Gorbachev are still fresh in people's memories and it is still satirised in the press (e.g. Mitrofanov 2000). Consequently, for example, although KHF was interested in developing a project around alcohol education, there was very little enthusiasm for such a project from Russian partners (KHF 2000: INT).

However, the emphasis on drugs over alcohol or solvents was in some instances also linked to organisational bias. Some organisations were set up or have evolved as specifically anti-drug; it is therefore not surprising that this was the main focus for their interventions. This was particularly true of the QuaNGOs in Saratov oblast' which developed anti-drug education programmes for use in schools. Harmony and Sotsium (Engel's) both evolved out of state psychological support services for young people and both rooted their programmes in their experience of treating young drug addicts and their families. So, for example, this helps to explain why although Harmony's "Rostok" programme aimed to prevent both alcoholism and drug addiction, the programme's introduction concentrated on drug addiction and intravenous drug use; adolescent alcohol use or alcoholism was not mentioned once

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[4] Krasovsky looked at this imbalance in Ukraine, which has a presidential National AIDS Committee, an executive body with a large staff, a National Coordinating Body on Drug Abuse Prevention, a consultation body with few staff, and a National Body for the Coordination of Action on Alcohol – which as of 1996 still did not actually exist (Krasovsky 1996: 7-8).

(<u>Profilaktika alkogolizma i narkomanii</u> Balakovo: Harmony 2000). The introduction also placed much emphasis on the need for better rehabilitation and treatment facilities for young drug addicts, an area into which Harmony would like to expand (Harmony 2000: INT).

The political importance of targeting drug use as opposed to other forms of substance misuse is even reflected by organisations that had evolved as primarily anti-alcohol, namely those in Russia's temperance movement; these organisations have felt the need to include anti-drugs rhetoric in their materials, even if they remain primarily concerned with combating the social and physical harm caused by alcohol. Consequently a publication by the Ekaterinburg Temperance and Health Society "Optimalist" entitled "Drug Addiction – So What is It?" ["*Narkomaniya – chto eto takoe*"] contains essays on many different aspects of alcohol and alcohol policy, but none on illicit drugs (Druzhinin 1998). The title is related to the broad definition of a narcotic as anything which acts as "a poison for the brain"; so narcotics by their definition include tea, coffee, chocolate, tobacco and alcohol as well as illicit drugs (Druzhinin 1998:8, 99).[5] The Saratov Temperance and Health Society *"Trezvost'"* employed a narrower definition of narcotics as being tobacco, alcohol as well as illicit drugs. Alcohol was their main focus, and thus emphasised that too many young people viewed alcohol as 'harmless' when it was still Russia's biggest killer (STH 1999: OBS). Consequently the educational work that *"Trezvost'"* carried out in schools remained focussed on alcohol, but by association, it was argued, should also be effective as anti-drugs education (STH 2000: INT).

The significance of emphasising illicit drug use over the use of solvents or alcohol is the effect this has on limiting the scope of the discursive framework through the perpetuation of specific narratives, which must be reproduced in order to maintain that illicit drug use is "the No. 1 problem in the youth sphere" (<u>"Net – narkotikam!"</u> Nizhnii Tagil: Tsentral'naya gorodskaya biblioteka 1998). As shown above, drug, solvent and alcohol misuse are often linked in theory, but not in practice. All forms of substance misuse are framed as being 'essentially the same' in accordance with 12

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[5] A later, expanded edition of the book did include more information specific to the use of tobacco, solvents and illicit drugs but the emphasis was still heavily on problems associated with alcohol use; the definition of what constituted a narcotic remained unchanged (Druzhinin 2000).

Step / Shichko thinking, but a closer analysis of the texts reveals that drug misuse is actually being portrayed as essentially different. For example, there are discussions of why young people take drugs (curiosity, peer pressure, to cope with difficulties) but the reasons for alcohol use are not discussed (<u>Profilaktika alkogolizma i narkomanii</u> Balakovo: Harmony 2000; Strebizh 1996: 13-6; Shteinberg 1999: 7-8). This implies both that the reasons for drug use are different to the reasons for alcohol use, and that the reasons for young people using alcohol are well understood, widely known and generally accepted.

The messages in the Sotsium (Engel's) schools-based programme initially aim to avoid treating different forms of substance misuse in isolation. Drugs, alcohol and tobacco are referred to in the same terms as being instantly addictive (i.e. from the first use); drug, alcohol and nicotine dependence are portrayed as incurable diseases; and their use inevitably leads to early death (Bakal et al. 1999a). However, this unity of approach declines through the course of the programme; the pre-school lessons through to the lessons for 15-17 year olds (years 9-11) become increasingly focussed specifically on illicit drugs (Bakal et al. 1999a; Bakal et al. 1999b). The lesson plans for years 9-11 only touch upon alcohol use once and though alcohol's status as a 'drug' is emphasised, illicit drug use is portrayed as essentially different through the importance of 'drug pusher' narratives. The promotion of alcohol through advertising, however, is not explored as an issue. That drug dealers get rich out of other people's misery is a strong message in the text, but no mention is made of the people who are making money out of Russia's alcohol problem (Bakal et al. 1999b). This is a good example of the inherent tensions in portraying alcohol and drug use as essentially the same where moral arguments about the evils of drugs are utilised, but similar moralising about alcohol use are not included.[6]

Drugs Kill! The Presentation of Risk
How the various risks associated with drug use were conceptualised in the lectures, leaflets and the schools-based programmes reflects general perceptions of drug use patterns in the two regions and underlying attitudes towards drug use and drug users.

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[6] Williamson (1997: 58) argues that the use of such moral arguments about drugs, but not tobacco and alcohol, in health education interventions is problematic in that the campaigns smack of hypocrisy which undermines their credibility in the eyes of their target audience - young people.

One of the striking features of the printed materials was the 'concreteness' of the statements made in the health education interventions. Drug use was not portrayed as a range of 'risky behaviours', but was spoken of in terms of certain and inevitable dangers: "*Drugs are a path which leads unavoidably to the grave or to crime.*" [Emphasis as original] (Bakal et al. 1999b: 93) or: "A life similar to hell, and a death in the dawn of [your] years – this is the price of excessive curiosity and false romanticism!" (Skazhi sebe: net! Nizhnii Tagil: Tsentral'naya gorodskaya biblioteka 1997)

The inevitable dangers were then reinforced by the choice of accompanying visual images, which also reinforce the concern with IDU through the common use of syringe imagery (see Diagrams 6.1, 6.2, 6.3, 6.4). 'Risk' as a concept was rarely discussed in terms of risk behaviours. It usually referred to what were perceived as 'risk groups' within the population – either because the group posed a risk to 'normal' society (drug users) or because they were individuals deemed at risk of becoming drug addicts.[7] Significantly, however, the latter risk group was defined less by socio-economic status or lifestyle than by a range of internal conflicts within the family. Children from broken homes, or with one or two parents with a drug or alcohol problem were generally viewed as being the highest 'risk group' (Bakal et al. 1999b: 20; Shteinberg 1999: 7-9; Profilaktika alkogolizma i narkomanii Balakovo: Harmony 2000). There were also some specific individual personality traits which put individuals at higher risk of being 'trapped' by drugs – and these traits were largely the result of poor parenting (Strebizh 1996: 11; Chto nado delat' roditelyam Ekaterinburg: Rubikon c. 1999; Pamyatka roditelyam Ekaterinburg: Kholis c. 1999; Profilaktika alkogolizma i narkomanii Balakovo: Harmony 2000).

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[7] The importance of distinguishing between 'risk groups' and 'risk behaviours' is a relatively recent concern in the West, in that it has been noted in relation to HIV prevention work – targeting groups not behaviours raises serious questions of identity and otherness. High risk behaviours can be practised by individuals who either do not fit into the proscribed 'risk group' or do not identify themselves as being part of it. The targeting of specific sections of society (such as gay men) can also serve to perpetuate prejudices against minority groups, whilst maintaining a false sense of security among the majority who come to view the issue as 'someone else's' problem (Patton 1996).

Diagram 6.1 "Narkotik opasen dlya zhizni!" Nizhnii Tagil: GTsMP 1998
(poster reproduced in entirety, original was A4-sized)

Diagram 6.2: Front cover illustration from Bakal et al. 1999a

The same image was used on different coloured backgrounds for Bakal et al. 1999b and Shteinberg 1999, the series was produced by Sotsium (Engel's).
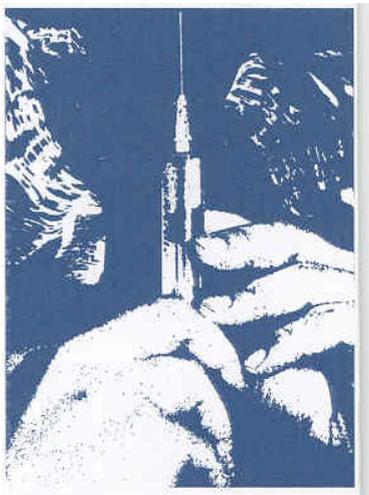
Diagram 6.3: Illustration taken from <u>Podrostkovaya narkomaniya… [II]</u> RTsKSODiM: Saratov 1999
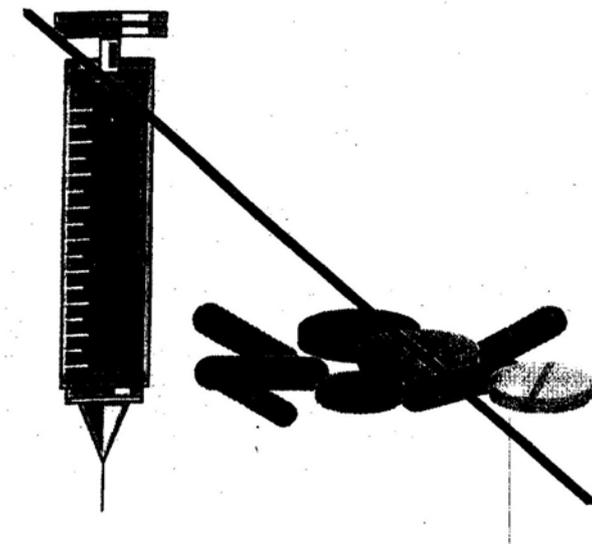

Diagram 6.4 Illustration taken from "<u>NET – narkotikam!</u>" Nizhnii Tagil: Central City Library 1998

This image was also used on the flyer "<u>Vnimanie!</u>" Nizhnii Tagil: Central City Library c. 1998

In the printed materials targeting youth, there was also little differentiation between different types of drugs; drugs were portrayed as equally addictive and deadly either directly or because 'soft drugs' are seen as an inevitable gateway into the use of 'hard drugs' which always leads to addiction. "Marijuana [is] the drug with which drug addiction usually starts." (Podumai o budushchem! Ekaterinburg: Rubikon c. 1999) [8] The specifics of different drugs were only discussed in the schools based programmes targeting older pupils – up to the age of 15 'drugs' (*narkotiki*) are treated as homogenous and the most detailed information on the specifics of different drugs was provided in the materials targeting parents. The relative risks of different ways of administering drugs only featured in the harm reduction materials, which targeted active injecting drug users, or again in some materials for parents (Shteinberg 1999: 14). The 'homogenous drug' described in the materials as '*narkotiki*' is therefore the embodiment of the health educators' key concerns. In the materials targeting youth where the generic '*narkotiki*' is used in place of specific names of drugs and in the Sotsium schools based programmes for the younger years (where drugs are spoken of only in euphemistic terms), it is clear that the main drug of concern is heroin and the mode of use is by injection. Therefore in the anti-drugs fairytale for pre-school children (*Skazka ob Ivane i zmeinom logove*) the prince gets led astray into fields of magical grass which induces a sleepiness and removes all your fears and worries.[9] "Strange people walk in the field their arms and legs all ragged, but they do not avoid the sharp thorns, they do not cry about the painful jabs – they laugh." (Bakal et al. 1999a: 13) The concern with intravenous heroin use is also reflected in the choices of visual images used in the materials, which often include syringes, but also sometimes poppy heads. Another striking example of the underlying concern with intravenous use is that the equivalent Russian colloquialism to getting 'hooked on drugs' – to be 'sat on the needle' [*sazhat' na igle*], with its clear reference to injecting drug use, is

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[8] In the West the 'gateway theory' has been widely criticised by different agencies involved in drugs education; the main argument against being that it does not stand up to any analysis of drug use statistics. Basically it is argued that although the vast majority of heroin users did 'start' on cannabis, cannabis is so widely used and heroin is still, relatively speaking, a 'minority' drug there cannot be a causal link. However, the 'gateway theory' continues to be supported by many policy makers who do not wish to appear 'soft on drugs', particularly in the UK and the US (Williamson 1997; Peele and Brodsky 1997)

[9] This description is consistent with the effects of heroin described in guides to street drugs: "The heroin experience, for those who don't let the drug run away with them, is warm, woozy, and carefree. Nothing matters anymore in their beautiful bubble." (Tyler 1986: 275)

often used in the materials (for example <u>"Net – narkotikam!"</u> Nizhnii Tagil: Central Municipal Library 1998).[10]

To point out this 'hidden agenda' is not to argue that the intravenous use of opiates is not a very serious problem in Russia, and due to associated risks of HIV transmission it is rightly a serious concern for health promoters. However, this concentration on the intravenous use of opiates and the associated risk of HIV transmission does seem to have eclipsed any more complex analyses of drug use patterns amongst Russian youth, as was found with the print media coverage. Referring to the range of illicit drugs available by the generic '*narkotiki*' is clearly limiting to any harm reduction initiative which aims to provide information on the relative dangers of different substances and modes of use.[11] The simplicity of the drugs messages given to parents and particularly youth could well be a reflection of the lack of input from young people generally or active drug users specifically in the development stage of different interventions. However, the treating of all illicit drug use as in some way homogenous is also a reflection of general attitudes towards the use of illicit drugs as being 'worse' than the use of other substances. No concept of 'recreational drug use' was presented in the materials, therefore the drug user / addict is 'other' in a way that the alcohol user / addict is not. Indeed, drug addicts in themselves are presented as a 'risk' for innocent youth, through often quoted statistics about how many young people are drawn into drug use by each drug addict in order to feed their own addiction.[12] The image of the drug addict is most often that of an amoral creature, in spite of the disease rhetoric around addiction, which also portrays the addict as a

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[10] Being sat on the needle also implies a certain lack of agency in that you are put there, however, giving up drugs, "coming off the needle" [soskochit' c igly], is much more active on the part of the user.

[11] A good example of a sociological study which approaches all drugs as being the same, and consistently uses the generic '*narkotiki*' is Popov and Kondrat'eva 1998.

[12] Whilst this statement with statistics often came up in interviews and was used in the media - even in official speeches, no provenance for the claims and statistics could be found. In the printed materials the range was as follows:

"Every drug user gives them [the dealers] another 3-4 other people." (Bakal et al. 1999b: 31)

"One drug addict has from 3 to 15 who have been tricked by him [*obmanutykh im*] around [him] who also, in turn, begin to "treat" ["*ugoshchat'*"] their acquaintances." (Bakal et al. 1999b: 60)

"The danger is that gradually around every drug addict with time a group forms of 5-6 people who also become drug addicts and, in turn, also pull their friends, acquaintances, classmates into this activity." (Bakal et al. 1999b: 83)

"Every drug addict attracts 15-17 people from their close companions into drug use." (<u>Lektsiya dlya roditelei</u> Ekaterinburg: Rubikon c. 1999)

patient in need of treatment (for example Strebizh 1996; <u>Chto nado delat'</u> Ekaterinburg: Rubikon c. 1999). In the above mentioned fairytale the addict is dehumanised in a most literal way, the hands and legs of the young prince turn into 'snakey' paws covered in scales, he loses his human appearance and turns into a snake after wandering into the fields of narcotic grass (Bakal et al. 1999a: 14).

This image of the drug addict in the materials is further complicated by the flexibility with which the term is applied. In spite of the denotative meaning of the terms 'drug addict' and 'drug addiction' as being medical conditions defined by specific clinical criteria (Shteinberg 1999: 13; <u>Chto nado delat'</u> Ekaterinburg: Rubikon c. 1999; <u>Simptomy narkoticheskogo op'yaneniya</u> Nizhnii Tagil: GTsMP 1998); the connotative usage also includes 'drug users' and 'drug use' which is not clinically defined.[13] Therefore, for example, in this discussion of the dangers of Ecstasy targeting parents 'drug user' and 'drug addict' are used interchangeably:

> "Users of these drugs [*Potrebiteli etikh narkotikov*] think that the
> tablets would be calming, sharpening the appreciation of colours and
> music. However, these drugs ruin the co-ordination of movements and
> may present a danger if having taken them the drug addict [*narkoman*]
> drives or works with any machinery." (Shteinberg 1999: 18;
> Shteinberg 1998: 16)

The terms seem to be most flexible when discussing statistics, for example, according to one source from Nizhnii Tagil "40% of the youth of Tagil aged 18-26 years are stable drug addicts [*narkomany*]. There are educational establishments in the city where every third student or pupil is a drug addict [*narkoman*]." (<u>"Net – narkotikam!"</u> Nizhnii Tagil: Central Municipal Library 1998). The use of '*narkoman*' here is probably connotative not denotative; it is extremely unlikely that forty per cent of Nizhnii Tagil's youth population actually fulfil all the clinical criteria to be medically defined as 'addicted', however, it is perfectly feasible that 40 per cent of youth have

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[13] The difference between a drug user and a drug addict may reasonably be equated with the difference between a drinker and an alcoholic. The significance of this distinction is one of accuracy when referring to different groups of people and different behaviours.

used drugs.[14] Similarly no evidence is supplied to show that it is specifically addicts who are poisoned by pills: "Every third death of a drug addict [*narkomana*] is due to poisoning by "pills" [*kolesami*] especially if they are mixed with alcohol." (Podumai o budushchem! Ekaterinburg: Rubikon c. 1999).[15]

Diagram 6.5 Content Analysis of Leaflets Targeting Different Audiences (occurrence of specified terms)
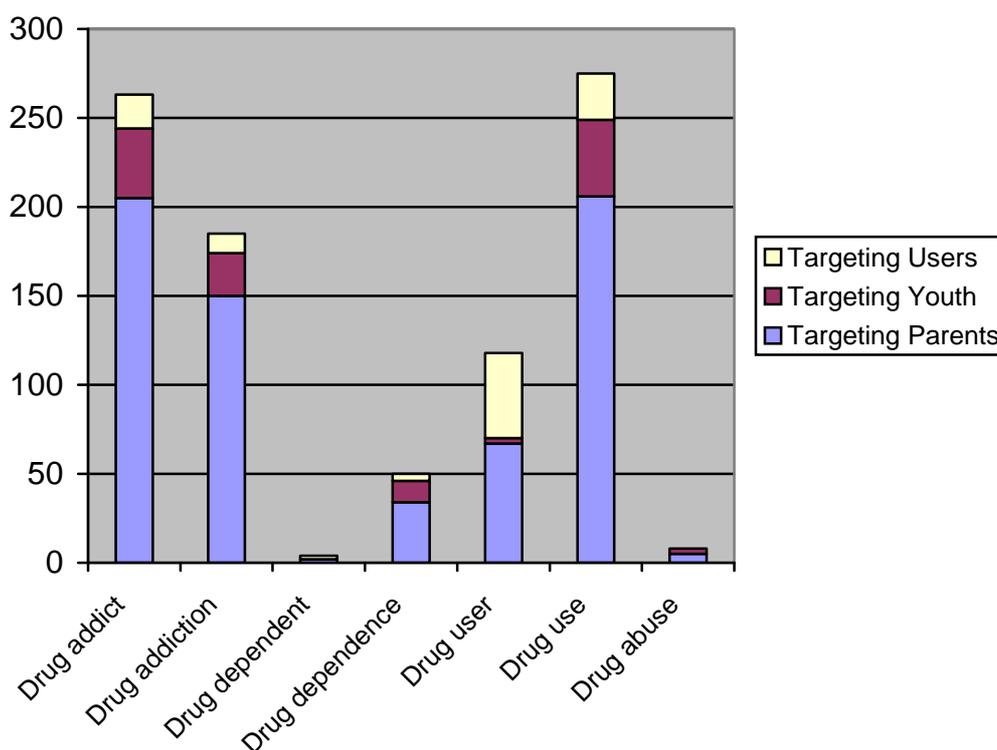
The prevalence of the term 'drug addict' over other possible terms is most clear in the content analysis (see Diagram 6.5). This fits well with the narrative of all drug use (the most common way of describing the act of being involved with drugs) as being

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[14] By the mid 1990s roughly 10 per cent of secondary school age children in Central and Eastern Europe had tried cannabis and a similar ratio had abused solvents, comparable figures for the US were 36 per cent for cannabis, 19 per cent for solvents and 21 per cent and 2 per cent respectively for German youth (UNICEF 2000: 27-8). A Russian survey found that 32 per cent of 16 year old school children in Ul'yanovsk had tried illicit drugs (Omel'chenko 1999: 12).

