Policy Responses to Drugs, Drug Users and HIV in Armenia: Need for Change

Research Paper

Written

by

Karine Markosyan, PhD, MPH

International Policy Fellow 2004-2005

Yerevan - 2005

TABLE OF CONTENTS

ABBREVIATIONS

RA – Republic of Armenia
fSU- former Soviet Union
HIV - Human Immunodeficiency Virus
AIDS – Acquired Immunodeficiency Syndrome
IDU – injection drug use/user
WHO- World Health Organization
UN – United Nations
UNAIDS – United Nations Special Programme on HIV/AIDS
UNGASS – United Nations General Assembly Special Session
UNCHR - UN High Commissioner for Human Rights
CND – Commission on Narcotic Drugs (within United Nations)
INCB – the International Narcotics Control Board (within United Nations)
UNODC- United Nations Office on Drugs and Crime
OSI – Open Society Institute
GFATM – Global Fund to fight AIDS, Malaria and Tuberculosis
UDHR – Universal Declaration of Human Rights
ICCPR - International Covenant on Civil and Political Rights
ICESCR - International Covenant on Economic, Social, and Cultural Rights
STI – sexually transmitted infections
VCT – voluntary counseling and testing
NGO – non-governmental organization
PLWHA – people living with HIV/AIDS
CCM – Country (Armenia) Coordination Mechanism on HIV/AIDS Issues
SCAD - Southern Caucasus Anti-Drug Programme

1. INTRODUCTION

The former Soviet Union continues to experience an unprecedented growth of HIV epidemic (1). This epidemic of intravenous drug users is an epidemic of the young: according to some research, the average age at first injection in the region is anywhere from 12 to 19 years (2). As many as 25 percent of intravenous drug users in Eastern Europe and Central Asia appear to be under 20 years old (3). These children deserve attention and care, irrespective of how society feels about drug use. Stigmatizing them could mean letting a generation of children die—a generation on which the promise of transition depends. Their drug use, the reasons behind it, and its consequences must be addressed with effective methods, even if those methods may make some people uncomfortable.

Compared to other countries in the region such as Russia and the Ukraine, the prevalence of HIV infection in Armenia is not high. From 1988 to March 1, 2005, 317 HIV carriers were registered in the country, 301 of them are citizens of the Republic of Armenia (4). The estimated prevalence rate according to the Sentinel Epidemiological Surveillance in May 2002 was <0.1 % (5). This rate is relatively low and it alone may not be enough to justify an immediate effort for an HIV prevention program in Armenia.

However, the economic crisis, considerable proportion of displaced and refugee populations, increased poverty, mass unemployment and out migration to countries where the HIV prevalence is high makes the HIV/AIDS epidemic a real danger for a small country with a population about three million (5). As declared at the Caucasus Area Meeting on National Responses to HIV/AIDS, "…the alarming situation and experience of Ukraine, Belarus and Russia demonstrate that the number of HIV cases can increase from hundreds to thousands within a year. Tomorrow can be late. We have to act today…" (6).

The official statistics show that the HIV epidemic in Armenia, as in other countries of fSU, is driven mostly by injecting drug use (53.5% of all registered cases) (4). In recent years, a considerable increase in the number of cases of infection through intravenous drug use has been observed. For example, until 1999 the number of cases of HIV infection via sexual contacts exceeded the number of cases of HIV infection through intravenous drug use, the interrelation ratio between such cases was 41 to 22 respectively. From 1999 to June 1, 2004, the ratio changed sharply to 55/113. So far, all the individuals infected via injecting drug use have been men. As a matter of fact, the majority of them temporarily inhabited in the Russian Federation (Moscow, St. Petersburg, Irkoutsk and Rostov) and the Ukraine (Odessa, Tiraspol and Kiev) and were probably infected with HIV there (7).

The studies have demonstrated that when HIV epidemic is driven by injecting drug use, early intervention is critical: once HIV has been introduced into a local community of injecting drug users IDUs), there is a possibility of extremely rapid spread (8). Moreover, once prevalence exceeds 5 to 10 percent among IDUs, overall infection rates frequently climb as high as 50 percent in fewer than five years (9). The rapidity of spread among IDUs means that any delay in implementation of HIV prevention interventions carries particularly serious consequences.

The data on the prevalence of drug use in Armenia is scarce. According to the operative data of the Ministry of Interior, the number of drug users in Armenia in 2000 was about 20,000 (50% residing in the capital city Yerevan) with 2,000 of them using injecting drugs (5). The "Rapid assessment of the spread of HIV infection including intravenous drug users" conducted by the National Center for AIDS Prevention in Yerevan, provided higher rates. It showed that in 2000 only in Yerevan there

were from 19,000-20,000 drug users, of whom approximately 10% were using intravenous drugs. The survey of general population conducted within the framework of the same study demonstrated that approximately 14% of respondents had experience of drug use (5). According to WHO EURO databases, the estimated number of IDUs in Armenia is between 7,000 to 11,000 which makes the prevalence rate of IDU among the general population 0.2-0.3% (10)[1]. The Sentinel Epidemiological Surveillance carried out in year 2000 found the rate of HIV prevalence among IDUs to be about 15% (5).

Thus, the epidemic of HIV in Armenia, largely driven by injecting drug use, is challenging both the national government and the international community to implement comprehensive strategies that would prevent a generalized epidemic. The window of opportunity to support such a response is very narrow, and the societal toll may be devastating.

More than twenty years of experience fighting AIDS demonstrated that not just more projects but strong leadership at all levels of society and evidence-based national strategic approaches are necessary for an effective response to HIV (11-14). Effective programs in less developed countries owe their relative success in part to healthy public policies and improved public health policies providing a supportive and enabling environment in which projects and programs can operate and be sustained (15-19).

The Armenian decision-makers seem to understand both, the seriousness of the situation and the necessity of strong leadership in addressing the problem. In 1997 the government adopted the Law of the Republic of Armenia (RA) on Prevention of Disease Caused by Human Immunodeficiency Virus (HIV-Infection) (20) (see the Armenian version of the Law in Annex 1). In 2002 the National Program on HIV/AIDS Prevention was ratified (21). In July, 2003 the Global Fund to Fight AIDS, Tuberculosis and Malaria has approved a two-year grant to support the National Program (22). In February 2003 the Law of the RA on Narcotic Drugs and Psychotropic Substances was ratified (23) (see the Law in Annex 2). The work on changing and improving the current legislation related to HIV/AIDS has started.

However, all these documents are mainly based on vertical decision-making. They don't take into account neither the evidence-based best international practices, nor the results of the research carried out in the country, which are scarce anyway. In addition to that, the general public as well as high-risk groups are unaware of the magnitude of problem (4,7,24-26). They have little opportunity to participate in decision-making process. The advocacy is extremely poor due to the lack of local expertise in the corresponding area. As a result, the success of the National Program can be undermined.

The majority of professionals working in the area of HIV prevention worldwide agree today that the greater part of dangers and harm attributed to drugs is engendered by inadequate drug policies rather than consumption of specific drugs. Drug policies which historically were rooted in prohibition and vigorous application of criminal sanctions, have made HIV prevention work with IDUs difficult. They have been proven to aggravate the HIV situation (27-49).

[1] Data in the WHO EURO databases are drawn mainly from national sources, and are generated by national surveillance, service providers, and NGOs, or by such international organizations as the UN Reference group on injecting drug users. Where no published or official data are available, preliminary estimates made by national experts during a workshop on estimating and modeling the HIV/AIDS epidemic in Europe are used. The workshop was jointly organized by WHO EURO and UNAIDS in summer 2003

Professionals agree that nowadays when the pandemic is threatening the very existence of humankind, the society should provide a response to the negative effects of drugs in terms of realistic consideration of common sense, science, public health, social welfare and human rights rather than fear, prejudice and punitive prohibitions. The research has demonstrated that: 1) when appropriate information, treatment, rehabilitation and conditions for safer drug injection are available for IDUs; and 2) when drug policies are focused on the reduction of demand rather than supply; then the HIV epidemic can be slowed and even reversed. The combination of aforementioned strategies is known as harm-reduction approach which is a national policy in a number of countries throughout the world (27-49).

Thus, the aforementioned data indicating that: 1) IDUs in Armenia are key to the dynamic of HIV epidemic; and 2) there are policy approaches that can create favorable environment for containing the HIV epidemic driven by injecting drug use - suggest that a generalized epidemic in Armenia could be prevented by adoption of those policy approaches. However, no template or universal approach can be sufficient. National responses must be tailored to local realities which therefore should be thoroughly studied.

A well-designed study, which would summarize the evidence on best international practices, including effective policy approaches and challenges to them, as well as the national realities, could create a research base for changing the Armenian legal framework on a way that it would be favorable for reducing the harm caused by injecting drug use.

2. THE STUDY'S PURPOSE AND OBJECTIVES

The purpose of this study has been to create a research base for re-orienting Armenian HIV and drug policies so that they would enable to meet the challenge of IDU-driven HIV epidemic and thus prevent a generalized HIV epidemic in the country.

To achieve the study's purpose, the following objectives have been set:

1) Summarize the evidence on best practices including policy approaches which have been successful in addressing the linkage of HIV and IDU internationally.
2) Identify those provisions in Armenian laws and policies which can contribute to the HIV-risk Point 17of IDUs.
3) Analyze challenges to effective responses to drugs, drug users and HIV in the countries of the former Soviet Union in general and in Armenia in particular.
4) Identify the conflicts of Armenian legal framework with the International Law and legal arguments in support of approaches favorable for reducing the harm caused by injecting drug use.
5) Identify opportunities for introducing desirable changes into Armenian HIV and drug policies and present recommendations for policy change.

3. METHODOLOGY/PHASES OF THE STUDY

The study has had two phases:

a) Desk research which has been done through the review and analysis of relevant materials both printed and electronic. The materials included: legal documents, resolutions, position papers, research articles, books and mass media articles on drugs, human rights and HIV in general and for Armenia in particular.

b) Primary research which has utilized key informant interviews. Study subjects have been purposively selected in accordance with data from the literature demonstrating which are the key stakeholders and groups of people relating to drug use and HIV-risk of IDUs. They included: officials from the Ministries of Health, Education, and Culture and Youth Affairs; parliamentarians; health care providers; policemen; NGO and mass media representatives.

4. RESULTS

4.1 International Responses to Drug Use, Drug Users and HIV infection: "Law Enforcement" versus "Public Health" Approach

The international coordination of narcotics' control is based on three protocols known collectively as the UN Drug Conventions—the 1961 Single Convention on Narcotic Drugs as amended in 1972, the 1971 Convention on Psychotropic Substances, and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (50-52).

The Single Convention of 1961 is so named because it replaced several international agreements that had regulated international trade and use of drugs throughout the first five decades of the twentieth century (53,54). Classifying more than 115 substances based on danger of abuse, dependence and medical benefit, the Single Convention mandated production of, trade in, or use of scheduled drugs exclusively for "medical and scientific" needs, set global targets for how much legal opium or coca needed to be produced to meet such needs, and required states to prevent production or diversion of drugs into illegal markets (50,54). Among the drugs of Schedule one are cocaine and opiates including morphin, heroin and methadone.

The 1971 convention expanded the lists of scheduled drugs by more than 100, adding LSD, methamphetamine, and a host of other more commonly prescribed psychotropics to the list of controlled substances (55). Licensing and targets for legal production of substances scheduled by the two treaties, as well as monitoring of efforts to prevent their diversion to illegal markets, is the responsibility of a "quasi-judicial" body known as the International Narcotics Control Board (INCB), a 13-member group of law enforcement, psychiatrists, pharmacologists, and other experts empowered by the 1961 convention (as amended in 1972) to assess how well countries were complying (56).

The 1988 convention added "precursor chemicals" used for manufacture of illicit drugs to the list of controlled substances, and created a host of measures regulating fiscal matters such as money laundering and seizure of assets. More importantly, it expanded the scope of the conventions to clearly include restrictions on demand as well as supply. All signatories are required to criminalize "possession, purchase or cultivation of narcotic or psychotropic drugs for personal consumption." The 1988 convention also requires that inciting someone else to use illicit drugs be made illegal (52).

The conventions reflect the historical approach to drugs and drug users, which is also the position of drug control entities of the United Nations (e.g., CND- Commission on Narcotic Drugs and INCB – International Narcotics Control Board). According to this approach, the law enforcement is the only way to control the narcotics. It views illicit drug use as "abnormal" and seeks to track, restrict, or eliminate illicit drugs, and those who sell or buy them, from social circulation. In this framework, primary emphasis rests on supply of and demand for drugs—drug users are understood and responded to as participants in illegal patterns of exchange. Emphasizing criminalization and containment, this framework identifies police action, interruption of trafficking, and penal institutions such as prisons as pivotal to effective response. Even those measures offered as an alternative to incarceration in many countries—forced drug treatment, for example—rely upon a punitive, law enforcement approach. Health care workers, nongovernmental organizations, and treatment programs are supposed to offer services to drug users without suspicion of undermining public order, violating moral norms, or contributing to unhealthy behavior (27).

The influence of conventions cannot be overstated: Countries that have ratified and signed the conventions are expected to incorporate their provisions into domestic law. It was surely never the intention of UN policymakers and national government officials that these treaties would hinder efforts to adequately confront epidemics. Yet, since the first two drug conventions predate the HIV epidemic entirely, and the third one was approved before widespread awareness of the role injection drug use would play in driving the epidemics of the former Soviet Union and Asia, they turned out inadequate to address drug-related HIV infection (35,57). Moreover, while compliance with conventions proved unable to stem the tide of drug use or the associated social and health risks, it appears to be accelerating, rather than containing, the spread of HIV (27-50, 58,59).

Public health approach to drugs and drug users, which is widely known as harm reduction, emerged as a response to a global crisis of HIV infection among people who inject. The advocates of harm reduction are reasoning that dangerous drugs will always be with us and that we had better learn how to live with them in a way that minimizes their adverse health and social consequences. Harm reduction approach focuses on risks rather than on the drugs themselves, considering both adverse health effects and the range of people affected. These include drug users, who are recognized as part of the deserving public, as well as their sexual partners, their children, and their extended families or communities. Similarly, this approach recognizes that all illegal drug use does not carry equal risk, identifies mediating factors that increase drug risk and related disease, and seeks to identify the tools and interventions that might best contain adverse health effects among the largest number of people. These include interventions for those drug users who are outside correctional or drug treatment systems, or those who have returned to drug use after a period of abstinence. In all countries, the majority of drug users remain outside treatment or penal systems (27-50, 58,59).

Interventions to stem HIV and other harms among injecting drug users have proven both easy to implement and highly effective (27-50, 58,59). Almost no drug user chooses to share needles if offered another option. Ongoing treatment with methadone, widely tested in developing and industrialized countries alike, has been shown to reduce both injection and social costs associated with drug use (60). More broadly, researchers evaluating the full spectrum of efforts to reduce drug-related harm—which include peer education, syringe exchange and safer injection rooms, methadone maintenance, overdose prevention—have demonstrated positive outcomes in countries from Australia, the United States, Belarus, and Thailand. Representatives of the Joint United Nations Programme on HIV/AIDS (UNAIDS) phrase it simply in their speeches and publications: "harm reduction works" (61-62).

However, years after gold-standard research has shown how swiftly injecting drug use can spread HIV—and how evidence-based approaches can effectively contain that explosive growth—countries with injection-driven epidemics continue to emphasize criminal enforcement over the best practices of public health.

The United Nations Office on Drugs and Crime (UNODC) dispatches millions of dollars annually and a wide range of scientific, military, and police experts to assist the law enforcement approach internationally. High-profile initiatives have included help in drafting strong laws on money laundering and asset seizure, arming counter-narcotics forces, establishing special courts to prosecute narcotics trafficking or consumption, training and equipping guards at railway stations and national borders, and promoting the use of drug sniffing dogs (63). In Central Asia, the UN also supported an experimental biochemical research program to engineer a new fungus capable of destroying the opium crops in Afghanistan (63). UNODC also supports a range of drug demand reduction efforts, including drug education materials, training and support for community educators, as well as alternative development assistance to help farmers change from cultivation of opium poppies or coca to other crops. However, the budget for supply reduction has historically been nearly three times that of drug demand reduction (64). In addition, more than $1 billion has been spent separately by the U.S. government for counter-narcotics operations including fumigation of fields with toxic herbicides and arming of local law enforcement with high-tech weapons of detection and destruction (65).

These measures in many cases have been understood as alternatives that cannot be refused. Although they have not been properly evaluated, the UN drug control agencies themselves acknowledge that both opium and coca production have increased significantly since the adoption of 1988 convention (66). Efforts to reduce crop production have been consistently offset by technological advances enabling greater drug yield from plants harvested (67). Nor has evidence supported efficacy of demand reduction efforts (68-70).

While the lion's share of international resources intended to assist drug responses at national levels flow to support the law enforcement approach, harm reduction projects are frequently illegal, unfunded, or insufficiently supported. Many governments keep such efforts as perpetual "pilot programs," effectively, delaying for years the comprehensive approaches that can contain injection-related HIV transmission.

One of the reasons for this situation is that throughout the UN system there is no agreement between drug control entities (e.g INCB and CND) and health promotion entities (e.g., WHO and UNAIDS) which results in sharp inconsistencies in policy recommendations with regard to drugs, drug users and HIV. While the drug control entities refer to the 1998 UN General Assembly (UNGASS) on drugs which was convened under UNODC director Pino Arlacchi's slogan "A Drug Free World–We Can Do It!," and where participants agreed to significantly reduce or eliminate drug use by 2008 (71), WHO and UNAIDS reference the 2001 UNGASS on HIV/AIDS and emphasize harm reduction interventions for reducing the spread of disease (11) .

However, while the UN drug control entities have successfully guided 179 nations, including all those in the former Soviet Union and Asia where injecting drug use is the primary mode of HIV transmission, to ratify one or more of the UN drug conventions and thus secure for them the force of law, health promotion entities merely recommended to use as guidance the principles of harm reduction. How committed WHO and UNAIDS are to translating the harm reduction principles into

practice is unclear: Neither, for example, has objected to overcriminalization of drug users by UN drug control entities, or convened an expert consultative group to identify perceived and actual tensions with UN drug control conventions or suggest strategies to resolve them. More importantly, neither WHO nor UNAIDS has worked with bilateral donors or recipient governments to bring a single harm reduction program to national scale in Asia or the former Soviet Union (27).

Therefore, the international response to drug, drug users and HIV continues to be defined by the law enforcement framework. However, because of such narrow policies and their consequences, national governments are unlikely to meet target goals of the 2001 UN General Assembly Special Session on HIV/AIDS.

Thus, by promoting strict compliance with United Nations drug control treaties, the UN Commission on Narcotic Drugs (CND) and other UN agencies are exacerbating the HIV epidemic in Central and Eastern Europe and the former Soviet Union.

4.2 Chronological developments of anti-drug legislation in Armenia

4.2.1 Brief History

During the Soviet era the Soviet Republics including Armenia shared the legacy of Soviet legislation. The formation of the Union of Soviet Socialist Republics (USSR) by the Treaty of the Union of 30 December 1922 and the adoption on 31 January 1924 of the Constitution of the USSR led to the enactment of certain all-union legislation intended to unify, inter alia, policies in the criminal law.

Provisions on narcotics were as follows:

- The manufacture and keeping for the purpose of sale and the sale itself of cocaine, opium, morphine, ether, and other stupefying substances without proper authorization
- deprivation of freedom or correctional-labor tasks for a term of up to one year with or without confiscation of part of property.

- The same actions committed in the form of business, and likewise the maintenance of dens in which the sale or consumption of the substances enumerated in the present Article is performed
- deprivation of freedom for a term of up to three years with confiscation of all property (72).

State control over narcotics was intensified on the basis of a Decree of 23 May 1928 (73) This Decree prohibited the free circulation of cocaine, salts thereof, hashish, opium, morphine, heroin, dionyne and salts thereof, and pantopon, subject to the union republic public health commissariats agreeing quantities needed for medicinal purposes. Imports and exports were regulated by the USSR People's Commissariat of Foreign and Internal Trade by agreement with public health agencies.

Throughout the 1930s, the USSR used the League of Nations and other international forums to display its ideological opposition to capitalist countries but nonetheless, on 29 January 1936, acceded to the 1925 Convention on drugs authorizing the carriage, bringing in, sale, and use of narcotics in amounts to meet research and medical applications. The 1925 Convention entailed no changes in Soviet legislation on the subject of narcotics, in as much as existing rules were deemed to be sufficient to give effect to Convention obligations (28).

In 1958 the Fundamental Principles of Criminal Legislation of the USSR and Union Republics were enacted. They contained several articles devoted to narcotics offences, notably the manufacture,

sale, and likewise the keeping or acquisition for the purpose of sale, of narcotic substances without a special authorization was considered a criminal offence which was punished by deprivation of freedom for a term of from one to ten years with or without confiscation of property and with obligatory confiscation of the narcotic substances (74).

In these early post-Stalin years great emphasis was placed in Soviet criminal policies on the rehabilitation of offenders through special treatment and/or labor facilities. Communism was declared to be attainable in the Soviet Union by 1980, and indeed was programmed to happen in Communist Party documents. Shaping "Soviet Man" was part of this exercise, including those whose deviant behavior fell within the scope of the criminal law.

Although it is fashionable to emphasize the "monolithic" features of the former Soviet Union, the situation was rather more complex. Alongside with the elements of uniformity introduced in the criminal law by the 1958 Fundamental Principles, there was creeping divergence among the union republic criminal codes as regards the domain of narcotics regulation. (74)

One antidote to the emergent divergencies was the USSR Edict of the Presidium of the Supreme Soviet of 25 April 1974 "On Intensifying the Struggle Against Narcotics Addiction". On the basis of this Edict, administrative responsibility was introduced for the consumption of narcotics without a doctor's prescription. Distinctions were drawn between "large-scale" and "especially large-scale" amounts of narcotic means and the circumstances under which punishments could be aggravated (committed a second time, or by an organized group, or by prior arrangement, or by an especially dangerous recidivist). Criminal responsibility was introduced for the stealing of narcotics, inclining to consumption, the organization and maintaining of dens to consume narcotics, and the illegal manufacture, acquisition, keeping, carriage, or sale of virulent and poisonous substances (74).

The union republics introduced analogous edicts and amended their criminal and administrative legislation accordingly. Whatever the incidence was in the USSR of criminal behavior of this nature, the legislation also was strongly motivated by the ratification by the USSR of the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances. However, the measures introduced in 1974, for all of their comprehensiveness and severity, did not characterize the consumption of narcotic means as criminal behavior. Rather, the consumption of narcotic means was made subject to administrative responsibility (in practice, however, a second or subsequent commission of the administrative offence engaged criminal responsibility) (28).

The true extent of narcotics addiction in the former Soviet Union has never been properly studied. It does seem to be the case that, measured by the number of individuals officially registered as narcotics addicts, the numbers nearly doubled between 1984-1990, from 35,254 to 67,622 for the Soviet Union as a whole. Whether these figures reflect an actual increase or more rigorous registration procedures by the USSR Ministry of Public Health is difficult to determine, nor do these statistics disclose whether the individuals rendered are merely "recreational consumers" or "experimenters", or are truly addicted (75).

While the incidence of criminal violations remained apparently low and the official Party line was that narcotizm and addiction were inherent in and endemic to the capitalist world, some Russian authorities believe an epidemic of narcotics addiction commenced in the USSR during the late 1970s. Instead of recognizing the problem and taking effective measures, the Soviet authorities are said to have dismissed the issue and missed the opportunity to develop integrated programs to combat the illegal turnover and consumption of narcotic means. When programs appeared in the late

1980s and early 1990s, the opportunity had been lost and narcotics addiction had proceeded too far and fast to be eliminated or contained (76).

Not until the 1980s did the issue of narcotics attract the attention of senior Communist Party organs, expressed in the form of programmatic decrees and concomitant legislation. The Central Committee on 19 October 1982 issued a Decree "On Serious Shortcomings in the Organization of the Struggle Against Narcotics Addiction" (77).

By December 1986 the issue of narcotics addiction was of sufficient concern to attract the attention of the Secretariat of the Central Committee, and again on 21 April 1987 at the same level with respect to antinarcotics propaganda. With perestroika well launched in the former Soviet Union, the Party decrees were assessed on 12 June 1987 again. Only the last Party decree was circulated in the open press; all others were distributed exclusively within Party channels. Consequently, the admission by the senior Party leadership that narcotics addiction was a problem serious enough to require attention came as something of a bombshell to many Soviet citizens, who had been taught that drugs were principally a problem of "bourgeois" societies (78).

It should be noted that from 1968 specialized treatment- correctional-labor colonies of various types functioned in the former Soviet Union for narcotics addicts. The use of narcotics by minors during the Soviet era engaged the attention of institutions outside the normal law enforcement systems. Under the Statute on Social Educators of Minors (79), the consumption of narcotics by minors could entail the appointment of a social educator.

Under the Statute on Therapeutic-Nurturing Dispensary for Persons Ill with Narcotics Addiction (80), children up to sixteen years of age by decision of a court could be referred to such dispensaries if they had evaded obligatory treatment in public health institutions or continued after undergoing such treatment to use narcotic substances. Under the Statute on Commissions for Cases of Minors (81), the Commissions were endowed with the right to both refer minors to the dispensaries for treatment, but also to petition a court for the release of minors before the period of their referral had expired. There are no statistics available as to the extent to which minors were referred for treatment, but some sources indicate the dispensaries went mostly unused.

In closing this concise account of the Soviet era, the overall trend was in the direction of greater legislative intervention against the illegal turnover of narcotics and increased attention to the treatment of narcotics addiction. The Soviet Union was, on the whole, well-disposed towards international efforts to restrict trafficking in drugs and collaborated with the international community to this end even during periods of sharp ideological hostility. Whether more might have been done is a question that may be asked of all States.

4.2.2 The legacy of the Republic of Armenia during the post Soviet period

The legislation of the Republic of Armenia has been closely tracking the international conventions to which it was a party. Article 6 of the new Armenian Constitution (adopted on July 5, 1995) provides:

- International treaties that have been ratified are a constituent part of the legal system of the Republic [of Armenia]. If norms are provided in these treaties other than those provided by laws of the Republic, then the norms provided in the treaty shall prevail. International treaties that contradict the Constitution may be ratified after making a corresponding amendment to the Constitution. (82, also see the excerpts from the Constitution in Annex 3).

The principle of treaty supremacy also is expressed in individual Armenian laws regulating narcotics and HIV infection. These provisions have the effect of making the conventions to which Armenia is a party an integral part of the Armenian legal system. It follows, also, that international agreements have an autonomous status within the Armenian legal system and, under the treaty supremacy clause, those agreements have priority over inconsistent Armenian legislation. This point is emphasized because it is very important for the following discussion.

In 1993 the Republic of Armenia assented to the three major UN Drug Control Conventions. Therefore, the guiding principle of Armenian drug-related legislation as it is defined in the 2003 Annual Drug Report of the RA is as follows: "The Government of the Republic of Armenia is ever-vigilant in its crusade against illegal drug trafficking and drug addiction, with the aim of protecting the nation from becoming involved in drug trafficking and drug dependency. The Government is guided by the slogan "Armenia Free of Drugs". Development of the national strategy in the drug abuse field is of great concern to all drug-related institutions" (7).

On December 21, 1993 the president of Armenia, following the international requirements of the Conventions, passed a new edict on "Reinforcement of Measures in Combat Against Drug Abuse and Illicit Drug Trafficking". This resulted in the establishment of the Interdepartmental Committee on Combating Drug Addiction and Drug Trafficking, which was comprised of the first deputy ministers of the relevant ministries, agencies and departments (7).

