# Health as International Politics

## Combating Communicable Diseases in the Baltic Sea Region

GEIR HØNNELAND
LARS ROWE

ROUTLEDGE

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## Combating Communicable Diseases in the Baltic Sea Region

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# List of Abbreviations

| | |
|---|---|
| BEAR | Barents Euro-Arctic Region |
| CBSS | Council of the Baltic Sea States |
| DOT | Directly Observed Therapy |
| DOTS | Directly Observed Treatment with Short-course (chemotherapy) |
| GP | General practitioner |
| GSHO | Group of Senior Health Officials (Task Force) |
| ITA | International Technical Adviser (Task Force) |
| IUATLD | International Union against Tuberculosis and Lung Disease |
| LFA | Logical Framework Approach |
| MERLIN | Medical Emergency Relief International |
| NGO | Non-governmental organisation |
| PHC | Primary health care |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Programme |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

# Preface

The dramatic rise in tuberculosis and HIV/AIDS in some of the former East Bloc countries caused great concern among Western experts around the turn of the millennium. To combat the emerging threat, the Council of Baltic Sea States (CBSS) launched in 2000 the Task Force on Communicable Disease Control in the Baltic Sea Region (the Task Force). During the period 2001–04, the Task Force implemented more than 100 projects to combat tuberculosis, HIV/AIDS and improve primary health care in the north-western parts of Russia and the Baltic states. As the projects were being implemented, several small evaluation teams of experts in medicine and social science were put together. This book represents the outcome of one of these evaluation teams. More precisely, it presents the results of the study of the Task Force from an international relations point of view. It is the 'contextual evaluation', as it came to be known in Task Force circles.

The work was financed by the Norwegian Ministry of Health through the Secretariat of the Task Force. We wish to extend our most sincere thanks to the three members of the Secretariat, Harald Siem, Andreas Skulberg and Janicke Fischer, for enthusiasm and active support during our work. They have in no way tried to influence the conclusions of our study, but provided the necessary practical guidance and medical expertise. Martin McKee at the London School of Hygiene and Tropical Medicine was kind enough to read and comment the manuscript and proved an invaluable source of suggestions for further reading. We enjoyed many fruitful discussions with Vanja Ohna at the Institute for Nutrition Research at the University of Oslo concerning several aspects of the work. Ain Aaviksoo, Jon Elvedal Fredriksen, Viktoras Meizis, Denis Pyzhikov, Sanita Sivicka and Veronika Vorobyova provided assistance during our field trips to Russia and the Baltic states. Our colleague Jørgen Holten Jørgensen conducted interviews in Petrozavodsk for us and his expertise on Russian affairs made him an obvious choice for broader-ranging discussions. FNI Director Arild Moe assisted us in the initial phases of the project and retained a lively and practical interest in the study as it progressed. Kari Lorentzen, Chris Saunders and Maryanne Rygg were, as always, indispensable in the library, in finding the right linguistic balance for the text, and in the technical formatting of the typescript. Thanks to you all! Thanks also to Kirstin Howgate at Ashgate and the two series editors Nana K. Poku and Robert L. Ostergard, Jr, for accepting the manuscript for the Global Health series.

One technical detail: Transcription from Russian to English is done according to the 'popular' rather than official linguistic standard, as the latter often results in spelling that is difficult to understand for people with little knowledge of Russian. Russian *e* is written as *ye* at the beginning of words and after vowels, but *y* is skipped in proper names with an established English form, e.g. Karelia. The hard and soft signs used in Russian are not transcribed.

The book builds on interviews with approximately 100 people involved in the Task Force in different ways and at different levels, mainly in Russia and the Baltic states.

The opinions of individual interviewees do not always match the impressions we gained at the aggregate level. Reality is fickle and elusive, but here is one story of how the Task Force began as an idea, was formed into a plan and put in motion.

*Geir Hønneland*
*Lars Rowe*
*Lysaker, January 2004*

# Chapter 1

# Introduction

> [We are facing] an unprecedented public health threat.
>
> (Task Force, 2000, p. 11)

## Introduction

At the end of the 1990s, the health situation in Russia and the Baltic states caused serious concern among medical experts and officials in the West. Life expectancy had decreased dramatically since the break-up of the Soviet Union, mainly as a result of diseases caused by malnutrition, smoking or alcohol consumption.[1] However, tuberculosis, a disease which in Western societies had been more or less eliminated or at least controlled effectively, was re-emerging and HIV/AIDS was already causing widespread suffering in the post-Soviet area. Faced with these looming epidemics, centuries-old fears of infectious diseases spreading like wildfire from person to person and country to country were being rekindled. Although Russia and the Baltic states were considered to be most at risk from tuberculosis and HIV/AIDS, some went so far as to suggest that the epidemics could destabilise the political climate in northern Europe as a whole.