[15] One does not necessarily need to have developed a psychological or physical dependence on ecstasy in order to suffer the ill effects of mixing it with alcohol. The main problems with mixing are associated with the increased risk of heat stroke as alcohol dehydrates the body (Tyler 1986: 289).

essentially addictive behaviour, and is the preferred term in materials targeting youth (see Diagram 6.6).

Diagram 6.6 Content Analysis of Leaflets Targeting Youth
(occurrence of specified terms)
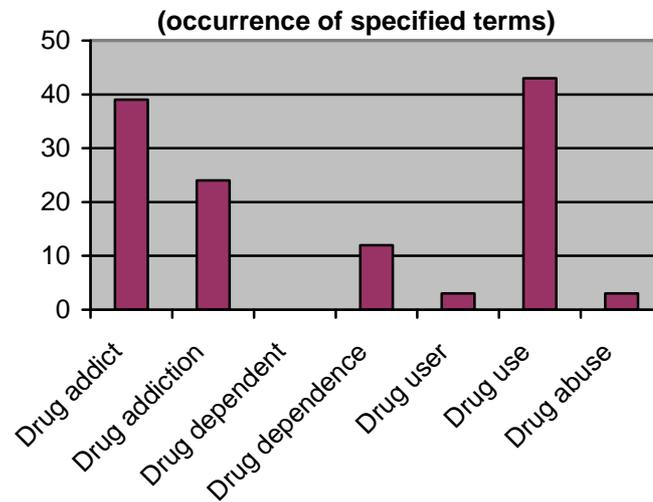
Diagram 6.7 Content Analysis of Leaflets Targeting Active Drug Users
(occurrence of specified terms)
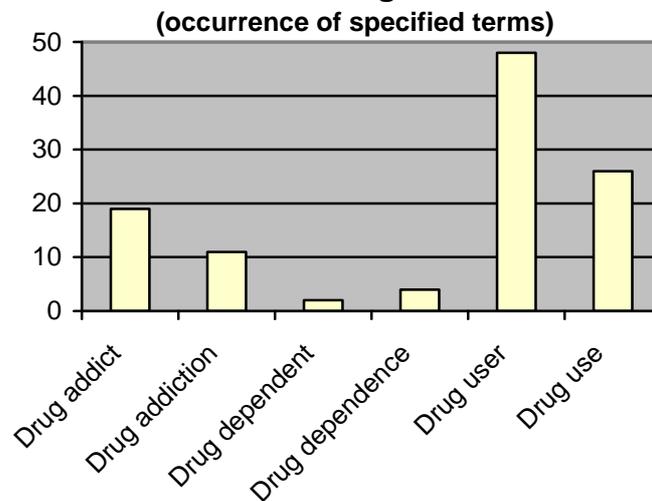
The content analysis of the printed materials, therefore, did show that 'drug use' happens, but also that there are few 'drug users' outside the harm reduction materials (see Diagram 6.7). In the materials targeting active drug users the terms 'drug use' / 'drug user' would appear to be seen as more appropriate than the terms 'drug addict' / 'drug addiction'; notably the term 'drug dependent' (this term being a feature of the 12 Step approach) is also largely reserved for this audience (see Diagram 6.7). However, given that the common source of information for all the leaflets targeting

active drug users was MSF (Moscow) it is in fact somewhat surprising that the terms 'drug addict' / 'drug addiction' are used as general terms at all.[16] This demonstrates that the flexibility of terminology around drug use and drug addiction is deeply ingrained, even in professional discourses that aim to follow a specific harm reduction strategy which, in the West, places great emphasis on using fixed terminology.

In the printed materials, the only professional discourse which consistently referred specifically to 'drug use' and 'drug users' was the legal discourse reproduced in leaflets aiming to inform youth, parents and active drug users of their legal status *vis a vis* controlled substances (Otvetsvennost' Nizhnii Tagil: Youth Affairs Committee 2000; Narkotiki i zakon Nizhnii Tagil: Youth Affairs Committee 2000; SPID… Ekaterinburg: Forpost 2000; Zashchiti sebya sam: zakon Balakovo: NAN 2000; Shteinberg 1999: 10-12).   However, this would not be an issue of 'political correctness', the accuracy of terminology would be the main concern – accuracy in terminology being the main safeguard against laws being misinterpreted. This is evidence that 'drug addict' / 'drug addiction' in Russian as in English should only be used to refer to a sub set of 'drug users' / 'drug use' and that these latter terms are accepted and understood, but as a part of legal discourse not medical or media.[17]

Aiming for Abstinence

As all illicit drug use was viewed in the materials as equally dangerous and inevitably leading to addiction and early death, the type of behaviour change amongst young people that the interventions sought was paradoxically quite mild; young people simply needed more information. If the drugs situation in the two regions was indeed as straightforward as the materials suggested, then young people can be divided into two fairly distinct groups – the users and non-users of illicit drugs. The users are targeted for behaviour change based on the harm reduction model (to try and contain HIV infection locally) and are also encouraged directly and indirectly (through their parents) to seek medical assistance in order to curtail all use. Non-users simply need

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[16] An examination of the MSF journal for active drug users in Moscow, Mozg, showed that 'drug use' and 'drug user' were consistently used as the standard terms (Mozg nos. 1-4 1999/2000).

[17] For example, the 1998 Federal Drugs Law does use the term '*narkomaniya*', but it defines it very specifically in Article 1 as: "an illness, brought about by the dependence on narcotic or psychotropic substances." '*Narkoman*' is not used and the law relates very clearly to the illicit use of different substances (Federal'nyi zakon 1998).

to be warned of the dangers of drug use in order to prevent even experimental use – as all drug use leads to addiction. Ignorance of the dangers and belief in different 'drug myths' were seen by many health educators as being key causes of young people ending up as naïve victims of drug pushers (see Bakal et al. 1999b). As a consequence of this, the schools-based programmes concentrated heavily not just on encouraging a negative attitude towards drugs, but also on building individual self esteem and the ability to resist peer pressure and so 'say no' to drugs (Profilaktika alkogolizma i narkomanii Balakovo: Harmony 2000; Bakal et al. 1999a; Bakal et al. 1999b).

However, more fundamental behaviour change was sought of parents, as many causes of drug addiction were seen to be rooted in the family (see below). Firstly, parents' knowledge level needed to be increased, so that they might recognise the signs and symptoms of drug use and so intervene and get treatment for their child in time. Secondly, and more dramatically, interventions sought fundamental change in the way family members communicated with each other. The importance of parents building a strong and open relationship with their children based on trust and honesty was frequently emphasised in the materials targeting parents, as a way of helping children avoid drug addiction. In the materials the importance of parents having good communication with their children was so that children would have someone to talk to if they had problems – without seeking solace in drugs; young people would also respect their parents wishes more and not take drugs if their parents disapproved. (Shteinberg 1999:4; Profilaktika alkogolizma i narkomanii Balakovo: Harmony 2000; Chto nado delat' Ekaterinburg: Rubikon c. 1999). Good communication would also mean that parents would be aware of their children's friends and interests (and so be aware of any changes which would indicate drug use) as well as knowing where their children were at any given time. The aim is to, if necessary, fundamentally change the internal dynamics of the family in order to facilitate the control and monitoring of children's behaviour.

The overriding aim in the leaflets, lectures and programmes was to encourage abstinence from all illicit drugs, not just on legal grounds but on the grounds of health as all drug use was portrayed as inevitably leading to addiction and ultimately death. Where alcohol use was included, therefore, it was also described in terms of

inevitable addiction and death, directly in materials produced within the temperance movement, and more obliquely elsewhere. It is not unusual to view abstinence from alcohol, as well as solvents and illicit drugs, as the ideal for young people, however in health education terms the main issue must be whether the young people share this sentiment. If the targeted non-user youth does not agree that all drug and alcohol use inevitably leads to addiction and death or that 'soft drugs' are an inevitable gateway into 'hard drugs', then they will probably reject any health education messages presented to them by what would be viewed as a non-credible source (Williamson 1997: 58). Without the involvement of target audiences in the development of interventions such a rejection cannot be either detected or countered.

6.3 Drug Takers and Drug Pushers

The central 'problem' as presented in the printed materials, was that of drug use (over alcohol use) and more specifically the intravenous use of heroin. The narratives employed in the materials therefore centred on these concerns, framing the health issues and defining how health education interventions were put together. Narratives around the drug situation in Russia concentrate on what the health educators perceived as being the root causes of substance misuse in Russia. This section focuses on these perceived causes of Russia's current drug problem, firstly through an analysis of how the drugs market is portrayed in the printed materials as the main 'external' factor. Secondly, the 'internal' and individual reasons for becoming a problem drug user are explored.

'Dealing in Death'

As a significant 'external' factor in Russia's drug problem, the role and image of drug dealing in the printed materials were central to drugs education narratives. The issue was not just external to the individual, but also to Russia, which was portrayed as a

besieged nation in the 'war on drugs': [18]

> "Drugs come into our oblast' from Tadjikistan. Couriers bring their goods from Turkey, Afghanistan… even bringing them in their own stomachs. […] The world-wide drugs mafia has a new strategy – all drugs to Russia!" (Bakal et al. 1999b: 84)

> "Russia has become a "Klondike" for the world's drugs producers" (Strebizh and Strebizh 1998: 13).

And this global besieging of Russia was even put in historical context:

> "The isolation of [Soviet] society could not go on forever, even brief "raisings" of the iron curtain gave new life to drug addiction "soviet-style" ["*po-sovetskii*"]. Thus, at the time of the Festival of Youth and Students [in 1957], practically all the drugs well-known in Europe at that time (marijuana, opium, hashish, cocaine) were imported into our country." (Strebizh 1996: 6)[19]

The besieged image pushes the drug problem beyond the borders of Russia – sometimes into the East (as a key source of the drugs on the market) but also into the West, as a corrupting influence on youth.[20] The 'westernising' of Russia's drug problem in media discourse was shown in the analysis of the print media (see Chapter 3) the use of anglicisms in articles about drugs acting as a mechanism to make the issue 'other'. This 'othering' of the drug problem was also a feature of the printed

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[18] In the expert interviews, as in the print media, drug dealers were often portrayed as being from certain ethnic minority groups (usually Tajik or Roma). Whilst it is hard to determine how professional and media discourses react to each other in terms of who 'leads' debates (Deacon et al 1999:2), when respondents were challenged the impression given was that the media were the primary source of such information. As has been discussed in Chapter 3, coverage of drugs busts emphasised the ethnicity of the accused only where they belonged to a minority group. However, the actual health education materials did not seem to incorporate rhetoric which would create and maintain such racial prejudices directly.

[19] The Sixth World Festival of Youth and Students held in Moscow in the summer of 1957 is also regarded as being "a major channel of information and access for Soviet young people to the latest music and styles." (Pilkington 1994: 67)

[20] The narrative of the West as a corrupting influence on Soviet / Russian youth has a long history, see Pilkington 1994.

materials, and gave the impression that the drug problem is somehow 'new' and a cultural import from the West. For example, the organisations which had had more contact with Western, predominantly American, organisations (namely Sotsium (Engel's), Harmony and Chance) were more inclined to use the American term '*marikhuana*' [marijuana] in their materials when referring to cannabis as opposed to the Russian term '*konoplya*' [hemp/cannabis].[21] Also the glossaries of drugs slang provided in the materials targeting parents showed the strong influence of anglicisms such as 'dealer' [*diler / diller*] and 'pusher' [*pusher*] (Strebizh 1996: 40; Shteinberg 1999: 24).

The besieged image of Russia in the materials not only 'blames foreigners' for the drug problem but would imply also that one of the central narratives in the printed materials is that increasing drug supply increases drug demand. Indeed, in the materials this was explicitly stated by some organisations (Strebizh 1996: 8; Strebizh and Strebizh 1998: 15; Profilaktika alkogolizma i narkomanii Balakovo: Harmony 2000). This narrative is central in supporting the development of different interventions by police forces and border patrols in controlling the supply of drugs to the market, reinforcing current global trends in the 'war on drugs'.[22] However, at a micro-level it also supports the image of the drug dealer as having a huge amount of power over individuals and communities, using great skill in trapping young people:

> "Drug dealers are already beginning to "work on" 10-12 year olds. These scum are able to press "where it hurts" ["*bol'nye mesta*"]. They deftly use knowledge of your psychology and "play" on this. They take into consideration communication problems, character complexes, personality particularities, etc." (Bakal et al. 1999b: 84)

Drugs are thus represented as commodities which are 'pushed' onto nations and individuals rather than 'pulled' through increased demand. The image of the drug dealer in the printed materials varies little between organisations, and one constant

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[21] In Europe 'cannabis' is still the preferred term. The adoption of the old Mexican word 'marijuana' by the American media in the late 1930s may be seen as part of the racist, but ultimately successful, campaign to ban cannabis in the US (Williamson 1997: 21; Plant 1999: 231).
[22] Despite linguistic shifts in the way the global drug problem is framed, most money devoted to the issue still concentrates on controlling supply rather than demand. (McAllister 2000: 246)

feature is that dealers are portrayed as highly predatory; they do not merely trade an illegally imported commodity, they actively promote and 'push' their wares in order to ensnare young users. "Remember! Free cheese only comes in mousetraps" (Skazhi sebe: net! Central Municipal Library: Nizhnii Tagil 1997; Tebe, podrostok..! RTsKSODiM: Saratov 1999). However, most often these predators are not described as alien 'adults' which are corrupting youth, so much as an enemy within, dealers are portrayed as desperate young drug addicts looking to catch others in order to feed their habit. This clearly fuels the view of drug users as being a 'risk' to wider youth in themselves (see above), but it also means that within the dominant narrative of drug pushing, drug addiction is not only caused by outside, alien factors:

> "Those who offer you drugs do it not at all out of a good attitude towards you but just because their money has run out. They have already cleaned out [*obchistili*] their own parents long ago of everything that it is possible to steal and not eat, they have stolen [it all] and so today they catch new idiots [*lokhov*], in order to get themselves money for a dose. They will trick you ["*lechit*'"] with tales of a fantastic high from drugs, forgetting to mention that in a short space of time drug addicts take drugs not for the high, but in order to not experience the pains from withdrawal. They will talk of friendship, mutual understanding [and] love with a single aim – a successful hunt for your money." (Lektsiya dlya podrostkov… Rubikon: Ekaterinburg c. 1999)

The problem is thus emphasised as being located within the community and rooted in the Russian youth sphere. Drug pushers are separate from drug runners who threaten national security and coordinate the drugs trade to target Russia. At an individual level it is an enemy within in the shape of the local drug addict who preys on naïve youth. The innocence, or sometimes ignorance, of the ensnared drug user is re-emphasised through an entrapment narrative of dealers 'giving away' drugs to young people who become unwittingly physically dependent:

> "Remember, I warned you that there are dangerous, harmful, narcotic substances from which [people] fall ill and die. There are people –

criminals – who sell and distribute drugs and force others to take and
sell them. How do they do this? They give [drugs] to try and the
person gets used to it [*privykaet*], wants more and [they] start to
demand money from him. Or [they] force [him / her] to attract other
lads. All these people become criminals." (Bakal et al. 1999b: 31)

This entrapment narrative clearly puts a strongly physiological focus on the drugs
issue, the psychological and social factors in the development of addiction being
implicitly rejected. Drugs are portrayed as not attractive in themselves; drugs are
made attractive specifically by young drug dealer/addicts whose only aim is to make
other young people dependent. In the entrapment narrative, drug users are not
portrayed purely as the innocent victims of drug pushers as these pushers are also
ensnared young users, so when a young person takes drugs they instantly move from
being innocent victim to public menace. Creating dependence is a central aim of the
dealers portrayed in these health education materials, and due to purely physiological
factors in this narrative, it only takes one or two free doses to create dependence. This
also supports the gateway theory of drug addiction being an inevitable consequence of
drug use, and serves to demonstrate that making drug addicts is easy.

Drug Users – the Guilty Party or Innocent Victims?
The image of the drug user as innocent victim of evil drug pushers does not, however,
fit comfortably with the subordinate narratives of the drug addict as being culpable for
their predicament. In the printed materials young people become drug addicts / users
through ignorance of the dangers, and through their own 'psychological weakness',
either due to their personal genetics or shortcomings in their immediate environment,
i.e. the family. This weakness may even have a moral aspect such as in the materials
produced by both Rubicon (Ekaterinburg) and Sotsium (Engel's) where the
importance of an internal 'rod' [*sterzhen'*] of moral values or character and willpower
in resisting drugs was emphasised (Bakal et al. 1999b; Lektsiya dlya roditelei…
Rubikon: Ekaterinburg c. 1999). Both organisations also aimed to provide young
people with this strength of character through their programmes in order to counter
the power of the drug dealers who work through peer pressure. Giving in to peer
pressure was presented as a sign of low self-esteem and moral weakness. It was

therefore the individual who was 'faulty'. This way an underlying and often medicalised assumption that ran through all the printed materials.

All the organisations cited 'curiosity' as a factor in the decision to 'say yes' to drugs and some materials refer to the results of sociological surveys of youth generally, or of drug using youth specifically as evidence of this (Strebizh 1996: 15; Strebizh and Strebizh 1998: 18; Profilaktika alkogolizma i narkomanii Balakovo: Harmony 2000; Lektsiya dlya roditelei… Rubikon: Ekaterinburg c. 1999). The way of combating this curiosity was seen as being to tell 'the truth' about the dangers of drugs, as young people's curiosity was no doubt the result of ignorance. Giving in to curiosity was therefore also a sign of psychological weakness – particularly if it happened after the young people had been provided with all the information about drugs that was deemed necessary through these interventions. "Some fall into the web by accident: from boredom, from curiosity or simply because they were not thinking. […] If you fall into this web, if you allow yourself to be tricked – only you yourself can answer for it" (Bakal et al. 1999b: 31). In the schools based programmes, young people are encouraged to work on themselves and to confront the personality flaws highlighted during the programme. This is their responsibility to themselves, and they are answerable for the consequences of not doing as directed (Bakal et al. 1999b; Profilaktika alkogolizma i narkomanii Balakovo: Harmony 2000).