On February 14, 1994 the Government of Armenia adopted the regulations of the Interdepartmental Committee for fighting drug addiction and drug trafficking in Armenia. The president of Armenia, by a decree dated November 27, 1995, introduced changes to the edict "Reinforcement of Measures in Combat Against Drug Abuse and Illicit Drug Trafficking". The amendment envisioned prevention activities for adolescents. The Interdepartmental Committee developed a National Strategic Plan on fighting drug addiction and illicit drug trafficking. This document outlines the main strategy of the Armenian Government to improve the drug control situation and enhance the implementation of anti- drug programs. The Interdepartmental Committee is responsible for the coordinated implementation of the National Strategic Plan. While endorsed by all relevant agencies, the implementation of the program lags behind due to a lack of funds (7).

The prime minister of Armenia issued a decree (N 496) on August 17, 2000 which established the Standing Commission on Drug Control. The main task of the Commission is to arrange the lists/tables of the drugs, psychotropic substances and their precursors to be controlled in Armenia, as well as to grade the amounts of drugs withdrawn from illegal trafficking in the country. Those classifications have a significant role in terms of evaluating drug-related crimes from the criminal and legislative viewpoint (7).

On December 14, 2001, within the framework of the Southern Caucasus Anti-Drug (SCAD) Program, a Task Force on drug-related legislation (TFL) was created. It is comprised of the representatives of relevant ministries and agencies, including the National Assembly, Ministry of Foreign Affairs, Ministry of Justice, Ministry of Health, Police, Prosecution, President's Administration and Court of Cassation. The TFL produced the "National Action Plan on Harmonization and Improvement of Drug-related Legislation" which was adopted at the Regional Seminar in Tbilisi, Georgia in December 2001 (7).

On April 1, 2002 the Government of Armenia adopted the "HIV/AIDS Prevention Program" which includes prevention of HIV/AIDS among intravenous drug users, needle exchange, etc. On October 18, 2002, the national experts developed the draft National Action Plan on Drug Information System during a seminar on "Data Collection on Drug Addiction and Drugs" (7).

On February 10, 2003 the president of Armenia ratified the law on "Narcotic Drugs and Psychotropic Substances" which was adopted by the National Assembly in December 2002 (7, also see the Law in Annex 2). The new Criminal Code of the Republic of Armenia was adopted on April 18, 2003 (83, also see the excerpts from the Criminal Code in Annex 4). The Code establishes the bases of criminal accountability and principles of criminal law, identifies those crimes and offences which pose a threat to society and specifies the various types of punishment.

On August 12, 2003 the Ministry of Health issued a decree (N 691) which endorsed the lists of big and especially big amounts of narcotic drugs and psychotropic substances. The decree is based on Article 266, Part 4 of the Criminal Code. The development of the draft for the National Program on Alcohol and Drug Abuse is still in the process of approval (7).

4.2.3. Narcotics Regulation in Armenia: The Law of the Republic of Armenia on "Narcotic Drugs and Psychotropic Substances" and Corresponding Provisions in the Criminal Code

The Law of the Republic of Armenia on "Narcotic Drugs and Psychotropic Substances" is the main document regulating the issues of interest for this study (see the Law in Annex 2). It was adopted by the National Assembly of the RA on December 26, 2002 and ratified by the president on February 10, 2003. The Law governs the relationships in the traffic of narcotic drugs and psychotropic substances, as well as establishes the legal bases of the national policy for interdiction in their illicit traffic, and the main measures in combating drug addiction for protecting the health of the citizens, the security of the state and the general public.

Above it has been mentioned that two frameworks have defined the international response to drugs, drug users and HIV, e.g. law enforcement and public health frameworks. It has also been mentioned that the law enforcement framework reflects the position of drug control entities within the United Nations System and is based on so-called UN drug Conventions. Since as early as in 1993 Armenia assented to the three major UN Drug Conventions, the law of the Republic of Armenia on "Narcotic Drugs and Psychotropic Substances" closely tracks the UN Conventions.

The principles of the national drug policy as outlined in the Article 6 of the Law, set as priorities "…the interdiction of drug addiction and legal violations related to the illicit traffic of narcotic drugs and psychotropic substances and the punishability, the discharge of liability and their inevitability for the illicit traffic of the narcotic drugs and psychotropic substances". Thus, the Law emphasizes the law enforcement approach. Within this approach, it prioritizes supply reduction versus demand reduction strategy.

The provisions of the Law concerning the sale, possession and consumption of narcotics can be characterized as "zero tolerance", since not only the sell and possession, but even the consumption of narcotic drugs or psychotropic substances is prohibited under Article 37 of the Armenian drug Law. Use of narcotic drugs without medical permission, is punished with a fine in the amount of up to 200 minimal salaries, or with arrest for the term of up to 2 months (see Article 271 of the Criminal Code of the RA in Annex 4).

It should be emphasized, that there is some disagreement between terminology of the Drug Law and Criminal Code. While the Drug Law mentions "illegal use of narcotic drugs or psychotropic substances", the article 271 of the Criminal Code speaks about narcotics only, not mentioning psychotropic substances. Therefore, it is not clear whether use of the latter is punishable either.

A similar pattern is seen in application of severe penalties to "traffickers." With regard to that, the article 266 of the Criminal Code states:

1. Illegal manufacture, processing, procurement, keeping, trafficking or supplying of narcotic drugs or psychotropic materials with the purpose of sale, is punished with imprisonment for the term of 3 to 7 years.
2. The same action committed in large amount is punished with imprisonment for the term of 5 to 10 years with property confiscation.
3. The same action committed in particularly large amount is punished with imprisonment for the term of 7 to 15 years with or without property confiscation.
4. The large and particularly large amounts of narcotic drugs or psychotropic materials are established by the competent state governance body of the RA.
5. Illegal turnover of narcotic drugs or psychotropic materials in small amounts does not entail criminal responsibility.
6. A person voluntarily submitting narcotic drugs or psychotropic materials will be relieved of criminal responsibility.

It is important to mention here that thresholds for trafficking penalties are very low. For example, 0.025 - 1g of heroin is considered a "large" amount and more than 1g is considered a "particularly large" amount. For hashish 'large' and 'extra large' amounts are 5-100g and more than 100g respectively. Thus, the drug law shows little distinction between small-scale dealers/ producers and industry kingpins.

Another article of the Criminal Code which is of interest for this study is article 274. According to that article, organization and maintenance of dens for consumption of drugs shall be punished by deprivation of freedom for a term of up to 4 years. This article is mentioned here because operation of safe injecting rooms which is one of harm reduction strategies may be interpreted as organization and maintenance of dens.

The medical assistance to drug abusers is also based on law enforcement framework. As the Article 47 of the Law provides, "…natural persons who may be supposed to be ill with narcotics addiction, or in a state of narcotics stupefaction, or to have consumed a narcotic means or psychotropic substance without the prescription of a medical doctor may be sent for a medical examination in public health institutions".

Compulsory measures of a medical character may be assigned by decision of a court to those ill with narcotics addiction who are under the medical examination and without medical prescription continue to use the narcotic drugs or psychotropic substances, as well as those individuals, who have been condemned for execution of crime, and need treatment.

Compulsory measures of a medical character may also be assigned to those patients who were diagnosed as "drug addicts" as a result of medical examination and are not able, even temporarily,

without any medical intervention, to overcome the physiological, psychological dependency on the narcotic drugs and psychotropic substances (Article 49).

Some other articles of the Law that are of particular interest for the purposes of this study are as follows:

The Article 4 provides the classification of narcotic drugs, psychotropic substances and their precursors" which in general follows the classification of UN Conventions. As in the case of Conventions, methadone is included in the List 1, which according to the definition of the Armenian Law is comprised of "narcotic drugs and psychotropic substances, the traffic of which is prohibited in the territory of the Republic of Armenia". Buprenorphine being in List II ("narcotic drugs and psychotropic substances, the traffic of which in the Republic of Armenia is limited"), is prohibited under Article 28 of the law stating that "…the use of narcotic drugs and psychotropic substances for the treatment of drug addiction is prohibited in the Republic of Armenia".

Since methadone and, more rare, buprenorphine maintenance programs have been an integral part of harm reduction approach, we will discuss in detail in subsequent chapters what kind of legal issues may arise under Armenian law with regards to maintenance programs.

Article 41 states that narcotics addiction as an illness may result in limitations on engaging in certain (risky) types of professional activity.

And finally Article 42 prohibits the advertisement and propaganda of the following: "…narcotic drugs, psychotropic substances and their precursors; the activities of the natural or legal persons targeted at the dissemination of the information about the forms of the use of the narcotic drugs, psychotropic substances and their precursors, the manufacturing methods, places of getting, using and acquiring them, as well as the publication of the literature and dissemination of that through the mass media, the dissemination of such information through the computer networks or other actions for the purpose of their dissemination". It also prohibits the propaganda of the advantages of the narcotic drugs, psychotropic substances and their precursors over one another.

The article defines "propaganda" so broadly that virtually any activity or literature specifically concerned with, for example, instructing consumers of narcotics or psychotropic substances to inject them safely with a view to reducing harm caused by the process of injecting or to discouraging the sharing of syringes and needles would seem to fall within the propaganda.

As the experience of other countries of the former Soviet Union demonstrated, the prohibition of propaganda of narcotic means and psychotropic substances, has proved to be a severe limitation upon the efficacy of harm reduction programs. This issue will be discussed in more details in subsequent chapters.

Thus, the Law of the Republic of Armenia on "Narcotic Drugs and Psychotropic Substances" can be characterized as strongly punitive. It hardly contains any provisions which would contribute to the reduction of harm caused by injecting drug use. Although it has been ratified recently, when it was obvious that HIV epidemic in Armenia is driven mostly by IDU, yet it has been not able to address this linkage.

The interviews with officials involved in drug issues in Armenia have demonstrated, that they don't consider the Armenian drug law to be very strict. Some of them welcome the law which requires to lock up drug users in prisons, because, as they say, this measure contributes to the social order. The others think that Armenia should stick to strict provisions of the law, because this is her obligation under the UN drug control treaties. Some Armenian policy makers are against the harm reduction approaches because they associate the latter with "legalizing" the consumption of narcotics which is again insistent with the U.N. drug conventions.

On the other hand, some NGO representatives (e.g. Anti-Drug Civil Union) state that a well-designed and locally tailored restrictive policy with the optimal balance between public health and law enforcement approaches and broad involvement of central and local governments, society and community as a unique coalition is the only way to succeed.

It is worth mentioning here that recently there have been some positive trends in drug-related policy-making process in Armenia. With the initiative of the Southern Caucasus anti-drug (SCAD) Programme, a package of amendments to the drug-law and corresponding articles of the Criminal Code has been developed. Although the extent to which the amendments will change the strict provisions is rather limited, nevertheless, the trend is promising.

4.2.4 Other IDU- and HIV-related laws and regulations in Armenia

Of the documents relating to HIV/AIDS, it is worth mentioning the Law of the Republic of Armenia on Prevention of Disease Caused by Human Immunodeficiency Virus (HIV-Infection) (unfortunately, the English version of the Law has been unavailable, therefore included in Annex 1 is the Armenian version of the Law) and the Law on the Provision of Health Care Services to the Population.

The Law of the Republic of Armenia on Prevention of Disease Caused by Human Immunodeficiency Virus (HIV-Infection) was adopted in 1997. According to the statistics, the number of registered HIV+ cases in Armenia by that time was 67, of whom only 12 persons were known to be infected through injecting drug use (5). Therefore, it is understandable that the law fails to address the linkage between HIV infection and the consumption of narcotics. Although the article 6 states that "infection of an individual with HIV does not serve as grounds for limitation of his/her rights and freedoms, excluding cases foreseen by the law", yet the law does not have special provisions against discrimination of IDUs.

The Article 16 obliges the infected persons to comply with measures of precaution for the purpose of precluding the dissemination of HIV infection. According to the Article 17, the violation of the Law entails responsibility in the procedure established by Armenian legislature. Depending upon the character of the offence and degree of social danger, there are different types of responsibility. Responsibility ensues from the very fact of violation, irrespective of whether any consequences ensued from the act or failure to act or not. If the infecting person knew that he had contracted an HIV infection, or if he knowingly placed another person in danger of catching an HIV infection, criminal responsibility would ensue under Article 123 of the Criminal Code of the Republic of Armenia.

The Article 11 provides for compulsory HIV testing of some groups of people including IDUs and persons at penitentiary institutions. According to the article 14, anonymity of test results is not guaranteed in cases foreseen by the Law of the RA. Both, the Law of the RA on the Provision of Health Care Services to the Population and the draft public health law state that the privacy of information with regard to diseases which impose threat to society (which HIV is definitely the case of) is not guaranteed.

Thus, the health-related laws are also not favorable for decreasing the HIV risk of IDUs.

It should be noted, however, that recently the Law on AIDS has been revised and the corresponding legislative initiative is in the agenda of the National Assembly. The revision includes elimination of mandatory HIV testing for high-risk groups.

4.3 Challenges to effective responses to drugs, drug users and HIV in Armenia

In any AIDS epidemic where injecting drug use is so central in driving the spread of the disease, the drug-, HIV- and human rights- related legislature and its application, as well as commitment to democratization and sustained engagement from NGOs and, more generally civil society, in issues addressing the problems of IDUs and PLWHA – all those are important determinants of the capacity of a country to mount an effective response to HIV/AIDS. This chapter will focus on the state of affairs with these determinants in Armenia and analyze their possible influence on national responses to drugs, drug users and HIV.

The aforementioned issues are understudied in Armenia. Thorough desk research found just a few studies aimed to explore them in Armenia. This study has partly filled in the existing gaps. However, the most part of the chapter is based on the research carried out in other fSU countries. Since 1) countries of the fSU have similar political and socio-economic problems; 2) patterns of HIV/AIDS epidemics in countries of the fSU are also similar, with epidemic in Armenia being a little bit behind those in Russia, Ukraine, Belarus etc; and 3) the laws of other fSU countries are similar to the Armenian ones - the secondary analysis of research, carried out in those countries, may allow to draw parallels with Armenia and make predictions on the further development of twin epidemics of HIV and drug use in Armenia.

4.3.1 Punitive drug laws and their enforcement as factors contributing to HIV/AIDS

The most widely used approach to "reduce the demand for drugs" in almost all countries of fSU has been cracking down on drug users directly and attempting to deny them the ability to "demand" drugs. Criminal statutes require imprisonment or institutionalization for purchase or possession even for small amounts of illicit substances (e.g., amounts for personal use), and apply severe penalties to possession of both "hard" and "soft" drugs. Injection of cocaine and heroin are thus equated with smoking of cannabis or consumption of Ecstasy, in spite of the fact that these behaviors vary greatly in their health risks and social costs (27).

Drug laws too often show little distinction between those who possess drugs for personal use, people engaged in small-scale, nonviolent distribution, and those who employ violence or racketeering within illicit drugs industries. The term heroin trafficking describes a range of practices, from producers and distributors who maintain private militias and fleets of trucks to Central Asian women who may carry 100 grams of someone else's heroin over a border to earn U.S. $20 (27).

Some of the Russian and Ukrainian laws and related criminal justice procedures are noted below:

_ The production, sale, possession, storage, and transportation of illicit drugs are prohibited in both countries. Russian anti-drug laws, which were overhauled in 1998, are somewhat harsher toward offenders: Criminal liability extends to smaller amounts of a drug than in Ukraine, and offenders can be sentenced to longer prison terms.
_ In both countries, an individual charged with possession of illegal drugs may escape criminal responsibility if he voluntarily surrenders the drugs and "actively participates in the investigation of drug-related offences."
_ Individuals charged with violating drug-trafficking laws are subject to "administrative surveillance" after they have completed their prison terms.
_ Pretrial detention of those charged with drug-related offenses remains accepted and common in certain circumstances. Policymakers in both countries are trying, with varying degrees of success, to reduce the number of detainees through the implementation of new concepts such as bail. Recently in Russia, decision-making responsibility regarding detention was transferred from the prosecutor's office to the court, which has been instructed to use pretrial detention in exceptional cases only (28, 25).

Extremely harsh are the regulations governing drug possession in Kazakhstan. Under the penal code, a person can be detained for as little as 0.5 grams of opiates (34).

The existence of laws does not necessarily say much about their enforcement. While some European countries have relaxed arrests for violation of drug prohibitions, making distinctions between cannabis and other drugs, between private and public use, and between personal use and commercial production (84), in countries of fSU, however, sharp expansion in arrests and increased powers of surveillance, rather than relaxation of regulation, appear to be the norm (27,28,34,35,63, 85).

The analysis of the de facto exercise of the strict provisions of the law demonstrated that although in Armenia "depolarization' and "decriminalization" schemes are not introduced officially, nonetheless, in practice, the police recently has been trying to be less strict with non-violent drug users.

The relative ease with which law enforcement operates in many poor or minority communities has resulted in severe penalties for drug users in these groups, and the virtual decriminalization of drugs for people with money or high social status (23, 85).

In the face of enforcement of these draconian laws, set-ups by the police, and sentences tied to conviction for both drug charges and additional false charges, many drug users end up serving prison sentences. The slow pace at which the wheels of justice turn means that large numbers of detainees experience months of pre-trial detention. The number of injecting drug users (IDUs) in region's prisons has increased dramatically over the past few years—not only because there are more drug users in general but also because they are more likely to be incarcerated. In Russia, which shares with the United States the highest incarceration rate in the world, the number of people imprisoned for non-medical use of drugs has increased five-fold from 1997 to 2000 (38, 86).

In countries with injection-driven HIV epidemics, there is perhaps no more powerful factor in HIV transmission than prisons (87-90). Drugs are widely available in places of detention. Ironically, in some cases, defendants are even given narcotic drugs by the police as a reward for confessing to a drug charge or another charge. (34). In seven Russian prisons studied in 2000, 43 percent of inmates had injected drugs, and 13.5% of them started doing so while in prison. About 1% of all prisoners reported injecting drugs for the first time while in prison (89).

The notoriously horrendous conditions in fSU's overcrowded prisons (cells meant for 28 in Russia hold up to 110 people) continue to deteriorate, posing additional health risks for imprisoned drug users. Few of them have access to even the most rudimentary health care. Although sexual relations and drug use in prisons are prohibited, they continue anyway, while condoms and sterile injecting equipment are generally unavailable (35,38,86,90). The aforementioned study in Russian prisons showed that 50% of all imprisoned IDUs shared needles and syringes and 10 percent had penetrative sexual intercourse with other prisoners (89).

Official government figures indicate that more than 36,000 Russian prisoners are currently infected with HIV (39, 91), a number that likely is much higher in reality. Some 10 percent of the one million inmates in Russian prisons are thought to have TB, a third of whom have a multidrug-resistant strain (92). A prison sentence is increasingly a death sentence for many IDUs. Such horrifying statistics indicate why IDUs are understandably terrified at the prospect of imprisonment.

According to 2003 Annual Drug Report of the RA, there are 12 penitentiary institutions and approximately 2,500 prisoners in Armenia (7). According to another source, the estimated number of prisoners in Armenia is 4,400 (114 per 100 000 population) (93). The "Law on AIDS" mandates the persons who are in penitentiary institutions to be tested for HIV, however, in recent years such tests have been conducted infrequently due to financial constraints. Testing of persons in penitentiary institutions began in 1989 and the first case of HIV infection was registered in 1996. In the same year the first 6 HIV carriers and 22 seropositive individuals, discovered as a result of only 1,100 tests being performed, were reported in Armenia. The following 319 tests carried out in 1997, discovered 5 HIV positive and 17 seropositive cases. From 1996 to May, 2000, approximately 1,800 persons in penitentiary institutions were tested, 15 of them were positive for HIV (two individuals were not citizens of Armenia), and the total number of seropositive individuals was 58 (7).

In 2000 within the framework of the Sentinel Epidemiological Surveillance project 182 persons in penitentiary institutions that belong to groups that are at high-risk for infection (homosexuals, IDUs, individuals with STDs and clinical symptoms) were tested. As a result of the testing, HIV prevalence was reported in the range of 8.8%, with the highest rate registered among homosexuals (10.1%) and the lowest rate among IDUs (5.8%) (5).

In 2002 another sentinel epidemiological surveillance was carried out. It found the estimated rate of HIV prevalence among all individuals in penitentiary institutions to be 5 to 6% (5).

Currently, there are 39 drug patients at the Narcology unit of the Prison Service of the Ministry of Justice. 29 of them are drug addicts and 7 of them receive the secondary treatment (7).

During 2003 the police in Armenia recorded 368 crimes and 419 administrative offences connected with drugs (in 2002 respectively 453 and 497). In 2003, 82 persons were convicted for the illegal use of drugs (article 271 part 1 of the criminal code) without doctor's prescription and 356 persons

were subjected to administrative accountability (compared with 112 and 426, respectively, for 2002) (7). The decline in the number of persons convicted for the illegal use of drugs can be explained by the findings of key informant interviews indicating that although in Armenia "depolarization' and "decriminalization" schemes are not introduced officially, nonetheless, in practice, the police recently has been trying to be less strict with non-violent drug users.

It should be mentioned that the number of minors involved in crimes connected with illegal drug trafficking during the recent past remains very low. This can be justified by the following figures: in 1998 there were 4 minors (up to 18 years old) involved in crimes connected with illegal drug trafficking, in 1999 – 3, in 2000 – 2, in 2001 – 3, in 2002 – 4 and in 2003 – 0. One reason for this low level of involvement by minors in this type of crime can be explained by national and cultural peculiarities, e.g. the high level of parent-child- relative-friend relationships. (7).

The information on the conditions in Armenian prisons is scarce. In 2004, the Penitentiary Department of the Ministry of Justice received a sub-grant from the Global Fund to Fight AIDS, Malaria and Tuberculosis to implement harm reduction projects in Armenian prisons. However, so far there is no information on whether the project has started and what services are available for IDUs in prisons. According to unofficial announcements by representatives of the Ministry of Justice, drug use is not practiced in Armenian prisons therefore it is needless to implement harm reduction there. In fall 2004 the International Red Cross carried out a study on the spread of HIV, Hepatitis B and Tuberculosis in Armenian prisons. However, the report on the study is not available either.

So far, the aforementioned draconian measures have failed to stem the surge in drug use in countries of the fSU (35). Several factors are behind this epidemic, most of which relate to ongoing post-Soviet transitions to democratic, capitalist societies. The transitions have been wrenching for much of the population as living standards have fallen, social inequality has worsened, and public health and other social support systems have deteriorated.

The majority of fSU countries are located on the main heroin trans-shipment routes from Afghanistan to Western Europe. The flow of drugs has increased substantially in recent years and law enforcement authorities have had little luck combating organized crime groups that control most drug trafficking in the region. Authorities' efforts to curb trafficking are hindered by corruption, lack of adequate funding, and their inability to confront the sheer magnitude and economic power of the drug trade. Drugs are relatively plentiful and cheaper than ever, especially in major cities along trafficking routes. It is estimated that there may be as many as four million active drug users in Russia and perhaps one million in Ukraine, higher percentages of the population than almost anywhere else in the world (35).

Efforts throughout the region to crack down on drug trafficking may have the unintended effect of increasing the proportion of those users who inject drugs. When supplies are low and prices are rising, users often switch from smoking to injecting because the latter method is more cost-effective (94,95). Furthermore, once users start injecting, they often do not revert back to using other, less harmful means, even if the price goes down and the purity increases (8,94.95). According to WHO EURO databases, the estimated prevalence rate of injecting drug use in some countries of the fSU was up to 2% in 2003 (10).

As the 1999 INCB report stated, “the rapid spread of illicit crop cultivation, trafficking and abuse of drugs, especially heroin, are observed in Central Asia and Caucasus, including Armenia”. Drugs are imported to Armenia mainly from Iran and Turkey, and countries of Central Asia, the Ukraine and Russia. According to the 2001 report of the Ministry of Interior of the RA “…sensitivity of Armenia to become a transit country for the illicit drug trafficking in the route Iran-Armenia-Russia is rapidly growing.” The extended frontiers with Iran and active communication with Turkey have provided a wide availability of heroin in the drug market, one gram of which costs USD 150-250 (5).

The data on the prevalence of drug use in Armenia is scarce. According to the operative data of the Ministry of Interior, the number of drug users in Armenia in 2000 was about 20,000 (50% residing in the capital city Yerevan) with 2,000 of them using injecting drugs (5). The “Rapid assessment of the spread of HIV infection including intravenous drug users” conducted by the National Center for AIDS Prevention in Yerevan, provided higher rates. It showed that in 2000 only in Yerevan there were from 19,000-20,000 drug users, of whom approximately 10% were using intravenous drugs. The survey of general population conducted within the framework of the same study demonstrated that approximately 14% of respondents had experience of drug use (5). According to WHO EURO databases, the estimated number of IDUs in Armenia is between 7,000 to 11,000 which makes the prevalence rate of IDU among the general population 0.2-0.3% (10).

Within the framework of the Southern Caucasus Anti-Drug (SCAD) Program in November of 2003, the AIDS Prevention Union NGO conducted a survey on tobacco, alcohol and drug use prevalence among 500 university students in Armenia. 19.4% of participants of the survey reported having used hashish or marihuana during life time, 71.9% of those used during the last year and 45.8% used during the last 30 days. Heroin use prevalence was as following: 1.4% used during life time, 85.7% of those used during last year and 57.1% used during last month. 61.3% of the participated students did not personally know people who take hashish or marihuana and 89.6% of them did not know people who take heroin (7).

The increase in injecting drug use has been followed by increase in HIV and other blood born infections. As of March 2003, the total number of Russians officially registered as having HIV stood at about 230,000, nearly triple the number recorded in 2000 (96). Even government officials, however, concede that this number is far too low; both the Russian Federal AIDS Center and UNAIDS believe that at least 1.5 million people in the country of 144 million are currently infected with HIV (96) The situation and the trajectory are similar in Ukraine, where the national HIV prevalence rate is already higher than 1 percent of the total population of 49 million (97).

Although the absolute numbers of persons living with the disease in Central Asia are small in comparison with those of Russia, HIV/AIDS in the five Central Asian countries has the potential to be a major calamity. The most recent U.N. report on the epidemic characterizes the growth of HIV/AIDS in Uzbekistan, for example, as "explosive," noting that there were as many new HIV infections in the first half of 2002 as in the previous ten years.(98). UNAIDS also highlights Tajikistan as being on the brink of a major epidemic in view of recent increases in heroin use (98).

In 2002, the government of Kazakhstan estimated that some 25,000 persons were living with HIV/AIDS in the country (population 16 million), though the number of "registered" cases is much smaller (99). Kazakhstan is estimated to have more than double the number of persons with HIV/AIDS of the other four Central Asian countries combined (34).

In the countries of Central Asia, Russia, Moldova, Belarus, Ukraine and the Baltic states, at least 60 percent of registered HIV/AIDS cases are injection drug users (100). In Russia the figure is 93 percent. In Ukraine, which has the worst HIV/AIDS epidemic in the region in terms of HIV prevalence in the adult population-about 1 percent-the percentage of IDUs among new HIV cases has declined from over 80 percent in 1997 to about 60 percent in 2001 as the growing epidemic is increasingly spread through sexual transmission in the general population (98).

From 1988 to March 1, 2005, 317 HIV carriers were registered in the country, 301 of them are citizens of the Republic of Armenia (4). The estimated prevalence rate according to the Sentinel Epidemiological Surveillance in May 2002 was <0.1 % (5).

The official statistics show that the HIV epidemic in Armenia, as in other countries of fSU, is driven mostly by injecting drug use (53.5% of all registered cases) (4). In recent years, a considerable increase in the number of cases of infection through intravenous drug use has been observed. For example, until 1999 the number of cases of HIV infection via sexual contacts exceeded the number of cases of HIV infection through intravenous drug use, the interrelation ratio between such cases was 41 to 22 respectively. From 1999 to June 1, 2004, the ratio changed sharply to 55/113. So far, all the individuals infected via injecting drug use have been men. As a matter of fact, the majority of them temporarily inhabited in the Russian Federation (Moscow, St. Petersburg, Irkoutsk and Rostov) and the Ukraine (Odessa, Tiraspol and Kiev) and were probably infected there (7).