The most severe effects of both epidemics were felt in Russia. For tuberculosis, after levelling out at around 30 cases per 100,000 population at the beginning of the 1990s, the rate rose dramatically towards the end of the decade, reaching approximately 80 cases per 100,000 population; see Figure 1.1. The HIV figures were even worse, rising steeply towards the end of the 1990s, prompting dramatic statements from Western medical experts and news agencies.[2] While reported cases per million population were just below 25 in mid-1997, a disturbing 130 cases were recorded by the end of 1999. Predictions indicated a doubling by the year 2000. Albeit serious, the situation was less dramatic in the Baltic states. In Estonia, while the number of tuberculosis cases was relatively low, the country suffered an outbreak of HIV among injecting drug users in 2000. Latvia paralleled the Russian case regarding both tuberculosis and HIV. In Lithuania, although the tuberculosis rates reached Russian and Latvian levels, the HIV rate remained as low as Sweden's, on the western shores of the Baltic Sea.

The entire situation was deemed unacceptable by Western experts, particularly the emergence of a multi-drug resistant tuberculosis strain, caused by insufficient or interrupted treatment of ordinary tuberculosis. Terms like 'worst-case scenario' and 'unprecedented public health risk' were used,[3] as were terms like 'katastroika' and 'mortality crisis'.[4] The worried Western community emphasised the correspondence between economic recession and high tuberculosis and HIV/AIDS incidence in the former Soviet areas. It was claimed that the social disruption could threaten the

eastern part of the Baltic Sea region and might destabilise the area not only socially, but politically, too. It was assumed that the health crisis would damage inter-state relations in the eastern areas of the region. Without basic security in terms of human health, it was said, basic security in the wider social and political sense could not be achieved.

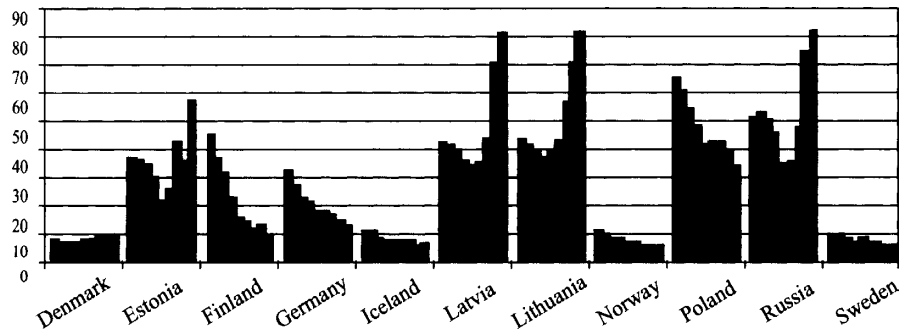


**Figure 1.1 Tuberculosis case notification rates per 100,000 population for the period 1982–1998 (2-year intervals) for the countries of the Baltic Sea region**

*Source*: http://www.baltichealth.org.

What, then, should be done? The traditional method of preventing the cross-border spread of infectious diseases is to enforce a strict quarantine regime in combination with an equally strict medical screening at national borders. But as nation states have become increasingly reliant on commercial and cultural interaction, a process commonly known as globalisation, these methods have lost much of their appeal. More specifically, the post-Cold War ambition of encouraging rather than discouraging cross-border contact in the European North rendered border-control measures both impractical and ideologically unacceptable.[5] Thus, the path chosen in the fight against communicable diseases in the region would be more, as opposed to less, human contact and cooperation.

New institutional structures were established at the international level to combat the new threats, the results of which are at the heart of this book's discussion. While it is too early to attribute conclusively changing trends in the spread of communicable diseases in the region to the political initiatives taken at the international level, it is possible to trace nonetheless how this massive international effort is being implemented and perceived in the recipient countries.

This introductory chapter continues with a brief review of the burgeoning literature in international politics on health issues and health as a global public good. It then provides an overview of the main political instruments created to encourage trans-