However, the most radical behaviour change sought in the printed materials was within the family, and this in itself is some measure of how important the role of the family is considered to be in the creation of drug addicts. "The main reasons which lead a teenager to use drugs, apart from genetic predisposition and birth trauma, are those which come about as a result of unfavourable familial relations" (Chto nado delat' roditelyam… Rubikon: Ekaterinburg c. 1999). All the printed materials targeting parents emphasised the need to maintain optimum levels of communication with children and the need to be supportive and loving in order to preserve children's self esteem. Materials targeting children too emphasised the need to communicate effectively with their parents and, in the Saratov educational programmes, providing these skills was a central aim. However, if by and large good parenting can prevent drug addiction, it follows that the balance of responsibility for Russia's drug problem

is perceived as lying with the parents directly through their bad parenting or, indirectly, through their faulty genes or birthing technique.

All the criticisms of bad parenting (and birthing) may be seen as implicitly directed towards Russian mothers rather than fathers. Although leaflets and lectures were aimed at 'parents', the image of 'the family' in the health education materials was largely equated with the image of the mother.[23] In an information leaflet for parents the only visual image is that of a mother and child (Pamyatka roditelyam… Kholis: Ekaterinburg c. 1999). To discourage drug use the child is encouraged to think of their mother crying by their grave as a result of their drug related death (Bakal et al. 1999b: 86). As the children of alcoholics are identified as being a 'risk group' it is the wives of alcoholic fathers that are given therapy [*trening*] to combat this risk (Harmony 2000:OBS). Gender issues were not evidently viewed by the health educators as an important aspect of health education, which is why they are sometimes notably absent: "Members of the club – former [male] drug addicts – are ready to help, irrespective of [your] nationality, belief, and financial circumstances." (My za zhizn' bez narkotikov! "I, You, He, She…": Nizhnii Tagil c. 2000)

Differences in the way young men and women are targeted by health educators, and how male and female drug users are described by them, are also evidence of this neglect. As children both boys and girls are portrayed as innocent and equally vulnerable to the corrupting influence of drugs and drug pushers, but as a future mother the same girl is concurrently more irresponsible and more 'morally wrong' if she gets into drugs: "Every woman either now or in the future. Everyone should know that a female drug addict is twice as dangerous for society as [she] causes evil not just to those around her, but also to her own children." (Strebizh and Strebizh 1998: 15-6) By contrast, in reproductive terms young males are made aware of the effect drug use has on their sexual potency, but this has no moral ramifications for future generations, the 'tragedy' is purely personal: "Boys – put your hands up if you

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[23] This is not a new phenomenon. As Attwood has argued in her work on late Soviet pedagogy "the family is presented as a warm, supportive, nurturant institution, an antidote to any inadequacies society still may have. However, 'the family' generally means 'the woman' – it is she who must support and nurture its other members" (Attwood 1985: 72).

want to become impotent, girls, put your hands up if you want to give birth to mutant babies." (Bakal et al. 1999b: 73)

However, in terms of discursive formations, the linguistic limitations on the development of gender neutrality in health education materials must also be acknowledged. The Russian language is more gendered than English by its very nature, all nouns are masculine, feminine or neuter, so even 'neutral' terms for 'drug user' [*potrebitel' / upotrebitel' narkotikov*] are 'gendered'. It is therefore, perhaps, unsurprising that Russian health educators do not appear to have challenged the dominance of the masculine form of nouns as the accepted common denominator. The printed materials use terms specific to male drug users, friends, teachers as the common denominator and the female equivalents are only used in specific reference to a female representative of those groups. Also, little effort has been made to avoid the use of male third personal singular sentence formations, for example: [24] "Do not try to catch **his** gaze, do not demand that **he** looks you in the eye – it is not conducive to an environment of trust, which you need now like never [before]." [emphasis mine] (Podrostkovaya narkomanii…[II] RTsKSODiM: Saratov 1999; but also Shteinberg 1998: 9; Shteinberg 1999: 8-9)

It could be argued that such structuring and language serves to exclude women and make them invisible in the print materials, so should be challenged in spite of the difficulties inherent in the language. However, in terms of health education being a response to a perceived problem, the use of highly masculine language could be more a reflection of the fact that drug addiction is viewed as a predominantly male problem. The impact of substance misuse on the crisis in male life expectancy in Russia is put forward as a key argument against drugs (Bakal et al. 1999b: 40). The image of drug addiction as being a male issue is best shown where women are actually made visible – in the alarm over the 'feminisation' of drug addiction:

> "In treatment facilities 13% of the general number of drug addicts are
> women. Unlike men, women quickly develop a drug habit which leads

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[24] Notable exceptions to this are the pamphlets produced by the Central City Library and the City Youth Affairs Committee in Nizhnii Tagil. Here passive constructions, the present tense and plurals are used to almost completely avoid 'masculine' sentences.

to [her] degradation: she becomes aggressive, indifferent to children and may commit crime. The feminisation of drug addiction is a completely new aspect of the drug addiction problem in Russia." (Strebizh and Strebizh 1998: 16)

The drug user is therefore portrayed in the materials as male predator; alternative ways of financing a drug habit are neglected, including the largely female preserve of commercial sex work. Poor family relationships (particularly with the mother) are viewed in the materials as the key factor in creating these drug addicts. However, young people only have themselves to blame if they become an addict after having received drugs education. The drug problem is thus reinforced as a problem of and for the individual:

"You are going out onto the open sea of life where there are storms, rocks and underwater reefs. But remember that you are at the helm [rulevye] of your own lives grip the steering wheel tightly in your hands. […] Everything is in your hands." (Bakal et al. 1999b: 101-2)

"*The people around me are to blame for everything, firstly [my] family, teachers and the object of my love*. […] – The feeling of grievance towards others, the feeling of bankruptcy [and] pessimism is the position of a victim. […] It is easier for some to blame conditions or those around them for everything than to take responsibility for their own fate." [italics as original] ("NET – narkotikam!" Central City Library: Nizhnii Tagil 1998)

This emphasis on the responsibility of the individual for their own actions and on mothers for the emotional dynamics within their families is not generally contextualised in wider socio-economic factors. Where such factors are mentioned, issues such as growing unemployment and economic hardship are things which are portrayed as surmountable obstacles, which the individual needs to approach and cope with without resorting to drug use. A way out of socio-economic difficulties can always be found, though with the support of specialist psychological services if necessary (Bakal et al. 1999b: 86). Other possible socio-economic factors which may

contribute to increasing drug use were rarely cited beyond concern that the state is not able to adequately finance health education programmes or adequate recreational facilities for young people (Programma regional'nogo kul'turno-prosvetitel'skogo […] Ekaterinburg: Living Thought c. 1999). The neglect of the socio-economic factors affecting health and behaviour, in favour of greater attention for individualised explanations is a key feature of the medical model of health (Nettleton 1995: 3), and the reductionism, as presented in the printed materials, would indicate that the medical model is still the most influential. The only real challenge to the medical model's claims to scientific objectivity is implicit in the printed materials that discuss the individual's flawed morality:

> "Having tried one drug (most often marijuana) a person is prepared to try another because morally [*nravstvennom plane*] he can no longer see a big difference between them: a teenager has internally crossed the mark between "I DON'T take drugs" and "I'll try it once, so what if I "get hooked" ["*zavyazhu*"]." (Chto nado delat' roditelyam… Rubikon: Ekaterinburg c. 1999)

6.4 Responding to the New Threat

Having examined the way substance misuse in Russia has been framed in different health education interventions through an analysis of what the health educators perceived as the problems and their root causes, it is now necessary to look in detail at the responses, which different actors have developed. One common way of working was through giving lectures and / or leaflets to parents or young people warning of the dangers of drug use. The provision of leaflets and lectures for children and parents was one of the earliest responses to increasing drug consumption in Russia and is the traditional way of conducting health education in Russia and the Soviet Union. It is this response which shall be examined next through a thematic analysis of the leaflets, categorised in terms of their target audience. Firstly there is a discussion of the differences between leaflets targeting parents and youth respectively, and this is then contrasted with the specific genre of harm reduction leaflets targeting active drug users.

The Generation Gap: Targeting Parents and Targeting Youth

Structurally the leaflets were diverse. No common structures were discerned, nor any template for how information should be ordered or presented to parents or young people uncovered, although there were many parallels in the content of the materials across regions and types of organisations. Of the fourteen printed materials targeting youth and the fourteen targeting parents, most were A4 photocopied sheets predominantly covered in text and not all were absolutely drug related. The glossy leaflets produced by 'The Federation' were not specific to substance misuse but were produced specifically to accompany their series of rallies which were not just anti-drugs, but also promoted chastity, temperance and traditional ideas of 'the family'. Consequently, no real information was imparted beyond statistical evidence that drug use and AIDS in Russia were growing concerns and a direct and simple 'say no to drugs' message, which was presented on a par with the messages of 'say no to premarital sex' and 'say yes to traditional families'. The Federation's leaflets gave more space to photographic images, and the one targeting youth (Molodezhnyi marsh… Ekaterinburg: 'The Federation' c. 2000), was only two thirds the size of an A4 sheet.

Although leaflets produced at the Ekaterinburg City Narcological Hospital were also photocopied A4 sheets, they were unique as their materials drew heavily on Western produced harm reduction materials and were edited by a British drugs counsellor (VSO4 2000: INT). The authorship of other materials was not always clear, though there was much evidence of information source overlap. Of those targeting youth, Strebizh (1996: 41) and "Vybor za toboi…" (Nizhnii Tagil: Youth Affairs Committee 2000) are absolutely the same. Also, the winning entry to an anti-drugs poster competition in Nizhnii Tagil was the same as 'The Federation's' logo, and the slogan was also a chant from their march as published in the leaflet targeting youth (Molodezhnyi marsh… Ekaterinburg: 'The Federation' c. 2000; My vybiraem zhizn'… Nizhnii Tagil: Youth Affairs Committee c. 2000). An absolute information overlap between the materials targeting parents from Saratov oblast, namely between Shteinberg (1998: 21-2; 1999: 22-3) and Podrostkovaya narkomaniya… [I] Saratov: RTsKSODiM 1999; Shteinberg (1998: 9-10; 1999: 8-9) and Podrostkovaya narkomaniya… [II] Saratov: RTsKSODiM 1999 was also noted. This overlap

accounts, at least in part, for the general appearance of homogeneity in the health messages put forward by different organisations.

Diagram 6.8 Topics Covered in Printed Materials Targeting Youth and Parents
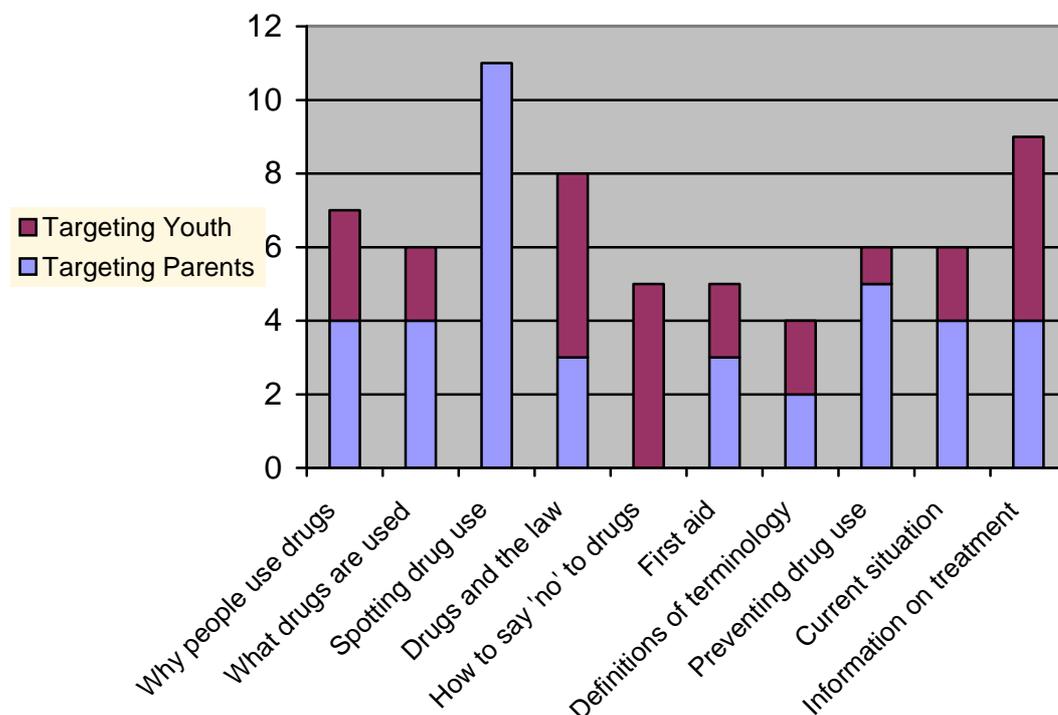
The nature of the information provided to different target audiences differed significantly. The most common types of information provided in the materials for parents or young people fell into ten categories, which are illustrated in Diagram 6.8. As the materials targeting parents included two editions of thirty page booklets for parents from each of the research regions (Strebizh 1996; Strebizh and Strebizh 1998; Shteinberg 1998; Shteinberg 1999), it seems inevitable that parents appeared to be given more information about drugs than their children, but the types of information provided in the materials for parents and youth still differs significantly. Parents are not given guidance on 'how to say no to drugs' and young people are not given information on spotting the signs and symptoms of drug use, which is an absolute must for parents (see Diagram 6.8). For young people the most important information would seem to be knowing how to say no to drugs, understanding the laws around drug use and what treatments are available to drug users. For parents, apart from

spotting drug use, the other essential is knowing how to prevent drug use / addiction in their own children.

As discussed above, the clear emphasis in the materials targeting young people was the dangers of drug use, the aim was to shock and instil fear of drugs, and often drug users, in the young audience. The relative dangers of different drugs is more frequently covered in materials targeting parents (see Diagram 6.8). This fits with the dominant narrative, which advocates the gateway theory, but it also shows how parents are more 'trusted' with specific information on drugs. As is discussed below, the child or adolescent's psychology is portrayed as an extremely delicate and highly malleable thing and individual psychology is the main determinant in whether or not a young person will use drugs. It is this malleability which means that parents need to have more information on drugs than their children do, after all: "The task for adults is to protect children from the fatal step [and] to be able to help the child in time if he has begun to take drugs." (Pomogite svoim detyam! Nizhnii Tagil: GTsMP 1998)

In order to help children who may have started using drugs, the parents are 'empowered' with knowledge about the symptoms and signs of drug use as well as knowledge about drugs culture.[25] The published booklets produced in both Ekaterinburg and Engel's contain glossaries of drug slang, the use of which may indicate that children, if not actively using drugs themselves, are socialising with drug users (Strebizh 1996: 39-40; Shteinberg 1998: 23-5; Shteinberg 1999: 23-6).[26] Parents are encouraged to watch their children closely for any signs and to bring in specialists if they have any suspicions. The information provided in most cases is extremely detailed and is even broken down into the specific bio-physical reactions to different types of drugs; consequently 'marijuana' users may be spotted by their 'red faces' whereas heroin users have 'pale faces' and 'dry skin' (Shteinberg 1998: 21-2; Shteinberg 1999: 22-3; Podrostkovaya narkomaniya… [I] Saratov: RTsKSODiM

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[25] This feeds into the narrative about all drug use being equally bad – the relative dangers associated with different types of drugs, the frequency and method of use were not generally covered. The frequency of use and of which drugs were only touched upon in the Western authored Mify o narkotikakh Ekaterinburg: City Narcological Hospital 2000 and Shteinberg (1998: 9); the latter section was edited out of the later edition (Shteinberg 1999).

[26] The Engel's booklets even include illustrations of drug related tattoos with descriptions of their specific meanings within criminal drug subculture (Shteinberg 1998: 25-7; Shteinberg 1999: 26-8).

1999; Strebizh 1996: 30-3; <u>Pamyatka roditelyam</u>… Ekaterinburg: Kholis c. 1999; <u>Simptomy narkoticheskogo op'yaneniya</u> Nizhnii Tagil: GTsMP 1998).[27]

The materials targeting parents empower them through the provision of detailed bio-medical knowledge so they may accurately monitor their children. The reductive emphasising of the biological over the psychological or social is a key feature of the medical model (Nettleton 1995:3), and also of the information on spotting the signs and symptoms of drug use provided in these printed materials. One 'challenge' to the medical model may be seen in that this knowledge is being made available to lay people, another feature of the medical model being the protection of medical knowledge by a medical profession limiting and defining who has access to this information (Nettleton 1995: 31-2). However, the provision of this medical knowledge to parents by health educators, who are mostly medical professionals, does not aim to empower the parents in relation to the medical professionals themselves, but in relation to the young people whom they are expected to monitor. Parents are expected to monitor young people so that they may intervene in time and refer the child to a medical specialist for treatment, consequently the importance of the medical profession in the process of monitoring and treatment is not undermined but reinforced and parents are used as a means of facilitating social control. If parents are in any doubt as to whether their child is using drugs they are told to seek a medical diagnosis, and with the importance of the gateway narrative, which problematises all drug use, any drug use may be seen as requiring therapeutic intervention:

> "If you detect that your child is taking drugs try to suppress the first impetuous [*burnuyu*] and harsh reaction to this information, as unrestrained displays of despair [and] irritation do not help your child but only push him away from you into the company of drug addicts. **It is imperative that you go to the doctors and specialists, even if the child says that they can cure themselves and "kick it"**

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[27] These detailed tables of signs and symptoms contrast with the information given in the Western authored materials (<u>Mify o narkotikakh</u> Ekaterinburg: City Narcological Hospital 2000; <u>Chto nado znat' vzroslym</u> Ekaterinburg: City Narcological Hospital 2000). Here it is emphasised that most emotional 'signs and symptoms' of drug use are also consistent with normal adolescent behaviour, so there is no way of knowing if the drug use is only periodic. Also, it is asserted that young people are very unlikely to be using drugs at home, so parents are very unlikely to see them actually under the influence.

["***zavyazat'***"]" [emphasis as original] (<u>Chto nado delat' roditelyam,</u>..
Ekaterinburg: Rubikon c. 1999)

"It is necessary to reassure him somehow, for example you could say
to your child that you know that if someone began taking drugs, then
beatings or threats do not help. It is a disease, which needs to be
treated… etc." (Shteinberg 1999: 9; Shteinberg 1998: 10;
<u>Podrostkovaya narkomaniya</u>… [II] Saratov: RTsKSODiM 1999)

Information is power, so the parents are empowered through being given knowledge
to facilitate monitoring; conversely, youth are controlled and contained in relation to
substance misuse through fear and ignorance. Information on types of and access to
treatment for addiction would appear to be seen by health educators as being more
important information for parents and young people than, for example, descriptions of
different drugs on the market or emergency first aid (see Diagram 6.8). All the
materials targeting parents and youth (except those produced by 'The Federation')
include contact information for the local narcological and other therapeutic services.
This emphasis on the treatment of addiction may be associated with the fact that most
of the organisations which produce health education materials are also involved with
the treatment of drug addiction. However, even if health education materials are not
acting as an 'advertisement' for the services of different state and non-state
organisations, this dual purpose arguably still contributes to the dominance of
medical-professional discourse within Russian health promotion. The treatment of
addictions is seen as necessary information for parents and young people in general,
rather than for drug users and their parents specifically.