The Sentinel Epidemiological Surveillance carried out in year 2000 found the rate of HIV prevalence among IDUs to be about 15% (3) demonstrating thus that IDUs are definitely key to the dynamics of the HIV epidemic in Armenia.

Thus, draconian drug policies and their harsh enforcement in the majority of countries of the fSU resulted in accelerated drug use and spread of HIV. Since Armenia has a lot in common with other fSU countries, it may be suggested that, even though the prevalence of HIV in Armenia is still low, explosive increase may occur very soon if effective actions are not taken.

4.3.2 Violation of human rights of IDUs, their discrimination, stigmatization and marginalization

AIDS is a human rights issue.
Mary Robinson, UN High Commissioner for Human Rights (1997-2002)

HIV/AIDS often inspires fear and hostility. This is not surprising: sexually transmitted diseases, injecting drug use, and the transborder diffusion of epidemics are seldom topics of polite conversation or informed public discourse. The traditional mores prevailing in many fSU countries at the start of the transition presented further obstacles to open, honest discussion of HIV/AIDS as a public health issue.

It has been too easy, therefore, for policy makers and publics to adopt moralistic, shortsighted approaches to HIV/AIDS and drug use. The fSU countries initially responded to the twin epidemics by tacitly or explicitly ignoring (in some cases revoking) human rights protections nominally afforded to its victims.

Bitter experience in all parts of the world demonstrated that enforcement of criminal laws against drugs usually is accompanied by severe abuses of human rights. People may have their property seized, or be thrown in jail for possessing small amounts of illicit drugs, and then denied housing, jobs, or voting rights after release (85). Given the consensual character of the drug trade and the ease with which drugs can be concealed, it is not easy to imagine ways to enforce criminal laws without arbitrary searches, entrapment, racial profiling, violations of bodily integrity, and other intrusions on privacy. Also, as police are reluctant to acknowledge practices that violate laws they are sworn to uphold, another consequence is that they accustom themselves to perjury. That is, they habitually lie in court when they testify about drugs. Lying and other abuses connected to drugs readily lead to patterns of behavior by law enforcement officials that affect all their work (101).

Human Rights Watch's research suggests that police in Kazakhstan arrest injection drug users and sex workers not for specific illicit acts, but primarily because of their status as drug users and sex workers. People at risk of infection and people living with AIDS face a triple threat. The Kazakhstan police are corrupt, abusive, and seemingly impervious to any oversight. The police routinely target injecting drug users and sex workers-more for their inability to shield themselves from extortion and then lack of credibility when they file complaints for abuse-than for any legitimate law enforcement purpose. Once injection drug users and sex workers are in custody, they are often forced to bribe arresting officers regardless of whether the arrest itself was legitimate or, in the case of sex workers, provide sexual "services" for the police. Those who are unwilling or unable to comply are routinely beaten, framed, and/or falsely charged with a crime.

But detention in a jail or prison is also risky. Ironically, in some cases, defendants are even given narcotic drugs by the police as a reward for confessing to a drug charge or another charge. Drugs are reportedly widely available in places of detention-but harm reduction services are limited or nonexistent in these facilities. As a result many injection drug users resort to unsafe injection practices behind bars. The practice of segregating HIV-positive inmates from other inmates fuels misinformation about HIV/AIDS and reinforces the stigma associated with being HIV- positive. Finally, as a result of having been identified as an injection drug user or a sex worker, the very people who most need access to accurate information, testing, counseling, and other services are either denied access to services because of who they are or are subjected to abuse by the authorities. This is a recipe for disaster. Information and services are not reaching the people most in need; abusive practices by a multitude of state actors breeds distrust of all state actors; and risky behaviors that could be changed continue unabated.

(34) Fanning The Flames: How Human Rights Abuses Are Fueling The AIDS Epidemic In Kazakhstan. Human Rights Watch, June 2003, v.15 (4D)

In addition to harassment and abuse from the police, the IDUs in fSU face additional violations of their human rights under existing laws or widely accepted practices. For example, blood or urine tests are demanded, even without evidence of drug use, and punishment delivered based on the results (27). In Russia, the Moscow City Duma recently proposed mandatory drug testing of all homeless people and sex workers, and recommended that businesses routinely test employees. When advocates objected that such testing violated the constitution, a deputy replied that “democracy is incompatible with public health” (86, 102).

Although compulsory testing for HIV is against the law in some fSU countries, IDUs and sex workers are still often tested without their consent when entering treatment facilities or pretrial detention centers (27,28,34,35).

In Armenia the compulsory HIV testing so far has been legal (see article 11 of HIV/AIDS Law In Annex 1) and widely practiced for some groups of people including IDUs and persons in penitentiary institutions. It should be noted, however, that recently the Law on AIDS has been revised and the corresponding legislative initiative is in the agenda of the National Assembly. The revision includes elimination of mandatory HIV testing for high-risk groups.

Also, existing policies in some countries require drug-treatment clinics to officially register IDUs who seek assistance (although some facilities decline to do so). Similarly, a person who visits an AIDS center for treatment is automatically registered with the public health authorities (27,28,34,35). Armenian Laws on AIDS and on Health Care Provision permit disclosure of medical information in cases envisioned by law.

Some of the fSU countries (including Armenia) also have controversial laws that hold all HIV-positive people, including IDUs, criminally liable if they knowingly endanger or infect another person with the virus (see article 123 of he Criminal Code of the Republic of Armenia). In addition, concealment by a person sick with an HIV infection, source of infection, and also persons who have had contacts with the said person, creating the danger of infection by HIV, entails administrative responsibility under the Administrative codes of some fSU countries (28).

Some 20 percent of the East European and fSU countries had not passed general anti-discrimination legislation, and half had not passed anti-discrimination laws designed to protect vulnerable groups (Armenia is among the latter) (103). As a result, PLWHA and IDUs as well as members of other at-risk groups (irrespective of whether they are living with HIV) often face discrimination that is rarely countered decisively by officials. A recent survey of NGOs providing harm reduction services throughout the region found that drug users are often 'informally discouraged or prohibited from receiving primary health care (100).

As a result of the aforementioned violations of rights, IDUs are reluctant to seek assistance from public health facilities out of fear that they will be turned over to authorities, denied health care, or even forced into repressive, custodial treatment programs against their will.

In Armenia, narcological medical aid and services can be provided only by institutions licensed by the Armenian Ministry of Health, regardless of their form of ownership. According to the 2003 annual report on drug, over the past few years, demand for drug treatment in Armenia has been low and steadily declining since 2000. The number of persons registered at the Republican Narcological Center in 2003 was 197, and the number of persons treated was only 7 (these numbers include both alcohol and drug addicts). The reason for such a situation may be that the patients do not trust the health care system.

(7) 2003 Annual Report on Drug, RA

Poor enforcement of human-rights-related legislation is an additional challenge. While some fSU countries (including Armenia) have made progress in passing human rights legislation and creating the formal structures associated with the rule of law, the gap between theory and practice is not

closing fast enough to fully protect the human rights of IDUs and PLWHA. In some cases, the reason for insufficient enforcement of laws is that countries are financially unable to comply with their own legislation on providing effective health care services to people living with HIV/AIDS. In other cases, however, the implementation of effective HIV-related legislation and policies is hampered by widespread disinterest, intolerance, and discrimination. Since the members of the marginalized groups are largely powerless, there is little political interest in taking official measures to guarantee their legal rights. IDUs and PLWHA are disproportionately poorer and often less able to build effective social networks. They are victims of violence and abuse (sometimes perpetrated with the collusion of the police), and public officials are not always interested in preventing such violations (88).

The Constitution of the RA has maintained the basic rights inherited from the socialist period. These include the right to life, right to non-discrimination and equality in access to health care, legal representation and support, housing and social interactions, freedom from violence and abuse, freedom from arbitrary arrest and detention (see excerpts from the Constitution of RA in Annex 3). In some respects, these guarantees were illusory even then. But nowadays, particularly when it comes to guarantees for IDUs and PLWHA, they are not enforced at all due to aforementioned reasons.

Criminalization of drug use along with violation of human rights and discrimination of IDUs has devastating epidemiological consequences. It results in so-called "spoiled" identity—a stigmatized status that is applied to drug users as a group even in the absence of particular behaviors. Stigma connected with drug use is fairly constant throughout the region, especially since national governments and the media strongly disapprove of drug use behavior regardless of the circumstances. They focus on destructive elements—drug-related crime, overdose, disengagement from society at large—and adopt "blame the victim" mentalities that remain punitive (35).

The survey of 500 students, mentioned earlier, may give some idea of the attitude of the public in Armenia towards drug users. According to it, 50.6% of Armenian students perceive a drug addict more as a criminal, 49.2% - more as a patient; 8.2% of those surveyed fully agree with the following statement: "People should be permitted to take hashish or marihuana", 48.5% fully disagree with this statement; 3.8% of the surveyed students fully agree with the following statement: "People should be permitted to take heroin", 65.7% fully disagree with this statement. 30.7% of those surveyed do not disapprove when people try heroin once or twice, 46.6% disapprove that. 31.9% of those surveyed do not disapprove when people smoke marihuana or hashish occasionally, 43.9% disapprove that. 2.6% of those surveyed consider it to be no risk in smoking marihuana or hashish regularly, 74.5% consider it to be great risk (7).

Stigma pushes injecting drug users and PLWHA further into the social margins. Once there they have little incentive to refrain from such risky behaviors as sharing needles or having unprotected sex. And while IDUs and PLWHA are among those most in need of assistance, public health authorities cannot reach them there, which reduces the effectiveness of prevention and treatment policies. This issue was broadly discussed at the conference "Moving Harm Reduction Policy Forward" organized in 2003 by Soros Foundation-Moldova (30).

From the speech by **Konstantin Lezhentsev, MD, Program officer, IHRD program, OSI-Budapest, Hungary**
…there is a special category of patients whose access to treatment (Highly Active Antiretroviral Therapy) was limited not only by the economic barriers, but to bigger extent by unwillingness of the medical infrastructure to meet the demands of these patients, as well as moralistic and stigmatizing approach determined rather by law enforcement than healthcare principles. The recent studies in western countries have shown that even with the wide availability of ARVs only 40% of IDUs are receiving HAART. More recent study from Vancouver demonstrated an increase in uptake of ART by IDUs but with still 30% of treatment eligible IDUs not receiving therapy. The situation in the Eastern European region is more alarming with less than 1% of HIV-positive ID-users receiving ARV treatment or even having access to general medical care (30).

The presentation by **Andrey Panov, "Peter-Positive" Self-Support Group, Saint-Petersburg, Russia** was the reflection of Saint-Petersburg through the eyes of HIV positive IDU. The speaker told them about the IDUs access to medical (HIV/AIDS testing, immunogram, diagnosing, ARV therapy and methadone treatment) and non-medical treatment, which did not cover the real needs of IDUs and represented a highly discriminatory attitude towards the affected group of population.
The access to services and treatment was determined by a vague criterion of "social usefulness", which provoked an ardent confused reaction on the part of the audience. The situation proved to be extremely festering – non-medical treatment was confined to mere registration without any confidentiality respected, labeling and stigmatization. In the only hospice there are no social workers whatsoever. The portrait of an HIV positive was presented as a prostitute (female) or "narcoman" (male). The speaker attributed the increase of suicide rate to the general public attitude to the affected group (30).

(30) "Moving Harm Reduction Policy Forward". Conference organized in 2003 by Soros Foundation-Moldova

Thus, while the protection of human rights is critical for the success of prevention of HIV/AIDS, the Armenian laws do not contain provisions that would guarantee the rights of IDUs and PLWHA. In addition to that, as the experience of other fSU countries shows, enforcement of laws also poses threat to human rights. And finally, even when the legal guarantees to human rights are in place, they are not enforced when IDUs and PLWHA are concerned.

4.3.3 Legal Regime of Harm Reduction Projects

While the violation of human rights of IDUs may accelerate the spread of HIV, services intended to protect their right to health can help to contain the epidemic. Experience from other regions shows that harm reduction activities must form a critical part of the response to HIV/AIDS. Numerous studies have documented the effectiveness of harm reduction programs (58).

From a harm reduction perspective, all positive behavioral changes—such as using clean injecting equipment—constitute meaningful progress. Though this may seem like a minor step in addressing the social effects of drug use, such changes can have powerful and widespread public health benefits, particularly in terms of reducing HIV transmission. Just as important, perhaps, they symbolically reassure at risk adolescents and young adults that they are vital members of society whose well-being is treasured.

Armenia was the last country in the region (Central and Eastern Europe and fSU) to start up the needle exchange. The first harm reduction project including HIV counseling, condom distribution and needle exchange launched in Armenian in August 2003. In late 2003 – early 2004 four other pilot needle exchange projects launched, funded by the Open Society Institute (OSI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Currently, within the framework of GFATM-funded program, three harm reduction projects are running in Yerevan, Gumry and Kapan. They include syringe/needle exchange, dissemination of condoms and educational-informational material, as well as VCT service, voluntary consulting on STI syndromial treatment and legal advising.

The results of monitoring carried out by the expert of the OSI in December 2004, as well as the interviews with the projects' staff demonstrated that the projects had huge problems with reaching out to the target population. The projects' staff does not enjoy the trust of IDUs, therefore IDUs do not routinely visit the projects' offices. In one of the projects' offices in Yerevan the OSI monitor met with an outreach staff who was an IDU in the past. That single staff was responsible for providing all harm reduction services to IDUs including needle exchange, distribution of educational materials and condoms. The two projects working in Yerevan (OSI- and Global Fund-funded) cover 147 and 250 IDUs respectively. In another large city, Vanadzor, the OSI-funded project covers 35 IDUs. Thus the coverage of IDUs is very law.

The present situation of harm reduction activities in Armenia can be described as being somewhere between what is tolerated and what is supported. We cannot say that they are merely tolerated because the harm-reduction component theoretically is included in the National HIV/AIDS Prevention Program. However, the financial support provided for harm reduction projects by the government is extremely limited (in any) to be able to cover the existing needs.

So far, the staff of pilot harm reduction projects has not had any problems with the law enforcement authorities which may be explained by the fact, that the representatives of the Ministry of Internal Affairs are involved in the country coordination mechanism (CCM) on HIV/AIDS issues. However, if the initiative is to be implemented in a broad scale, some legal issues may arise under Armenian law with regard to harm reduction programs.

Since the Armenian experience with harm reduction projects is very short, the discussion on their legal status will be based mostly on the experience of other fSU countries. Of all components of harm reduction approach, these countries have some experience only with the needle/syringe exchange centers. Therefore, they will be especially emphasized. However, legal issues which may arise with respect to other components will be discussed as well.

Needle exchange centers

A "needle/syringe exchange center" is a place, usually comprising two or three small rooms, located in an area frequented by persons who consume narcotic means or psychotropic substances where sterile syringes and/or needles, swabs, condoms, and special literature are distributed free of charge to registered persons and used syringes and needles are collected in exchange for proper sterilization and destruction. As a rule, center clients may be subject to medical examination upon registration (including tests for hepatitis and HIV), receive counseling, advice and literature on less painful and harmful ways of administering or consuming narcotics, as well as free condoms, encouragement to reduce or cease the use of narcotics and to form a permanent relationship with the center in order to control their addiction, and information about risks of HIV infection and means of reducing those

possibilities. Some centers also operate "outreach" programs, under which workers or volunteers distribute syringes, needles, and other paraphernalia literally on the street or visit premises known to be frequented by addicts; these volunteers collect used syringes or needles for disposal (58).

It is crucial to the concept of harm reduction that active narcotics consumers are targeted, and clients of a needle exchange center will need to establish to the satisfaction of the center that they are within that category. Measures are taken to ensure that center personnel are not involved in the sale or turnover of narcotics and that the center itself does not become a site, or a "den", where narcotics are consumed or traded (58).

Although sharing syringes and needles plays an overwhelming role in the transmission of HIV infection, there are other risks to consumers of narcotics, some with implications for HIV and others for the state of health generally. These include, through ignorance or necessity, the use of unsafe or unhygienic practices when preparing narcotics for consumption (use of impure mixtures to "cut" or enhance the concentration of narcotics, non-sterile syringes or needles, contaminated or even lethal liquids, and so on). Paradoxical though it may seem, harm reduction may involve helping a consumer to properly master the techniques of safely consuming narcotics in order to reduce harmful and possibly fatal consequences to his health while, at the same time, drawing him into harm reduction practices, counseling, and treatment with a medium-term aim of persuading him to cease the consumption of narcotics. Clients of centers may therefore be taught to clean needles and syringes, eliminate or reduce contaminants, or take other measures to reduce HIV and hepatitis. Counseling and, through the distribution of literature, education are intended to form or alter social norms of behavior and make HIV prevention and reduction of narcotics consumption the norm. Harm reduction programs cannot be truly effective if this aspect of their operation is prohibited or curtailed. In addition, for the community at large harm reduction centers help to reduce the transmission of HIV, reduce the fear of narcotics-related crime, and so on (58).

However, seen through the eyes of a jurist, a "needle exchange center" is a place visited by individuals known to acquire and keep narcotics or psychotropic substances who register and by doing so, confirm their past record and their present intention to engage in behavior that did or will constitute an administrative or criminal offence (Article 271 of the Criminal Code of the RA). Moreover, in order to receive syringes and/or needles, swabs, possibly disinfectants to sterilize needles, together with other materials useful to assist them in perpetuating their illness; these clients leave in exchange for what they receive syringes or needles contaminated with blood and/or residual traces of narcotic means or psychotropic substances (i.e., evidence of having acquired and/or kept such means or substances). The "needle exchange center", staffed sometimes by nonmedical personnel, or the outreach staff of the centers, acquires and keeps used needles and syringes, which may or may not ultimately be properly disposed of, that contain remnants or residue of narcotic means or psychotropic substances comprising, individually or in aggregate, amounts that exceed the legal minimums under Armenian legislation. Although it is crucial to such programs that the clients of the centers are protected by confidentiality, there is doubt as to the extent to which center personnel can properly withhold information should the law enforcement personnel insist upon disclosure (28).

Thus, this legal perception places needle exchange programs directly at odds with a sophisticated strategy that emphasizes the exclusion of non-medical and scientific use of narcotic means and psychotropic substances from society through zero or low levels of tolerance and severe repressive measures.

Further, distribution of literature and oral consultations provided to clients may be interpreted by jurists as narcotics-related propaganda or, in some cases, as inclining to the consumption of narcotics (28), which both are prohibited under drug laws and Criminal Codes of countries of the fSU (including Armenia). The violation of the article on propaganda by a juridical person can result in suspension of the activity thereof for a period of up to three months or termination of the activity by decision of a court. The violation of the article on inclining to the consumption of narcotics (Article 272 of the Criminal Code) entails more severe punishment.

As a result of the aforementioned factors, neither the concept of needle exchange centers itself nor its implementation enjoys the full support of authorized agencies in countries of the fSU (27, 28, 34,35).

Serious doubts have been expressed by senior Russian law enforcement personnel about the value of what they regard as "legalizing" the consumption of narcotics. "Needle-exchange programs" are associated with such legalization (104). Other observers report "tension" and "resistance" in relations between the Russian Ministries of Public Health and Internal Affairs as regards harm reduction. Law enforcement officials reportedly have declared that harm reduction activities violate several articles of the 1998 Federal drug law and, more generally, that a "syringe exchange program not only increases the number of persons who consume narcotics, but also facilitates transition to `harder' types of narcotics, attracts criminal contingents from other regions, and is viewed by the healthy strata of society as a moral-ecological intervention threatening national security" (105).

A conclusion may be drawn from the aforementioned that needle-exchange centers cannot operate optimally on a nationwide scale unless such programs can be introduced in their entirety without legal risk, challenge, or unwarranted intrusion.

As the experience of other countries demonstrates, besides legal factors, there are cultural ones that may frustrate needle exchange programs seriously. As a Russian observer put it: "One may give out thousands of syringes to everyone, but all the same they will be common, shared about the group. Russian children need a shared high, need the illusion of love and friendship. In a world where all consider you to be an alien, groups necessarily emerge in which a hot craving must be quenched" (106).

This characterization of Russian behavior has been vigorously contested by others well acquainted with the behavior of addicts; they suggest that although there may sometimes be a sharing of the narcotic or psychotropic substance within a collective, most are deeply aware of the potential negative, even lethal, consequences of sharing syringes, needles, or other paraphernalia and use their own in collective situations (107).

While the "sharing" of syringes and needles is the main risky behavior, there are other patterns, which were demonstrated to contribute to HIV infection in fSU countries even if new syringes were provided. Infection may occur through a drug solution taken from a common container. Another channel of infection was the preparation of narcotics for injection, wherein consumers used their own blood as a reagent. Some addicts believed their own blood was capable of absorbing "harmful contaminants". Yet others tested the quality of a narcotic means by the appearance of their own blood dropped into a prepared narcotics solution (blood coagulation, or erythromycins), under the impression that the future toxic effect of the narcotic could be determined in this way. It also happens that if a consumer cannot pay for the entire amount of a narcotic means drawn into his syringe, the portion not paid for is returned to the container for common use (107).

The narcotic means and psychotropic substances used also played a role; it is believed, in the spread of HIV. Prior to 1999 nearly all territories in Russia recorded instances of HIV infection related to the consumer's use of an opium solution prepared from poppy straw. By 1997, however, nearly all-homemade opiates had been replaced by heroin marketed in the form of powder to be dissolved by consumers. The unprecedented increase in the incidence and prevalence of HIV in 1999 is traced to individually made heroin solutions within small and unstable groups of two to four consumers. While some of this infection may represent the sharing of common syringes and needles, a material factor is believed to be the injection of narcotics solutions from a common container or washing syringes in a common water basin before or after injection. The situation has been exacerbated by Contaminated ready-made solutions of narcotics on the market.(107).

Thus, besides sharing needles and syringes, there are other factors, that may frustrate needle exchange programs, therefore, they have to be explored comprehensively before introducing this approach on a large scale.

There are few studies that shed some light onto the risky behaviors of Armenian IDUs. One of them is the "Rapid assessment of the situation on spread of injecting drug use and HIV infection" which was carried out in Yerevan in year 2000 and involved 148 IDUs (5). Some results of the study are as follows:

Interviews and focus discussions revealed that 29% of the IDUs had shared syringes many times. Practically all shares do not properly clean used needles and syringes (the majority of them wash the equipment in boiled water). According to the information received, there are cases of using blood as a dissolvent during preparation of drugs. Majority of drug users believes that using a disposable syringe (84%) or changing a needle (10,5%) they practice safer injecting. However, in the most instances, they use a communal pot, spoons etc. while preparing a drug.

Despite the fact that syringes are relatively inexpensive and freely available in pharmacies, they are purchased by drug users only in case of absolute necessity. Besides, 7% of drug users have a low level of self-control and self protection. 16% of the surveyed male drug users indicate that they have sex with female drug users. Diminished ethical norms are typical of female drug users. It results in irregular sexual encounters. 84% of injecting drug males have sex with female non-drug users and 48% of them lead irregular sexual life (have sex with more than two partners during a year). Almost all the surveyed drug users indicate availability of condoms but only 31% of them use condoms consistently, 33% of IDUs practice unprotected penetrative sex. More than a half of drug users' sex partners do not use drugs, but they practice unprotected sex.

Thus, the risky behaviors of Armenian IDUs are similar to the ones in other countries of the Soviet Union, therefore, due to the time limitation and lack of resources, this project has not focused on them, but rather based its recommendations on findings in other fSU countries.

Drug injection rooms

This approach entails the establishment, or allowing the establishment of facilities where intravenous (IV) drug abusers may inject themselves. The stated purpose of such a practice would be to provide addicts with a hygienic environment where to inject, reducing their exposure to infectious diseases and making available minimum health services to them. Drug-injection rooms are currently operating in Australia (on a trial basis), Germany (as a recently legalized practice), Spain (municipal

regulation) and in the Netherlands and Switzerland (tolerated without a clear legal status) (58). Discussion of the feasibility of having them has already begun in Canada and Norway. In Luxembourg they seem to be permitted under the law, but it is not clear whether they are actually permitted by the authorities. The actual modalities differ from country to country, in some a broad range of medical and therapeutic options are offered, on a voluntary basis, with the use of the facilities; in others, such options may be very limited (58).

It might be claimed that this approach is incompatible with the obligations to prevent the abuse of drugs, derived from article 6 of the Armenian drug law 2003 as well as from article 38 of the 1961 Convention and article 20 of the 1971 Convention. Furthermore, encouraging addicts to use drug-injection rooms could arguably be construed as inclining to the illicit use of drugs, which is a criminal offence according to the article 272 of the Criminal Code of the RA. And finally, through eyes of some jurists, establishment of drug injection rooms can be seen as organization of dens, which is a criminal offence under the law of the RA.

Substitution and maintenance treatment

Substitution treatment can be defined as the prescription of a drug with similar action to the drug of dependence, but with lower degree of risk, with specific treatment aims (108). Substitution therapies do not in and of themselves treat HIV infection. Their role in the reduction of HIV is indirect. Insofar as they help the consumers of narcotic means to reduce or cease injecting, they decrease the incidence of behavior deemed to be primarily responsible for the spread of HIV.

The medical prescription of substitute narcotics for those which produce narcotics-dependency has been associated with opiate addiction since methadone was introduced as an opiate substitute in 1965 (109). Methadone continues to be the narcotic means most widely used in substitution therapy in the developed world. It can be used for gradual withdrawal or long-term maintenance. An alternative to methadone is Levo-alpha-acetylmethodol (LAAM). The principal difference is that the opioid effect of LAAM is slower to take effect and lasts for up to 72 hours compared to methadone, which lasts for up to 24 hours. Other substitutes such as buprenorphine and clonidine have been tried as heroin substitutes (108).

For historical reasons the United Kingdom has a long tradition of opiate prescribing. In December 2002 a total of 91 medical doctors were licensed to prescribe diamorphine in Britain (28). In 1993, faced with continuing high rates of HIV and narcotics-related crime rates, the Swiss Federal Government approved a controlled experiment under which injectable opiates would be prescribed to heavily dependent consumers for whom all other forms of treatment had failed. Initial results have been positive, and the programme has been extended (109). Experience in the United States suggests that people who consumed methadone on the basis of individually-tailored prescriptions were half as likely to be infected with HIV when compared with consumers not participating in methadone programs (108)

In the United Kingdom although the majority of consumers dependant on opiates are prescribed in oral form, about 3,000 patients consume methadone by way of injection (28).

Although substitution therapies have been used for nearly four decades in some countries, they remain, insofar as methadone and buprenorphine are concerned, illegal in Armenia under the 2003 Law on Narcotic Drugs and Psychotropic Substances. Methadone, being a List I narcotic drug, is categorically prohibited, and buprenorphine, a List II narcotic drug, is prohibited under Article28 of the Law.

As the results of the survey carried out within the scope of this project demonstrated, however, Armenian medical specialists are of the view that substitution treatment should be introduced in Armenia.

In Armenia drug addicts can receive treatment at a narcological center and in-patient psychological centers. There is only one specialized narcological center in this field. Services provided by the narcological center to drug addicts are divided into two parts: in-patient and out-patient treatment services. The state budget covers the treatment expenditures of drug addicts. With no differentiation between the type or severity of the disease, the allocated amount for treatment now constitutes 120,000 AMD/per person (about $215), versus 96,000AMD/per person (about $170) in 2002.

Drug addicts receive their treatment either in hospitals or at home. The treatment place is chosen by the doctor, taking into account disease severity and the patient's wishes. The available treatment of drug addiction in Armenia is limited to the first stage (poisoning), second stage (abstinence) and third stage (post-abstinence) treatments. There is no remission put into practice in the country. The treatment is distinguished according to the drug type and disease severity. There is no substitution treatment in Armenia.

(7) 2003 Annual Report on Drug, RA

Thus, unfortunately, harm reduction remains controversial and is resisted in many fSU countries (including Armenia). Existing programs serve as models of effectiveness, but inadequate resources limit their impact. Without increased support, the promise of harm reduction in reducing HIV risk and improving the lives of drug users cannot be realized. In some countries, advocacy efforts undertaken by harm reduction projects have had some very promising results. But an effective response to the HIV threat requires much more. In many countries, the inclusion of harm reduction NGOs in policy processes remains on paper, as suspicion and intolerance continue to dominate official attitudes toward their clients.

4.3.4 Poor democratization and underdeveloped civil society

As it was stated above, respecting the human rights and responding to the concerns of IDUs and PLWHA must be vital elements of any effective response to the epidemic. Such concerns can only be articulated, understood, and addressed when the individuals and communities with the most at stake are included in policy making processes, and when supportive environments for dialogue and mutual understanding are established.

In countries of the fSU, the appropriate human rights response is complicated by the disempowering legacy of communism. Alienation from the state was a key factor behind the collapse of the old order in the late 1980s and early 1990s. Pervasive social controls and the cynicism and apathy they generated atomized societies and hindered the development of the grass roots organizations needed to articulate individual and community concerns (88).

During the first (and, less frequently, the second) half of the 1990s democratization processes have been weakened and distorted by the armed conflicts and sharp declines in incomes. In some countries, democracy is not recognized as the official model for political development. Competitive electoral regimes, independent media and judiciaries, and vibrant civil societies are absent. Law enforcement agencies are not subject to effective social control (88).

Such conditions raise doubts about the significance of formal guarantees of human rights and result in distrust in the state. Many people who are HIV- positive or who engage in high-risk forms of behavior believe that candid discourse with government or other actors in these matters will result in punishment and social exclusion (IDUs have more reasons for fear and distrust than other vulnerable groups because injecting drug use unlike other risk behaviors is criminalized in fSU countries). Many harbor doubts about whether their governments and societies value and want to help them. Distrust in the state undermines the success of public policies seeking to reverse the spread of HIV (88).

Countries that have had success in stemming the spread of HIV/AIDS have done so thanks to sustained engagement from NGOs and more generally civil society. Key cornerstones of effective responses to HIV—confidentiality, counseling, support and community empowerment, efforts to overcome stigma and discrimination, harm reduction practices, patient treatment literacy—have been developed and are implemented by community based organizations. NGOs are typically flexible and cost effective. They are staffed by committed people with strong community ties, people who are willing to make personal sacrifices for the good of their communities. Involving PWLWHA and IDUs in policy, planning, and program implementation also helps to break the stigmatization and discrimination associated with HIV/AIDS and injecting drug use, as well as educate the public about these diseases (88).

However, communism's aftermath has not provided particularly fertile soil for the flowering of civil societies. Still, the collapse of the Soviet system was accompanied by the rise of independent social movements in many Central and East European countries. Introduction of political pluralism and free elections resulted in the legalization of NGOs, many of which initially received extensive support from external donors. The relatively favorable epidemiological trends for HIV/AIDS reported by the EU accession countries are due in part to the successful development and evolution of their civil societies (88).

Following the dissolution of the Soviet Union in 1991, NGOs in fSU countries underwent a period of rapid development. However, they remain heavily reliant on external donors, and relations between civil society and state organs are too often non-cooperative. In many fSU countries NGO engagement in HIV/AIDS related activities is limited to those in which the state is either not interested, or for which it cannot procure funding. NGOs seeking to work with governments sometimes face barriers in the form of legislation that does not permit government agencies to subcontract NGOs for certain activities and programs, or transfer funds to NGO accounts. In too many countries of the region regulations pertaining to NGOs and their activities are scattered across the national legislation and confuse rather than promote engagement by groups representing the interests of at-risk communities.

At the same time, NGOs in many fSU countries have yet to surmount obstacles that make them less than ideal partners for governments, particularly in the HIV/AIDS field. These include inadequate skills, knowledge, management experience, and funding; high staff turnover; and a mistrust of the authorities that is not always justified (88).

The extent to which people living with and affected by HIV are engaged in the response to HIV/AIDS varies from country to country in the region. Organizations of people living with and affected by HIV were established in Estonia and Russia (110, 111). The Russian Network of People Living with HIV/AIDS, which was launched in 1999 with help from UNAIDS, now links over 150

people living with HIV/AIDS from 25 Russian regions. The All-Ukrainian Network of People Living with HIV/AIDS, which was established in 2000, in November 2002 was one of the co-organizers of the International Conference on Care, Treatment and Support for People Living with HIV/AIDS (112) that was held in Kyiv. Most recently, in May 2003 a conference, entitled Choosing Life, Choosing Action: Increasing Advocacy Possibilities for Rights of People Living with HIV/AIDS in the Newly Independent States' gathered HIV activists from across the former Soviet space was held in Minsk (88).

But despite these successes, NGOs representing the interests of people living with or affected by HIV/AIDS in fSU countries continue to face numerous political, financial, and social obstacles (113). Since some of the high-risk behaviors are still criminalized in the countries of fSU (for example, injecting drug use), it is hard to imagine how people engaged in such behaviors can officially establish an NGO or get involved in an NGO.

Of several dozens of Armenian NGOs whose missions among others include HIV/AIDS and injection drug use issues, only few are active. The others from time to time apply for grants, but usually do not succeed in securing them. However, the adjective "non-governmental" is hardly applicable to those organizations which are active, because the majority of them are managed, staffed or supported by people occupying high-level positions in governmental organizations. The latter statement is true for all 8 NGOs, which are represented in the Country Coordination Mechanism (CCM) on HIV/AIDS prevention. The leaders of those NGOs formerly worked (some of them are still working) at the National Center for AIDS Prevention, at the Republican Nacological Center or at the Ministry of Health. At least two of those NGOs were established in 2003, solely with the purpose to apply for sub-grants within the scope of GFATM grant. Since the decision on who receives the sub-grants was also made by CCM, it is not surprising that all 8 NGOs, members of CCM, became the main sub-recipients of the GFATM grant, as well as other funds intended for HIV- and drug-related NGOs.

The number of skilled staff working in those NGOs is limited to their leaders. The rest of the staff which in practice bares the responsibility for implementation of main components of the National Program on HIV Prevention has inadequate skills and knowledge in the area of HIV/AIDS, as well as poor management experience. This may undermine the success of the National Program. Another weakness of NGOs working in the areas of HIV/AIDS and drugs is the lack of strong ties with vulnerable populations. In each NGO there are just a couple of representatives of at-risk groups which is not sufficient to get decision-makers to listen to their opinions.

Thus, while the commitment to democratization and sustained engagement from NGOs and more generally civil society are critical for stemming the spread of HIV/AIDS, many countries of fSU including Armenia, have not been effective in that.

At the conclusion of the "Results" section it can be stated that the punitive drug laws, the lack of anti-discrimination provisions in other laws and policies, the controversial status of harm reduction projects, as well as the lack of commitment to democratization and sustained engagement from NGOs and, more generally civil society, in issues addressing the problems of IDUs and PLWHA – all those factors are challenging effective responses to drugs, drug users and HIV in countries of fSU. The results of the primary research, although scarce, have demonstrated, that Armenia is not exceptional, and that the problems and patterns here are similar to the ones in other fSU countries.

5. DISCUSSION

Conflicts of Existing Armenian Drug and HIV-related Policies with the International Law: Legal Arguments in Support of Policies Favorable for the Reduction of Harm Caused by Injecting Drug Use.

In this chapter we are going to discuss, what kind of possibilities exist for changing Armenian legislature in a way, that it would enable the IDUs to decrease their risk for HIV infection.

According to the Article 6 of the new Armenian Constitution adopted on July 5, 1995 (see the excerpts from the constitution in Annex 3), the guiding principle of Armenian legislature is the supremacy of International treaties to which Armenia is a party. Under the supremacy of International treaties, Armenia can implement new approaches to HIV and drug use only if there is sufficient justification/ evidence that the new approaches are consistent with International treaties.

Let us discuss separately each of the factors which, as it was demonstrated above, may increase the vulnerability of IDUs to HIV, and see if it is consistent with the provisions of International Treaties and evidence-based best practices.

.

Drug prohibition

As it was stated above, strict measures for the possession and sell of small amounts of narcotics as well as for consumption of drugs without medical prescription are among those provisions of Armenian laws and policies that may directly or indirectly increase the vulnerability of IDUs to HIV. They result in incarceration of hundreds of non-violent drug users annually. The higher prevalence of HIV in Armenia's penal institutions —'HIV incubators' — is a serious cause for concern in this respect.

Criminal justice system that throws non-violent drug users into inhumane prisons, where HIV spreads quickly through sex and shared needles, has been criticized as a form of cruel and unusual punishment prohibited by international law (114).

Policy makers may disagree in the abstract about the relative weights of crime and punishment, the appropriate legal response to social deviance, or tolerance of 'immoral' behavior. From a practical public health perspective, however, hundreds prisoners are released from the country's prisons annually. These individuals are a bridging population that poses a major threat in terms of spreading HIV to the general population. This suggests that Armenia can no longer afford abstract, moralistic approaches to what could become a devastating public health problem. A better policy balance must be found between exclusion and criminalization on the one hand, and tolerance, inclusion, and treatment on the other. The experience of industrialized countries may be helpful in this respect.

It demonstrates that although drug prohibition is globally universal (this is the requirement of UN drug Conventions), yet, there are differences in the way that it is implemented. Many of the developed countries have implemented several 'depolarization' or 'decriminalization' schemes (84). 'Depolarization' or 'decriminalization' entails 'removal of penal controls and criminal sanctions in relation to an activity, which however remains prohibited and subject to non-penal regulations and sanctions (115). Depenalization can be '*de jure'*, involving changes to the legal statutes themselves, or '*de facto'*, where the laws remain unchanged but the way the law is enforced by police is altered by administrative instructions.

De jure depenalization can include prohibition with civil penalties, and partial prohibition. Under the former, possession and use remain illegal but civil rather than criminal penalties apply and more severe sanctions are maintained for larger scale possession supply offences. Such a system applies to cannabis use in 11 U.S. states (Oregon, Maine, Colorado, California, Minnesota, Ohio, Mississippi, New York, N. Carolina, and Nebraska since the 1970's; and in Nevada since 2001) and 3 Australian jurisdictions - South Australia (1987), The Australian Capital Territory (1992) and Northern Territory (1996) (58). Under partial prohibition personal use activities are legal, but commercial activities are illegal. Examples exist in Columbia (116), Spain where possession is only considered punishable if it is for consumption in public places (117) and Switzerland (118).

De facto depenalization can include prohibition with cautioning and/or diversion schemes (examples of which operate for a range of drugs in Italy, Portugal and Australia and prohibition with an expediency principle. Under the latter, all-drug related activities are illegal, however, cases involving defined small quantities are not investigated or prosecuted by police. Examples of this system operate for cannabis in Belgium, Germany, Denmark and the Netherlands (84). Overall, the evidence suggests that depenalization results in the reduction of adverse social costs on individuals. However, while there are different types of depenalization, each with it's own strengths and weaknesses, the effectiveness of each example will also depend on how it is implemented in any one location, recognizing that what works well in one socio-cultural context might not work well in others.

Thus, while under treaty supremacy Armenia is obliged to prohibit the possession, sale and use of illicit drugs, there are possibilities for *de jure* and *de facto* decriminalization of some drug-related offences.

Human Rights

In the age of HIV/AIDS epidemics, the human rights issues acquired heightened significance (119). Discrimination against drug users and people living with HIV/AIDS is a serious threat to people anywhere in the world where injection-related HIV is a problem. As the HIV epidemic grew, national policies in the industrialized world came increasingly to include explicit provisions against discrimination based on HIV status, protections for vulnerable persons including confidentiality of HIV testing, and prohibitions of the use of mandatory testing by the state.

As it was demonstrated above, however, few such provisions are present in the law and policy of former Soviet states including Armenia. Moreover, the policies of the most of fSU countries including Armenia, provide for compulsory testing of IDUs, disclosure of test results and tracing contacts of HIV positive people. Such practices violate an individual's right to autonomy and privacy. Compulsory HIV testing combined with involuntary disclosure of test results increases the chances that the identity of people living with HIV/AIDS will be revealed without their permission, thereby facilitating official or unofficial discrimination. International standards and practices recognize that there are very few circumstances (e.g. when blood or tissues are donated) in which testing should be required, or in which unauthorized disclosure of HIV status is permitted (88). The failure to guarantee these rights reduces the number of people who seek HIV testing, and keeps members of high-risk groups outside the reach of public health systems.

Both the Armenian Constitution and International agreements contain provisions that can help Armenian policy makers to apply the appropriate human rights lens to the development of adequate national response to the HIV epidemic.

The Constitution of the RA has maintained the basic rights inherited from the socialist period. These include the right to life, right to non-discrimination and equality in access to health care, legal representation and support, housing and social interactions, freedom from violence and abuse, freedom from arbitrary arrest and detention. In some respects, these guarantees were illusory even then. Still, these guarantees are not without value. This positive legacy of the Soviet period, when combined with regional and international human rights conventions, could facilitate the promotion of de facto recognition of the human and civil rights needed to empower IDUs and PLWHA.

Most of the human-rights-related provisions of international agreements are based on the essential rights outlined in the 1948 Universal Declaration of Human Rights (UDHR). The Declaration states that all persons have the right to "a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services"(120). In addition to UDHR, the following key human rights agreements can be considered when developing comprehensive HIV/AIDS policies:

- International Covenant on Civil and Political Rights (ICCPR) (including the Optional Protocol to the Covenant on Civil and Political Rights);
- International Covenant on Economic, Social, and Cultural Rights (ICESCR);
- International Convention Against Torture and Other Cruel, Inhuman or Degrading Treatments or Punishments;
- European Convention of Human Rights.

Article 2 of the ICCPR protects all persons from discrimination on the basis of "race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" for the rights recognized in the Covenant (121). This article has been widely interpreted by the U.N. Commission on Human Rights and other U.N. bodies to include HIV status as a factor on the basis of which discrimination is prohibited (122). The right to the highest possible standard of health is explicitly set out in the International Covenant on Economic, Social and Cultural Rights (ICESCR), which stipulates that state parties recognize "the right of everyone to enjoyment of the highest attainable standard of physical and mental health (123).

Article 8 of the European Convention of Human Rights provides for the right to respect for private and family life. Privacy includes sexual activities and sexuality, as well as personal medical information (124). In the light of this provision, the articles of Armenian laws (AIDS Law, Health Law, criminal and administrative codes) providing for compulsory testing, disclosure of medical information and tracing contacts of PLWHA and IDUs are in conflict with the International Law.

Further, although they do not have the force of international law, the United Nations Guidelines on HIV/AIDS and Human Rights are frequently used as a guide to policy and law related to HIV/AIDS. The Guidelines were formulated in September 1996, during the Second International Consultation on HIV/AIDS and Human Rights which was convened by the Joint UN Program on HIV/AIDS (UNAIDS) and the Office of the UN High Commissioner for Human Rights (UNCHR) (125). In 2002, following the Third International Consultation on HIV/AIDS and Human Rights, UNAIDS issued a comprehensive document revising Guideline 6 of the original International Guidelines (126).

The Guidelines urge national governments to identify and revise public health laws that block effective strategies for HIV/AIDS prevention and care. Governments should ‘review and reform

public health laws to ensure that they adequately address public health issues raised by HIV/AIDS', and be 'consistent with international human rights obligations'.

The Guidelines recommend the protection of the right to confidentiality through the enactment of general confidentiality and privacy laws, and state that 'HIV-related information on individuals should be included within definitions of personal/medical data subject to protection and should prohibit the unauthorized use and/or publication of HIV-related information on individuals.' Further, public health, criminal and anti-discrimination legislation 'should prohibit mandatory HIV-testing of targeted groups, including vulnerable groups'.

On HIV-related human rights abuses, the U.N. Guidelines suggest that states should establish HIV/AIDS focal points in relevant government branches, including national AIDS programs, police and correctional departments, the judiciary, government health and social service providers and the military, for monitoring HIV-related human rights abuses and facilitating access to these branches for disadvantaged and vulnerable groups. Further, criminal law should be reviewed in order that it not be 'an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users'.

The most prominent international agreement related to HIV/AIDS is the Declaration of Commitment passed at the United Nations General Assembly Special Session on AIDS (UNGASS) in June 2001 (11). The meeting at which the Declaration was developed was unprecedented; never before had member states gathered for a special session to discuss a specific threat to global health. 189 Delegations to the General Assembly (including all fSU countries) approved the Declaration, thereby recognizing the complexities of the epidemic and committing their governments to meet a set of goals aimed at stemming the spread of HIV and assisting those already infected.

The UNGASS Declaration, inter alia, emphasizes human rights: it commits signatory countries to a series of target dates based on the assumption that 'respect for the rights of people living with HIV/AIDS drives an effective response.' By 2003, for instance, member countries were to 'ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups; in particular to ensure their access to, inter alia education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic' (11).

Thus, while a body of national legislation and International agreements designed to protect human rights and prohibit discrimination is now in place in Armenia, this legal framework is far from a sufficient answer to the country's HIV/AIDS challenge. Armenia has yet to bring her national legislation into full compliance with her international obligations, particularly in terms of the relevant anti-discrimination statutes.

Harm reduction initiatives

As it was demonstrated it the "Results" Section, some legal issues may arise under Armenian laws with respect to harm reduction initiatives. This may prevent them to enjoy the full support of authorized agencies In order to operate optimally on a nationwide scale, such programs should be legalized, and thus made able to operate in their entirety without legal risk, challenge, or unwarranted intrusion. What kind of arguments in support of legalizing harm reduction initiatives can we find in International documents and research data?

The evidence demonstrating the benefits of harm reduction projects can strongly support their legalization. Numerous studies confirm that needle exchange programs decrease needle sharing, reduce HIV prevalence, and connect members of marginalized groups with drug treatment and other services (88, 127,128). These studies also conclude that such programs do not lead to higher rates of illegal drug use or injection (38). One study of 81 cities around the world compared HIV infection rates among injecting drug users in cities that had needle exchange programs with those that did not. In the 52 cities without such programs, HIV infection rates increased by an average of 6 percent annually. In the 29 cities with needle exchange programs, HIV infection rates decreased by an average of 6 percent annually (129). Providing an injecting drug user with clean needles, condoms, and safer sex information is significantly more cost effective than treating a person with AIDS (130).

Basing on the aforementioned studies, the UN defined its position with regard to needle exchange as follows:

-Several surveys of the effectiveness of programs for the exchange of syringes and needles has shown a reduction of the risk connected with the consumption of narcotics by injection, and also a reduction of the level of HIV infection; the link between the activity of such programs and the growth of consumption of narcotics by injection or other socially-dangerous types of behavior has not been discovered. Moreover, these programs have served as a point of contact between people abusing narcotics and organizations providing services to them, including services for the treatment of narcotics dependence. The benefit of such programs significantly grows if their activity extends beyond the exchange of syringes and incorporates instruction in the methods of preventing HIV infection, consultation, and referral to other services (131).

As regards drug injection rooms, the evidence of their effectiveness is not that strong. However, there is good evidence that, when developed in consultation with the wider community, a range of operational models for drug injection rooms is possible, and these can serve differing populations and local needs (132). Data concerning the number of visits they receive provides evidence of the amount of injecting that is transferred to a safer environment, probably decreasing nuisance and in which skilled personnel with access to emergency equipment are in attendance. In line with their objectives, consumption rooms have demonstrated an ability to attract more marginalized and vulnerable drug users. There are indications that they are likely to have an impact on overdose deaths and may reduce risk behaviors for blood-borne viruses. However, these cannot yet be well-quantified. Beyond this, they can provide access to a range of drug treatment, health and social care services. As yet, the cost-effectiveness of consumption rooms is uncertain. Whilst they show some promise, further research is required to clarify their overall impact and value for money (58).

The third component of harm reduction programs, which is methadone maintenance is supported by an evidence-base developed over almost 40 years and from across many different countries. International experience strongly suggests that broader application of substitution therapy will reduce the numbers of injecting drug users, lower crime and HIV prevalence rates, help connect injecting drug users with health care systems where they can be treated for HIV and other health problems, and allow injecting drug users to develop more constructive lives for themselves and their communities (100, 108, 133-141). Methadone is also cost effective, with annual patient costs in the region (Eastern Europe and fSU) generally below $1,150 (and sometimes as low as $20) (100).

An estimated half million people receive substitution therapy worldwide, over half of whom live in countries belonging to the European Union (142,143). European countries in which methadone is most widely available, such as the United Kingdom, also report low HIV prevalence rates among intravenous drug users (144). In East European and fSU countries, however, use of substitution

therapy remains highly limited. Some 6,500 people in the region (most of whom are in Central and South Eastern Europe) are currently using substitution therapy. By contrast, nine countries—Albania, Armenia, Azerbaijan, Belarus, Kazakhstan, Russia, Tajikistan, Turkmenistan, and Uzbekistan—do not offer substitution therapy at all, despite the fact that most of the people living with HIV live in these countries. The fact that substitution therapy is most available in those countries in the region where it is least necessary—and least available where it is most needed—is worthy of special attention (88).

Unfortunately, substitution therapy often makes public health and other policy makers uncomfortable because it is seen as condoning drug use. The alternative view is to see substitution therapy as a way to effectively control drug use and the ills that accompany it. In any case, regardless of how uncomfortable one may feel about substitution therapy, rising HIV prevalence rates leading to a generalized epidemic can only be seen as considerably more threatening (88).

Even if the gold-standard evidence demonstrates that harm reduction works, it can not be legalized in Armenia unless it is consistent both with Armenian legislature and International Treaties, Armenia is a party to. Let us see if harm reduction is consistent with UN Drug Conventions and other International Treaties and Guidelines.

Although they do not have the force of international law, the United Nations Guidelines on HIV/AIDS and Human Rights may be used to justify harm reduction initiatives as ones, called to protect the rights of IDUs to health (125). Guideline 6, entitled 'Access to Prevention, Treatment, Care and Support,' was revised in 2002 during the International Consultation on HIV/AIDS and Human Rights in the light of 'significant developments' since the original guidelines were published in terms of the 'right to health' and 'advances in the availability of diagnostic tests and HIV/AIDS-related treatments, including antiretroviral therapies' (126) The new text specifically mentions that effective HIV-prevention technologies include 'condoms, lubricants, sterile injection equipment [and] antiretroviral medicines.' It further declares that '[based] on human rights principles, universal access requires that these goods, services and information not only be available, acceptable and of good quality, but also within physical reach and affordable to all' (126).

Further, although UN drug Conventions predated the HIV epidemics driven by injection drug use and therefore they do not address the linkage of IDU and HIV, nevertheless, some three important features of the conventions could justify drug substitution therapy, safer injection rooms, and syringe exchange. First, all of these measures could be seen as medical treatment, and permissible under the conventions. Second, the conventions urged reduction of drug use and its adverse consequences, which clearly include HIV, thus potentially justifying measures to reduce infection. Finally, the conventions prohibited intentional incitement to or encouragement of drug use, and none of the harm reduction measures could be said to be performed with the intent of incitement of greater drug use (145).

Based on those features, legal analysts within and outside the UN system have noted that measures to reduce the spread of drug-related HIV infections, including distribution of clean syringes, can be interpreted as legal under the conventions, which call for alleviation of human suffering, exempt appropriate medical interventions from criminalization, and specify that demand reduction should aim both at preventing the use of drugs and at reducing adverse consequences of drug use (146-147).

Now, let us discuss in the light of UN Drug Conventions as well as other International Treaties each component of harm reduction initiative that arises concerns under Armenian law. As it was stated above, one of the legal issues that may arise under Armenian law with respect to needle exchange is that distribution of literature and oral consultations provided to clients may be interpreted by jurists as narcotics-related propaganda or, in some cases, as inclining to the consumption of narcotics.

An argument in support of legality of providing literature and consulting, can be found in the International Covenant on Civil and Political Rights (121). The right to receive and impart information without interference is embodied in the article 19, which states that all persons shall have the right 'to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice' (121). Article 9.1 of the OSCE Copenhagen Document clearly sets out that the right to freedom of expression 'will include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers' (148) Freedom of speech '…including the freedom to seek, receive and disseminate information and ideas through any medium of information, regardless of state borders' is guaranteed also by the article 24 of the 1995 Constitution of. Armenia (82).

In the light of these provisions, the staff of needle exchange centers has a right to disseminate information while the clients have a right to receive information. Article 42 of the Armenian 2003 drug Law is an exception to this constitutional guarantee imposed in the interests of protecting public health. However, the legality of that exception must be doubted in light of the jurisprudence of the European Court of Human rights, whose jurisdiction has been accepted by the RA. Article 42 of the drug law is in violation of Article 10 of the European Convention on Human Rights since it interferes with the right of the staff of harm reduction centers to impart information and of clients to receive information (124).

Drug injecting rooms is another component of harm reduction initiative which might be claimed to be incompatible with UN Drug Conventions. Article 6 of the Armenian drug law 2003 obliges to prevent the abuse of drugs. This obligation is derived from article 38 of the 1961 Convention and article 20 of the 1971 Convention. It should not be forgotten, however, that the Conventions create an obligation to treat, rehabilitate and reintegrate drug addicts. The implementation of those provisions depends largely on the interpretation by the Parties of the terms in question.

If, for example, the purpose of treatment is not only to cure a pathology, but also to reduce the suffering associated with it (like in severe-pain management), then reducing IV drug abusers exposure to pathogen agents often associated with their abuse patterns (like those causing HIV/AIDS, or hepatitis B) should perhaps be considered as treatment. In this light, even supplying a drug addict with the drug he depends on could be seen as a sort of rehabilitation and social reintegration, assuming that once his drug requirements are taken care of, he will not need to involve himself in criminal activities to finance his dependence (24).

Needless to say that, to be consistent with a comprehensive demand-reduction strategy, any such approach would also require counseling and other health and welfare services, aimed to promoting healthier life-styles and, eventually, abstinence (28).

Through eyes of some jurists, establishment of drug injection rooms can be seen as organization of dens, which is a criminal offence under the law of the RA. Inclining to the illicit use of drugs is

contrary to article 3, paragraph 1 (c)(iii) of the 1988 Convention either. In this respect, one should bear in mind the element of intent required in paragraph 1 of article 3, and recall the position of the Commentary on the 1988 Convention:

- 3.7 The various types of conduct listed in article 3, paragraph 1 are required to be established as criminal offences only "when committed intentionally", unintentional conduct is not included. It accords with the general principles of criminal law that the element of intention is required to be proved in respect of every factual element of the proscribed conduct. It will not be necessary to prove that the actor knew that the conduct was contrary to law (149).

It would be difficult to assert that, in establishing drug-injection rooms, it is the intent of Parties to actually incline to the illicit use of drugs. On the contrary, it seems clear that in such cases the intention of governments is to provide healthier conditions for IV drug abusers, thereby reducing their risk of infection with grave transmittable diseases and, at least in some cases, reaching out to them with counseling and other therapeutic options. Albeit how insufficient this may look from a demand reduction point of view, it would still fall far from the intent of committing an offence as foreseen in the 1988 Convention (28).

The third component of harm reduction initiative is substitution and maintenance treatment. Insofar as methadone and buprenorphine are concerned, substitution therapies are illegal in Armenia under the 2003 Law on Narcotic Drugs and Psychotropic Substances. Methadone, being a List I narcotic drug, is categorically prohibited, and buprenorphine, a List II narcotic drug, is prohibited under Article 28 of the Law.