Targeting the Users

Of the printed materials which do target active drug users specifically, only one is a
guide to different sorts of rehabilitation centres, so that users may decide whether or
not they are ready for treatment (<u>Tsentr reabilitatsii</u> Ekaterinburg: City Narcological
Hospital 2000). Otherwise, whilst the contact details of treatment organisations are
given, the main message in the materials targeting active drug users is essentially that
of harm reduction, and the harm reduction materials have common 'ancestry' in MSF
publications. The four "<u>Zashchiti sebya sam</u>" leaflets from Balakovo are

acknowledged as being based on MSF materials, and the journal Harmony developed for drug users, "Doza razuma", also quotes MSF sources. The "Zashchiti sebya sam" leaflet from Nizhnii Tagil and the "SPID…" leaflet published by Outpost in Ekaterinburg (2000) do not explicitly name MSF as the main information source, but the level of information overlap would strongly indicate that MSF materials were used extensively in the development of both.[28] All the Balakovo materials and the harm reduction leaflet from Nizhnii Tagil include the hierarchy of principles of safer injecting drug use, the safest or most acceptable behaviour being to not take drugs at all, the least safe / acceptable being to use someone else's syringe after disinfection.

Although there is no general consensus on the meaning of the term 'harm reduction', as a goal for drug policies and programmes, its essential feature is "the attempt to ameliorate the adverse health, social, or economic consequences associated with the use of mood-altering substances without necessarily requiring a reduction in the consumption" (Inciardi and Harrison 2000: viii). In other words harm reduction interventions do not aim to 'cure' drug users, but to facilitate and encourage behaviour change to improve health. Due to the historical success of such an approach in reducing HIV infection rates among IDUs (see Stimson and Donoghoe 1996), and the keenness of some Western funding bodies to finance harm reduction initiatives in order to contain the spread of HIV in Russia (see Chapter 5), IDUs are the main target groups for these interventions and HIV transmission is the main concern. The harm reduction leaflets contain information on HIV / AIDS; hepatitis A, B and C; overdose; STI; vein health; as well as legal advice. "Doza razuma", as it is in a journal format similar to "Mozg", also contains a discussion piece on Dutch drug laws, a crossword and part one of a drug user's (Denis') life story.

A clear feature of the leaflets targeting active drug users was the difference in the language used to describe drug use and drug users (see Diagram 6.7). Although 'drug addicts' still feature, it is as nothing compared with the frequency with which the term 'drug user' appears in the texts. The texts do focus heavily on the importance of

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[28] As discussed in the previous chapter MSF was theoretically a part of the KHF funded needle exchange project in Ekaterinburg, and Outpost developed this leaflet as a part of this project. The GTsMP in Nizhnii Tagil was not directly involved in this project, but overlap was clear with the use, for example, of the cartoon punk demonstrating safer injecting sites and emergency first aid, which may also be seen in many early MSF publications (e.g. Mozg #1:1999).

specialist medical intervention, though with specific disease foci this could be seen as appropriate. However, an aim of the editorial team of "Doza razuma" is unquestionably to encourage drug users to curtail all use. Hence, the inclusion of part one of the inspirational story of Denis who, after long-term and chaotic use of ephedrine, found faith whilst in prison and is now clean (Outreach worker NAN Balakovo 2000: INT). However, it is in harm reduction materials that the legal restrictions on drugs education are most apparent. Any emphasis on abstinence may therefore be a reflection of legislation which prohibits the promotion of drug use. All these materials necessarily carry a 'disclaimer' assuring the backing of the Russian Ministry of Health, the materials being part of a recognised harm reduction programme. The Outpost leaflet is even more explicit in its self-defence:

> "This information is not providing propaganda in favour of drugs and
> their use. On the contrary its aim is to provide all people, irrespective
> of whether they take drugs or not, with information which gives them
> skills in making decisions about protecting their own health." (SPID…
> Ekaterinburg: Forpost 2000)

That "Mozg", MSFs harm reduction journal for drug users, has been shut down a number of times, increases its credibility within the drug using communities in Moscow (Outreach Worker MSF 2000: INT), but it is also a demonstration of the difficulties of working within current legislation when it is strictly enforced.

The specific difficulties of dealing with current legislation is also reflected in the different approaches towards the provision of information about drugs and the law, which health educators provide to youth, parents and active drug users. All the legal information is very detailed, giving references to specific laws on the misuse, supply, storage and production of drugs and the punishment for these crimes, irrespective of whether the information is targeting parents, youth or drug users. However, there is a sense in which such information is provided to parents and particularly young people as a warning: the legal jargon is left to stand alone without any commentary. By contrast the same legal information for active drug users is given with explanations and advice; the aim is for the drug users to know their rights and so be better able to protect themselves. For example, there are explanations of what is meant by 'supply',

'intent to supply', etc. as well as advice on your rights if arrested, and even tips on what to do if framed or beaten whilst in custody (Zashchiti sebya sam: zakon Balakovo: NAN 2000; SPID… Ekaterinburg: Forpost 2000).

Harm reduction may be seen as a separate discourse within the discursive framework around drugs education in Russia. It employs a different language and has different aims, within strict legal limitations. The aim of reducing the harm to society and individuals without necessarily aiming for abstinence from all drug use is applied very narrowly and specifically to injecting drug users who are considered high risk for HIV transmission. For 'normal' society the conservative drugs discourse holds, with the dominant narratives of the gateway theory: drug pushing (as opposed to drug pulling); and individual culpability in drug use / addiction. Harm reduction messages do not fit in with these conservative drug discourses so have not been passed on to general youth or parents. The 'misfit' between these two competing discourses is demonstrated in the differences between Shteinberg 1998 and Shteinberg 1999 – the first and second editions of a handbook for parents and teachers as a part of Sotsium (Engel's)'s schools-based anti-drugs programme. The handbook appears to have been heavily influenced by the harm reduction style information pamphlets which are produced in Western Europe. However, a close reading of the two texts showed the gradual editing out of the more 'radical' health promotion elements, particularly the following advice in the first edition to parents whose children have moved beyond experimental to prolonged use:

> "With those teenagers who are already experiencing dependence on drugs it is necessary to work especially carefully. However, basic attention needs to be given not to the fact of the drug use, but to the problems which have reduced the teenager to this activity. If you are successful in resolving these problems, it is possible that the teenager will stop taking drugs or cut down their use to a minimum. At the same time it is very useful to talk to teenagers about how to reduce the [negative] influence of drugs on [their] health." (Shteinberg 1998: 9)

**Diagram 6.9 Content Analysis of Shteinberg
1998 and Shteinberg 1999**
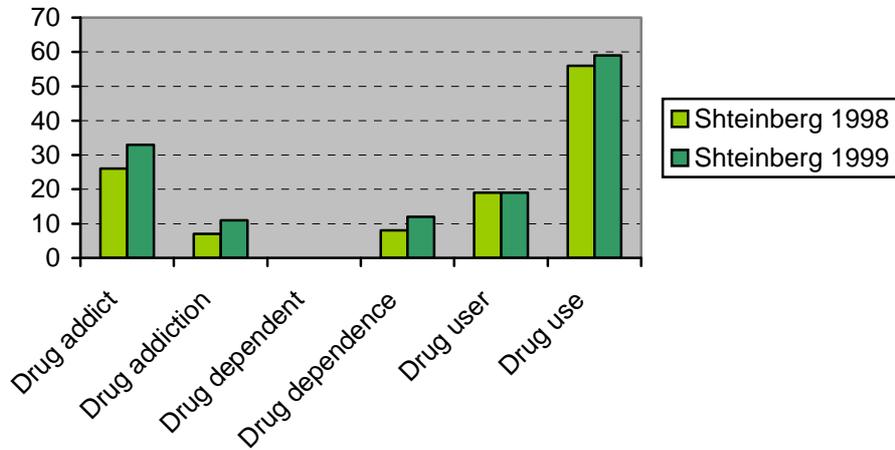
This section was not replaced with anything similar in the second edition, which instead included more information about: the definition of physical and psychological dependence (Shteinberg 1999: 13-4); methods of drug use (Shteinberg 1999: 14); and the bio-physical effects of opiate usage (Shteinberg 1999: 16). Such editorial shifts are subtle, but the changes in the language become clearer through content analysis (see Diagram 6.9). In the later edition the terms 'drug addict' and 'drug addiction' are used more frequently, whereas there is little difference in the frequency of the term 'drug use'. How the language and messages used in the parents and teachers handbook compare with the content of the schools based programme are discussed below.

6.5 Social Control through Health Education

Most organisations worked in schools, for example, Rubicon aimed to access young people through giving their lectures to young people in a school setting. However these lectures, like leaflets, rallies and posters are essentially 'one off' actions designed for short-term maximum impact. The long-term interventions examined here are those which were designed to run as a course over a number of weeks and to build skills for behaviour change as well as to provide basic information, such as the well documented programmes "Rostok" in Balakovo and "Sotsium Narkorisk" in

Engel's. As acknowledged above, there is a strong Saratov oblast bias in the long-term schools-based health education interventions available at the time of conducting fieldwork. The Holis programme in Sverdlovsk oblast was not available in printed form, so references to this are based purely on interview data, i.e. on one person's interpretation of the programme prepared for a Western audience through dialogue rather than a 'standard' text prepared with a Russian audience in mind. The Living Thought programme was community based rather than schools based and was not fully developed as the organisation had not, at the time of fieldwork, been successful in securing funding - one of the most significant factors in whether or not an organisation was able to produce any printed materials.

Both the 'Rostok' programme in Balakovo and the 'Sotsium – Narkorisk' programme in Engel's had been successful in securing funding from Western funding bodies (both Eurasia Fund and the Open Society Institute) and support from different ministries. The Sotsium (Engel's) programme, 'Sotsium-Narkorisk', is recommended by the Saratov Oblast Ministry of Education as the textbook on the subject (Bakal et al. 1999a: 1). The 'Rostok' programme had Federal backing from the Russian State Committee for Youth Affairs, as well as local support from the Saratov Oblast Ministry for Youth Affairs, Sport and Tourism (Profilaktika alkogolizma i narkomanii Balakovo: Harmony 2000). The Holis programme for primary school children was financed from the Ekaterinburg city budget, through the city Education Department.

The Specifics of Longer-Term Approaches

Clearly there were structural differences between the printed programmes and the other printed materials as they were larger texts; they were more detailed and they were not intended for 'lay' consumption. Apart from the Living Thought programme, which was essentially a funding application, these materials targeted pedagogues who were trained in how to implement the programme effectively and consequently contain explicit theory sections which underpin and explain how the programme is designed and how it is intended to work in practice. This meant that the ideologies and narrative frameworks did not need to be 'revealed' through discourse analysis in the same way that they were for the other printed materials.

The 'Rostok' and 'Sotsium-Narkorisk' programmes operate on different scales. The 'Sotsium-Narkorisk' programme has curricula for four different age groups (from pre-school to school leavers) while the 'Rostok' programme is designed for youth aged 11-16 years only. Each curriculum in the 'Sotsium-Narkorisk' programme is structured in the same way: there is a methodological introduction which outlines the aims of the programme, the specific psychology of each target age group, and gives detailed instructions on how to conduct the lessons. The methodological recommendations are followed by exact lesson plans, which pedagogues are told need to be followed to the letter. The necessary worksheets, diagrams and stories are provided in appendices. The general introduction to the drug problem in Russia and the different issues around substance misuse are detailed in the handbook for parents and teachers which accompanies the programme (Shteinberg 1999). The 'Rostok' programme is less detailed, but contains the same elements, firstly an introduction to the drug situation in Russia, then information on the nature of substance misuse. This is followed by an outline of the programme's aims, its anticipated results and its methodological underpinning. Finally there are lesson plan outlines, which are elaborated upon during the pedagogues' training. Outlines for the specialist, teacher, and parent training sessions are also provided, as the 'Rostok' project is as much about training professionals in the skills necessary for coping with drug use as an issue as it is about preventing drug use among young people.

It can be argued that in spite of their ministerial backing both the 'Rostok' and 'Sotsium-Narkorisk' programmes, as print materials, are, like the Living Thought programme, promotional texts which have to 'sell' themselves and their methods to the specialists who were expected to fund and implement them. This promotional aspect can be seen in the emotive nature of the language used in all three programmes in their initial framing of substance misuse issues in Russia. The 'Rostok' programme aims to provide information for those "whose nearest live under the narcotic sword of Damocles" (Profilaktika alkogolizma i narkomanii Balakovo: Harmony 2000); 'Sotsium-Narkorisk' warns that the "the number of voluntary slaves to drugs, who wish to be in a synthetic paradise is growing menacingly" (Shteinberg 1999: 4). Living Thought's programme even refers to drug addiction as society's "cancerous tumour" (Programma regional'nogo kul'turno-prosvetitel'skogo […] Ekaterinburg: Living Thought c. 1999). Similarly emotive language was often employed in the

other print materials to underline the severity of the problem (in materials targeting parents) and to deter potential users (in materials targeting youth). However, here the use of highly emotive language in the introductory texts serves to emphasise the danger substance misuse poses to the community and thus show how the proposed programmes are 'essential'. This is then combined with 'scientific' language to emphasise the programmes' efficacy. The discourse therefore shifts from the emotive to the scientific; in order to demonstrate the strength, rationality and viability of the proposed programmes, "specialist" evaluations are provided (Shteinberg 1999: 4; Profilaktika alkogolizma i narkomanii Balakovo: Harmony 2000) or "innovative methodologies" [*novatorskikh tekhnologii*] are employed (Programma regional'nogo kul'turno-prosvetitel'skogo […] Ekaterinburg: Living Thought c. 1999).

Along with emotive language, the importance of such anti-drug programmes is underlined with the use of story-parables, particularly in the Saratov oblast long-term interventions. Only four other materials employ a story-parable device, and as devices they are only used for targeting young people and children – adults get the necessary information in an unfiltered form.[29] The story-parables take the form of fairytales for younger children and are designed to psychologically programme the child, but for older children and teenagers they are tragic stories ostensibly from real life about the dangers of drug use, and the aim is to shock. For example, the "Rostok" programme gives five short punchy profiles of (specifically) injecting drug users who have accessed services in Balakovo; one is 'Serezha': "Serezha, aged 16. Fine facial features, an embarrassed smile, punk rock fan. 2 years hooked on drugs [*"sidit" na igle*], hepatitis carrier, had to give up studying, his mother's tears, hopelessness in his father's eyes." (Profilaktika alkogolizma i narkomanii Balakovo: Harmony 2000). The "Sotsium-Narkorisk" programme uses story-parables from newspaper articles, for example, a grandmother who has to rent out her flat in order to pay for her granddaughter's drug habit and a mother who could not cure her son – now in prison – of his drug addiction and would rather have him dead. (Bakal et al. 1999b: 68-9)

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[29] The short-term materials which employ story-parables are as follows: "Narkomaniya – put' v bezdnu" Nizhnii Tagil: GTsMP 1998; "Lektsiya dlya podrostkov […]" Rubikon: Ekaterinburg c. 1999; Strebizh and Strebizh 1998: 27-9; Strebizh 1996: 42. (NB the stories provided in the Chance materials are designed to be read to adolescents as a warning.) It could also be argued that "Doza razuma" Balakovo: Harmony 2000 employs the story-parable device with the tale of Denis who falls into injecting drug use without thinking.

These stories are undoubtedly chosen for the strength of their emotional impact, and the 'human interest story' is also a core journalistic device. However, the fairytales used in the programmes for children are not mere illustrations. In the 'Sotsium-Narkorisk' programme for pre-school age children the whole programme is based around an anti-drugs fairytale, "The Tale of Ivan and the Dragon's Lair" [*Skazka ob Ivane i zmeinom logove*] and in the curriculum for years 1-3, eight fairytales are utilised. The potential impact of the story-parables is emphasised in the methodological guidelines: "The tale is the universal means of forming deep-laid structures of psychical reality, of the psychical subconscious in the depths of which the basic motivations for a person's behaviour ripen." (Bakal et al. 1999a: 4) Story-parables are then a rich source of information in metaphorical form, "which the child can take in directly with feelings, virtually without touching the conscious [mind]", the tale does not need to be understood, but to be lived on an emotional level (Bakal et al. 1999a: 4).[30] From this explanation of the significance of the story-parable it is clear that the child's mind is viewed as ultimately malleable; adults are viewed as fixed in their behaviour patterns so story-parables are not employed.[31]

Schools-Based Health Education

As one might expect, the psychological impact of the long-term schools- and community-based programmes is deemed to be all important. The programmes aim not just to provide information in order to encourage a 'healthier lifestyle' but also to facilitate changes in negative behaviours and maintain positive behaviours through skills provision, more efficient surveillance and psychological coding. The skills provided varied across the different programmes, the 'Living Thought' proposal concentrated on developing the necessary skills for young people to participate in alternative ways of keeping entertained and being involved in the community

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[30] Western behaviourist psychologists, such as Meichenbaum, also argue the power of story-parables: "To experience a fantasy or to read or listen to a story is, in some sense, to be there" (Martin and Pear 1992: 354).

[31] There are two story-parables provided in a 'fairytale' format for the pre-school programme – both essentially the same but with different endings – one positive and one negative. The alternative endings theoretically allow the child to explore different modes of behaviour safely, and, through reinforcement, positive patterns are encouraged; thus the stories have both a 'modelling' and 'programming' function. Programming positive behaviour is possible as children inevitably identify with the hero of the story (Bakal et al. 1999a).

(Programma regional'nogo kul'turno-prosvetitel'skogo […] Ekaterinburg: Living Thought c. 1999). The skills promoted by the 'Rostok', 'Sotsium-Narkorisk' and Holis programmes were rooted more in "practical psychology", and concentrated on improving communication skills, resisting peer pressure and increasing self-esteem.