Interpreting Armenian legislation to prohibit methadone and buprenorphine for use in substitution therapy would not appear to be consistent with the 1972 Protocol, to which Armenia became a party in 1993, amending the 1961 United Nations Single Convention. Article 38(1) of the 1961 United Nations Single Convention, as amended in 1972, requires that the Parties give special attention to and take "all practicable measures" for the prevention of the abuse of drugs and "… for the … treatment … of the persons involved …". In the narrow sense "treatment" is construed by the commentators to cover the "process of withdrawal of the abused narcotic drugs, or where necessary that of inducing the abuser to restrict his intake of narcotic drugs to such minimum quantities as might be medically justified in the light of his personal condition". Treatment thus encompasses, inter alia, "medically justified `maintenance programmes'", also known as substitution therapy (150).

The same position follows from the 1988 United Nations Convention, to which Armenia is a party. Article 3(4)(b)(c) and (d) make provision for treatment systems. The Commentary to the Convention provides that "treatment" will typically include "individual counselling, group counselling, or referral to a support group, which may involve out-patient day care, day support, in-patient care or therapeutic community support. A number of treatment facilities may prescribe pharmacological treatment such as methadone maintenance … Further treatment services may include drug education, training in behaviour modification, acupuncture, family therapy, relapse prevention training…"(151).

The Legal Affairs Section of the United Nations Drugs Control Programme has said that "in its more traditional approach methadone substitution/maintenance treatment could hardly be perceived as contrary to the text or the spirit of the treaties. It is a commonly accepted addiction treatment, with several advantages and few drawbacks. Although results are mixed and dependent on many

factors, its implementation along sound medical practice guidelines would not constitute a breach of treaty provisions"(152).

It should be noted that the 2003 Law of the RA on Narcotic Drugs and Psychotropic Substances contains an express commitment of the State to support "scientific research in the development of new forms and methods for the treatment of drug addiction" (Article 6[5]). One must presume that "treatment" in the Law reflects the obligations of Armenia under the 1972 Protocol as recorded in Article 38 thereof.

Thus, there are sufficient arguments in International Law in support of harm reduction initiatives. The advocates of harm reduction initiatives can use these arguments in their efforts to change the Armenian legal framework so that it would not pose difficulties for different harm reduction initiatives to operate optimally on a nationwide scale without legal risk, challenge, or unwarranted intrusion.

Civil Society

The desk research points out that inability of the region's policy makers to fully reach IDUs stem from communism's legacy of distrust and disempowerment. The NGOs and other civil society groups that have played key roles in halting or reversing the spread of HIV/AIDS in many countries are newcomers in much of the region, which is undergoing a profound democratization experiment. In many countries IDUs and members of other risk groups have doubts about whether the post-communist state will respect their human rights if they seek to avail themselves of testing and treatment services. Overcoming this legacy requires that states in this region unambiguously recommit themselves to the democratization agenda, in order to protect human rights and build the rule of law.

International experience shows that in order to prevent a generalized epidemic, the response of national governments must extend beyond the health sector. A multisectoral response requires engagement from all relevant government agencies beyond the health care sector, as well as NGOs and the private business. Governments must create mechanisms for engaging civil society and private sector partners in rapid yet sustainable ways. They also must create an appropriate regulatory environment for NGOs. Such an environment should be based on respect for freedom of association, assembly, and expression. It should be transparent and supportive, have clear, helpful guidelines for NGO operations, and allow for flexibility with donor agencies. The need to involve people living with HIV/AIDS or at risk of contracting HIV has also been internationally recognized as an important part of the response to HIV since the earliest years of the epidemic (88).

The 2001 UNGASS Declaration of Commitment described in the previous chapters lays the foundation for appropriate national responses to the HIV epidemic. It states that strong leadership at all levels of society is essential for an effective response to the epidemic. Leadership by governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society (11).

Civil society groups can best articulate the needs of people living with or at risk of HIV. They can suggest effective methods to meet the needs of at risk groups. They are often best suited to deliver HIV-related services, because of these services' highly sensitive and individualized nature. Civil society groups can monitor progress in the implementation of national and sub-national HIV/AIDS projects, as well as government compliance with international obligations. In order to effectively

play these roles, NGOs must be included in regional, global, national, and local policy processes. This was explicitly recognized by fSU governments when they signed the UNGASS Declaration in 2001. The UNGASS Declaration also recognizes the important role that people living with and affected by HIV can play in combating the epidemic (103).

Another document of regional significance which builds on the UNGASS declaration is the Declaration of the Commonwealth of Independent States for Expanded Regional Response to the HIV/AIDS Epidemic. It was adopted at the CIS summit on 30 May 2002 (153). It contains activities and policy objectives with proposed implementation dates, and assigns responsibilities for implementation. The declaration envisions by 2003 the development, adoption, and strengthening of multisectoral response strategies, including national AIDS prevention strategies.

Thus, while the international experience demonstrate the importance of democratization for addressing HIV/AIDS and IDU, the UNGASS Declaration of Commitment on HIV/AIDS and Declaration of the Commonwealth of Independent States for Expanded Regional Response to the HIV/AIDS Epidemic oblige signatory countries to commit themselves to democratization agenda and to involve NGOs and civil society in large in solving the problems connected with HIV/AIDS and IDUs.

In conclusion of the discussion it may be stated that while the Armenian legal framework in its current state compromises effective national response to drugs, drug users and HIV, the International Law provides sufficient arguments in favor of changing it in a way that it would create enabling environment for reducing the vulnerability of IDUs to HIV and thus would contribute to the containment of HIV epidemic in Armenia.

6. CONCLUSION

Responding to the epidemic means acknowledging its existence and finding the commitment to confront it. Because many people living with HIV in fSU countries including Armenia are not yet visibly ill, the extent of the problem is not fully evident, and is therefore more easily denied. The epidemic is nonetheless real and growing.

The analysis of policy issues associated with injecting drug use and HIV in fSU countries including Armenia suggests that, it is overcriminalization of drug use and the inability of governments to reach out to IDUs that threatens the effective response to drugs, drug users and HIV. Meeting the challenge of injection-driven HIV/AIDS is thus fundamentally a matter of governance. Problems of using state structures to protect those most at risk are closely tied to the region's overall democratization agenda.

The punitive drug- and HIV-related laws and policies and the abusive way they are enforced result in incarceration of non-violent drug users, and increase their vulnerability to HIV. Exclusionary policies such as mandatory HIV testing, disclosure of medical information and absence of anti-discrimination statutes effectively deny the human rights of at risk groups and exacerbate the public health threat posed by the epidemic.

The controversial status of harm reduction initiatives and the lack of support from governments undermines their ability to operate in their entirety on a nationwide scale without legal risk, challenge, or unwarranted intrusion. This limits the access of IDUs to services, which could help them to decrease their vulnerability to HIV.

Many fSU governments including Armenia have constructed the legal frameworks needed to protect the human rights of IDUs and PLWHA. What is often lacking now seems to be the will to move forward. Governments increasingly seem caught between the recognized inadequacy of 'traditional' public health approaches (based on full disclosure, name-based tracking, and notifying those who may have been exposed to HIV) on the one hand versus the enormity of the task of mobilizing other government bodies, NGOs, and the private sector to mount a broad-based campaign against the epidemic on the other.

Virtually all fSU governments are signatories to international conventions guaranteeing human rights for their citizens in general and people living with and affected by HIV/AIDS in particular. But many of these countries have yet to fully overcome the legacies of the communism, which reduced state legitimacy and disempowered individuals and communities. It is in this sense that developing an effective response to HIV/AIDS is inseparable from the region's democratization agenda.

Applying the human rights lens to the HIV/AIDS underscores the importance of developing truly multisectoral responses. Better public health infrastructure and harm reduction programs will not help health ministries combat the epidemic if police forces and judiciaries treat injecting drug users as criminals, or if education systems and national leaders do not aggressively seek to overcome the ignorance and fear that surrounds AIDS and traditional attitudes toward drug use.

Although the numbers of NGOs in the region are growing, many governments have not yet managed to fully engage them in national and sub-national programming to combat HIV/AIDS. This is a major weakness, since civil society groups can often best articulate the needs of people living with

or at risk of HIV. They can suggest effective methods to meet the needs of these groups, and are often best suited to deliver IDU- and HIV-related services, because of these services' highly sensitive and individualized nature. Civil society groups can monitor progress in the implementation of national and sub-national HIV/AIDS projects, as well as government compliance with international obligations.

A concerted effort to halt the spread of IDU and HIV is required. This effort requires leadership from the highest levels of government and civil society combined with reconsideration of the policy emphasis on criminalization and law enforcement, and a greater willingness to reach out to representatives of at risk groups. The response should be multisectoral, reflecting the fact that HIV/AIDS is a broad threat to human development, rather than solely a health issue. More attention should be paid to NGOs (particularly those involving members at risk) and media, and to providing consumables (condoms, clean needles) under harm reduction programs.

Many provisions of national laws and policies which are not favorable for the reduction of harm caused by injecting drug use, are in conflict with the International Law. The Declaration of the Commonwealth of Independent States for Expanded Regional Response to the HIV/AIDS Epidemic calls for revisions of national legislation to bring it into full compliance with international obligations. The International Conventions on human rights, as well as the UNGASS Declaration of Commitment, the United Nations guidelines on HIV and Human Rights and evidence-based best practices can guide legislators in improving the legal framework so that it would be favorable for reducing the harm caused by injecting drug use. Besides, while some provisions of outdated UN Drug Conventions were used by national decision-makers as an excuse for implementing zero tolerance approaches to drug users, the updated commentaries to them can be used for re-orienting the laws and policies towards harm reduction.

Thus, effective responses to the injecting drug use-driven HIV epidemic must be

- multisectoral, combining capacity building in the public health infrastructure with engagement from other government ministries, local authorities, and civil society groups
- based on a defence of the human rights of IDUs and PLWHA
- be informed by the logic of the harm reduction approach to the epidemic,
- focus on leadership, both at the highest levels and at the grass roots, in order to galvanize and engage those who would otherwise remain on the sidelines.

These conclusions suggest a number of policy **recommendations.**

7. RECOMMENDATIONS

1. Social priorities should be rebalanced, away from claims of morality, intolerance and law enforcement approaches that exclude injecting drug users from the social mainstream.

2. Mandatory imprisonment/institutionalization for possession of small amounts of illicit drugs which serve to accelerate HIV infection must be repealed.

3. Overall, the legal framework has to be brought into full compliance with international obligations. In particular,
   - policies that violate the right to non-mandatory HIV testing must be eliminated;
   - a policy or official edict should be issued to specifically ban the release of confidential HIV information;
   - another policy or official edict should be issued to interpret the article of the Armenian Constitution on non-discrimination to ensure that no person can be discriminated against based on HIV status or injecting drug use.

4. The legislation should be changed in order to enable harm reduction programs to operate in their entirety on a nationwide scale without legal risk, challenge, or unwarranted intrusion. In particular,
   - the legal definitions and interpretations of "inclining", "propaganda" and "den" should be changed so as to exclude actions which are an integral part of a harm reduction strategy or program;
   - since methadone is expressly prohibited under Armenian law and the use of other narcotics for substitution therapy is problematic, it is recommended that the medical use of methadone and other narcotic substitutes, such as buprenorphine, be authorized for experimental use under appropriate control of relevant governmental agencies.

5. The governments should play an active role in establishing and supporting a large, strategically located network of harm reduction programs, and in providing adequate training to program personnel.

6. Obstacles to greater engagement in HIV/AIDS programming by civil society groups must be identified and removed.

7. The representatives of IDUs and persons infected by HIV should be included in policy making and other initiatives directed at the epidemic. Otherwise many human rights guarantees will remain abstractions for these groups.

REFERENCES

1. 2004 Report on the Global AIDS epidemic. Joint United Nations Programme on HIV/AIDS (UNAIDS) 2004
2. Structural Collapse Sets the Scene for the Rapid Spread of HIV/AIDS Among Young People in Eastern Europe: A UNAIDS Press Backgrounder for World AIDS Day,1999. Online: http://gbgm-umc.org/programs/wad99/easteuro2.html).
3. Dehne, K. The Determinants of the AIDS Epidemic in Eastern Europe. In "Monitoring the AIDS Pandemic" Report, Geneva, 1999.
4. National Center for AIDS Prevention of the Republic of Armenia [homepage on the Internet, cited March, 2004]. Available from: http://www.armaids.am/index.htm
5. Grigoryan, S., Mkrtchyan, A., and Davidyants V. (Eds.). *HIV surveillance in the Republic of Armenia, 2000-2002*. Yerevan (Armenia): National Center for AIDS Prevention, 2002.
6. Caucasus Area Meeting on National Responses to HIV/AIDS. *Declaration-Address of Heads of States, Parliaments, Governments and Public Organizations of Azerbaijan, Armenia and Georgia*., Odessa, 2000.
7. Republic of Armenia. 2003Annual Drug Report. Yerevan, 2004
8. Preventing the Transmission of HIV among Drug Abusers: A position paper of the United Nations System. 8th Session of ACC Subcommittee on Drug Control, 28-29 September 2000, www.unaids.org
9. Rhodes, T., G. V. Stimson, et al. 1999. Drug injecting, rapid HIV spread, and the 'risk environment': Implications for assessment and response. *AIDS 13Suppl A*: S259-69.
10. WHO EURO data collection. Joint workshop of WHO EURO and UNAIDS. Summer 2003.
11. Declaration of Commitment on HIV/AIDS. United Nations General Assembly Special Session on HIV/AIDS. 25-27 June, 2001
12. Peterson, JL & DiClemente, RJ (Eds) *Handbook of HIV Prevention*. Kluwer Academic/Plenum Publishers. New York, Boston, Dordrecht, London, Moscow, 2000.
13. The global strategy framework on HIV/AIDS. *UNAIDS*, Geneva, June 2001.
14. Malinovska-Sempruch, K. Dare to Act. *Harm Reduction News,* Summer 2001, **2**(2), p.1.
15. Summary booklet of best Practices. *UNAIDS*, Geneva, June 1999.
16. A measure of success in Uganda: The value of monitoring both HIV prevalence and sexual behavior (Case study). *UNAIDS*, Geneva, May 1998.
17. Relationships of HIV and STD declines in Thailand to behavioral change: A synthesis of existing studies. *UNAIDS*, Geneva, 1998.
18. AIDS: The Brazilian experience. *Ministry of Health of Brazil,* 2001.
19. Pisani, E. *Acting early to prevent AIDS: The case of Senegal*. UNAIDS, Geneva, June 1999. 23p.
20. The Law of the Republic of Armenia on Prevention of Disease Caused by Human Immunodeficiency Virus (HIV-Infection). http://www.armaids.am
21. National Programme on HIV/AIDS Prevention. *Republic of Armenia, Yerevan*, 2002
22. Support to the National Programme on HIV/AIDS Prevention. Proposal approved by the GFATM. http://www.theglobalfund.org/search/portfolio.aspx?countryID=ARM
23. The Law of the Republic of Armenia on Narcotic Drugs and Psychotropic Substances. www.drugnfp.am
24. Markosyan, K. et al. HIV risk of Armenian female commercial sex workers: Barriers and facilitators of preventive behaviors 11th annual conference on the European Public Health Association. Rome, Italy, 2003

25. Markosyan, K. et al. Misconceptions of Armenian female commercial sex workers with regard to HIV/AIDS, 10th International Congress on Public Health organized by the World Federation of Public Health Associations. Brighton, England, United Kingdom, 2004
26. Markosyan, K. et al. Challenges of HIV-prevention among Armenian Commercial Sex Workers. XIV International AIDS Conference, Bangkok, Thailand, 2004
27. Wolfe, D. & Malinowska-Sempruch, K. *Illicit Drug Policies and the Global HIV Epidemic: Effects of UN and National Government Approaches*. A working paper commissioned by the HIV/AIDS Task Force of the Millennium Project. Center for History & Ethics, Mailman School of Public Health, Columbia University, International Harm Reduction Development Program, Open Society Institute, 2004.
28. Butler, WE. *HIV/AIDS and Drug Misuse in Russia: Harm Reduction Programmes and the Russian Legal System*, Family Health International, London, 2003
29. Drug prevention and HIV/AIDS epidemic in Central Asia,2004 http://www.usaid.gov/locations/europe_eurasia/car/hiv_aids/hiv/drugprev.htm
30. Moving Harm Reduction Policy Forward. International Conference. Chisinau, Moldova, November 19-21, 2003, Soros Foundation-Moldova, Open Society Institute
31. Malinovska-Sempruch, K. Drug Use, Trafficking and the HIV epidemic in Central Asia. Eurasia Policy Forum on HIV and Harm Reduction in Central Asia, April 2004. http://www.eurasianet.org/policy_forum/epf030101.shtml
32. Mikkelsen, H. Building Expanded Responses to HIV/AIDS and Injecting Drug Use in Central Asia. Eurasia Policy Forum on HIV and Harm Reduction in Central Asia, April 2004. http://www.eurasianet.org/policy_forum/epf030101.shtml
33. Dobkin, J. Assessing and Responding to the AIDS Threat in Central Asia. Eurasia Policy Forum on HIV and Harm Reduction in Central Asia, April 2004. http://www.eurasianet.org/policy_forum/epf030101.shtml
34. Fanning The Flames: How Human Rights Abuses Are Fueling The AIDS Epidemic In Kazakhstan. Human Rights Watch, June 2003, v.15 (4D)
35. Malinowska-Sempruch, K., Hoover, J., and Alexandrova, A. *Unintended Consequences: Drug Policies Fuel The HIV Epidemic in Russia and Ukraine.* Open Society Institute, IHRD, April 2003
36. The Regional Conference on Drug Abuse in Central Asia: Situation Assessment and Responses. Tashkent, 26-28 June 2002. United Nations Office for Drug Control and Crime Prevention and the Government of the Republic of Uzbekistan. Co-sponsored by the Government of Austria, USAID, OSCE and WHO/EURO
37. Drug Abuse and HIV/AIDS: Case Studies Booklet. Central and Eastern Europe and the Central Asian States. Vienna and Geneva, 2001 www.unaids.org
38. Drugs, AIDS, and Harm Reduction: How to Slow the HIV Epidemic in Eastern Europe and the Former Soviet Union. IHRD International Harm Reduction Development, Open Society Institute, 2001.
39. Council of the Baltic Sea States' Task Force on Communicable Disease Control in the Baltic Sea Region. http://www.baltichealth.org/cparticle65128-7717a.html
40. Smiths, T. Breaking down Barriers, Breaking the Silence. *The Asian Harm Reduction Network (AHRN) Newsletter,* March 2002, Issue 27, p.1
41. 13th International Conference on the Reduction of Drug Related Harm. Ljubljana, Slovenija, March 2002.
42. Hungarian Civil Liberties Union on Harm Reduction Drug Policy. *HCLU,* February. 2002
43. Drucker, E. Drug Prohibition and Public Health: 25 Years of Evidence. *The Drug Policy Letter,* May-June 1999, (No.40), pp.4-18.

44. Oleinik, S. The Swiss Approach: Harm Reduction or Fighting Drug Use? *Newsletter "Harm Reduction in Russia"*, 2001-2002 English Issue, pp 5-6.
45. Neyer, A. Harm Reduction Programs Exemplify Open Society Values. *Harm Reduction News,* Summer 2001, **2**(2), p.3
46. Hide, L. What is Harm Reduction? *The Newsletter of the International HIV/AIDS Alliance,* Sep-Oct 2002, **3,** pp 3-4.
47. What's Happening in Asia and the Pacific? *The Asian Harm Reduction Network (AHRN) Newsletter,* Issue 27, March 2002, pp1-4.
48. Foster, R. Harm Reduction Where HIV is Moving the Fastest; A Talk with Kasia Malinovska-Sempruch. *Harm Reduction Communication,* Summer 2001, No.12, pp 20-21.
49. Subata, E. Harm Reduction Training for Public Health Coordinators in Vilnius. *Harm Reduction News,* Fall 2000, **1**(1): pp 8-9.
50. The Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol. *United Nations*, *Treaty Series*, vol. 976, No. 14152
51. Convention on psychotropic substances of 1971. *United Nations*, *Treaty Series*, vol. 1019, No. 14956.
52. United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. Official Records of the United Nations Conference for the Adoption of a Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Vienna, 25 November-20 December 1988*,* vol. I. *United Nations publication,* Sales No. E.94.XI.5.
53. Walsh, S. Some Aspects of International Drug Control and Illicit Drug Trafficking. In: D. Rowe (Ed) *International Drug Trafficking*. Chicago, Office of International Criminal Justice—University of Illinois. 1988.
54. Bewley-Taylor, DR. Challenging the UN drug control conventions: Problems and possibilities. *International Journal of Drug Policy* 14: 171-179, 2002.
55. Room, R. *Impact and implications of the international drug control treaties on IDU and HIV/AIDS prevention and policy*. Toronto, Health Canada, 2003.
56. Role of the INCB, International Narcotics Control Board. *INCB,* 2003. www.incb.org. Accessed September 27,2003.
57. Rossi, C. A critical Reading of the Reports of the International Narcotics Control Board and of the U.S. Bureau for International Narcotics and Law Enforcement Affairs. *World Drugs Report*. New York, International Antiprohibitionist League. 2003.
58. Hunt, N. *A Review of the Evidence-Base for Harm Reduction Approaches to Drug use: Forward Thinking on Drugs*. 2004. Available at: http://www.forward-thinking-on-drugs.org/review2-print.html
59. Drug Policies = Death: HIV/AIDS in Central and Eastern Europe. A report by the Drug Law and Health Policy Network on the Current Impact of Law and Policy on Spread of HIV in Central and Eastern Europe and Former Soviet Union. *Drug Policy Institute*, 2002. Available at: http://www.drugpolicy.org/docUploads/drugpolicies_death.pdf
60. Ward, J., R. Mattick, et al. The effectiveness of methadone maintenance treatment: an overview. *Drug and Alcohol Review* 13: 327-336, 1994.
61. Cravero, K. *Address to the Commission on Narcotic Drugs.* Commission on Narcotic Drugs, Vienna, 2002.
62. Hankins, C. *Opening Ceremony Address*. 13th International Conference on Drug Related Harm, Ljubljana, Slovenia, 2002.
63. Lubin, N., A. Klaits, et al. *Narcotics interdiction in Afghanistan and Central Asia: Challenges for international assistance*. New York, Open Society Institute, 2002.

64. CND: Programme, sector, execution modality and location by cost and volume changes,1998-1999. Vienna, Commission on Narcotic Drugs, 1999. E/CN.7/1999/13
65. 2003 National drug control strategy. Washington, DC, United States Office of National Drug Control Program, 2003.
66. Global illicit drug trends. New York, United Nations Office for Drug Control and Crime Prevention, 2002
67. Global Illicit Drug Trends. Vienna, United Nations Office on Drugs and Crime, 2003
68. Nakachol, K. *Drug bonfire marks international day against drugs*. Bangkok Post, 1997.
69. China marks U.N. anti-drug day with executions, public rallies. Beijing. June 26. *Associated Press.* 2001
70. China executes 64 to mark U.N. anti-drug day. Shanghai. June 26. *Associated Press.* 2002.
71. United Nations General Assembly Special Session on Drug Abuse. 1998
72. Karev, DC (ed.) Уголовное законодательство СССР и союзных республик (1957), p. 60.
73. Decree of the All-Union Central Executive Committee and Council of People's Commissars of the USSR of 23 May 1928 "On Measures of Regulation of Trade in Narcotic Substances". See СЗ СССР (1928), no. 33, item 290.
74. Zagorodnikov, NI, Iakubovich, MI. and Vladimirov. MA (eds.), Советское уголовное право. Часть особенная [Soviet Criminal Law: Special Part] (1965), p. 427
75. Paoli, L. *Illegal Drug Trade in Russia* (2001), p. 141
76. Prokhorova, ML. Наркотизм: уголовно-правовое и криминологическое исследование [Narcotism. Criminal- Law and Criminological Research] (2002), p. 80.
77. Decree of the Central Committee of the Communist Party of the USSR of 19 October 1982 "On Serious Shortcomings in the Organization of the Struggle Against Narcotics Addiction"
78. Anisimov, LN. Наркотики – правовой режим [Narcotics – Legal Regime] (1974), p. 126
79. The Statute on Social Educators of Minors. 1967
80. The Statute on Therapeutic-Nurturing Dispensary for Persons Ill with Narcotics Addiction. 1986.
81. The Statute on Commissions for Cases of Minors. 1987
82. Constitution of the Republic of Armenia, 1995
83. Criminal Code of the Republic of Armenia. April 11, 2004.
84. Prosecution of drug users in Europe. *EMCDDA Insights*, N5, June 2003.
85. Curtis, M. Empowered to Fight Against Injustice *Harm Reduction News*, Spring 2004, v. 5(1), p1.
86. Levinson, L.. *Russian drug policy: Need for a change. Stating the problem and revealing the actual picture*. 2003.
87. Wolfe, D. Policy Reform is Key to Harm Reduction. *Harm Reduction News*, Fall 2004.
88. HIV/AID in Eastern Europe and the Commonwealth of Independent States: Reversing the Epidemic: Facts and Policy Options. *UNDP*, Bratislava, 2004.
89. Health Promotion Program in the Russian Prison System: Prisoner Survey 2000, *Medecins Sans Frontieres – Holland*, November, 2000.
90. Curtis, M. Fighting for Prison Health. *Harm Reduction News*, Fall 2004, v. 5(3), p1.
91. Schoofs, M. Jailed Drug Users are at the Epicenter of Russia's Growing AIDS Scourge. *Wall Street Journal,* June 25, 2002.
92. Schwalbe, N. TB is the Largest Killer of Those with HIV. *Letter to the Wall Street Journal,* July 18, 2002.
93. International Centre for Prison Studies. 2003. http://www.kci.ac.uk/depsta/rel/icps/worldbrief/europe/html

94. Deany, P. HIV and Injecting Drug Use: A New Challenge to Sustainable Human Development. *The Centre for Harm Reduction, MacFarlane Burnet Centre for Medical Research, Australia, UNDP HIV and Development Programme, UNDP Asia-Pacific Regional Programme on HIV and Development*, Dec.2000.
95. Burrows, D. Factors that predict HIV epidemics among injecting drug users. *Harm Reduction News*, v.1(1).
96. AIDS Foundation East-West, based on data from the Russian Federal AIDS Center, March 2003.
97. UNAIDS. Ukraine Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2002 update.
98. AIDS Epidemic Update, December 2002.
99. Interfax-Kazakhstan News Agency, November 28, 2002
100. Injecting Drug Users, HIV/AIDS Treatment and Primary Care in Central and Eastern Europe and the Former Soviet Union: Report of a survey. *Central and Eastern European Harm Reduction Network (CEEHRN)*, July 2002. Available at: http://www.soros.org/harmreduction/pub_files/CEEHRN_treatment_access.pdf)
101. Neyer, A. Focus: Human Rights. *Harm Reduction News*, Spring 2003, v. 4 (1), p1.
102. Draft laws proposed by the Moscow City Duma contradict the constitution of the Russian Federation and generally accepted principles of the international law. *Central and Eastern European Harm Reduction Network*, Vilnius, 2003.
103. Report of the Secretary General: Progress towards Implementation of the Declaration of Commitment on HIV/AIDS, UN General Assembly, 58th session, 25 July 2003, New York, p. 11.
104. Tantsorov, LP & Tselinskii, BP in Sergeev, AN (ed.). Противодействие незаконному обороту наркотических средств и психотропных веществ: Учебное пособие [Counteracting Illegal Turnover of Narcotic Means and Psychotropic Substances: Instructional Manual]. Moscow, UBNON MVD Rossii, Moskovskaia akademiia MVD Rossii, Izd-vo "Shchit-M", 2000-02, I, pp. 101-102.
105. Rhodes, T. & Sarang, A. HIV Transmission and HIV Prevention Associated With Injecting Drug Use in the Russian Federation (unpublished paper, 2002), pp. 35-36 (Appendix 1). Cited in reference # 28: Butler, WE. *HIV/AIDS and Drug Misuse in Russia: Harm Reduction Programmes and the Russian Legal System*, Family Health International, London, 2003.
106. Tantsyrev, A. "Триколор с героином" [Tricolour with Heroin], Колокол, no. 5 (2002), p. 57.
107. Ladnaia, NN, Pokrovskii, VV. and Sokolova, EV. HIV Epidemiology in Russian Regions in 2002. Unpublished paper, 2002, Cited in reference # 28: Butler, WE. *HIV/AIDS and Drug Misuse in Russia: Harm Reduction Programmes and the Russian Legal System*, Family Health International, London, 2003.
108. Reviewing Current Practices in Drug-Substitution Treatment in the European Union. *EMCDDA Insights*, N3, November 2000.
109. United Nations International Drug Control Programme, World Drug Report (Oxford, Oxford University Press, 1997.
110. ESPO Society. See Center on AIDS Information and Support, http://www.aids.ee.)
111. Club 'Positive', online in Russian: Info Plus Educational Center: http://infoplus.aids.ru/lavka/products/161.html
112. All-Ukrainian Network of People Living with HIV/AIDS, online: LGVS, http://www.lgvs.org.ua