The surveillance of young people's behaviour was improved through the programmes, as through the short-term interventions, by providing adults with the necessary information on identifying different narcotics and the symptoms of their use (Shteinberg 1999: 15-23; Profilaktika alkogolizma i narkomanii Balakovo: Harmony 2000). The skills the programmes aim to develop in parents and teachers are also to aid them in the monitoring and surveillance of their children's behaviour, as much as to improve family dynamics in order to 'prevent' substance misuse. Consequently, one aim of the 'Rostok' programme is "[t]o teach parents the correct behaviour and response in cases where the child has been identified as using or experimenting with chemical substances." (Profilaktika alkogolizma i narkomanii Balakovo: Harmony 2000). The surveillance aspects of Living Thought's envisaged programme are understandably more community based. Local communities working with NGOs and law enforcement agencies help to eradicate drug dealing 'hotspots' and get drug addicts into treatment through a 'neighbourhood watch' style scheme. This panoptic close observation of the local environment is also extended to returning former prisoners and local children who, in earlier stages of the programme, have been 'identified' as demonstrating deviant behaviour. (Programma regional'nogo kul'turno-prosvetitel'skogo […] Ekaterinburg: Living Thought c. 1999)

The psychological coding aspect of these programmes is strongest in 'Sotsium-Narkorisk', and as shown above, the aims and methodology are explicit. The 'Sotsium-Narkorisk' programme concentrates coding efforts on young children, before they reach year 5 as it is assumed that before this age they will not have come into contact with drugs. After this age (years 5-11) the aims are to 'demythologise' drugs and to neutralise potential risk factors, the programme no longer aims to work on a subliminal level, and participants are informed as to the content and aims of lessons. As with the 'Sotsium-Narkorisk' programme, the 'Rostok' aim of psychological coding is explicit, the prevention work being conducted mainly through lectures for children and young people but also through "deepened psycho-corrective

prophylactic workshops [*treningy*] for school and college students (aged 11-16)." (<u>Profilaktika alkogolizma i narkomanii</u> Balakovo: Harmony 2000)

Both the 'Rostok' and 'Sotsium-Narkorisk' programmes have behaviourist elements, which aim to 'correct' psychological deficiencies and psychologically 'code' young people. As a method of social control this is not unique. What is most striking about this aspect of the programmes is the absence of any discussion of ethics. Whether the young people are active or passive participants in these programmes, i.e. whether the young people are fully informed of the aims of the programme and agree to participate freely in them, is not discussed in ethical terms, only practical ones. It is argued that if the child is too well informed of the lessons' theme then the programme cannot work on the 'indirect' level (Bakal et al. 1999b: 8). There would appear to be no ethical dilemma with the behaviourist aspects of these programmes as they are conducted by professionals for the greater good of society – indeed they are merely reinforcing "socially desirable norms" (Bakal et al. 1999a: 5). It would seem, therefore, that professionals may act without the expressed consent of the children or their guardians.[32] This is a reflection of the power of professional status but it also reflects continuing paternalistic attitudes within state structures and wider society, the state's 'right' to intervene is not questioned, the rights of the child are not an issue. Although the foci of the programmes were either local communities or individual psychology through the schools-based programmes, the ultimate aim was to create stronger social control either from without, through greater awareness and observation, or from within by providing individuals with the psychological tools to control their own behaviour. The programmes are about the containment and control not just of deviance, but of youthful bodies and minds; youth empowerment was encouraged only within strictly defined parameters set by professionals.

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[32] Although this may not seem ethically contentious, the first article of the Nuremberg code (1947), which defines what is acceptable practice in medical research involving human subjects, sets out the parameters of informed consent as follows: "The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercize free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or any other form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him [sic] to make an understanding and enlightened decision." (Vollmann and Winau 1996: 1448) In the follow up code, the Declaration of Helsinki (1964), the position of minors is made clear in article 11: "Whenever the minor child is in fact able to give consent, the minor's consent must be obtained in addition to the consent of the minor's legal guardian." (Vollmann and Winau 1996: 1449)

There is a heavy emphasis on the control, development and correction of individual psychology in the schools-based programmes. The child's psychology is represented as malleable and amenable to intervention, and the emphasis is on individualised therapeutic interventions in order to control social deviance in young adults. This has the effect of medicalising substance misuse as an issue, and portraying psychology as an exact medical science capable of 'curing' social ills. Consequently, in interviews and in texts the programme authors utilised an 'immunity' metaphor. Particularly the 'Sotsium-Narkorisk' programme was seen as acting like a "social inoculation" against drugs (Bakal et al. 1999b: 5), the use of a biomedical metaphor reflecting the programme authors' desire for their work to be seen as having a biomedical, 'scientific' basis. This is not a uniquely Russian phenomenon. Exponents of behaviourist interventions in the West are equally convinced of its efficacy and 'scientific' nature, for example:

> "The immediate future of behaviour modification appears to be very bright. Some day, a thorough knowledge of behavioural techniques may become an accepted necessity in our culture and will be taught to children in elementary school along with good hygiene and physical fitness. Perhaps these children will grow up to see a world in which good applications of behavioural principles will be second nature to everyone and will result in a happy, informed, skilful, productive culture without war, poverty, prejudice or pollution." (Martin and Pear 1992: 389)

What is clear from an analysis of these long-term interventions is that there is also no challenge to such an idealistic approach. Psychology is presented in these texts as an exact medical science free from the cacophony of competing voices that has actually characterised the development of psychology as a discipline.

The therapeutic and individual psychology emphasis in these programmes, and in other print materials (for example, Chto nado delat' […] Rubikon: Ekaterinburg c. 1999; Pamyatka roditelyam Kholis: Ekaterinburg c. 1999), serves to individualise substance misuse and addiction, to the neglect of potential social factors. The

individualisation of drug use as presented in the "Sotsium-Narkorisk" programme was also reflected in data from interviews with the authors. Drug addiction, it was argued, did not follow 'Western' patterns; in Russia the wealthy children were most at risk rather than the deprived [*neblagopoluchenye*], who cannot afford drugs (Sotsium (Engel's) 2000: INTS).[33] Possible social factors such as youth unemployment were explicitly rejected as factors in Russia's contemporary drug problem, in favour of individual psychology and ability to pay (Chirkina 2000: INT). The 'Sotsium-Narkorisk' programme (like the 'Rostok' programme and the Rubicon materials), focussed on individual choice – making the 'right' decision, resisting peer pressure and valuing the self too much to harm it with drugs. Such an approach frames choices around drug use as being unifactoral and individual, i.e. when a young person says 'yes' to drugs it is only because they did not have the correct seeds of knowing right from wrong planted at an early enough age. Such individualisation of health issues, without acknowledging possible social factors is a key criticism of the medical model of health (Jones 1997: 29; Nettleton 1995: 5-6; Annandale 1998: 7).

These long-term interventions also adhere to the medical model's professionalisation of health interventions. As argued in the "Rostok" programme, the growing drug problem in Russia "demands the taking of measures without delay, and the preparation of specialists able to professionally solve the arising problem." (Profilaktika alkogolizma i narkomanii Balakovo: Harmony 2000) The key words here are 'specialists' [*spetsialistov*] and 'professionally' [*professional'no*] – the involvement of lay people such as youth themselves or drug users is thereby implicitly rejected. Professional voices in the 'Rostok' programme are those deemed to be most credible by the programme designers in lessons with a 'roundtable' format where the specifics of drugs, addiction and HIV/AIDS are discussed with the participation of health professionals and the police. The role of professionals in solving the drug problem is emphasised through the formulation of the issue as being part supply related (the job of law enforcement agencies), part environmental tolerance towards drug taking (the job of the state and society) and part individual psychology. The latter can only be helped through "professional consultation with

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[33] Although it was asserted that it was rich youth who was most 'at risk', the poorest region of the town (Kirpichnyi) was still cited as the area which had the worst drug problems (Chirkina 2000: INT).

specialists: psycho-therapeutic and narcological help from a psychologist or doctor" (Shteinberg 1999: 4). Therefore even Living Thought's envisaged community-based programme includes the setting up of a socio-psychological help service which has a professional, as opposed to community, led staff of twelve including a lawyer, a narcologist and a psychologist (Programma regional'nogo kul'turno-prosvetitel'skogo […] Ekaterinburg: Living Thought c. 1999).

Conclusion

An analysis of the printed materials has shown that some elements of the medical model of health do still predominate in the collected health education materials, although there have been significant shifts. The five main assumptions of the medical model were outlined in Chapter 1 as: mind-body dualism, the mechanical metaphor, medicine's technological imperative, reductionism and the doctrine of specific aetiology. It is therefore against these five assumptions that the extent to which these health education interventions are still operating within the medical model can be measured. Firstly, in relation to body-mind dualism, the importance of psychology in the framing of issues and the inclusion of psychologists as creators of interventions and as key actors in addiction therapy is extremely significant. Psychologists, in words if not in actual status, are placed on a par with narcologists, and the role of individual psychology in whether young people say 'no' or 'yes' to drugs is emphasised. Biophysical and biochemical factors are important in narratives around instant addiction but the potential user is treated more holistically, the changes in individual brain chemistry brought on by drug use and individual psychology are as one in narratives about drugs corrupting 'pleasure centres' in the brain.

As a consequence of this holistic approach, in the second assumption, the mechanical metaphor, the doctor as mechanic is replaced by the therapeutic psychologist using 'corrective' psychology to fix deviance. However, with this the role of the medical professional in both the prevention and cure of drug addiction still maintains its central position. Parents are encouraged to spot the signs of use early and if in any doubt to refer to a qualified psychologist or narcologist. The importance of the medical professional in the definition and treatment of a given condition, a feature of

the medical model of health, is thus reinforced even where there has been a shift in the relative importance of the doctor-narcologist and the therapeutic psychologist. However, the non-invasive nature of correction and prevention based in psychology does serve to undermine medicine's technological imperative, the third assumption, even if it remains strong in the treatment of addiction by narcologists.

Fourth, biomedical explanations of substance misuse do feature significantly in the printed materials, particularly through the asserted importance of genetics in the development of addiction. As the mind-body dualism has been largely removed, psychology and biology have become intertwined, so that genetic predisposition towards addiction or drug use may be 'cured' through psycho-therapeutic preventive interventions. However, this approach is still reductive as potential social factors are neglected, or actively rejected, so that interventions maintain their focus on individual behaviour, psychology and biology. The doctrine of specific aetiology, the fifth assumption of the medical model, is thus reflected in the reductivism in understanding the root causes of Russia's drug problem. Substance misuse is a multifactoral and highly complex social issue and whilst its complexity is acknowledged in many of the printed materials, it is more of a nod in the direction of a more complex approach to the situation. The way in which the interventions have been designed actually points to a more simplified approach which targets the individual as both the cause of, and solution to, the problem.

The dominant professional medical discourse is produced and reproduced by organisations which, irrespective of their positioning in relation to the state, are dominated by psychologists who portray their discipline as highly 'scientific'. Therefore it is most reasonable to see the shift in emphasis between biomedical and psychological explanations of drug use as being a progressive medicalisation of psychology in the field of substance misuse rather than as a challenge to the medical model of health in this field. The medicalisation of psychology actually underlines the dominance of the medical model in health education in the field of substance misuse in post-Soviet Russia where psychology must be seen as 'objective' and 'scientific' and be supported by physiological and biochemical evidence in order for it to be deemed 'valid'.

In this chapter it has been shown that the main concern of health education interventions in the field of substance misuse has been that of drugs. The drugs issue has been framed within a conservative discourse which subscribes to the gateway theory, with the associated narratives of instant addiction and inevitable death. A corollary of the gateway theory is that drugs are treated as largely homogenous. The drug problem is presented as one of predominantly male injecting drug use and drug users are presented as both victims and villains in the drug problem. These narratives do not fit with the competing harm reduction discourse which, as an approach, is applied only to active injecting drug users. Both the conservative drugs discourse and the harm reduction discourse subscribe to the aim of abstinence, although this is not a general feature of harm reduction approaches in the West. The conservative drugs discourse also individualises the root causes of Russia's drug problem whilst emphasising the increase in drug supply as a central factor in increasing drug use, the increase in drug supply being driven by factors beyond Russia's borders. This works as part of a complex narrative which portrays drug use as being the result of drug 'pushing' rather than drug 'pulling', i.e. that there is no demand for drugs without supply. At a micro level the demand is created by dealer / users – the entrapment narrative.

The responses to the problems and their causes (as outlined above) target parents in order to improve surveillance over their children by empowering them by increasing the amount of information available to them. Parents / mothers are targeted in health education interventions as the ones best placed to improve intra-family dynamics and communication. Children and young people are also targeted as individuals who may be able to improve communication within the family, but most emphasis is on improving their self-esteem and ability to resist peer pressure. This is done explicitly with older youth and subliminally with young children. The dominant conservative drugs discourse does not compete with the dominance of the medical model within the health education initiatives. Both the conservative drugs discourse and the medical model of health here serve to individualise the causes and solutions to Russia's drug problem. How the dominant conservative drugs discourse and the subordinate harm reduction discourse have been created and perpetuated within health promotion in Russia and how health education initiatives and healthy public policy initiatives come together within the medical model of health and conservative drugs

discourse is explored next. The health promotion initiatives in Saratov and Sverdlovsk oblast shall also then be contextualised in wider national and global debates.

CONCLUSION

In this thesis, the hypothesis that health promotion in the field of substance misuse in post-Soviet Russia remains fixed within a medical model of health has been tested through an analysis of the way in which health promotion is developing in two regions – Saratov and Sverdlovsk oblasts. The data were collected through a combination of interview, observation and document, including media, analysis. The relative and changing roles of state, non-state and international actors in the development of health promotion interventions, and the way health education materials framed the issue of substance misuse both showed that the medical model of health is indeed still hegemonic among approaches to health promotion in post-Soviet Russia.

It was clear from the print media, recent legislative reform and political debate as well as the range of health education programmes encountered in the field that the most prominent social concern was that of drug use, rather than the misuse of alcohol or solvents. An analysis of Russian legislation around substance misuse showed that the government is most interested in approaching the issue of drugs through the lens of national security and the alcohol issue from the perspective of reintroducing the state monopoly in order to increase budgetary revenues. Alcohol, solvent and drug use have been treated at a practical, discursive and policy level as distinct problems. This has occurred even where problematic substance misuse has been framed within 12 Step rhetoric, which argues that addictions are simply different manifestations of 'chemical dependence'. However, while this differentiation between different forms of substance misuse may be viewed as 'artificial', it is how all Western societies and governments have legislated and treated substance misuse through the twentieth century (Williamson 1997). Some drugs (in the broadest sense) are widely tolerated and some are not – the definitions of acceptable and unacceptable use are culturally determined (see Plant 1999). Russia has tightened its drugs laws and hardened its attitude towards illicit drug users in order to toe the line with US government attitudes in this area – as has most of Western Europe. Drugs have come to be considered a national security threat in Russia, whereas alcohol has come to be seen as central to national economic stability.

The five features of the medical model presented in Chapter 1 (body-mind dualism, the mechanical metaphor, reductionism, the technological imperative, the doctrine of specific aetiology) were all identified in the way substance misuse was presented in the print media

and in the health interventions encountered in both regions. Although there had been a shift in the range of actors working in the field of substance misuse, the shift had not been from state health care structures to grassroots NGOs, but from state preventive medicine structures to state-initiated psychological support services. This has not been conducive to the development of community empowerment approaches to health promotion and has not led practitioners to challenge the dominance of the medical model beyond body-mind dualism. Consequently while the approach to individuals with addictions may now be considered more holistic, health promotion interventions continue to focus on the individual in their micro-environment (reductionism), as they had done in the Soviet era. Interventions aim to address 'psychological imperfections', which have been reconstructed as individual 'risk factors' for drug use (the mechanical metaphor).

Another core narrative in the dominant discourse around drug misuse, was that individual psychological disposition towards substance misuse had to be activated by a 'pusher'. Drug users were presented as inevitably involved in 'entrapping' unsuspecting innocent youth in order to feed their habit. Drug users in themselves therefore became a part of the specific aetiology constructing drug misuse / addiction as a disease. However, it should also be noted that through the identification of 'potential' addicts, essentially 'healthy' young people are pathologised by being labelled as belonging to 'risk groups'. No evidence of any contact with drugs is necessary. The screening elements of such approaches are conducive to the extension of surveillance medicine and social iatrogenesis.

There were not found to be great variations in the content of health promotion interventions either between the two research regions or the regional centres and outlying small towns. Indeed the most striking aspect of the data was the high degree of homogeneity in narratives and practices. These narratives were common across different print media, legislation and health educational materials targeting professionals, parents and youth. Harm reduction approaches were incorporated into the main alternative to the conservative hegemonic approach, but they were subordinate discourses evident only in the materials made available to people known to be drug users and in the youth print media. The position of these narratives at the margins of health promotion practice in Russia is a reflection of the marginal and relatively powerless position of both drug users and wider youth in Russian society. However, Russia is not unique in this marginalisation of 'pragmatic' approaches within health promotion – although the Western origins of harm reduction messages have been

demonstrated, and they are exported as they are deemed to reflect best practice, it would be wrong to assume that the export of harm reduction strategies reflects general practice in the West.

The research also demonstrated that aspects of harm reduction discourse are being incorporated and adapted into the hegemonic discursive framework, which is now using harm reduction techniques to identify and control groups labelled 'risks'. 'Harm reduction' can thus become a top-down intervention that does not seek or value input from the client group, who are defined as part of the social problem rather than a part of its solution. This is echoed in the health education interventions targeting youth where the agenda is set by adults and their concerns. For community empowerment models to be a reality, the client group must be central to the definition and resolving of issues – health promotion programmes need to be initiated from the bottom up even where they are facilitated from the top-down. The marginalisation of the primary target audiences for health promotion interventions around drug misuse is a considerable barrier to the development of alternative approaches.

However, from the fieldwork it was also clear that the severe shortage of finance was a more fundamental barrier to the development of any health promotion initiatives and this must be emphasised. Health promotion needs financing, and in order to attract funds, health promotion must be considered a priority by powerful actors. This is more than adequately demonstrated in the different levels of state funding for drug as opposed to alcohol education – evident in the dearth of the latter. A key finding from the fieldwork was the constant flux of programmes and interventions. In the vast majority of cases interventions ceased not because they had successfully achieved all their aims or been proven to be ineffective, interventions finish because organisations failed to find new, or indeed any, sources of funding. Although different health promotion programmes in the UK, for example, also need to bid for limited funds, the socio-economic problems in Russia are more extreme and the additional pressure on acquiring the necessary resources need to be acknowledged as adding an extra dimension to the issue. This is particularly true with regard to the gaps in funding for programmes at a federal and local level, where health education is simply not prioritised or programmes are allocated resources which are never received. The organisations developing programmes are, necessarily, strongly influenced by the agendas of Western funding bodies. This was revealed in the mixing of mutually exclusive approaches to health promotion within single organisations, in order to maximise and concentrate revenues.

The Western funding bodies encountered were aiming to develop 'civil society' through their programmes. Projects involving community empowerment for health would be one way of contributing to this, but for such empowerment to be a reality, the funding bodies would need to open themselves up to lobbying from their client group (i.e. the Russians). However, such an approach would be unlikely from a Western funding organisation, particularly if it was based in a foreign government, because an agenda set locally by the Russian client group might not fit with the predetermined aid objectives of a foreign power. Western funders would need to be more reflexive about the way they operate in Russia if they are to engage genuinely in health promotion activities. Western funders also need to be more realistic about their goal of local sustainability for programmes where both problem and solution have been defined through the limitations of their grant guidelines.

The findings presented in this thesis are in line with global patterns and health promotion debates in that they demonstrate that there is no singular approach to a given health issue, although the medical model does still predominate. The findings also emphasise how hard it is to actually achieve the HFA2000 goal of community empowerment, which is why it was not generally achieved by its year 2000 deadline. This in itself is a clear demonstration of the fact that many barriers to community empowerment and development are common to all countries. The single most significant barrier, however, is that real empowerment means a real devolution of power to a local and even individual level; any loss of power is likely to be resisted. Therefore, any direct or implied criticisms of projects or programmes encountered in the fieldwork need to be read within this global context. Some aspects of the findings show the uniqueness of Russian health promotion, but overall the hegemonic conservative discourse around substance misuse is not unique to Russia, nor is the overall dominance of the medical model in defining and resolving social problems. In Russia, as elsewhere, for health promotion to develop new and innovative approaches to health / social issues, old narratives need to be challenged and not just accepted as 'fact'. Hegemonic discursive frameworks can only be tested by listening to the voices of less powerful and marginal groups, and this provides a key area for future research in the field of both health promotion in Russia and area studies in the field of substance misuse.

The thesis makes a significant contribution to the field of Area Studies as, although post-Soviet health care has received considerable attention, this research is the first to address

specifically how health promotion is developing in Russia. The selection of research regions beyond Moscow and St Petersburg also contributes to the growing body of empirically based work on Russia's regions, which highlights the importance of centre-periphery tensions between federal level policy and the reality of policy implementation or resistance at the local level. The findings in this thesis provide the basis for further research into the development of health promotion in post-Soviet Russia, and other countries of the former Soviet Union. This thesis focused on initiatives around substance misuse, but the theoretical framework and methodological approach developed here might easily be applied to an investigation into other health programmes such as interventions around coronary heart disease, diabetes, sexual health, etc. The findings also contribute to the growing body of work which highlights the need to develop new, more flexible models of health promotion to explain the specifics of countries in the process of economic, political and social transformation. These countries are neither 'developed' nor 'developing', and so challenge inflexible theories and models developed with only 'The West' or 'The South' in mind.

REFERENCES

English Language Sources

Y Anderson and Z Heritage (1996) "The voluntary setting and its contribution to health promotion" in A. Scriven and J. Orme (eds) Health Promotion: Professional Perspectives Basingstoke: Macmillan, pp. 179-186

E Annandale (1998) The Sociology of Health and Medicine: A Critical Introduction Cambridge: Polity Press

D Armstrong (1993) "Public health spaces and the fabrication of identity" Sociology 27:3, pp. 393-410

D Armstrong (1994) "Bodies of Knowledge / Knowledge of Bodies" in C Jones and R Porter (eds) Reassessing Foucault: Power, Medicine and the Body, London: Routledge, pp. 17-27

D Armstrong (1995) "The rise of surveillance medicine" Sociology of Health and Illness 17:3, pp. 393-404

A Aslund (1991) Gorbachev's Struggle for Economic Reform, London: Pinter Publishers

L Attwood (1985) "The new Soviet man and woman – Soviet views on psychological sex differences" in B Holland (ed.) Soviet Sisterhood: British Feminists on Women in the USSR London: Fourth Estate, pp. 54-77

D A Barr and M G Field (1996) "The current state of health care in the former Soviet Union: Implications for health care policy and reform" American Journal of Public Health, 86:3, pp. 307-312

Z Bauman (1997) Postmodernity and its Discontents Cambridge: Polity Press

A Beattie (1991) "Knowledge and control in health promotion: a test case for social policy and social theory" in J Gabe, M Calnan and M Bury (eds) The Sociology of the Health Service London and New York: Routledge, pp. 162-202

U Beck (1992) Risk Society: Towards a New Modernity [trans. Mark Ritter] London: Sage Publications

Bellona (1999) Balakovo Nuclear Power Plant: Fact sheet 60 [Online] URL: http://www.bellona.org/imaker?id=12676&sub=1 [16 January 2001]

D Benner (1999) The Unification Church [Online] URL: http://religiousmovements.lib.virginia.edu/nrms/unification2.html accessed [26 March 2001]

D Black et al. (1982) "Inequalities in health: the Black Report" in P Townsend and N Davieson (eds) Inequalities in Health: the Black Report [new edition] Harmondsworth: Penguin

M Bobak, M McKee, R Rose and M Marmot (1999) "Alcohol consumption in a national sample of the Russian population" Addiction 94:6, pp. 857-866

T Boikova (1986) "The controversial coupon" [Sovetskaya Rossiya 27 March 1986] Current Digest of the Soviet Press 38:17, pp. 7-8

J Brown and N Rusinova (2001) "Curing and crippling: popular perceptions of biomedicine and its competitors in St Petersburg" paper presented at the BASEES Conference, 7-9 April, Fitzwilliam College, Cambridge

Y M Brudny (1991) "The heralds of opposition to *Perestroyka*" in E A Hewitt and V H Wilson (eds), Milestones in Glasnost and Perestroyka: Politics and People, Washington DC: The Brookings Institution, pp. 153-189

M Bruno (1998) "Playing the co-operation game: Strategies around international aid in post-Socialist Russia" in S Bridger and F Pine (eds) Surviving Post-Socialism: Local Strategies and Regional Responses in Eastern Europe and the Former Soviet Union London and New York: Routledge

M Buckley (1993) Redefining Russian Society and Polity, Oxford: Westview Press

R Bunton (1992) "Health promotion as social policy" in R Bunton and G Macdonald (eds) Health Promotion: Disciplines and Diversity, London and New York: Routledge, pp. 129-152

D Burrows (2000) Starting and Managing Needle and Syringe Programs: A Guide for Central and Eastern Europe and the Newly Independent States of the Former Soviet Union New York: Open Society Institute, International Harm Reduction Development [Online] URL: http://www.soros.org/harm-reduction [16 May 2001]

R Castel (1991) "From dangerousness to risk" in G Burchell, C Gordon and P Miller (eds) The Foucault Effect: Studies in Governmentality Chicago: University of Chicago Press, pp. 281-298

R Caplan and R Holland (1990) "Rethinking health education theory" Health Education Journal 49:1, pp. 10-12

P Cohen (2000) "No more kicks" New Scientist, vol. 116, no. 2242, 10 June 2000, pp. 22-26

M S Conroy (1990) "Abuse of drugs other than alcohol and tobacco in the Soviet Union" Soviet Studies, 42:3, pp. 447-480

J M Cooper (2000) "Minatom: the Last Soviet Industrial Ministry" in S Harter and G Easter (eds) Shaping the Economic Space in Russia: Decision making processes,

institutions and adjustment to change in the El'tsin Era, Aldershot: Ashgate, pp. 147-162

D Deacon, M Pickering, P Golding and G Murdoch (1999) Researching Communications: A Practical Guide to Methods in Media and Cultural Analysis London: Arnold

DfID (2000) Britain-Russia Development Partnership Factsheets London: DfID

K Dissanayake, N Geller and E Zyrina (1999) A Directory of Non-Governmental Organisations of Sverdlovsk Oblast, Russia London: The BEARR Trust

M Douglas (1966) Purity and Danger: An Analysis of the Concepts of Pollution and Taboo London: Routledge and Kegan Paul

M Douglas (1986) Risk Acceptability According to the Social Sciences, London: Routledge and Kegan Paul

M Douglas (1992) Risk and Blame: Essays in Cultural Theory, London and New York: Routledge

E Drucker (2000) "From Morphine to Methadone: Maintenance Drugs in the Treatment of Opiate Addiction" in J A Inciardi and L D Harrison (2000) Harm Reduction: National and International Perspectives, pp. 27-45

G Easter (1997) "Redefining Centre-Regional Relations in the Russian Federation: Sverdlovsk Oblast'", Europe-Asia Studies 49:4, pp. 617-635

L Essig (1999) Queer in Russia: A Story of Sex, Self and the Other Durham and London: Duke University Press

F Engels (1987 [1886]) The Condition of the Working Class in England [revised edition] Harmondsworth: Penguin

Eurasia Foundation (2000) Grant Program Guidelines Washington: The Eurasia Foundation

A Evers (1993) "The welfare mix approach. Understanding the pluralism of welfare systems" in A Evers and O Svetlik (eds) Balancing Pluralism: New Welfare Mixes in Care for the Elderly Aldershot: Avebury, pp. 3-31

A Evers (1995) "Part of the welfare mix: the third sector as an intermediate area" Voluntas 6:2, pp. 159-182

L Ewles and I Simnett (1995) Promoting Health: A Practical Guide (Third Edition) London: Bailliere Tindall (in association with the Royal College of Nursing)

M G Field (1994) "Post-Communist medicine: Morbidity, mortality, and the deteriorating health situation" in J R Millar and S L Wolchik (eds.) The Social Legacy of Communism, Cambridge: Woodrow Wilson Center Press, pp 178-195

M G Field (1997) "Health in Russia: The Regional and National Dimensions" in P J Stavrakis et al. (eds) Beyond the Monolith: The Emergence of Regionalism in Post-Soviet Russia Washington: Woodrow Wilson Center Press, pp. 165-180

M Fitzpatrick (2000) The Tyranny of Health: Doctors and the Regulation of Lifestyle, London and New York: Routledge

F Fossato and A Kachkaeva (2000) Russian Media Empires VI RFE/RL Report [Online] URL: http://www.rferl.org/nca/special/rumedia6/ [29 January 2002]

M Foucault (1991) "The Birth of the Asylum" in P Rabinow (ed.) The Foucault Reader, London: Penguin Books, pp. 141-167

M Franchetti (2001) "Russians thrash their drug takers to stop addiction" The Sunday Times (17 June 2001) p. 25

E Goffman (1968) Asylums: Essays on the Social Situation of Mental Patients and Other Inmates, Harmondsworth: Penguin Books

H Graham (1987) "Women's smoking and family health" Social Science and Medicine 25:1, pp. 47-56

L Gurjeva (2001) "Attitudes of the Russian medical profession to traditional medicine, 1950-2000" paper presented at the BASEES Conference, 7-9 April 2001, Fitzwilliam College, Cambridge

C Hann (1996) "Introduction: Political society and civil anthropology" in C Hann and E Dunn (eds) Civil Society: Challenging Western Models London and New York: Routledge, pp. 1-26

N Hart (1985) The Sociology of Health and Medicine Ormskirk: Causeway Books

J Hemment (1999) "Russia's democratization industry: civil society and the manufacture of the third sector" paper presented at the CREES Annual Conference, 18-20 June 1999, Cumberland Lodge, Windsor

J A Holstein and J F Gubrium (1995) The Active Interview (Qualitative Research Methods Volume 37) Thousand Oaks: Sage Publications

D Howorth (1995) "Discourse theory" in D Marsh and G Slater (eds) Theory and Methods in Political Science Basingstoke: Macmillan, pp. 115-133

Human Rights Watch (2000) United States: Punishment and Prejudice: Racial Disparities in the War on Drugs [Online] URL: http://www.hrw.org/reports/2000/usa/ [29 January 2002]

J A Inciardi and L D Harrison (2000) "Introduction: The concept of harm reduction" in J A Inciardi and L D Harrison (eds) Harm Reduction: National and Internatioal Perspectives Thousand Oaks: Sage Publications, pp. vii-xix

Institute for East West Studies [IEWS] (1999a) <u>Russian Regional Report</u> #43, 17 November 1999

Institute for East West Studies [IEWS] (1999b) <u>Russian Regional Report</u> #48, 22 December 1999

Institute for East West Studies [IEWS] (2000a) <u>Russian Regional Report</u> #30, 2 August 2000

Institute for East West Studies [IEWS] (2000b) <u>Russian Regional Report</u> #7, 24 February 2000

Institute for East West Studies [IEWS] (2000c) <u>Russian Regional Report</u> #29, 26 July 2000

Institute for East West Studies [IEWS] (2000d) <u>Russian Regional Report</u> #12, 28 March 2000

Institute for East West Studies [IEWS] (2000e) <u>Russian Regional Report</u> #40, 10 October 2000

Institute for East West Studies [IEWS] (2000f) <u>Russian Regional Report</u> #43, 21 November 2000

N N Ivanets and M I Lukomskaya (1990) "The USSR's New Alcohol Policy" <u>World Health Forum</u>, 11, pp 246-252

N D Jewson (1976) "The disappearance of the sick-man from medical cosmology, 1770-1870" <u>Sociology</u> 10, pp. 225-244

L Jones (1997a) "Promoting health: everybody's business?" <u>in</u> J Katz and A Peberdy (eds) <u>Promoting Health: Knowledge and Practice</u>, Basingstoke: Macmillan Press (in association with The Open University), pp. 2-17

L Jones (1997b) "What is health?" <u>in</u> J Katz and A Peberdy (eds) <u>Promoting Health: Knowledge and Practice</u>, Basingstoke: Macmillan Press (in association with The Open University), pp. 18-36

L Jones and A Cribb (1997) "Ethical issues in health promotion" <u>in</u> J Katz and A Peberdy (eds) <u>Promoting Health: Knowledge and Practice</u>, Basingstoke: Macmillan Press (in association with The Open University), pp. 89-101

V Jupp and C Norris (1993) "Traditions in Documentary Analysis" <u>in</u> M Hammersley (ed.) <u>Social Research: Philosophy, Politics and Practice</u>, London: SAGE Publications, pp. 37-51

R Kay (2000) <u>Russian Women and Their Organizations: Gender, Discrimination, and Grassroots Women's Organizations in Russia 1991-6</u> Basingstoke: Macmillan

O Kharkhordin (1995) "The Soviet individual: Genealogy of a dissimulating animal" in M Featherstone, S Lash and R Robertson (eds) Global Modernities London: SAGE Publications, pp. 209-226

F W Kielhorn (1996) "The history of alcoholism: Bruhl-Cramer's concepts and observations" Addiction, 91:1, pp. 121-128

T Koehler (1999) "Belarusian Youth Organisations between State, Foreign Donors and Informal Realm" MA dissertation, CREES University of Birmingham: Birmingham

J Kornai (1992) The Socialist System: The Political Economy of Communism, Oxford: Clarendon Press

J M Kramer (1988) "Drug addiction in the Soviet Union" Problems of Communism 37:2, pp. 28-40

J M Kramer (1989) "Drug abuse in Eastern Europe: An emerging issue of public policy" Slavic Review, 49:1, pp. 19-31

J M Kramer (1991) "Drug abuse in the USSR" in D E Powell, A Jones and W D Connor (eds) Soviet Social Problems New York: Westview, pp. 94-118

C Krasovsky (1996) "Special focus commentary: The crisis facing the CIS" Drugs: Education Prevention and Policy, 3:1 pp. 7-15

S Kvale (1995) "The Social Construction of Validity" Qualitative Inquiry 1:1 pp. 19-40

S Kvale (1996) "The 1,000 Page Question" Qualitative Inquiry 2:3 pp. 275-284

M Lalonde (1974) A New Perspective on the Health of Canadians Ottawa: Information Canada

S D Lane, P Lurie, B Bowser, J Kahn and D Chen (2000) "The coming of age of needle exchange: A history through 1993" in J A Inciardi and L D Harrison (eds) Harm Reduction: National and International Perspectives, Thousand Oaks: Sage Publications, Inc. pp. 47-68

W Laqueur (1989) The Long Road to Freedom: Russia and Glasnost', London: Unwin Hyman

D A Leon, L Chenet, V M Shkolnikov, S Zakharov, J Shapiro, G Rakhmanova, S Vassin and M McKee (1997) "Huge Variations in Russian Mortality Rates 1984-94: Artefact, Alcohol or What?" The Lancet, 350: 9075, 9 August 1997, pp. 383-388

M B Levin (1997) "Marxism, Bolsheviks and alcoholism" in J Simpura and B M Levin (eds) Demystifying Russian Drinking: Comparative Studies from the 1990s, Helsinki: Stakes, pp. 59-76

D Lupton (1999) <u>Risk</u>, London and New York: Routledge

W B McAllister (2000) <u>Drug Diplomacy in the Twentieth Century: An International History</u>, London and New York: Routledge

S MacGregor (1999) "Medicine, custom or moral fibre: Policy responses to drug misuse" <u>in</u> N South (ed.) <u>Drugs: Cultures, Controls & Everyday Life</u> London: SAGE Publications, pp. 67-85

L McKie (1995) "The art of surveillance or reasonable prevention? The case of cervical screening" <u>Sociology of Health and Illness</u>, 7:4, pp. 441-457

M Marmot (1999) "Introduction" <u>in</u> M Marmot and R G Wilkinson (eds) <u>Social Determinants of Health</u>, Oxford: Oxford University Press, pp. 1-16

G Martin and J Pear (1992) <u>Behavior Modification: What it is and How to do it</u> Englewood Cliffs: Prentice-Hall International, Inc.

C Merridale (2000) <u>Night of Stone: Death and Memory in Russia</u> London: Granta

J Myers and K Marsden (1996) "A self-help approach to health promotion" <u>in</u> A Scriven and J Orme (eds) <u>Health Promotion: Professional Perspectives</u> Basingstoke: Macmillan, pp. 187-195

J Naidoo and J Wills (1994) <u>Health Promotion: Foundations for Practice</u> London: Bailliere Tindall

S Nettleton (1995) <u>The Sociology of Health and Illness</u> Cambridge: Polity Press

S Nettleton and R Bunton (1995) "Sociological critiques of health promotion" <u>in</u> R Bunton, S Nettleton and R Burrows (eds) <u>The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk</u>, London and New York: Routledge, pp. 41-58

D Nutbeam (1986) "Health promotion glossary" <u>Health Promotion</u> 1:1, pp. 113-127

D Nutbeam and E Harris (1999) <u>Theory in a Nutshell: A Guide to Health Promotion Theory</u>, Roseville NSW: McGraw-Hill Australia

L Osheverova (1993) "Children left to be picked up" [<u>Izvestiya</u> 14 September 1993, p.5] <u>Current Digest of the Post-Soviet Press</u> 45:37, p. 27

R Parish (1995) "Health promotion: rhetoric and reality" " <u>in</u> R Bunton and G MacDonald (eds) <u>Health Promotion: Disciplines and Diversity</u> London and New York: Routledge, pp. 13-23

T Parsons (1951) <u>The Social System</u> London: Routledge and Kegan Paul Ltd.