113. Dudnik,R & Bijl, M. Involvement of People Living with HVI/AIDS: Reality or Fiction? (AFEW) Poster presentation, *International Harm Reduction Conference*, Chiang-Mai,Thailand, 2003.
114. The CPT Standards. *Council of Europe, European Committee for the prevention of torture*, 2001.
115. Demand Reduction: A Glossary of Terms. *United Nations Office for Drug Control and Crime Prevention (UNDCP)*. New York, 2000.
116. Lenton, S, Heale, P, Erickson, P, Single, E, Lang, E. and Hawks, D. The regulation of cannabis possession, use and supply: A discussion document prepared for the Drugs and Crime Prevention Committee of the Parliament of Victoria*. (NDRI Monograph No. 3)*. National Drug Research Institute, Curtin University of Technology, Perth, 2000.
117. Dorn, N & Jamieson, A. European Drug Laws: the Room for Manoeuvre. London: Drugscope, 2001.
118. Liberalization plans leave cannabis in legal limbo. *Swissinfo,* July 29, 2002.
119. Mann, JM. Human rights and AIDS: The future of the pandemic. In: Mann, JM, Gruskin, S, Grodin, M and Annas, GJ. eds. *Health and human rights: A reader.* New York and London: Routledge, p. 217, 1999.
120. Universal Declaration of Human Rights (UDHR), *article 25(1*). 1948.
121. International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force Mar. 23, 1976.
122. The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). *United Nations Commission on Human Rights,* Resolutions 1995/44, 1996/33 and 1999/49.
123. International Covenant on Economic, Social and Cultural Rights, article 12. G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force Jan. 3, 1976.
124. European Convention of Human Rights.
125. HIV/AIDS and Human Rights International Guidelines (from the second international consultation on HIV/AIDS and human rights). *Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS*, 23-25 September 1996, Geneva, U.N. Doc. HR/PUB/98/1, Geneva, 1998.
126. Access to Prevention, Treatment, Care and Support. Guideline 6 of the International Guidelines on HIV/AIDS and Human Rights. Revised in 2002. Available at http://193.194.138.190/hiv/g6.pdf
127. Innovative Approaches to HIV Prevention: Selected Case Studies, *UNAIDS*, Geneva, 2000. Available at (http://www.unaids.org/en/in+focus/topic+area/injectiondrug+use.
128. Des Jarlais, D, Friedman, P, Grund, JP et al. HIV Risk Behaviour among Participants of Syringe Exchange Programs in Central and Eastern Europe and Russia. *The International Journal of Drug Policy*. 13, 2002: 165-170.
129. Multi-city Study on Drug Injecting and Risk of HIV Infection. *World Health Organisation International Collaborative Group*, Geneva, 1994.
130. Return on Investment in Needle and Syringe Programs in Australia. *Commonwealth Department of Health and Ageing. Commonwealth of Australia*, Sydney, 2002.
131. Prevention of HIV Among Narcotics Addicts: UN position. *Round table no. 4*. p.8. 2002.
132. Mattick, RP, Kimber, J, Kaldor, J, MacDonald, M, Weatherburn, D, & Lapsley, H. Six-month process evaluation report on the Medically Supervised Injecting Centre (MSIC). Sydney: National Drug and Alcohol Research Centre, 2001.

133. Ward, J, Mattick RP & Hall, W. Methadone Maintenance Treatment and other Opioid Replacement Therapies. Amsterdam, 1998.
134. Gerstein, DR, Harwood HJ (Eds.) *Treating drug problems. Vol 1. A study of the evolution, effectiveness, and financing of public and private drug treatment systems.* Washington: National Academy Press, 1990.
135. Advisory Council on the Misuse of Drugs. *AIDS and drug misuse, Part 1*. London: HMSO, 1988.
136. Farrell, M, Ward, J, Mattick, RP, Hall W, Stimson G, Des Jarlais D, Gossop M and Strang J. Methadone maintenance treatment for opiate dependence: A review. *British Medical Journal*, 309, 997-1001, 1994.
137. Marsch, LA. The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behavior and criminality: A meta analysis. *Addiction*. 1998 93(4). 515-532.
138. Mattick RP, Breen C, Kimber J, Davoli M. Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence: Cochrane Review. In: The Cochrane Library, Issue 1, 2003. Oxford: Update Software.
139. Belin,E et al. High Dose Methadone Reduces Criminal Recidivism in Opiate Addicts. *Addiction* (1999); 7 (1): 19-29.
140. Ward, J et al. Key Issues in Methadone Maintenance Treatment. University of New South Wales Press, 1992, New South Wales: 41-61.
141. CIDAD Group of Experts in Demand Reduction, Drug Substitution Treatment for Opiate Use. 2001. Available at: http://www.cidad.oas.org
142. Substitution Treatment: A Key Component of Drug Treatment', European Monitoring Centre for Drugs and Drug Addiction, Lisbon, 2001.
143. Solberg, U. Maintenance Therapy in the European Union and in Norway. Fifth Conference of European Opiate Addiction Treatment Association, Oslo, 2002.
144. Stimson, G. AIDS and Injection Drug Use in the United Kingdom, 1987-1993: The Policy Response and the Prevention of the Epidemic. *Social Science and Medicine* 41(5): 699-716.
145. Flexibility of treaty provisions as regards harm reduction approaches. *International Narcotics Control Board (INCB)*, E/INCB/2002/W.13.SS.5.. Vienna, 2002
146. Report of the INCB for 2002. *International Narcotics Control Board*, E/INCB/2002/1, Vienna, 2002.
147. Fazey, C. The Commission on Narcotic Drugs and the United Nations International Drug Control Programme: Politics, policies and prospect for change. *International Journal of Drug Policy* 14: 155-169, 2003.
148. The OSCE Copenhagen Document, article 9(1).
149. Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988 (1998).
150. Commentary on the Protocol Amending the Single Convention on Narcotic Drugs 1961 (1976), p. 84.
151. Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988 (1998), pp. 87-88.
152. United Nations International Narcotics Control Board, E/INCB/2002/W.13/SS.5, 30 September 2002. 75th Session, Point 17. Vienna, 30 October - 15 November 2002.
153. Programme of Urgent Response of the CIS Member States to the HIV/AIDS Epidemic. CIS Summit. Moscow, May 30, 2002.

ANNEXES

Annex 1. THE LAW OF THE RA ON THE PREVENTION OF THE DISEASE CAUSED BY HUMAN IMMUNODEFICIENCY VIRUS (AIDS LAW)

ՀԱՅԱՍՏԱՆԻ ՀԱՆՐԱՊԵՏՈՒԹՅԱՆ
ՕՐԵՆՔԸ

ՄԱՐԴՈՒ ԻՄՈՒՆԱՅԻՆ ԱՆԲԱՎԱՐԱՐՈՒԹՅԱՆ ՎԻՐՈՒՍԻՑ ԱՌԱՋԱՑԱԾ ՀԻՎԱՆԴՈՒԹՅԱՆ ԿԱՆԽԱՐԳԵԼՄԱՆ ՄԱՍԻՆ

Սույն օրենքը սահմանում է մարդու իմունային անբավարարության վիրուսից առաջացած հիվանդության կանխարգելման, ախտորոշման և հսկողության իրականացման կարգը, ինչպես նաև մարդու իմունային անբավարարության վիրուսից առաջացած հիվանդության կանխարգելման կազմակերպական, իրավական, տնտեսական և ֆինանսական հիմունքները:

ԳԼՈՒԽ 1

ԸՆԴՀԱՆՈՒՐ ԴՐՈՒՅԹՆԵՐ

Հոդված 1. Սույն օրենքում օգտագործվող հիմնական հասկացությունները

Մարդու իմունային անբավարարության վիրուս (այսուհետև՝ ՄԻԱՎ)՝ վիրուս, որն ախտահարում է մարդու իմունային համակարգը և հանգեցնում ձեռքբերովի իմունային անբավարարության համախտանիշի առաջացմանը:
Ձեռքբերովի իմունային անբավարարության համախտանիշ (այսուհետև՝ ՁԻԱՀ)՝ հիվանդություն, որը հանգեցնում է օրգանիզմի ընդհանուր պաշտպանողական համակարգի գործունեության խանգարմանը, որի հետևանքով օրգանիզմը դառնում է ընկալունակ զանազան հիվանդությունների նկատմամբ:
ՄԻԱՎ-ով վարակված անձ՝ մարդ, որի օրգանիզմում հայտնաբերվել է մարդու իմունային անբավարարության վիրուսը: ՄԻԱՎ-ով վարակված անձը, չունենալով համախտանիշի արտաքին նշաններ, հանդիսանում է վարակի աղբյուր:

Հոդված 2. ՁԻԱՀ-ի կանխարգելման ծառայությունը

Հայաստանի Հանրապետության բնակչության ՄԻԱՎ վարակի կանխարգելման, հսկման նպատակով ստեղծվում է ՁԻԱՀ-ի կանխարգելման հանրապետական կենտրոն (ՁԻԱՀ ԿՀԿ): ՁԻԱՀ ԿՀԿ-ի կառավարման և ֆինանսավորման կարգը, կառուցվածքն ու լիազորությունները սահմանում է Հայաստանի Հանրապետության առողջապահության բնագավառի լիազորված պետական մարմինը (այսուհետ՝ լիազորված պետական մարմին):
ՄԻԱՎ վարակի կանխարգելման միջոցառումների անցկացման և հատկացված միջոցների նպատակային և արդյունավետ օգտագործման համար լիազորված պետական մարմինը մշակվում է պետական նպատակային ծրագիր, որը հաստատում է կառավարությունը:

Հոդված 3. Սույն օրենքի գործողության ոլորտը

Սույն օրենքը տարածվում է Հայաստանի Հանրապետության քաղաքացիների, Հայաստանի Հանրապետության տարածքում գտնվող օտարերկրյա քաղաքացիների և քաղաքացիություն չունեցող անձանց (այսուհետև՝ անձինք), ինչպես նաև Հայաստանի Հանրապետության տարածքում գործող ձեռնարկությունների, հիմնարկների և կազմակերպությունների (անկախ սեփականության ձևից) վրա:

Հոդված 4. Հայաստանի Հանրապետության կառավարության լիազորությունները ՁԻԱՀ-ի կանխարգելման բնագավառում

Հայաստանի Հանրապետության կառավարությունը՝
ա) պարբերաբար տեղեկացնում է բնակչությանը ՁԻԱՀ-ի կանխարգելման միջոցառումների մասին.
բ) իրականացնում է ՁԻԱՀ-ի համաճարակային հսկողություն՝ Հայաստանի Հանրապետության տարածքում լիազորված պետական մարմինների միջոցով.
գ) հաստատում է Հայաստանի Հանրապետությունում ՄԻԱՎ-ով վարակված անձանց և ՁԻԱՀ-ով հիվանդների որակյալ մասնագիտացված բժշկական օգնություն և սպասարկման նպատակային ծրագրերը.
դ) պայմաններ է ստեղծում ՁԻԱՀ-ի գիտական և գործնական հետազոտությունների համար.
ե) իրականացնում է դեռահասների բարոյական և սեռական դաստիարակությանն ուղղված միջոցառումներ.
զ) ստեղծում է պայմաններ ՁԻԱՀ-ի կանխարգելման բնագավառի կադրերի պատրաստման համար.
է) Հայաստանի Հանրապետության միջազգային պայմանագրերին համապատասխան տեղեկատվություն է փոխանակում ՄԻԱՎ-ի և ՁԻԱՀ-ի տարածվածության մասին.
ը) հաստատում է ՄԻԱՎ-ով վարակված օտարերկրյա քաղաքացիների՝ բուժման նպատակով Հայաստանի Հանրապետություն մուտք գործելու կարգը:

Հոդված 5. ՁԻԱՀ-ի կանխարգելման և բուժման ծրագրերի ֆինանսավորումը

ՁԻԱՀ-ի կանխարգելման և բուժման ծրագրերի պետական ֆինանսավորումը դիտվում է որպես առաջնային՝ ելնելով հասարակության, ինչպես նաև անձանց կյանքի և առողջության անվտանգության ապահովման անհրաժեշտությունից:
ՁԻԱՀ-ի կանխարգելմանը, ՄԻԱՎ-ով վարակված անձանց բուժմանն ու սոցիալական պաշտպանվածությանն ուղղված նպատակային ծրագրերի ֆինանսավորումը կատարվում է «Բնակչության բժշկական օգնության և սպասարկման մասին» Հայաստանի Հանրապետության օրենքի 25 հոդվածով սահմանված կարգով:
ՁԻԱՀ-ի կանխարգելման և ՄԻԱՎ-ով վարակված անձանց բուժման միջոցառումներն իրականացվում են Հայաստանի Հանրապետության օրենսդրությամբ սահմանված կարգով լիազորված առողջապահական ձեռնարկություններում, որոնց ցանկը հաստատում է կառավարությունը:

Հոդված 6. ՄԻԱՎ-ով վարակված անձանց իրավունքների և ազատությունների պաշտպանության երաշխիքները

Անձի ՄԻԱՎ-ով վարակված լինելու փաստը չի կարող հիմք հանդիսանալ նրա իրավունքների և ազատությունների սահմանափակման համար՝ բացառությամբ օրենքով նախատեսված դեպքերի:

Հոդված 7. Օտարերկրյա քաղաքացիների և քաղաքացիություն չունեցող անձանց՝ Հայաստանի Հանրապետության մուտք գործելու պայմանները

Երեք ամսից ավելի ժամկետով Հայաստանի Հանրապետություն մուտքի արտոնագիր (վիզա) ստանալու համար դիմած օտարերկրյա քաղաքացիները, ինչպես նաև քաղաքացիություն չունեցող անձինք ներկայացնում են ՄԻԱՎ-ի հետազոտման հավաստագիր (սերտիֆիկատ)՝ Հայաստանի Հանրապետության կառավարության կողմից սահմանված կարգով:
Հավաստագիր չներկայացնելու դեպքում օտարերկրյա քաղաքացիները և քաղաքացիություն չունեցող անձինք պարտավոր են մեկ ամսվա ընթացքում Հայաստանի Հանրապետության տարածքում անցնել ՄԻԱՎ-ի հայտնաբերման լաբորատոր հետազոտություն:
Սույն հոդվածի առաջին և երկրորդ մասերի դրույթները չեն տարածվում օտարերկրյա պետությունների դիվանագիտական ներկայացուցիչների և հյուպատոսական հիմնարկների աշխատակիցների, միջազգային կամակերպությունների աշխատակիցների և նրանց ընտանիքի անդամների վրա:

Հոդված 8. Օտարերկրյա քաղաքացիների և քաղաքացիություն չունեցող անձանց օրգանիզմում ՄԻԱՎ-ի հայտնաբերման հետևանքները

Հայաստանի Հանրապետության տարածքում գտնվող օտարերկրյա քաղաքացիների և քաղաքացիություն չունեցող անձանց օրգանիզմում ՄԻԱՎ-ի առկայությունը հաստատելուց հետո նրանք ենթակա են վարչական վտարման Հայաստանի Հանրապետությունից՝ Հայաստանի Հանրապետության օրենսդրությամբ սահմանված կարգով:
Սույն հոդվածի գործողությունը չի տարածվում ՄԻԱՎ-ով վարակված այն օտարերկրյա քաղաքացիների, ինչպես նաև քաղաքացիություն չունեցող անձանց վրա, ովքեր բուժման նպատակով մուտք են գործում Հայաստանի Հանրապետություն՝ Հայաստանի Հանրապետության կառավարության սահմանված կարգին համապատասխան:

Հոդված 9. Միջազգային պայմանագրերը

Եթե Հայաստանի Հանրապետության միջազգային պայմանագրերով սահմանված են այլ նորմեր, քան նախատեսվում է սույն օրենքով, ապա կիրառվում են միջազգային պայմանագրերի նորմերը:

ԳԼՈՒԽ 2

ՄԻԱՎ-ի ՀԱՅՏՆԱԲԵՐՄԱՆ ՆՊԱՏԱԿՈՎ ԿԱՏԱՐՎՈՂ ԲԺՇԿԱԿԱՆ ՀԵՏԱԶՈՏՈՒԹՅՈՒՆՆԵՐԻ ՊԱՅՄԱՆՆԵՐԸ և ԿԱՐԳԸ

Հոդված 10. Լաբորատոր հետազոտությունները

ՄԻԱՎ-ի հայտնաբերմանն ուղղված լաբորատոր հետազոտությունները կատարվում են Հայաստանի Հանրապետության օրենսդրությամբ սահմանված կարգով լիազորված առողջապահական ձեռնարկություններում (անկախ սեփականության ձևից):
ՄԻԱՎ-ի լաբորատոր հետազոտության դրական արդյունքների դեպքում ՁԻԱՀ-ի ԿՀԿ-ի կողմից պարտադիր կարգով կատարվում է կրկնակի հետազոտություն:
ՄԻԱՎ-ի հայտնաբերման լաբորատոր հետազոտությունները կամավոր են և անանուն՝ բացառությամբ սույն օրենքի 11 հոդվածով նախատեսված դեպքերի:
Այն անձինք, որոնց պետք է ներարկեն արյուն, արյան բաղադրամասեր կամ կենսաբանական հեղուկներ, փոխպատվաստեն օրգաններ և հյուսվածքներ, կարող են պահանջել դրանց լաբորատոր հետազոտություն՝ ՄԻԱՎ-ի հայտնաբերման նպատակով:

Հոդված 11. Պարտադիր բժշկական հետազոտությունը

Պարտադիր բժշկական հետազոտության ենթակա են՝
ա) արյան, կենսաբանական հեղուկների, հյուսվածքների և օրգանների դոնորները.
բ) աշխատանքի բերումով արյան, կենսաբանական հեղուկների, հյուսվածքների և օրգանների հետ առնչվող բուժաշխատողները.
գ) ազատազրկման վայրերում գտնվողները.
դ) սեռական ճանապարհով փոխանցվող հիվանդություններով տառապող անձինք.
ե) հղի կանայք.
զ) ՄԻԱՎ-ով վարակված մայրերից ծնված երեխաները.
է) թմրամոլներ
ը) երեք ամսից ավելի ժամկետով Հայաստանի Հանրապետությունից դուրս ծառայողական, գործնական և մասնավոր ուղևորություններից վերադառնող անձինք:
Պարտադիր բժշկական հետազոտությունից հրաժարված անձինք չեն կարող լինել արյան, կենսաբանական հեղուկների, հյուսվածքների և օրգանների դոնորներ:
Բուժհաստատություններում աշխատանքի ընդունվող անձինք նախազգուշացվում են իրենց՝ ՄԻԱՎ-ի հայտնաբերման պարտադիր բժշկական հետազոտության ենթարկելու մասին:
Աշխատանքի բերումով արյան, կենսաբանական հեղուկների, հյուսվածքների և օրգանների հետ առնչվող բուժաշխատողները ՄԻԱՎ-ի հայտնաբերման պարտադիր բժշկական հետազոտությունից հրաժարվելու դեպքում փոխադրվում են այլ աշխատանքի կամ ազատվում են աշխատանքից աշխատանքային օրենսդրությամբ սահմանված կարգով:
Պարտադիր բժշկական հետազոտության կարգը սահմանում է Հայաստանի Հանրապետության կառավարության կողմից լիազորված պետական մարմինը:

ԳԼՈՒԽ 3

ԱՇԽԱՏԱՆՔԱՅԻՆ ԳՈՐԾՈՒՆԵՈՒԹՅԱՆ ԲԵՐՈՒՄՈՎ ՄԻԱՎ-ով ՎԱՐԱԿՎԵԼՈՒ ՎՏԱՆԳԻՆ ԵՆԹԱԿԱ ԱՆՁԱՆՑ ՊԱՇՏՊԱՆՎԱԾՈՒԹՅՈՒՆՆ ԱՇԽԱՏԱՆՔԻ ԲՆԱԳԱՎԱՌՈՒՄ

Հոդված 12. ՄԻԱՎ-ով վարակվելու վտանգին ենթակա անձանց սոցիալական պաշտպանվածությունն աշխատանքի բնագավառում

Ձեռնարկությունների, հիմնարկների և կազմակերպությունների ՄԻԱՎ-ով վարակված անձանց ախտորոշումն ու բուժումն ապահովող աշխատողների, ինչպես նաև այն աշխատողների համար, որոնց աշխատանքը կապված է ՄԻԱՎ պարունակող նյութերի հետ, սահմանվում է՝
ա) հավելավճար աշխատավարձի նկատմամբ.
բ) կրճատված աշխատանքային օր.
գ) լրացուցիչ վարձատրություն.
դ) լրացուցիչ արձակուրդ
Վերոհիշյալ արտոնությունները տալու պայմանները և կարգը սահմանում է Հայաստանի Հանրապետության կառավարությունը:
Առողջապահական ձեռնարկությունների տնօրենությունները պարտավոր են ապահովել բուժաշխատողների պարտականությունների կատարման համար անվտանգության անհրաժեշտ միջոցներ և պայմաններ Հայաստանի Հանրապետության կառավարության կողմից լիազորված պետական մարմնի կողմից սահմանված կարգով:
Հոդված 13. Բժշկական օգնություն և սպասարկում ստանալիս կամ ցուցաբերելիս ՄԻԱՎ-ով վարակված անձանց պատճառված վնասի փոխհատուցման իրավունքը

Բժշկական օգնություն և սպասարկում ստանալիս կամ ցուցաբերելիս ՄԻԱՎ-ով վարակվելու դեպքում անձինք իրավունք ունեն պատճառված վնասի փոխհատուցման՝ Հայաստանի Հանրապետության օրենսդրությամբ սահմանված կարգով:

ԳԼՈՒԽ 4

ՄԻԱՎ-ով ՎԱՐԱԿՎԱԾ ԱՆՁԱՆՑ և ՆՐԱՆՑ ԸՆՏԱՆԻՔԻ ԱՆԴԱՄՆԵՐԻ ԻՐԱՎՈՒՆՔՆԵՐԸ և ՊԱՐՏԱԿԱՆՈՒԹՅՈՒՆՆԵՐԸ

Հոդված 14. ՄԻԱՎ-ով վարակված անձանց իրավունքները

ՄԻԱՎ-ով վարակված անձինք իրավունք ունեն՝
ա) ստանալ հետազոտության արդյունքների մասին գրավոր տեղեկություններ.
բ) ստանալ ոչ խտրական վերաբերմունք.
գ) պահանջել բժշկական գաղտնիության պահպանում՝ բացառությամբ Հայաստանի Հանրապետության օրենսդրությամբ սահմանված դեպքերի.
դ) շարունակել աշխատել՝ բացառությամբ Հայաստանի Հանրապետության կառավարության կողմից սահմանված դեպքերի.
ե) ստանալ համապատասխան խորհրդատվություն, ծանոթանալ ՄԻԱՎ-ի տարածումը բացառող նախազգուշական միջոցառումներին:
ՄԻԱՎ-ով վարակված անձինք առանց իրենց գրավոր համաձայնության չեն կարող լինել գիտական փորձերի և հետազոտությունների օբյեկտ:

Հոդված 15. ՄԻԱՎ-ով վարակված երեխաների և նրանց ծնողների (օրինական ներկայացուցիչների) իրավունքները

ՄԻԱՎ-ով վարակված մինչև 16 տարեկան երեխաներն օգտվում են մինչև 16 տարեկան հաշմանդամ երեխաների համար Հայաստանի Հանրապետության օրենսդրությամբ սահմանված իրավունքներից:

ՄԻԱՎ-ով վարակված երեխայի ծնողները (օրինական ներկայացուցիչները) իրավունք ունեն՝

ա) երեխայի հետ գտնվել հիվանդանոցում, այդ ժամկետում ազատվելով աշխատանքից, և ստանալ երեխայի և իրենց համար սահմանված նպաստները.

բ) օգտվել տարեկան արձակուրդից իրենց հարմար ժամանակ:

ՄԻԱՎ-ով վարակված երեխային խնամելու նպատակով աշխատանքից ազատվելու ժամանակահատվածը հաշվառվում է աշխատանքային ստաժում:

Հոդված 16. ՄԻԱՎ-ով վարակված անձի պարտականությունները

ՄԻԱՎ-ով վարակված անձը կամ նրա օրինական ներկայացուցիչը պարտավոր է պահպանել ՄԻԱՎ-ի տարածումը բացառող լիազորված պետական մարմնի կողմից հաստատված նախազգուշական միջոցառումները:

ԳԼՈՒԽ 5

ԵԶՐԱՓԱԿԻՉ ԴՐՈՒՅԹՆԵՐ

Հոդված 17. Պատասխանատվությունը սույն օրենքը խախտելու համար

Սույն օրենքը խախտող անձինք, ինչպես նաև ձեռնարկությունները, հիմնարկները և կազմակերպությունները պատասխանատվություն են կրում Հայաստանի Հանրապետության օրենսդրությամբ սահմանված կարգով:

Հոդված 18. Օրենքի ուժի մեջ մտնելը

Սույն օրենքը ուժի մեջ է մտնում հրապարակման պահից:

Annex 2. THE LAW OF THE REPUBLIC OF ARMENIA ON NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES

This law governs the relationships in the traffic of the narcotic drugs and psychotropic substances, as well as establishes the legal grounds of the national policy for interdiction of their illicit traffic, and the main measures in combating drug addiction for the purposes of the health protection of the citizens, the security of the state and the general public.

CHAPTER 1

General provisions

Article 1. The Scope of the Law

The law shall govern the processes that ensure the licit traffic, as well as the interdiction for the illicit traffic of the narcotic drugs and psychotropic substances in the territory of the Republic of Armenia

Article 2. Legislation on the narcoti c drugs, psychotropic substances and their precursors (compounds)

1. The legislation of the Republic of Armenia on narcotic drugs, psychotropic substances and their precursors consists of this law, other laws a legal acts.
2. If there are norms establi shed in any international treaty of the Republic of Armenia other than stipulated by this law, then the norms in the international treaty shall prevail.

Article 3. Terms Used in this Law

The following main terms are used in this law:

"Narcotic drug s, psychotropic substances and their precursors" means any set of natural or synthetic substances, preparations and plants, the traffic of which and the control over which in the territory of the Republic of Armenia shall be undertaken pursuant to the legislation of the Republic of Armenia and the international treaties of the Republic of Armenia, including the UN 1961 Single Convention on Narcotic Drugs, the UN 1971 Convention on Psychotropic Substances and the UN 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

"Analogues of narcotic drugs and psychotropic substances" means the substances that are not included in the set of the narcotic drugs, psychotropic substances and their precursors established by this law.