C Patton (1996) "Save sex / save lives: Evolving modes of activism" in T Rhodes and R Hartnoll (eds) <u>AIDS, Drugs and Prevention: Perspectives on Individual and Community Action</u> London and New York: Routledge, pp. 118-132

S Peele and A Brodsky (1997) "Gateway to nowhere: How alcohol came to be scapegoated for drug abuse" <u>Addiction Research</u> 5:5, pp. 419-426

H A Pilkington (1994) <u>Russia's Youth and its Culture: A Nation's Constructors and Constructed</u> London and New York: Routledge

H A Pilkington (1998) "'The future is ours' Youth culture in Russia 1953-present" in C Shelley and D Shepherd (eds) <u>Russian Cultural Studies: An Introduction</u> Oxford: Oxford University Press, pp. 368-85

S Plant (1999) <u>Writing on Drugs</u> London: Faber and Faber

D E Powell (1973) "Drug abuse in Communist Europe" <u>Problems of Communism</u> 22:4, pp. 31-40

M Punch (1993) "Observation and the Police: The Research Experience" in M Hammersley (ed.) <u>Social Research: Philosophy, Politics and Practice</u>, London: SAGE Publications, pp. 181-199

P Reddaway (1983) "Dissent in the Soviet Union" <u>Problems of Communism</u> 32:6, pp. 1-15

A Richardson (1991) "Health promotion through self-help: the contribution of self-help groups" in B Badura and I Kickbusch (eds) <u>Health Promotion Research: Towards a New Social Epidemiology</u>, WHO Regional Publications, European Series No. 37, Copenhagen: WHO, pp. 467-475

E Richardson (1999) "The struggle for sobriety: Anti-alcohol campaigning under Gorbachev and Yeltsin" <u>Research Papers in Russian and East European Studies</u> ResPREES: No. REES99/1, Birmingham: University of Birmingham

D Riley and P O'Hare "Harm reduction: History, definition, and practice" in J A Inciardi and L D Harrison (2000) <u>Harm Reduction: National and International Perspectives</u>, pp. 1-26

J Riordan (1996) "Sexual minorities: the status of gays and lesbians in Russian-Soviet-Russian society" in R Marsh (ed.) <u>Women in Russia and Ukraine</u> Cambridge: Cambridge University Press

M Rivkin-Fish (1999) "Sexuality education in Russia: defining pleasure and danger for a fledgling democratic state" <u>Social Science and Medicine</u> 49, pp. 801-814

A Roxburgh (1991) <u>The Second Russian Revolution: The Struggle for Power in the Kremlin</u>, London: BBC Books

Russian American Chamber of Commerce (1999a) Sverdlovsk Oblast Regional Profile [Online] URL: http://www.rmi.net/racc/regions/Sverdlovsk_region.html [16 January 2000]

Russian American Chamber of Commerce (1999b) Saratov Oblast Regional Profile [Online] URL: http://www.russianamericanchamber.org/regions/Saratov.html [16 January 2001]

M Ryan (1978) The Organization of Soviet Medical Care Oxford and London: Blackwell

S Rybak (1994) "Rise in crime is overtaking rate at which cases are brought to court" [Segodnya 11 March 1994, p. 6] Current Digest of the Post-Soviet Press 46:10, p. 20

R Sakwa (1991) Gorbachev and his Reforms 1985-1990 Englewood Cliffs (NJ): Prentice Hall

R Sakwa (1996) Russian Politics and Society (2nd Edition), London and New York: Routledge

R Sakwa (1998) Soviet Politics in Perspective (2nd Edition) London: Routledge

G E Schroeder (1979) "The Soviet economy on a treadmill of 'reforms'", in Joint Economic Committee, Congress of the United States, Soviet Economy in a Time of Change Washington DC: US Government Printing Office, pp 312-340

D Scott (1998) "Qualitative Approaches to Evaluations of Health-Promoting Activities" in D Scott and R Weston (eds) Evaluating Health Promotion Cheltenham: Stanley Thornes (Publishers) Ltd. pp. 31-48

D Seedhouse (1996) Health Promotion: Philosophy, Prejudice and Practice Chichester: John Wiley and Sons

J Shapiro (1997) "Health and health care policy" in S White, A Pravda and Z Gitelman (eds) Developments in Russian Politics 4 Basingstoke: Macmillan Press Ltd, pp. 169-188

D J B Shaw (1999) Russia in the Modern World: A New Geography, Blackwell Publishers: Oxford

M Shaw, D Darling and G Davey Smith (1999) "Poverty, social exclusion, and minorities" in M Marmot and R G Wilkinson (eds) Social Determinants of Health, Oxford: Oxford University Press, pp. 211-239

L I Shelley (1996) Policing Soviet Society: The Evolution of State Control London and New York: Routledge

V Shlapentokh (1989) Public and Private Life of the Soviet People: Changing Values in Post-Stalin Russia, Oxford: Oxford University Press

D Silverman (2000) <u>Doing Qualitative Research: A Practical Handbook</u> London: SAGE Publications

J Simpura and B M Levin (eds) (1997) <u>Demystifying Russian Drinking: Comparative Studies from the 1990s</u>, Helsinki: Stakes

V Skultans (1999) "Narratives of the body and history: illness in judgement on the Soviet past" <u>Sociology of Health and Illness</u> 21:3, pp. 310-328

D Slider (1997) "Regional and Local Politics" <u>in</u> S White, A Pravda and Z Gitelman (eds) <u>Developments in Russian Politics 4</u> Basingstoke: Macmillan Press, pp. 251-265

D Slider (2001) "Politics in the Regions" <u>in</u> S White, A Pravda and Z Gitelman (eds) <u>Developments in Russian Politics 5</u> Basingstoke: Palgrave, pp. 147-168

S G Solomon (1989) "David and Goliath in Soviet public health: The rivalry of social hygienists and psychiatrists for authority over the *bytovoi* alcoholic', <u>Soviet Studies</u>, 41:2, pp. 254-275

P Stephenson, C Worzala, F Donnay, O Frolova and T Melnik (1998) "Improving women's health services in the Russian Federation: Results of a pilot project" <u>World Bank Technical Paper No. 404</u> Washington DC: The World Bank

S Stephenson (2000) "Civil society and its agents in the post-communist world: the case of the Russian voluntary sector" <u>Social Policy Review</u> 12, pp. 272-294

A Stevenson-Sanjian (1994) "The social construction of deviance and the transition from communist rule" <u>in</u> J R Millar and S L Wolchik (eds) <u>The Social Legacy of Communism</u> New York: Woodrow Wilson Center Press / Cambridge University Press

G V Stimson and M C Donoghoe (1996) "Health promotion and the facilitation of individual change: The case of syringe distribution and exchange" <u>in</u> T Rhodes and R Hartnoll (eds) <u>AIDS, Drugs and Prevention: Perspectives on Individual and Community Action</u>, pp. 10-21

B Stothard and O Romanova (1999) "Moscow Materials: useful habits" <u>Drugs: Education, Prevention and Policy</u> 6:3, pp. 309-319

M A Storey (1995) "The Formation of the Healthy Lifestyle: Theory and Practice of Health Education in the Soviet Union, 1917-1991" MA thesis, Graduate School, Georgetown University: Washington DC

P Strong (1980) "Doctors and the 'dirty work' – the case of alcoholism" <u>Sociology of Health and Illness</u> 2:1, pp. 24-47

D Tarschys (1993) "The success of a failure: Gorbachev's alcohol policy 1985-88" <u>Europe-Asia Studies</u> 45:1, pp. 7-25

I Tartakovskaya (2000) "The changing representation of gender roles in the Soviet and post-Soviet press" in S Ashwin (ed.) Gender, State and Society in Soviet and Post-Soviet Russia, London: Routledge, pp. 118-136

(1999) The Territories of the Russian Federation (1st Edition), London: Europa Publications Ltd.

K Thomson (2001) "Services for people with learning difficulties in the Russian Federation: a case-study approach to the development of a post-communist welfare system" PhD thesis, CREES University of Birmingham: Birmingham

N Thorogood (1992) "What is the relevance of sociology for health promotion?" in R Bunton and G Macdonald (eds.) Health Promotion: Disciplines and Diversity, London and New York: Routledge, pp. 42-65

S J Tillinghast and V E Tchernjavskii (1996) "Building health promotion into health care reform in Russia" Journal of Public Health Medicine 18:4, pp. 473-477

E Tkatchenko, M McKee and A D Tsouros (2000) "Public health in Russia: the view from the inside" Health Policy and Planning 15:2, pp. 164-9

K Tones and S Tilford (1994) Health Education: Effectiveness, Efficiency and Equity [second edition] London: Chapman and Hall

F Tonkiss (1998) "Analysing discourse" in C Seale (ed.) Researching Society and Culture London: SAGE Publications, pp. 245-260

V G Treml (1987) "Gorbachev's anti-drinking campaign: A noble experiment or a costly exersise in futility?" RFE/RL Supplement, 18 March 1987

V G Treml (1991) "Drinking and alcohol abuse in the USSR in the 1980's" in D E Powell, A Jones and W D Connor (eds), Soviet Social Problems, New York: Westview, pp. 119-136

A Trojan, H Hildebrandt, C Deneke and M Faltis (1991) "The role of community groups and voluntary organizations in health promotion" in B Badura and I Kickbusch (eds) Health Promotion Research: Towards a New Social Epidemiology, WHO Regional Publications, European Series No. 37, Copenhagen: WHO, pp. 441-466

A Tyler (1986) Street Drugs London: Hodder and Stauton

UNICEF (2000) "Young People in Changing Societies" Regional Monitoring Reports No. 7 Florence: UNICEF Innocenti Research Centre

UNICEF (2001) "A Decade of Transition" Regional Monitoring Reports No. 8 Florence: UNICEF Innocenti Research Centre

G Vines (1999) "The gene in the bottle" New Scientist 164:2214, 27 November1999, pp.39-43

J Vollmann and R Winau (1996) "Informed consent in human experimentation before the Nuremberg code" <u>British Medical Journal</u> 313, pp. 1445-9

VSO (1999) <u>Strategic Plan Eastern Europe 1999-2003</u> London: VSO

C Waldby (1996) <u>AIDS and the Body Politic: Biomedicine and Sexual Difference</u> London and New York: Routledge

J Waterson (2000) <u>Women and Alcohol in Social Context: Mother's Ruin Revisited</u> Basingstoke: Palgrave

A Watt and S Rodmell (1993) "Community involvement in health promotion: Progress or panacea?" <u>in</u> A Beattie, M Gott, L Jones and M Sidell (eds) <u>Health and Wellbeing: A Reader</u> Basingstoke: Macmillan (in association with the Open University), pp. 6-13

K Weare (1992) "The contribution of education to health promotion" <u>in</u> R Bunton and G Macdonald (eds) <u>Health Promotion: Disciplines and Diversity</u>, London and New York: Routledge, pp. 66-85

J R Wedel (1998) <u>Collision and Collusion: The Strange Case of Western Aid to Eastern Europe 1989-1998</u> Basingstoke: Macmillan 1998

D Wedgwood Benn (1996) "The Russian Media in Post-Soviet Conditions" <u>Europe-Asia Studies</u> 48:3, pp. 471-9

T Whewell (2000) "Poachers turned gamekeepers?" <u>Crossing Continents</u> BBC Radio 4 (23 March 2000)

A White (1989) "Social movements: Unofficial associations and social welfare in Novosibirsk" <u>Detente</u> 16, pp. 26-30

S White (1996) <u>Russia Goes Dry: Alcohol, State and Society</u>, Cambridge: Cambridge University Press

C Williams (1991) "Old habits die hard: Alcoholism in Leningrad under NEP and some lessons for the Gorbachev administration" <u>Irish Slavonic Studies</u> 12, pp. 69-96

C Williams (1994) "Sex education and the AIDS epidemic in the FSU" <u>Sociology of Health and Illness</u> 16:1, pp. 81-102

C Williams (1995) <u>AIDS in Post-Communist Russia and its Successor States</u> Aldershot: Avebury

C Williams (1996) "Russian health care in transition" <u>in</u> C Williams, V Chuprov and V Staroverov (eds), <u>Russian Society in Transition</u>, Aldershot: Dartmouth, pp. 183-202

K Williamson (1997) <u>Drugs and the Party Line</u> Edinburgh: Rebel inc.

World Health Organisation (1978) <u>Declaration of Alma-Ata</u> [Online] URL: http://www.who.dk/policy/AlmaAta.htm [6 July 1999]

World Health Organisation (1986) <u>Ottawa Charter for Health Promotion</u> [Online] URL: http://www.who.dk/policy/ottawa.htm [6 July 1999]

E Zdravomyslova and E Chikadze (2000) "Scripts of men's heavy drinking" <u>Idatutkimus</u>, 2:2000, pp. 35-52

Russian Language Sources

R Arifdzhanov (1994) "Zdorov'e pyushchego naseleniya Rossii vnov' beregaya pod okhranu gosudarstva" <u>Izvestiya</u> (no. 078) 26 April 1994, p. 1

S Avdeev (1999) ""Uralmashevtsy" menyayut imidzh" <u>Izvestiya</u> (no. 207) 3 November 1999, p. 2

V Averbukh (1998) "Rossiyu zakhlestyvaet tret'ya volna bezprizornosti" <u>Izvestiya</u> (no. 172) 15 September 1998, p. 5

E A Babayan (1997) "Drugs: vne zakona" <u>Ptyuch</u> (no. 6) June 1997, p. 76

E Babenko (1997) "S 1 iyulya pokhmel'e legche ne stanet" <u>Segodnya</u> (no. 129) 25 June 1997, p. 2

S Baimukhametov (1998) "My p'em ne po svoei vole" <u>Izvestiya</u> (no. 124) 9 July 1998, p. 6

S V Bakal et al. (1999a) <u>Programma zanyatii po preduprezhdeniyu narkogennoi zavisimosti u detei starshego doshkol'nogo vozrasta</u> Saratov: Izdatel'stvo saratovskogo universiteta

S V Bakal et al. (1999b) <u>Programma zanyatii po preduprezhdeniyu narkogennoi zavisimosti u detei shkol'nogo vozrasta: Posobie po provedeniyu psikhologo-pedagogicheskogo treninga</u> Saratov: Izdatel'stvo saratovskogo universiteta

T Bateneva (1997a) "Verkhi ne mogut, zato mogut nizy" <u>Izvestiya</u> (no. 031) 18 February 1997, p. 2

T Bateneva (1997b) "Bolnykh opyat' sdelayut zekami" <u>Izvestiya</u> (no. 071) 16 April 1997, p. 5

T Bateneva (1997c) "Klyuch k lecheniyu v rukakh samogo bol'nogo" <u>Izvestiya</u> (no. 141) 30 July 1997, p. 6

T Bateneva (1998a) "Narkopozhar strakhom ne potushish'" <u>Izvestiya</u> (no. 007) 16 January 1998, p. 2

T Bateneva (1998b) "Narkology obvinyayut diskoteki" <u>Izvestiya</u> (no. 135) 24 July 1998, p. 2

T Bateneva (1999a) "Korona Andreya Anichkova" <u>Izvestiya</u> (no. 124) 9 July 1999, p. 5

T Bateneva (1999b) "Kazhdyi vtoroi russkii – yaponets" <u>Izvestiya</u> (no. 131) 20 July 1999, p. 6

T Bateneva (2000a) "Narkomana nado peregret'. Metodika sibirskikh vrachei porazila anesteziologov vsego mira" <u>Izvestiya</u> (no. 125) 8 July 2000, p. 2

T Bateneva (2000b) "Retsept dlya naroda" <u>Izvestiya</u> (no. 170) 9 September 2000, p. 8

T Bateneva (2000c) "Permskii period" <u>Izvestiya</u> (no. 231) 7 December 2000, p. 8

E Berezina (1994) "Otsepenelye" <u>Rabotnitsa</u> (no. 12) December 1994, pp. 16-18.

V Brodzkii (2001) "Pevitsa Zemfira: khochy skazat' cherez "Komsomol'ku" vsem - ya ne narkomanka!" <u>Komsomol'skaya pravda</u> (no. 059) 3 April 2001, p. 2

B Bronshtein (2000) "Konsilium akusherov" <u>Izvestiya</u> (no. 033) 22 February 2000, p. 9

S Builo (1994) "6 kilogrammov opiya za odin tol'ko den'" <u>Segodnya</u> (no. 234) 7 December 1994, p. 7

S Builo (1996) "Rasstrel, Soldaty-pervogodki perestrelyali voinskii karaul" <u>Segodnya</u> (no. 187) 11 October 1996, p. 6

M Buyanov (1998) "Narkoman dolzhen znat': on – nepolnotsennyi chlen obshchestva" <u>Izvestiya</u> (no. 214) 14 November 1998, p. 5

S Chugaev (1996) "G. Zyuganov prodolzhaet kleimit' SMI" <u>Izvestiya</u> (no. 120) 29 June 1996, p. 1

A Chuikov (1999) "Bol'nykh v soldaty zabrivat' ne budut" <u>Izvestiya</u> (no. 058) 2 April 1999, p. 2

O Dmitrieva (1985) "Ryumka protiv detstva" <u>Komsomol'skaya pravda</u> (no. 130) 8 June 1985, p. 2

S Dobrynina (1998) "Tainye tropy chumy XX veka" <u>Nezavisimaya gazeta</u> (no. 017) 4 February 1998, p. 4

M Domashenko (1993) "Pyatnadtsatiletnii alkogolik" <u>Rabotnitsa</u> (no. 8) August 1993, pp. 26-7

A I Druzhinin (1998) <u>Narkomaniya – Chto eto takoe. (Eto dolzhen znat' kazhdii rossiyanin.)</u> Ekaterinburg: BF Shichko

A I Druzhinin (2000) <u>Narkotiki: alkogol', geroin, nikotin i drugie</u> Ekaterinburg: Izdatel'stvo "Poligrafist"

G M Entin (1985) "Ne sokrashchaite gody svoei zhizni" <u>Zdorov'e</u> (no. 8) August 1985, p. 10

<u>Federal'nyi zakon</u> (1998) "O narkoticheskikh sredstvakh i psikhotropnikh veshchestvakh" Moskva: Izdatel'stvo "Ost-89"

I Fedorov (1994) "Deistviya narkologov ne ravny protivodeistviyu" <u>Segodnya</u> (no. 102) 2 June 1994, p. 9

V Filippov (1997) "'Metro' v Vologde vsegda peregruzheno" <u>Izvestiya</u> (no. 141) 30 July 1997, p. 6

A A Gabiani (1987) "Narkomaniya: gorkie plody sladkoi zhizni" <u>Sotsiologicheskie issledovaniya</u> 1:1987, pp. 48-53

A A Gabiani (1990) <u>Na krayu propasti: narkomaniya i narkomany</u> Moskva: "Mysl'"

A A Gabiani (1992) "Kto takie narkomany?" <u>Sotsiologicheskie issledovaniya</u> 2:1992, pp. 78-83

V Gel'man (2000) "Transformatsii i rezhimy. Neopredelennoct' i ee posledstviya" <u>in</u> V Gel'man, S Ryzhenkov and M Bri (eds) <u>Rossiya regionov: transformatsiya politicheskikh rezhimov</u> Moscow: Izdatel'stvo "Ves' Mir" / "Berliner Debatte Wissenschaftsverlag"

Goskomstat (2000) <u>Regiony Rossii: statisticheskii sbornik</u>, [Online] URL: http://www.info.gks.ru/scripts/1cinet.exe?R44 [4 March 2002]

V V Gul'dan, O L Romanova, O K Sidenko, A M Korsun and M V Shvedova (1989) "Predstavleniya shkol'nikov o narkomanii i toksikomanii" <u>Sotsiologicheskie issledovaniya</u> 3:1989, pp. 66-71

I Guseeva (1996) "Seks & narkotiki" <u>Dilizhans</u> (no. 10), pp. 26-9

"Ispoved' byvshei narkomanka" (2000) <u>Ptyuch</u> (no. 7-8), July 2000, p. 78

B F Kalachev (1989) "Narkotiki v armii" <u>Sotsiologicheskie issledovaniya</u> 4:1989, pp. 56-61

V Kantor (1993) "Peite ostorozhno" <u>Segodnya</u> (no. 102) 24 December 1993, p. 6

O Karmaza (1997) "GOROD-SPID" <u>Komsomol'skaya pravda</u> (no. 229) 11 December 1997, pp. 8

V D Kaz'min (1988) "Kogda rozhdaetsya slaboumnyi rebenok" <u>Zdorov'e</u> (no. 9), September 1988, pp. 13-14

L E Kesel'man (1998) "Sotsial'nye koordinaty rossiiskogo narkotizma" <u>Mir Rossii</u> 4: 1998, pp. 93-112

V Khamraev (1997) "Do pensii dozhivet lish' polovina nyneshnykh podrostok" <u>Segodnya</u> (no. 096) 15 May 1997 p. 3

A P Kiryushchenkov (1986) "V nasledstvo ot p'yushchei materi" <u>Zdorov'e</u> (no. 7), July 1986, pp. 8-9

A Kislov and S Orlenko (1998) "Budet li na ulitsakh Saratova krasnye fonari?" <u>Izvestiya</u> (no. 032) 20 February 1998, p. 4