"Licit traffic of narcotic drugs, psychotropic substances and their precursors" means the cultivation, production, manufacturing, processing, dispatch, stocking, release, sale, acquisition, use, delivery, distribution, export, import and ex termination of the narcotic

drugs, psychotropic substances and their precursors pursuant to the legislation of the Republic of Armenia.

"Illicit traffic of narcotic drugs, psychotropic substances and their precursors" means the traffic in narcotic drugs , psychotropic substances and their precursors in violation of the legislation of the Republic of Armenia (hereinafter, an illicit traffic of the narcotic drugs and psychotropic substances).

"Drug addiction" means the individual's sick physical and (or) psychological status determined by the use of the narcotic drugs or psychotropic substances.

"A patient with drug addiction" means the individual that has received the diagnosis of "drug addiction" as a result of the medical examination undertaken in the manner defined by law.

"Illicit use of narcotic drugs and psychotropic substances" means the use of the narcotic drugs or psychotropic substances without any medical prescription.

Article 4. Classification of Narcotic Drugs, Psychotropic Substances and Their

Precursors

1. The composition (list) of the narcotic drugs, psychotropic substances and their precursors (hereinafter, also narcotic drugs and psychotropic substances) subject to control in the Republic of Armenia, shall be approved by the G overnment of the Republic of Armenia. Any amendments to the list of the narcotic drugs and psychotropic substances shall be made pursuant to the procedure established by the Government of the Republic of Armenia.
2. Depending on the types and measures of control, there are such narcotic drugs and psychotropic substances and their precursors specified in the list of the narcotic drugs and psychotropic substances (list 1), the traffic of which is prohibited in the territory of the Republic of Armenia (he reinafter, prohibited substances), narcotic drugs and psychotropic substances (list 2), the traffic of which in the Republic of Armenia is limited (hereinafter, narcotic drugs), narcotic drugs and psychotropic substances (list 3), for the control over th e traffic of which there are certain conditions defined in the Republic of Armenia (hereinafter, psychotropic substances), such precursors (list 4), the traffic of which is limited in the Republic of Armenia, and over which there are control mechanis ms established (hereinafter, precursors).

Article 5. National policy in licit traffic and interdiction of illicit traffic of the narcotic drugs and psychotropic substances

1. The national policy in the traffic (including the illicit traffic) of the n arcotic drugs and psychotropic substances shall constitute the licensing of the activities related to the traffic of the narcotic drugs and psychotropic substances, the establishment of requirements set for such activities, the implementation of measures f or the use of the narcotic drugs and psychotropic substances for health and medical -rehabilitation purposes, the registration of the narcotic drugs (psychotropic substances) and their traffic, the establishment of control and supervision over their traf fic, as well as the campaign against drug addiction and the illicit traffic of narcotic drugs and the psychotropic substances.

2. The national policy in the licit traffic and the interdiction of the illicit traffic of the narcotic drugs and psychotro pic substances shall be run on the basis of program guidelines.

Article 6. Principles of the National Policy in the Licit Traffic and the Interdiction of Illicit Traffic of the Narcotic Drugs and Psychotropic Substances

The principles of the natio nal policy in the licit traffic and the interdiction of the illicit traffic of the narcotic drugs and psychotropic substances are as follows:

1) the control and supervision over the traffic of the narcotic drugs and the psychotropic substances;
2) the licensing of the types of activities related to the traffic of the narcotic drugs and the psychotropic substances;
3) the priority interdiction of drug addiction and legal violations related to the illicit traffic of the narcotic drugs and psychotropi c substances;
4) the punishability, the discharge of liability and their inevitability for the illicit traffic of the narcotic drugs and psychotropic substances;
5) the state support for undertaking scientific research in the development of new forms and methods for the treatment of drug addiction;
6) the state support for combating drug addiction and for the development of the network of medical and rehabilitation institutions for the patients with drug addiction;
7) the international cooperat ion in interdiction of the illicit traffic of narcotic drugs and psychotropic substances.

CHAPTER 2

The institutional bases for the licit traffic and interdiction of the illicit

traffic of the narcotic drugs and psychotropic substances

Article 7. Autho rities for the supervision over the traffic and the interdiction of the illicit traffic of the narcotic drugs, psychotropic substances and their precursors

The main responsibilities of the authority (hereinafter, the authority) entrusted with the supervision of the traffic and the interdiction of the illicit traffic of the narcotic drugs, psychotropic substances and theirs precursors are:

-to draft recommendations on the laws, normative legal acts regulating the traffic of the narcotic drugs, psychotr opic substances and their precursors, and to furnish them to the Government;

-to draft the "list for the identification and the criteria of the narcotic drugs, psychotropic substances and their precursors in the Republic of Armenia" and to furnish

4

recommendations on amendments in it to the Government of the Republic of Armenia for approval;

-to discuss the licensing of the types of activities relating to the traffic of the narcotic drugs, psychotropic substances and their precursors upon the recomm endation of the public administration competent authority;

-to collect and analyze the information about the fulfillment of the obligations assumed by the Republic of Armenia under the international treaties on the regulation of the traffic of the narco tic drugs, psychotropic substances and their compounds and to forward recommendations to the Government of the Republic of Armenia;

-to approve the list of the names and the quotas for the analogues of the narcotic drugs, psychotropic substances and th eir precursors, the narcotic plants, instruments, equipment, computer software, scientific -practice manuals and materials subject to use by the RoA Government entrusted public administration competent authorities for the operative - investigation, expert exa mination, scientific, academic purposes;

-to assess the state of affairs in the area of drug addiction and drug business in the Republic of Armenia and to furnish annual statistics to the Government of the Republic Armenia;

-to approve the vegetati on season periods for the plants containing narcotic drugs and psychotropic substances in the Republic of Armenia and the borderlines of the areas that are respectively subject to supervision.

Article 8. The Interministerial Commission for the Licit Traffic and Interdiction of the Illicit Traffic in Narcotic Drugs and Psychotropic Substances

To concord the actions taken by the public authorities in the traffic and interdiction of the illicit traffic of the narcotic drugs and psychotropic substances , an Interministerial Commission may be set up (hereinafter, the commission) upon the decision of the Government of the Republic of Armenia. The rules of procedure and the main objectives of the Commission shall be established by the Government of the Re public of Armenia.

Article 9. The General Procedure for Activities Relating to the Traffic of the Narcotic Drugs and the Psychotropic Substances

1. The traffic of the narcotic drugs and psychotropic substances in the territory of the Republic of Armenia shall be undertaken in the manner established by this law and other legal acts.

2. All the types of the activities relating to the traffic of the narcotic drugs and psychotropic substances in the territory of the Republic of Armenia shall be under taken in accordance with the Republic of Armenia legislation and the international treaties of the Republic of Armenia, only after having obtained a license for the specific type of activity relating to the traffic of the narcotic drugs and psychotropic su bstances.

5

Article 10. Licensing of Activities Pertaining to the Traffic of the Narcotic Drugs and Psychotropic Substances

1. The licenses for the activities relating to the traffic of the narcotic drugs and the psychotropic substances shall be issue d in a complex procedure by Authorities that are entrusted by the public administration competent authority.
2. The licenses for the types of activities related to the narcotic drugs and psychotropic substances shall be issued for a term of up to three y ears.
3. The licensing relationships in the traffic of the narcotic drugs and psychotropic substances shall be governed under the Law of the Republic of Armenia on Licensing **.**

CHAPTER 3

The requirements set for the activities relating to the traffic o f the narcotic drugs, the psychotropic substances and their precursors

Article 11. The limitation of the traffic in a number of the narcotic drugs, psychotropic substances and their precursors

1. The use of the prohibited substan ces shall be authorized only in the cases stipulated by Articles 31, 32 and 33 of this law.
2. The traffic of the narcotic drugs and psychotropic substances shall be authorized only for the medical purposes, pursuant to the medical prescription, as well as for the purposes stipulated by Articles 31, 32 and 33 of this law.
3. The limitations in the traffic of the precursors shall be established by the Republic of Armenia legislation and the international treaties of the Republic of Armenia.
4. The traffic in the analogues of the narcotic drugs and psychotropic substances shall be prohibited in the Republic of Armenia.

Article 12. The Quota Setting for the Production, Stocking, Import and Export of the Narcotic Drugs and Psychotropic Substances

1. The quotas for the production, stocking, import and export of the narcotic drugs and psychotropic substances shall be set by the Government of the Republic of Armenia.
2. The limitations established for the stocking of the narcotic drugs and psychotrop ic substances as per paragraph 1 of this Article shall not refer to the stocking of the narcotic drugs and psychotropic substances confiscated from the illicit traffic.

Article 13. Cultivation of New Narcotic Drugs and Psychotropic Substances

1. The cultivation of the new narcotic drugs and psychotropic substances shall be authorized only for the purposes stipulated by this law.

2. The cultivation and the state registration of the new narcotic drugs and psychotropic substances used for medical purpos es shall be carried out pursuant to the procedure established by the Government of the Republic of Armenia.
3. The cultivation of the new narcotic drugs and psychotropic substances shall be undertaken only according to the state orders and shall be dele gated to the scientific research organizations under the availability of a license for the specified activity. If such cultivated narcotic drug or psychotropic substance is assumed to be used for medical purposes, then its clinical trial shall be undertake n in accordance with the legislation of the Republic of Armenia.

Article 14. The Production and Manufacturing of the Narcotic Drugs and Psychotropic Substances

1. The production of the narcotic drugs and psychotropic substances included in the list of the narcotic drugs for the purposes defined by this law shall be carried out within the scopes of the national quotas, under the availability of the license for the production of the specific narcotic drugs and psychotropic substances.
2. The manufactur ing of the narcotic drugs and psychotropic substances included in

the list of the narcotic drugs for the purposes defined by this law shall be undertaken under the availability of a license for the manufacturing of the specific narcotic drugs and psychotropic substances.

3. The production and manufacturing of the narcotic drugs and psychotropic substances included in the list of the psychotropic substances for the purposes defined by this law shall be undertaken irrespective of the form of ownership, unde r the availability of the license for the production and manufacturing of the specific psychotropic substances by the organizations.

4. The organizations producing narcotic drugs and psychotropic substances in the Republic of Armenia shall be subject to state registration in accordance with the legislation of the Republic of Armenia and the international treaties of the Republic of Armenia.

5. The organizations manufacturing narcotic drugs and psychotropic substances shall be subject to state registrati on in compliance with the legislation of the Republic of Armenia.

Article 15. The Processing of Narcotic Drugs and Psychotropic Substances for the Purpose of Extracting Preparations Included in the Lists of the Narcotic Drugs and Psychotropic Substances

The processing of the narcotic drugs and psychotropic substances for the purpose of extracting preparations contained in the lists of the narcotic drugs and psychotropic substances, as well as the extraction of the substances from them, that are not co nsidered to be narcotic drugs and psychotropic substances, shall be undertaken in the procedure established by the Government of the Republic of Armenia, under the availability of a license for the mentioned type of the activity.

Article 16. The Stocking of the Narcotic Drugs and Psychotropic Substances

7

1. The stocking of the narcotic drugs and psychotropic substances shall be undertaken by organizations, as per the procedure defined by the Government of the Republic of Armenia, in specially equipped p remises and under the availability of a license for the mentioned type of the activity.

2. The stocking of the narcotic drugs and psychotropic substances in any quantities, for the purposes other than stipulated by this law, shall be prohibited.

Article 17. The Import and Export of the Narcotic Drugs and Psychotropic Substances

1. The export and import of the narcotic drugs, the psychotropic substances and their preparations included in the lists of the narcotic drugs and psychotropic substances sh all be undertaken by license issued by the public administration competent authority entrusted by the Government of the Republic of Armenia and filled in pursuant to the sample form established by the UN Commission on Narcotic Drugs (CND).

When drawing u p the import or export license for the narcotic drugs and psychotropic substances, the public administration authority entrusted by the Government of the Republic of Armenia must be guided with the quotas approved by the UN International Narcotics Control Board (NCB).

There is no export license required in the event of natural disasters and emergency situations.

The license may not be given to another person **.**

2. The requests for the import and export of the narcotic drugs and psychotropic substances shall be concurred with the pubic administration competent authority entrusted by the Government of the Republic of Armenia on a form established by the UN acting conventions for the issuance of the import and export licenses.

The application for the exp ort and import authorization shall contain the name, naming, address of the importer or the exporter, as well as the name of the consignee, the international non -proprietary name for each substance, or lacking such a name, the name of

the substance mention ed in the lists and schedules of the international conventions, the pharmaceutical form, if a preparation, the commercial name, if any, the quantity of each substance or preparation, concerned to which a relevant action is taken, the period, within which it must be effected, as well as the type of the transport used or the form of transportation and the point of the passage of the frontier on the national territory.
The application for the export authorization shall be accompanied by an import license (certificate, permit) issued by the administration of the importing country or region.
3. The forms of the licenses shall be approved by the public health authority of the Republic of Armenia and the State Customs Committee under the Government of the Republic of Armenia, upon the recommendation of the public administration competent authority entrusted by the Government of the Republic of Armenia .
8
The export and import licenses shall contain such information, which are included in the request furnished for getting a license, including the name of the competent organization, which has qualified for that.
The license must contain the following information:
1) The name and the address of the place of location or the residence of the importer or exporter,
2) the names of the narcotic drugs and psychotropic substances (if any, the international non -proprietary name),
3) the quantity of the imported/exported substances and the substance that lacks water in base, and, if in the form of a preparation, the p harmaceutical form, the doze of he controlled substance in its contents,
4) the date of expiry of the license,
5) the seal of the public administration competent authority entrusted by the Government of the Republic of Armenia, and the signature of t he director.
The export license shall also contain information about the issuance number and the endorsement date of the import license (the other country's identical document).
The export license shall contain also the issuance number and date of the import license (the other country's identical document), the name of the authorizing competent entity, which testify that the import of the narcotic drugs and psychotropic substances concerned is authorized.
4. One copy of the import license shall be provided to the importer, and the other, to the competent authority of the exporting country for the purpose of drawing up a license (the other country's identical document) for the narcotic drugs and psychotropic substances, a copy of which is sent to th e importing country customs services, and the other, to the public administration competent authority entrusted by the Government of the Republic of Armenia.
In addition to the copies of the licenses furnished to the Customs Services of the Republic of Armenia and the public administration competent authority entrusted by the Government of the Republic of Armenia, a copy of the license shall accompany the consignment, and the other copy shall be sent to the competent authority of the importer country. After having undertaken the import, the competent authority of the importing country shall return the last copy of the export license, on which a reference, verifying the quantity actually imported, shall be made.
The export license shall be drawn up on t he basis of the import license (the other country's identical document) which shall be issued by the competent authority of the importing country.
The ratified copy of the export license (the other country's identical document) shall be attached to each group of consignment and the competent authority shall send the copy of that license (the other country's identical document) to the competent authority of the importing country or region (administration).

9
5. If the actually exported consignment quantit y of the narcotic drugs and the psychotropic substances is lesser than that declared in the export license, then the competent organization of the exporting country shall make a note about that fact in a relevant document and in all the official copies of the latter.
6. When the consignment enters the territory of the Republic of Armenia or when the date mentioned in the import license expires, the competent organization shall send to the competent authority of the exporting country (administration) the a bove-stated license, whereby mentioning the actually imported quantity of each narcotic drug and psychotropic substance.
7. The commercial documents, i.e. the invoice, bill of lading, customs, transportation, and other shipment documents, shall contain information about such names of the plants, substances and their preparations, by which they are represented in the lists of the international conventions, if any, also the commercial names, the consignments quantities exported from the national territory and subject to import to that territory, if known, the name and address of the exporter, importer, as well as the consignee. The invoices must carry the stamp with the number and the date of issuance of the license ratified by the public administration au thority entrusted by the Government of the Republic of Armenia.
8. The export from the territory of the Republic Armenia or the import of the consignment into that territory by the address of the bank or the post -office shall be prohibited.
9. The export of the consignment from the Republic of Armenia territory to the address of the bonded warehouses shall be prohibited, except for those cases when the Government of the importing country shall mention in the import certificate the authorization to import such consignment.
The import of the consignment to the territory of the Republic of Armenia by the address of the customs bonded warehouses shall be prohibited except for those cases when the competent organization states in the import certificate th e authorization to import such consignment.
Each withdrawal from the bonded warehouse shall require an authorization of the organizations having jurisdiction over the customs warehouse. The sending of the consignment abroad under the purposes of this Ar ticle shall be viewed as a new export. The plants, substances and preparations held at the bonded warehouse may not be subject to any action that changes their nature, while the packaging may not be changed without the permission of the authorities having jurisdiction over the customs warehouse.
10. The narcotic drugs and psychotropic substances entering the territory of the Republic of Armenia or exported thereof without the accompanying import or export license issued in the manner defined, which are in consistent with the license, shall be held by the competent authorities till the time an evidence about their authorized dispatch or a court ruling about their confiscation is furnished.
11. The transit dispatch of the narcotic drugs, psychotropic substa nces and their precursors through the territory of the Republic of Armenia shall be authorized, unless otherwise stipulated by law.
10
12. The provisions of the previous paragraph shall not apply in the case of the consignment transportation to another coun try by aircraft. If the aircraft has to make an interim or forced landing in the territory of the Republic of Armenia, then the consignment shall be viewed as exported to the country of destination, if for certain reasons, it is unloaded.

Article 18. General Procedure for the Carriage of the Narcotic Drugs and the Psychotropic Substances

1. The right to carriage of the narcotic drugs and psychotropic substances within the

territory of the Republic of Remain shall be reserved to organizations that posses s a licensee for such type of activity.
2. The protection of the narcotic drugs and psychotropic substances shall be ensured by the organizations that perform their carriage.
3. The procedure for the carriage of the narcotic drugs and psychotropic substa nces within the territory of the Republic of Armenia, as well as for the drawing up of the documents required for that, shall be established by the Government of the Republic of Armenia.
4. The natural persons shall be permitted to carry the narcotic dru gs and psychotropic substances received for the medical purposes pursuant to Article 22 of this law under the availability of the documents issued by the pharmaceutical organization, and proving the legality of receiving the narcotic drugs and the psychotr opic substances.

Article 19. The Prohibition of the Delivery of the Narcotic Drugs and Psychotropic Substances

1. The delivery of the narcotic drugs and psychotropic substances by post, including their international delivery, shall be prohibited.
2. The delivery of the narcotic drugs and psychotropic substances in the form of the humanitarian aid shall be prohibited, except for those cases, when the narcotic drugs or psychotropic substances in emergency situations are sent to a specific area pursuant to the Government decision.

Article 20. The Distribution, Release and Sale of the Narcotic Drugs and Psychotropic Substances

The distribution, release and sale of the narcotic drugs and psychotropic substances shall be undertaken by the entities, in t he procedure established by the Government of the Republic of Armenia, under the availability of a license endorsed for the mentioned type of activity.

Article 21. The Acquisition of the Narcotic Drugs and Psychotropic Substances

The acquisition of the narcotic drugs and psychotropic substances for the purposes of production, manufacturing, processing, sale, use, including the medical purposes shall be
11
undertaken by the entities pursuant to this law, under the availability of the license indorsed for the mentioned type of activity.

Article 22. The Release of the Narcotic Drugs and Psychotropic Substances to Natural Persons

1. The release of the narcotic drugs and the psychotropic substances to natural persons shall be carried out only in the pub lic health pharmaceutical entities under the availability of the license endorsed for the specified type of activity. The lists of the medical and pharmaceutical personnel, as well as the institutions and entities, who are reserved with the right to releas e the narcotic drugs and psychotropic substances to citizens, shall be established by the Government of the Republic of Armenia.
2. The narcotic drugs and psychotropic substances designated in the lists of the narcotic drugs and psychotropic substances s hall be released for medical purposes by prescriptions.
3. The procedure for the release of the narcotic drugs and psychotropic substances to the natural persons shall be established by the Government of the Republic of Armenia.
4. The public health au thority of the Republic of Armenia shall determine the maximum periods of the designation of the specific narcotic drugs and psychotropic substances included in the lists of the narcotic drugs and psychotropic substances, as well as the quantity of the nar cotic drugs and psychotropic substances, which may be released by a single prescription.
5. In the case of the designation of the narcotic drugs and psychotropic substances

included in the lists of the narcotic drugs and psychotropic substances, the ther apist shall be obliged, through the examination of the patient find out the need for the future designation and make relevant records in the medical document.
6. The health system pharmaceutical institutions and entities shall be prohibited to release an y narcotic drugs and psychotropic substances included in the list of the narcotic drugs and psychotropic substances by a prescription that has been endorsed more than ten days ago.

Article 23. The Prescriptions for the Release of the Narcotic Drugs and Psychotropic Substances

1. The narcotic drugs and the psychotropic substances shall be released by subscriptions of special form.
2. The forms of the specified prescriptions, the procedure for their registration, recording and maintenance, as well as t he rules for their drawing up shall be established by the public health authority.
3. The handing of the prescriptions containing designated narcotic drugs and psychotropic substances without the relevant medical instructions, or with the violation of t he rules required for their drawing up shall be prohibited and shall entail a liability pursuant to the legislation of the Republic of Armenia.

12

Article 24. The Packaging and Labeling of the Narcotic Drugs and Psychotropic Substances

1. The internal and external packaging and labeling of the narcotic drugs and psychotropic substances used for the medical purposes must be in compliance with the requirements of this law, the laws and other legal acts on pharmaceuticals of the Republic of Armenia.
2. The external packaging of the narcotic drugs and psychotropic substances must exclude the possibility of withdrawing the narcotic drug and the psychotropic substance from the package, without detriment to the wholeness of the mentioned package.
3. The intern al packaging of the narcotic drugs and psychotropic substances used for the medical purposes must be highlighted with a double red -marked plies.
4. In the event of the non compliance of the internal and external packaging and the labeling of the narcotic drugs and the psychotropic substances used for the medical purposes with the requirements of the paragraphs 1 -3 of this Article, the narcotic drugs and psychotropic substances shall be subject to extermination pursuant to the legislation of the Republic of Armenia.

Article 25. The Extermination of the Narcotic Drugs, Psychotropic Substances and their Precursors, the Instruments or Equipment

1. The narcotic drugs, psychotropic substances, as well as the instruments and equipment used in their manufactur ing, the future use of which has been recognized as inappropriate, shall be subject to extermination, pursuant to the procedure established by the Government of the Republic of Armenia.
2. The extermination of the narcotic drugs, psychotropic substances and their precursors shall be carried out in the cases, if:
1) their expiry date has passed,
2) the narcotic drug or the psychotropic substance has been exposed to chemical to physical effect, as a result of which it has become useless and the recover y or processing of which is no longer possible,
3) the unused narcotic drug has been returned by the kin of the late patient,
4) the circumstance of the preparation as being a narcotic drug or psychotropic substance is not possible to be found out,
5) the narcotic drugs or psychotropic substances confiscated from the illicit traffic

may not be used for medical, scientific and other purposes, as well as other cases established by the legislation of the Republic of Armenia.

Article 26. Internatio nal Cooperation

13

The public administration authorities entrusted by the Government of the Republic of Armenia for the campaign against the illicit traffic of the narcotic drugs, psychotropic substances and their precursors and the legalization of the pr operty and proceeds generated as a result of that, shall cooperate with the similarly functioning authorities of foreign states and international organizations, pursuant to the international treaties.

Article 27. Control over the Traffic of the Prec ursors

1. Any function during the undertaking of the activity related to the traffic of the precursors, in which case the quantity of the ingredient is exposed to modification, shall be recorded in a special ledger. The ledgers shall be kept for ten ye ars after the last records has been made in them.
2. The procedure for the keeping and maintenance of the ledgers shall be established by the Government of the Republic of Armenia.
3. The legal persons undertaking activities related to the t raffic of the precursors shall be obliged to report on a monthly basis about their activities to the competent authorities.
4. In those cases, when there are sufficient grounds to assume that one of the ingredients of the precursors is designed for the i llicit production of the narcotic drugs or psychotropic substances, upon the applications of the authorities specified in paragraph 1 of Article 38 of this law, the activities of the organizations related to the traffic of the mentioned ingredient may be t erminated for up to three months.

CHAPTER 4

The use of the narcotic drugs and psychotropic substances

Article 28. The Use of the Narcotic Drugs and Psychotropic Substances for Medical Purposes

1. The narcotic drugs and psychotropic substances included in the lists of the narcotic drugs and psychotropic substances may be used for medical purposes.
2. The use of the narcotic drugs and psychotropic substances authorized for the medical purposes shall be governed by the re quirements of the legislation of the Republic of Armenia on pharmaceuticals not in conflict with this law.
3. The public health authority shall establish the procedure and the terms for the use the narcotic drugs and psychotropic substances designed for medical purposes.
4. The control over the narcotic drugs and psychotropic substances in the pharmaceutical entities and health institutions shall be undertaken by the procedure established by the public health authority.
5. The treatment of drug addic tion with the narcotic drugs and psychotropic substances included in the list of the narcotic drugs shall be prohibited in the Republic of Armenia.

14

6. Pursuant to the procedure established by the public health authority, it is permitted to authorize the import (export) of the narcotic drugs and psychotropic substances, included in the list of the narcotic drugs and psychotropic substances, in limited quantities, kept in the pharmacy -bags of the international aircraft and railway trains for emergency aid purposes.
7. The authorization stipulated by paragraph 6 of this Article must have a mentioning about the authority or authorities responsible for the stocking and use of the narcotic drugs and psychotropic substances, as well as the terms for getting, registering, stocking and releasing them, and shall stipulate the procedure for accountability on their use.
8. The control over the use of the narcotic drugs and psychotropic substances in the

mentioned pharmacy -bags shall be assumed by the public heal th authority, as well as the authorities enforcing the interdiction of the traffic of the narcotic drugs and psychotropic substances.

Article 29. The Use of the Narcotic Drugs and Psychotropic Substances for the Treatment of the Transit Passengers

1. The patient that is on a transit visit in the Republic of Armenia territory, for the treatment purposes, may carry with himself narcotic drugs and psychotropic substances that are included in the lists of the narcotic drugs and psychotropic substances, in compliance with the procedure established by the Government of the Republic of Armenia.
2. If the individual specified in paragraph 1 of this Article stays in the Republic of Armenia territory and needs to acquire additional narcotic drugs and psychotro pic substances for the purpose of continuing his treatment, the release of it shall be carried out by the prescription issued in the Republic of Armenia, pursuant to the regulations for the medical aid to be provided to the foreign citizens.

Article 30. The Use of the Narcotic Drugs and Psychotropic Substances in Veterinary

1. The list of the narcotic drugs and psychotropic substances used for the veterinary, as well as hunting purposes shall be established by the competent authorities in health and agriculture.
2. The terms and procedure for the use of the narcotic drugs and psychotropic substances in veterinary shall be established by the Government of the Republic of Armenia.

Article 31. The Use of the Narcotic drugs and Psychotropic Substanc es for Scientific and Academic Purposes

The use of the narcotic drugs and psychotropic substances for scientific and academic purposes shall be permitted by the organizations having a license for specified types of activities.

Article 32. The Use of the Narcotic Drugs and Psychotropic Substances in Expert Examination

15

Any expert examination with the use of the narcotic drugs and psychotropic substances shall be authorized to the legal persons under the availability of the licenses for engagement in such activities.

The expert examination and other such functions in the expert examination divisions of the General Attorney office, the Ministry of Justice of the Republic of Armenia, the Police, the National Security, and Customs authorities shall be undertaken without any license.

Article 33. The Controlled Transportation and Purchase of Tests of the Narcotic Drugs, Psychotropic Substances and their Precursors for the purposes of Operative-Investigation

The authorities that undertake operative -investigation activities, to disclose any offences relating to the illicit traffic of the narcotic drugs, psychotropic substances and their precursors, in the manner defined by the legislation of the Republic of Armenia, shall have the right to undertake con trolled transportation and test purchases of the narcotic drugs and psychotropic substances.

Article 34. Accountability about the Activities Relating to the Traffic of the Narcotic Drugs and Psychotropic Substances

The legal persons that have a license for the activities relating to the traffic of the narcotic drugs and psychotropic substances shall be obliged, pursuant to the procedure established by the Government of the Republic of Armenia, to furnish to the public administration authority entrusted by the Government, quarterly reports on the license terms and requirements, as per the procedure defined by the Government.

Article 35. The Inventory of the Narcotic Drugs and the Psychotropic Substances

1. The legal persons possessing a license for the activities relating to the traffic of the narcotic drugs and psychotropic substances shall be obliged on a quarterly basis to conduct an inventory registration of the narcotic drugs and psychotropic substances under the possession of these persons and des ign a balance sheet containing the costs of the substances and commodities.

2. The data on the variations in the balance sheet or the information about the incompliance of the balance sheet data with the findings of the inventory shall be notified to the competent authorities within three days after their detection.

Article 36. The Registration of the Activities related to the Narcotic Drugs, Psychotropic Substances and their Precursors

Any function during the implementation of the activities relat ed to the traffic of the narcotic drugs, psychotropic substances and their precursors, during which the quantities and the conditions are changed, shall be subject to registration in special ledgers. The ledgers shall be maintained after the last records f or the period of ten years. The Government of the Republic of Armenia shall establish the procedure for keeping and maintaining the ledgers.

CHAPTER 5

The interdiction of the illicit traffic of the narco tic drugs, psychotropic substances and their precursors

Article 37. The Prohibition of the Use of the Narcotic Drugs or Psychotropic Substances without Medical Prescription

The use of the narcotic drugs or psychotropic substances without the medical prescription shall be prohibited in the Republic of Armenia.

Article 38. The Authorities Interdicting the Illicit Traffic of the Narcotic Drugs, Psychotropic Substances and their Precursors

1. The interdiction of the illicit traffic of the narcotic drugs , psychotropic substances and their precursors, in the procedure established by the Government of the Republic of Armenia, shall be undertaken by the General Attorney office, Police, National Security, Customs and Health Authorities of the Republic of Arme nia within the scopes of their jurisdictions.

2. The interdiction activities of the illicit traffic of the narcotic drugs, psychotropic substances and their precursors shall be coordinated by the competent authorities responsible for addressing the probl ems relating to the narcotic drugs, psychotropic substances and their precursors.

3. The interdiction of the illicit traffic of the narcotic drugs, psychotropic substances and their precursors shall be undertaken pursuant to the target programs.

Article 39. The Funding of the Interdiction Measures Against the Illicit Traffic of the Narcotic Drugs, Psychotropic Substances and Their Precursors

The funding of the target programs against the illicit traffic of the narcotic drugs, psychotropic substance s and their precursors shall be undertaken by the state budget and the other sources of funding not prohibited by legislation.

Article 40. Inquiries on Cases Related to the Illicit Traffic of the Narcotic Drugs, Psychotropic Substances and Their Precurso rs and Performance of Assignments

1. The inquiries of the judges, prosecutors, as well as investigators and the inquiry officials related to the licit and illicit traffic of the narcotic drugs, psychotropic substances and their precursors, shall be und ertaken by official individuals, within three days after receiving such inquiries, excluding the days off and the holidays.

2. The information through such inquiries shall be furnished by the bank and the credit organizations pursuant to the legislation of the Republic of Armenia.

Article 41. The Limitations of Getting Engaged in Certain Types of Professional Activities

1. There are limitations established for the patients suffering drug addiction in the Republic of Armenia for the protection of the citizens' health, their rights and legal interests,
17
the security and defense purposes of the state, regarding the professional and more risk - bound activity.

2. The official individuals of the authorities mentioned in paragraph 1 of Article 38 of this law and the management of the legal persons, in the manner defined by the legislation, within their jurisdiction, shall dismiss individuals under narcotic addiction from any type of professional and risk -bound jobs.

3. The list of the certain types of pr ofessional and risk -bound activities, the limitations for the engagement in which have been set and which are stated in paragraph 1 of this Article, shall be established by the Government of the Republic of Armenia.

Article 42. Prohibition of Propagatio n and Limitation of Advertising about the Traffic of Narcotic Drugs, Psychotropic Substances and Their precursors

1. The advertisement and propogation of the narcotic drugs, psychotropic substances and their precursors, the activities of the natural or legal persons targeted at the dissemination of the information about the forms of the use of the narcotic drugs, psychotropic substances and their precursors, the manufacturing methods, places of getting, using and acquiring them, as well as the publicatio n of the literature and dissemination of that through the mass media, the dissemination of such information through the computer networks or other actions for the purpose of their dissemination, shall be prohibited.

2. It is prohibited to propagate t he advantages of the narcotic drugs, psychotropic substances and their precursors over one another.

3. The commercials on the narcotic drugs and psychotropic substances included in the lists of the narcotic drugs and psychotropic substances may be exclu sively undertaken in professional literature for the medical and pharmaceutical personnel. The dissemination of the pharmaceuticals containing narcotic drugs or psychotropic substances for the purposes of commercials shall be prohibited.

4. The violation of the norms under this Article shall lead to a liability pursuant to the legislation of the Republic of Armenia.

5. In the event there are evidences about the habitual violations detected by the organization as per paragraphs 1, 2, and 3 of this Art icle, upon the recommendation of the authorities mentioned in paragraph 1 of Article 38 of this law, the activity of the legal persons specified may be suspended for three months or may be terminated by the court ruling.

6. Upon the request on the termin ation of the activities of the organization on the grounds specified in paragraph 5 of this Article, an application may be furnished to the court by the authorities specified in paragraph 1 of Article 38 of this law.

Article 43. Provision and Dissemin ation of Information on the Illicit Traffic of the Narcotic Drugs, Psychotropic Substances and Their Precursors in the Republic of Armenia

18

1. The searches, collection, provision and dissemination of the information about the cultivation, development, p roduction, processing, manufacturing of the narcotic drugs, psychotropic substances, their precursors and their analogues, the methods, mechanisms, computer software, scientific -practice manuals and materials; illicit acquisition of data on the technical possibilities of the instruments and equipment, application, acquisition, stocking, sale, dispatch for sale, carriage, transit transportation, forms of use, and concealing of the traces, places and locations; the disguise, concealing, hiding; the actions aimed at the

decrease of the efficiency of the detection forms and methods, and the technical capacities for the equipments detecting those actions; the forms, methods and mechanisms for the planting, cultivation, collection and use of the plants co ntaining narcotic drugs and psychotropic substances, as well as the consulting on that regard, shall be prohibited and shall impose a liability pursuant to the legislation of the Republic of Armenia.
2. The searches, collection and use of informati on specified in paragraph 1 of this Article shall be authorized to only the public administration authorities entrusted by the Government of the Republic of Armenia, for the purposes of implementation of activities against the illicit traffic of the narcot ic drugs, psychotropic substances and their precursors.

Article 44. The Confiscation of the Narcotic Drugs, Psychotropic Substances and Their Precursors

1. The narcotic drugs, psychotropic substances and their precursors confiscated during the illicit traffic, as well as the instruments and equipment that have been used in their manufacturing, shall be confiscated in the manner established by law. They shall be destroyed in the procedure established by the Government.
2. The narcotic drugs, psycho tropic substances and their precursors mentioned in paragraph 1 of this Article, as well as the instruments and the equipment, the future use of which has been recognized by the confiscating authority as inappropriate, shall be destroyed in the manner defi ned by the legislation of the Republic of Armenia.
3. The property that has been obtained as a result of the illicit traffic of the narcotic drugs, psychotropic substances and their precursors or is used for the purpose of the mentioned activities shall be subject to confiscation pursuant to the legislation of the Republic of Armenia.

Article 45. The Rights and Obligations of the Officials Authorized for the Control over the Fulfillment of the Requirements of this Law

1. Under the availability of the sufficient data on the violations of the activities of the traffic in narcotic drugs, psychotropic substances and their precursors, the officials of the General Attorney, Police, National Security, Customs and Border Services of the Repu blic of Armenia shall have the right, within the scopes of their jurisdiction, to:
1) check the compliance of the procedure for the production and manufacturing of the narcotic drugs, psychotropic substances and their precursors with the regulations estab lished, if needed, to take samples for their comparative analysis;
2) to seal the relevant premises and require to furnish documents and provide explanations,

3) to give mandatory assignments to the entities having an authorization for the types of activities related to the traffic of the narcotic drugs, psychotropic substances and their precursors for the elimination of the violations detected.
2. The officials of the pre -investigation and post -investigation authorities, the investigators or the pr osecutors, in the event of the availability of the offence, may:
-to enter the areas used for the purposes of entrepreneurship and other activities (except for the areas of the foreign diplomatic representations and consulates and their official transportation) to make an examination in the presence of the owner of the property or his representative or his authorized persons, and in the event of their absence, also the representatives of the public administration or local self -government authorities, inc luding also the transportation means, to confiscate by protocol the necessary documents directly pertaining to the fact of the violation, samples the raw material and products, to seal the archives of the documents, money, commodities and substances,
-to require and to get information and explanations from the officials and their persons of substantive liability about the fact of violation,
-to require making reinspections, inventory assessments, other testing actions,

-to suspend the actions of t he persons having committed legal violations.
3. In the event of detection of any violations related to the traffic of the narcotic drugs, psychotropic substances and their precursors, the legal persons that undertake the specified activities, shall be obliged, within the scopes of their jurisdictions, to take measures for their elimination, while in the event of the administrative offences and crime, to provide the necessary materials to the relevant authorities.
4. The officials specified in para graph 1 of this Article, shall be obliged to take measures for the prevention of the administrative violations and criminal offences relating to the traffic of the narcotic drugs, psychotropic substances and their precursors and to expose the offenders to a liability.

CHAPTER 6
Medical assistance to the drug addicts

Article 46. Medical Investigation

1. The medical investigation shall be carried out by the public health authority entrusted by the Govern ment of the Republic of Armenia in the manner established by the legislation of the Republic of Armenia.
2. The decision on the medical investigation of the person using a narcotic or a psychotropic substance at an off -patient or in -patient clinical in stitution, as a result of the medical investigation, shall be made by the doctor -narcologist or the therapist doctor - narcologist undertaking the medical investigation.

Article 47. Medical Examination

1. Any individual, towards whom there are sufficient grounds to suspect, that he is suffering from the drug addiction, is under the effect of the drugs or is using narcotic drugs or

psychotropic substances without any medical prescription, shall be sent to medical examination.
2. The medical examination of the individuals specified in paragraph 1 of this Article shall be made by the public health competent authorities on the basis of the medical investigation results or upon the application forwarded by the individual on voluntary basis. The individuals specified in paragraph 1 of this Article shall be subject to mandatory investigation and treatment in the procedure established by the Government of the Republic of Armenia.
3. The decisions on sending the individuals specified in paragraph 1 of thi s Article for medical investigation may be appealed to the court in the manner established by the legislation of the Republic of Armenia.
4. The expenses for the medical investigation of the individuals specified in paragraph 1 of this Article shall be paid through the state budget funds, in the manner established by the Government.

Article 48. Medical Observation

1. The individual, who without the medical prescription, rarely or regulatory in the short term uses narcotic drugs and psychotropic s ubstances and who by the medical examination at an off - patient or in-patient clinic is devoid of any imminent danger of the physiological or psychological stable dependency, shall be subject to a short -term medical observation.
2. An individual who has voluntarily received a mandatory or obligatory treatment course has recovered partly or fully, shall be subject to long term medical observation.
3. The mandatory medical observation shall be established for the patients needing long-term medical obse rvation and, in all the cases, the individuals with up to 21 years of age.

Article 49. The Medical Assistance Provided to the Drug Addicts

1. The medical assistance to the drug addicts shall be provided pursuant to the

requirements set in paragraph 1 of Article 47 of this law.
2. The medical assistance to the teenagers of up to 14 years shall be provided upon the application forwarded by the legal representatives, while to the teenagers of 14 –18 years old, upon their consent, except for the cases prescribed by law.
3. The medical assistance (voluntary, mandatory and compulsory) shall be provided to those individuals suffering drug addiction, who without the medical prescription, regularly use narcotic drugs and psychotropic substances, have acq uired a physiological or psychological dependency, as a result of the medical examination have received the diagnosis of "Drug addiction", who is however able to at least temporarily, independently overcome the physiological and, psychological dependency o f using narcotic drugs and psychotropic substances.
21
4. Emergences (mandatory, compulsory) medical assistance shall be provided to the patient suffering drug addiction, who needs it, if he, without the medical prescription, permanently uses the narcot ic drugs and psychotropic substances, who has acquired an unrecoverable physiological or psychological dependency, has received the diagnosis of "Drug addiction" as a result of medical examination and is not able, even temporarily, without any medical inte rvention, to overcome the physiological, psychological dependency on the narcotic drugs and psychotropic substances.
5. To those drug addicts, who are under the medical examination and without medical prescription continue to use the narcotic drugs or p sychotropic substances, as well as those individuals, who have been condemned for execution of crime, and need treatment, may have compulsory treatment measures established upon the court ruling.
6. The patients suffering addiction, when getting medical assistance, shall be availing themselves of the patient rights, pursuant to the legislation of the Republic of Armenia on the protection of the citizens' rights.
7. The state shall guarantee the patients with drug addiction to get free medical assistance in the procedure defined by the Government, which includes an examination, consulting, diagnosis, treatment and medical -social rehabilitation.

Article 50. The Activities of the Health Institutions in Providing Medical Assistance to the Patient s with Drug Addiction

1.The state shall support in the examination of the drug addicts, their consultation, and treatment and medical -social rehabilitation.
2. The procedure for the medical observation and registration of the drug addicts shall be established by the Government of the Republic of Armenia.

Article 51. Coordination of Activities in Providing Medical Assistance to the Patients with Drug Addiction

1. The coordination of the medical aid services to the patients suffering drug addiction, which encompasses the health organizations, shall be undertaken by the public health competent authority.
2. The public health authority shall develop and furnish for the approval of the RoA Government such target programs which are aimed at the improv ement of the narcological assistance to the public and the development of the narcological service, the development of advanced methods for the diagnosis of the drug addiction and their introduction, the treatment and medical social rehabilitation of the patients suffering drug addiction.

CHAPTER 7

The guidelines of the national policy program against illicit traffic of narcotic drugs and substances

Article 52. Annual Program

22
1. The activities against the drug addiction and the illicit traff ic of the narcotic

drugs shall be undertaken in the periods and procedures established by the Annual program.
2. The annual program shall be furnished to the National Assembly by the Government of the Republic of Armenia in the draft state budget.

Article 53. The Content of the Annual Program and the Principles for Drafting It

The annual program shall encompass:
1) The main objectives of the program,
2) The scopes of the activities planned and the schedule for thei r implementation,
3) The appropriations of the funds for the activities planned,
4) The program implementation principles and the priorities in the implementation of the activities planned,
5) An analysis (information reference) about the illici t traffic of the narcotic drugs and psychotropic substances (including, its concealed status), as well as the quantitative and qualitative description of drug addiction among the public, the structure and dynamics of the criminal activity relating to the i llicit traffic of the narcotic drugs and psychotropic substances.
6) The measures planned in the treatment of the drug addicts and rehabilitation of their health.
7) Measures for combating drug addiction among the population (particularly youth and teenagers), interdiction of drug addiction, the propagation of anti drug campaign,
8) Measures taken in providing the competent public authorities, responsible in combating the illicit traffic of the narcotic drugs and psychotropic substances, with appropriate material and technical base,
9) Activities planned by authorized entities,
10) The data on the scopes of the activities against illicit traffic of narcotic drugs and psychotropic substances and thei r funding ratios in the Republic of Armenia (including the assistance received from the foreign states and international organizations) and the procedure for the supervision of those activities,
11) Measures planned for providing the medical and rehabil itation entities with material and technical base for the treatment of the drug addicts,
12) A reference about the production and use of the narcotic drugs and psychotropic substances (including for the medical, scientific, academic, expert examination, operativeinvestigation and veterinary purposes),

13) Other conditions, that are necessary for the comprehensive introduction of the program.
3) Together with the annual program, the Government shall also furnish the draft laws on ensuring its implem entation to the National Assembly.

Article 54. The Reporting about the Performance of the Annual Program

The report on the performance of the annul program shall be considered as the constituent part of the annual report on the budget exec ution of the current year.

CHAPTER 8

Concluding provisions

Article 55. The liability of the officials and the citizens of the Republic of Armenia, as well as the foreign citizens and the individuals without any citizenship for the violation of this law

1. In the event of the violation of this law, the citizens and the officials of the Republic of Armenia, as well as the foreign citizens and the individuals without citizenship, shall carry a liability pursuant to the legislation of the Republic of Armenia.
2. The authorization of the foreign citizens and individuals without citizenship, who have committed a crime for participating in the illicit traffic of the narcotic drugs and psychotropic substances and their precursors, to enter the Republic of Armenia territory may

be prohibited. But, if they are already in the territory of the Republic of Armenia, they shall be expelled from the country.

Article 56. The Entry into Force of this Law

This law shall enter into force in three months after its official promulgation.

V. Dallakyan
V. Bostanjyan
MPs of the National Assembly of the Republic of Armenia

Annex 3. EXCERPTS FROM CONSTITUTION OF THE REPUBLIC OF ARMENIA

Article 4. The state guarantees the protection of human rights and freedoms based on the Constitution and the laws, in accordance with the principles and norms of international law

Article 6. The supremacy of the law shall be guaranteed in the Republic of Armenia.
The Constitution of the Republic has supreme juridical force, and its norms are applicable directly. Laws found to contradict the Constitution as well as other juridical acts found to contradict the Constitution and the law shall have no legal force. Laws shall take effect only after official publication. Unpublished juridical acts pertaining to human rights, freedoms, and duties shall have no juridical force. International treaties that have been ratified are a constituent part of the legal system of the Republic. If norms are provided in these treaties other than those provided by laws of the Republic, then the norms provided in the treaty shall prevail. International treaties that contradict the Constitution may be ratified after making a corresponding amendment to the Constitution

Article 16. All are equal before the law and shall be given equal protection of the law without discrimination

Article 18. Everyone is entitled to freedom and the right to be secure in their person. No one may be arrested or searched except as prescribed by law. A person may be detained only by court order and in accordance with legally prescribed procedures.

Article 20. Everyone is entitled to defend his or her private and family life from unlawful interference and defend his or her honor and reputation from attack. The gathering, maintenance, use and dissemination of illegally obtained information about a person's private and family life are prohibited. Everyone has the right to confidentiality in his or her correspondence, telephone conversations, mail, telegraph and other communications, which may only be restricted by court order

Article 34. Everyone is entitled to the preservation of health. The provision of medical care and services shall be prescribed by law. The state shall put into effect health care protection programs for the population and promote the development of sports and physical education.

Article 40. Everyone is entitled to receive legal assistance. Legal assistance may be provided free of charge in cases prescribed for by law. Everyone is entitled to legal counsel from the moment he or she is arrested, detained, or charged.

Article 44. The fundamental human and civil rights and freedoms established under Articles 23 27 of the Constitution may only be restricted by law, if necessary for the protection of state and public security, public order, public health and morality, and the rights, freedoms, honor and reputation of others.

Annex 4. EXCERPTS FROM THE CRIMINAL CODE OF THE REPUBLIC OF ARMENIA

Article 123. Infecting with AIDS virus.

1. Subjecting another person to the obvious danger of infection with AIDS, is punished with correctional labor for the term of up to 2 years, or with arrest for the term of up to 2 months, or with imprisonment for the term of up to 1 year.
2. Infecting another person with AIDS willfully or self-confidently, by another person who was aware that he had the disease, is punished with imprisonment for the term of up to 1 year.
3. The committed actions envisaged in part 2 of this Article, which was committed:

1) in relation to 2 or more persons;
2) in relation to a minor,
3) in relation to a pregnant woman,

are punished with imprisonment for the term of 3 to 8 years.

Article 266. Illegal turnover of narcotic drugs or psychotropic materials with the purpose of sale.

1. Illegal manufacture, processing, procurement, keeping, trafficking or supplying of narcotic drugs or psychotropic materials with the purpose of sale, is punished with imprisonment for the term of 3 to 7 years.
2. The same action committed:

1) by a group of persons;
2) in large amount;
3) at the place of imprisonment or arrest;
4) in disciplinary/educational institution,

is punished with imprisonment for the term of 5 to 10 years with property confiscation.

3. Actions envisaged in parts 1 or 2 of this Article, if they were committed:

1) by an organized group;
2) in particularly large amount,

is punished with imprisonment for the term of 7 to 15 years with or without property confiscation.

4. The large and particularly large amounts of narcotic drugs or psychotropic materials are established by the competent state governance body of the RA.

5. Illegal turnover of narcotic drugs or psychotropic materials in small amounts does not entail criminal responsibility.

6. A person voluntarily submitting narcotic drugs or psychotropic materials will be relieved of criminal responsibility for illegal manufacture, processing, procurement, keeping, trafficking or supplying of narcotic drugs or psychotropic materials.

Article 267. Breach of regulations for manufacture, procurement, keeping, accounting, dispensing, transportation or supply of narcotic drugs or psychotropic materials

1. Breach of regulations for manufacture, procurement, keeping, accounting, dispensing, transportation or supply of narcotic drugs or psychotropic materials by the person who is in charge of their observance, if it resulted in theft or illegal turnover of afore-mentioned materials, is punished with a fine in the amount of 200 to 500 minimal salaries, or with imprisonment for the term of up to 3 years, with deprivation of the right to hold certain posts or practice certain activities for up to 3 years.
2. The action envisaged in the first part of this article, if it was committed in large amounts, is punished with a fine in the amount of 500 to 800 minimal salaries, or with imprisonment for the term of 2 to 4 years, with deprivation of the right to hold certain posts or practice certain activities for up to 3 years.

3. The action envisaged in the first part of this article, if it was committed in particularly large amounts, is punished with imprisonment for the term of 3 to 5 years, with deprivation of the right to hold certain posts or practice certain activities for up to 3 years.

Article 268. Illegal turnover of narcotic drugs or psychotropic materials without the purpose of sale.

1. Illegal manufacture, processing, procurement, keeping, delivery or supply of narcotic drugs or psychotropic materials without the purpose of sale, is punished with arrest for the term of up to 2 months or with imprisonment for the term of up to 1 year.
2. The same action committed in large amount:

Is punished with imprisonment for the term of up to 3 years.

3. The same action committed in particularly large amount:

Is punished with imprisonment for the term of 2 to 6 years.

Article 269. Theft or extortion of narcotic drugs or psychotropic materials.

1. Theft or extortion of narcotic drugs or psychotropic materials, is punished with imprisonment for the term of 3 to 7 years.
2. The same action committed :

1) by a group of persons with prior agreement;
2) by abuse of official position;
3) with violence not dangerous for life or health, or with threat of such violence,
4) in large amount,

is punished with imprisonment for the term of 6 to 10 years with or without property confiscation.

3. The action envisaged in part 1 or 2 of this Article which was committed:

1) by an organized group;
2) in particularly large amount;
3) with violence dangerous for life or health, or with threat of such violence,

is punished with imprisonment for the term of 8 to 15 years with or without property confiscation.

Article 270. Illegal transfer of narcotic drugs or psychotropic materials or forgery of recipes or other documents which entitle their receipt.

Illegal transfer of narcotic drugs or psychotropic materials or forgery of recipes or other documents which entitle their receipt, is punished with imprisonment for the term of up to 2 years, with or without deprivation of the right to hold certain posts or practice certain activities for up to 3 years.

Article 271. Use of narcotic drugs.

1. Use of narcotic drugs without medical permission, is punished with a fine in the amount of up to 200 minimal salaries, or with arrest for the term of up to 2 months.
2. The person who surrenders drugs is exempted from criminal liability.

Article 272. Abetting or involving into use of narcotic or psychotropic drugs.

1. Abetting or involving into use of narcotic or psychotropic drugs, is punished with correctional labor for the term of up to 2 years, or with arrest for the term of up to 3 months, or with imprisonment for the term of up to 3 years.
2. Abetting or involving into the use of narcotic or psychotropic drugs, committed:

1) in relation to a minor;
2) in relation to two or more persons;
3) by deception;
4) with violence or with a threat to commit violence,

is punished with imprisonment for the term of 3 to 8 years.
3. The same action, if this negligently caused the death of the aggrieved or caused grave damage to his health,

is punished with imprisonment for the term of 6 to 12 years.

Article 273. Illegal cultivation or raising of herbs prohibited for processing, containing narcotic, psychotropic or toxic substances.

1. Cultivation or raising of herbs prohibited for processing containing narcotic, psychotropic or toxic substances, done in large amount, is punished with a fine in the amount of 300 to 500 minimal salaries, or with arrest for the term of 1-3 months, or with imprisonment for the term of up to 2 years.
2. The same action committed:

1) by several persons with prior agreement;
2) by an organized group;
3) in particularly large amount, is punished with imprisonment for the term of 3 to 8 years.

Article 274. Organization and maintaining of dens for the use of narcotic or psychotropic drugs.

1. Organization and maintaining of dens for the use of narcotic or psychotropic drugs, is punished with imprisonment for the term of up to 4 years.
2. The same action committed:

1) by an organized group;
2) by abuse of official position,
3) in disciplinary/education institutions, is punished with imprisonment for the term of 3 to 7 years.

Article 275. Illegal turnover of strong or toxic substances for the purpose of sale.

1. Illegal manufacture, processing, procurement, keeping, trafficking, supply of strong substances which are not considered to be narcotic or psychotropic drugs, for the purpose of illegal sale, is punished with imprisonment for the term of up to 3 years.
2. The same action committed:

1) by a group of persons with prior agreement,
2) in large amount, is punished imprisonment for the term of 2 to 5 years.
3. The action envisaged in part 1 or 2 of this Article which was committed:

1) by an organized group,
2) in particularly large amount;

is punished with imprisonment for the term of 4 to 8 years.

4. A person voluntarily submitting strong or toxic substances will be relieved of criminal responsibility for illegal manufacture, processing, procurement, keeping, trafficking, supplying or selling of strong or toxic substances.

Article 276. Breach of rules for manufacture, procurement, keeping, accounting, transfer, transportation or supply of strong or toxic materials.

Breach of rules for manufacture, procurement, keeping, accounting, transfer, transportation or supply of strong or toxic materials, if this caused theft or other significant damage, is punished with a fine in the amount of up to 300 minimal salaries, or correctional labor for up to 2 years, or with imprisonment for the term of up to 2 years, with deprivation of the right to hold certain posts or practice certain activities for 3 years.

Article 277. Breach of sanitation and epidemic regulations.

1. Breach of sanitation and epidemic regulations which negligently caused mass diseases or poisoning of humans, is punished with a fine in the amount of up to 200 minimal salaries, or correctional labor for up to 2 years, or with imprisonment for the term of up to 3 years, or with deprivation of the right to hold certain posts or practice certain activities for up to 3 years.
2. The same action which negligently caused heavy damage to health or human death, is punished with imprisonment for the term of up to 5 years

Article 278. Concealing information about circumstances dangerous for human life or health.

1. Concealing or distortion of facts, phenomena or events dangerous for human life or health, or the environment, committed by a person in charge of providing such information to the population, is punished with a fine in the amount of 200 to 400 minimal salaries, or with imprisonment for the term of up to 2 years, or with or without deprivation of the right to hold certain posts or practice certain activities for 3 years.
2. The same action which:

1) was committed by abuse of official position;
2) caused damage to human health or death, by negligence, is punished with a fine in the amount of up to 300-500 minimal salaries, or with imprisonment for the term of 2-6 years, or with or without deprivation of the right to hold certain posts or practice certain activities for 3 years.