M Latysheva (1998) "V lipetskikh tyur'makh nachali bor'bu so SPIDom" <u>Segodnya</u> (no. 153) 16 July 1998, p. 6

S Leskov (1999) "A u tebya SPID – znachit my umrem" <u>Izvestiya</u> (no. 194) 15 October 1999, p. 1

S Leskov and L Orekhova (1997) "V Kaliningrade sobirayutsya legalizovat' prostitutsiyu" <u>Izvestiya</u> (no. 176) 17 September 1997, p. 2

T Liri [Timothy Leary] (1996) "Flashbacks" <u>Ptyuch</u>, (no. 3), March 1996, p. 33

V Litovkin (1996) "Ubiitsi sakhalinskikh soldat zaderzhany. Istoky tragedii ishchut" <u>Izvestiya</u> (no. 194) 15 October 1996, p. 1

V Litovkin (1998) "Alkogoliki i narkomany Moskvy v armii sluzhit' ne budut" <u>Izvestiya</u> (no. 056) 27 March 1998, p. 1

V Litovkin and B Reznik (1996) "Novaya tragediya na Sakhaline: soldaty snova strelyali v soldat" <u>Izvestiya</u> 11 October 1996, p. 2

Mezhvedomstvennaya komissiya po delam nesovershennoletnikh pri Pravitel'stve Saratovskoi oblasti (2000) <u>Sbornik gosudarstvennykh uchrezhdenii, obshchestvennykh organizatsii, fondov, zanimayushchikhsya profilaktikoi pravonarushenii nesovershennoletnikh, zashchitoi ikh prav i zakonnykh interesov</u> Saratov: SGPT-6

A Milovidova (1996) "Narkotiki – eto vredno, no vredno li o nikh znat'?" <u>Dilizhans</u> (no. 10), pp. 2-3

Ministerstvo zdravookhraneniya Rossiiskoi Federatsii [Minzdrav] (1996) <u>Gosudarstvennyi Doklad: O sostoyanii zdorov'ya naseleniya rossiiskoi Federatsii v 1995 godu</u>, Moskva: Ministerstvo zdravookhraneniya

A Mitrofanov (2000) "Vspomnim" <u>Izvestiya</u> (no. 087) 16 May 2000, p. 12

V Moskalenko (1991a) "Byiti zamuzh za… alkogolika" <u>Rabotnitsa</u> (no. 3) March 1991, pp. 24-6

V Moskalenko (1991b) "Deti v alkogol'noi sem'e" <u>Sem'ya i shkola</u> (no. 8) August 1991, pp. 34-6

V Moskalenko (1992) "Poteryannyi rebenok" <u>Sem'ya i shkola</u> (nos. 4-6) April-June 1992, pp. 26-7

V Moskalenko (1994) "Naprasnaya zhertva" <u>Krest'yanka</u> (no. 2) February 1994, pp. 22-3

A V Nemtsov (1995) <u>Alkogol'naya situatsiya v Rossii</u> Moskva: Fond "Zdorov'e i Okruzhayushchaya Sreda"

O Nosova (1999) "Kolyu v Kaliningrade znaet kazhdaya sobaka" <u>Komsomol'skaya pravda</u> (no. 130) 16 July 1999 p. 4

E L Omel'chenko (ed.) (1999) <u>Podrostki i narkotiki: opyt issledovaniya problemy v shkolakh Ul'yanovska</u> Ul'yanovsk: UlGU

E L Omel'chenko (ed.) (2000) <u>Geroinashegovremeni: sotsiologicheskie ocherki</u> Ul'yanovsk: Izdatel'stvo "Srednevolzhskii nauchnyi tsentr"

"O merakh po preodolehiyu p'yanstva i alkogolizma" <u>Meditsinskaya Gazeta</u> (no. 39), 17 May 1985, pp. 1-2

I Petrova (1996) "'Vintovaya' lestnitsa" <u>Dilizhans</u> (no. 10), pp. 12-13

V A Popov and O Yu Kondrat'eva (1998) "Narkotizatsiya v Rossii – shag do natsional'noi katastrofy" <u>Sotsiologicheskie issledovaniya</u> 8:1998, pp. 65-8

"Pravda ob E" (1996) <u>Ptyuch</u> (no. 3), March 1996, p. 25

E Radov (1998) "Bortsy za bezopasnyi kaif" <u>Ptyuch</u> (no. 1) January 1998, pp. 76-7

"Rastavlyaya tochki nad E" (1997) <u>Ptyuch</u> (no. 5), May 1997, pp. 52-3

Rossiiskaya gazeta (1998) "Narkomaniya v Rossii: ugroza natsii" <u>Rossiiskaya gazeta</u> (no. 041) 3 March 1998, p. 3

N Rostova (1999) ""Dno" vysshevo razryada" <u>Komsomol'skaya pravda</u> (no. 111) 21 June 1999, p. 12

N Ryzhkov (1992) <u>Perestroika: istoriya predatel'stv</u>, Moskva: Novosti

V Sedov (1996) "Proroky psikhodelicheskogo raya" <u>Dilizhans</u> (no. 10), pp. 4-9

K A Shchadilova (ed.) (1989) "Narkomaniya s tochki zreniya sotsiologa, vracha, pravoveda i zhurnalista (obsuzhdenie za "kruglym stolom" redaktsii)" <u>Sotsiologicheskie issledovaniya</u> 2:1989, pp. 38-51

L Shinkarev (1998) "V Rossii – narkopozhar" <u>Izvestiya</u> (no. 004) 13 January 1998, pp. 1, 5

B Shkol'nikov, E Andreev and T Malevaya (eds.) (2000) <u>Neravenstvo i smertnost' v Rossii</u> Moskva: Mosk. Tsentr Karnegi

I E Shteinberg (ed.) (1998) <u>Podrostkovaya narkomaniya: igry so smert'yu (1st edition)</u> Saratov: Izdatel'stvo Saratovskogo Universiteta

I E Shteinberg (ed.) (1999) <u>Igry so smert'yu: podrostkovaya narkomaniya (2nd edition)</u> Saratov: Izdatel'stvo Saratovskogo Universiteta

V Sidorov (1998) "My p'em, a vina finnov?" <u>Izvestiya</u> (no. 155) 21 August 1998, p. 5

U Skaibeda (1999) "Bratki vyshibayut "dur'" s rodiny El'tsina" <u>Komsomol'skaya pravda</u> (no. 204) 2 November 1999, pp. 12-3

S A Stivenson (1996) "O fenomene bezdomnosti", <u>Sotsiologicheskie issledovaniya</u>, 8:1996, pp. 26-33

V V Strebizh (ed.) (1996) <u>Vnimanie: opasnost'! Deti i narkotiki (2nd edition)</u> Ekaterinburg: Diamant

V V Strebizh and O Yu Strebizh (1998) <u>Vrednye privychki nesovershennoletnykh</u> Ekaterinburg: Detskii Pravozashchitnyi Fond "Shans"

A Tarasov (1996) "Gorod, kotoryi lopnul" <u>Izvestiya</u> (no. 211) 10 November 1996, p. 1

E Tokareva (1985) "Slabost' ili popustitel'stvo?" <u>Izvestiya</u> (no. 250) 7 September 1985, p. 3

A Tret'yakova (1996) "Opasnaya zavisimost'" <u>Sem'ya i shkola</u> (no. 6) June 1996, pp. 16-19

"Uluchshat' narkologichskuyu pomoshch'" <u>Meditsinskaya Gazeta</u> (no. 90 13 November 1985, p. 1

B Urigashvili (1997) "Glavnyi voennyi vospitatel' umeet ob"yasnit' tragedii" <u>Izvestiya</u>, 11 June 1997, p. 2

N Varsegov (2001) "Ocharovannyi strannik: Otmyvayut gryaz', podostovernym dannym, bratki svoim aparteidom bannym" <u>Komsomol'skaya pravda</u> (no. 147) 15 August 2001, p. 8

A Verda (1997) "Demograficheskii krest Rossii" <u>Nezavisimaya gazeta</u> (no. 087) 15 May 1997, pp. 1-2

D Volchek (2000) "Narkotik, kotoryi vsegda s toboi" <u>Om</u> (no. 1-2) January-February 2000, pp. 110-112, 141)

A G Zerenin (1995) "Ryumka vodki i proizvoditel'nost' truda" <u>Zdorov'e</u> (no. 6) June 1985, pp. 26-7

D Zharkov (1996) "Zakon i narkotik" <u>Ptyuch</u> (no. 8) August 1996, pp. 42-3

A Zheludok (1994) "Kto, kak i gde budet teper' lechit'sya ot alkogolizma?" <u>Izvestiya</u> (no. 011) 20 January 1994, p. 3

L A Zhuravleva (2000) "Faktory i usloviya narkotizatsii molodezhi" <u>Sotsiologichskie issledovaniya</u> 6: 2000, pp. 43-8

V Zuikov (1995) "Sever prodolzhayut spaivat'" <u>Izvestiya</u> (no. 005) 12 January 1995, p. 5

German Language Sources
I Shedrova (2001) "Übungen im Schnee" <u>Der Spiegel</u> No. 3 (15 January 2001), p. 129

Appendix 1: List of Organisations at which Interviews were Conducted (1999-2000)

Appendix 1 is not available in the web version of this thesis

Appendix 2: Leaflets, Pamphlets and Unpublished Materials

Efforts have been made to ensure that details are as complete as possible, including authorship, sponsorship (particularly for health education materials), print run and year. Where such information is not clear some estimates have been made based on interview data and circumstantial evidence and is indicated by the use of 'circa' [c.]. Where materials had ISBN numbers to denote that they were regular publications, they have been included in the bibliography rather than here. These materials have been divided into four thematic groups and are grouped by the organisation which produced them.

Leaflets targeting youth:

Narkotiki, chto ya khochu znat' o nikh: dlya tekh, komu 14-21 Ekaterinburg: City Narcological Hospital 2000 (editor J. Rushworth).

Podumai o budushchem! Ekaterinburg: Rubikon c. 1999 (author: S. V. Mityushov, sponsors: "Baz" Joint-Stock Company).

Molodezhnyi marsh: "Ya vybirayu zhizn'!" Ekaterinburg: the Urals Interregional Federation of Families for Unification and Peace in the Whole World c. 2000 (co-sponsors: "Mirekc" Advertising and Publishing Agency; Kholis; "Alpha-K" Company; "My" Design Studio; EMTS [Ekaterinburg telecom]; Baskin Robbins; Casio Citizen "Belka Ural"; "Shelkovyi put'" Fabrics; "Format" Printing House; "Uralmash" Factory).

My vybiraem zhizn' [poster] Nizhnii Tagil: Municipal Administration Youth Affairs Committee c. 2000 (artist: unknown young winner of local competition).

Skazhi sebe: net! Kak ne stat' zhertvoi narkomanii Nizhnii Tagil: Central Municipal Library Information Dept. 1997 (author: T. M. Kozienko).

"Net – narkotikam!": Mneniya "za" i "protiv" Nizhnii Tagil: Central Municipal Library Information Dept. 1998 (author G. A. Safronova).

Otvetstvennost' za pravonarusheniya, svyazannye s nezakonnym oborotom narkoticheskikh sredstv Nizhnii Tagil: Municipal Administration Youth Affairs Committee 2000 (produced with the NGO Support Resource Centre).

Narkotiki i zakon (informatsiya dlya vsekh) Nizhnii Tagil: Municipal Administration Youth Affairs Committee 2000.

Vybor za toboi (sovety molodomu cheloveku) Nizhnii Tagil: Municipal Administration Youth Affairs Committee 2000.

Narkotik opasen dlya zhizni! [poster] Nizhnii Tagil: Municipal Preventive Medicine Centre 1998, 1000 copies printed.

Narkomaniya – put' v bezdnu Nizhnii Tagil: Municipal Preventive Medicine Centre 1998, (authors M G Tsetlin and M M Vedishcheva © 1991 All-Union Scientific-Research Centre of Preventive Medicine, USSR Ministry of Health, Moscow). 1000 copies printed.

Tebe, podrostok! Saratov: Regional Centre of Complex Social Services for Children and Young People 1999.

Tebe, podrostok..! Saratov: Regional Centre of Complex Social Services for Children and Young People 1999.

Leaflets targeting parents:

Mify o narkotikakh dlya roditelei Ekaterinburg: City Narcological Hospital 2000 (editor J. Rushworth).

Chto nado znat' vzroslym o narkotikakh: Esli u Vas est' deti, prochitaite etot buklet Ekaterinburg: City Narcological Hospital 2000 (editor J. Rushworth).

Chto nado delat' roditelyam, chtoby rebenok ne stal narkomanom Ekaterinburg: Rubikon c. 1999 (author S. V. Mityushov? Sponsors: Nash Dom Nash Gorod Urals Region Political Movement?).

Pamyatka roditelyam: chto delat' chtoby uberech' detei ot narkotikov Ekaterinburg: Kholis c. 1999 (sponsors: the Urals Interregional Federation of Families for Unification and Peace in the Whole World and the Sverdlovsk Oblast Federation of Women for Peace in the Whole World [both Unification Church front organisations]). 3000 copies printed.

Ya vybirayu zhizn'! Zdorovyi obraz zhizni, nastoyashchaya druzhba, chistaya lyubov', schastlivyi brak Ekaterinburg: the Urals Interregional Federation of Families for Unification and Peace in the Whole World c. 2000, 10,000 copies printed.

Pomogite svoim detyam! Nizhnii Tagil: Municipal Preventive Medicine Centre 1998, 1000 copies printed.

Vnimanie, poditeli! Rebenok i narkotiki [poster] Nizhnii Tagil: Municipal Preventive Medicine Centre 1998, 1000 copies printed.

Simptomy narkoticheskogo op'yaneniya Nizhnii Tagil: Municipal Preventive Medicine Centre 1998 (author: E. L. Svirskii, Sverdlovsk Oblast Preventive Medicine Centre with "Psychiatry") 4000[?] copies printed.

Podrostkovaya narkomaniya: pamyatka dlya roditelei (I) Saratov: Regional Centre of Complex Social Services for Children and Young People 1999.

Podrostkovaya narkomaniya: pamyatka dlya roditelei (II) Saratov: Regional Centre of Complex Social Services for Children and Young People 1999.

Leaflets targeting active drug users:

Tsentr reabilitatsii: Kak sdelat' vybor Ekaterinburg: City Narcological Hospital 2000 (editor J. Rushworth).

SPID: gepatit: infektsiya, peredavaemye polovym putem: zabolevaniya ven: zakon Ekaterinburg: Forpost 2000.

Zashchiti sebya sam: ob okhrane zdorov'ya tekh, kto upotreblyaet narkotiki Nizhnii Tagil: Municipal Preventive Medicine Centre and Engel'sskii Regional Narcological Clinic 1998.

Zashchiti sebya sam: skazhem net gepatitu Balakovo: NAN 2000 (based on MSF materials).

Zashchiti sebya sam: SPID i VICh Balakovo: NAN 2000 (based on MSF materials).

Zashchiti sebya sam: peredozirovka Balakovo: NAN 2000 (based on MSF materials).

Zashchiti sebya sam: zakon Balakovo: NAN 2000 (based on MSF materials).

Doza razuma: zhurnal dlya potrebitelei narkotikov Balakovo: Harmony 2000.

Mozg #1, Moscow: MSF 1999.

Mozg #2, Moscow: MSF 1999.

Mozg #3, Moscow: MSF 1999.

Mozg #4, Moscow: MSF 2000.

Promotional leaflets:

Uvazhaemye papy i mamy! [poster] Ekaterinburg: Rubikon c. 2000 (author Mityushov; sponsor "Nash Dom – Nash Gorod").

Rubikon Ekaterinburg: Rubikon c. 2000.

Rubikon Ekaterinburg: Rubikon c. 2000 (with "Nash Dom – Nash Gorod").

Shans Detskii pravozashchitnyi fond Ekaterinburg: Chance c. 1999.

OO RKPITs "Zhivaya mysl'" Ekaterinburg: Living Thought 1999.

Vdvoem vsegda legche telefon doveriya Ekaterinburg: Kholis c. 1999 (sponsors: "Yuran" Trading House).

Sluzhba sotsial'no-psikhologicheskoi pomoshchi Ekaterinburg: Forpost c. 2000.

Vnimanie! Sluzhby sotsial'noi pomoshchi Nizhnii Tagil: Municipal Administration Youth Affairs Committee c. 2000.

My za zhizn' bez narkotikov! Nizhnii Tagil: "I, You, He, She…" c. 2000.

Molodezhnyi tsentr sotsial'no-psikhologicheskoi i pravovoi pomoshchi Pervoural'sk: Sotsium c. 2000 (sponsored by the Youth Affairs Committee, Pervoural'sk Municipal Education Department).

Press – reliz Engel's: Sotsium c. 2000.

Informatsionnaya spravka Engel's: Practical Psychology Service Centre [Sotsium] c. 2000.

Lectures and School Programmes:

Lektsiya dlya podrostkov starshego i srednego shkol'nogo vozrasta Ekaterinburg: Rubikon c. 1999 (author S. V. Mityushov; sponsor "Nash Dom-Nash Gorod").

Lektsiya dlya roditelei po profilaktike narkomanii Ekaterinburg: Rubikon c. 1999 (author S. V. Mityushov; sponsor "Otechestvo"?).

Plan provedeniya programmy obucheniya No. 8 [Handout 1 for parents attending drugs prevention lecture series] Ekaterinburg: Rubikon c. 2000 (with "Nash Dom – Nash Gorod".

Osnovnye pravila programmy obucheniya [Handout 2 for parents attending drugs prevention lecture series] Ekaterinburg: Rubikon c. 2000 (with "Otechestvo").

Printsipy dostizheniya tseli [Handout 3 for parents attending drugs prevention lecture series] Ekaterinburg: Rubikon c. 2000.

Privykanie… [Handout 4 for parents attending drugs prevention lecture series] Ekaterinburg: Rubikon c. 2000.

Programma obucheniya metodike profilaktiki narkomanii [Handout 5 for parents attending drugs prevention lecture series] Ekaterinburg: Rubikon c. 2000 (with "Nash Dom – Nash Gorod").

Dannye anketirovaniya [Handout 6 for parents attending drugs prevention lecture series] Ekaterinburg: Rubikon c. 2000.

[Handout at drugs seminar for professionals] Ekaterinburg: Forpost 2000.

Programma regional'nogo kul'turno-prosvetitel'skogo i informatsionnogo tsentra "Zhivaya mysl'" po problemam profilaktiki zloupotrebleniya psikhoaktivnymi veshchestvami sredi molodezhi Ekaterinburg: Living Thought c. 1999.

Tekhnoligii sotsial'no-psikhologicheskoi raboty v profilaktike narkomanii Saratov: Regional Centre of Complex Social Services for Children and Young People 2000 (with the RF State Youth Policy Committee and Saratov Oblast Ministry of Youth, Sport and Tourism Affairs; editor: E. B. Baryabina).

Profilaktika alkogolizma i narkomanii v uchebnykh zavedeniyakh Balakovo: Harmony 2000 (author: L. B. Markaryan; sponsor: Eurasia Foundation?).

Anketa dlya uchashchikhsya nachal'noi shkoly (2-3 klassy) [survey questions for schools programme] Engel's: Sotsium c. 2000.