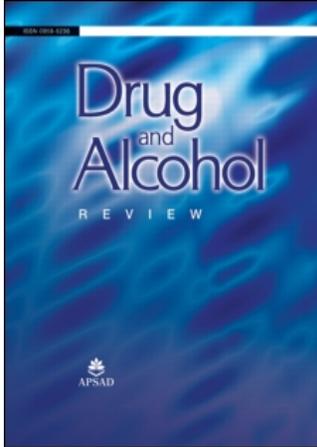


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Responding to HIV infection associated with drug injecting in Eastern Europe

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HARM REDUCTION DIGEST 3*

Responding to HIV infection associated with drug injecting in Eastern Europe

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*Note from the Editor

In some countries in Eastern Europe the spread of HIV infection associated with drug injecting has been rapid. While, in several cities in the region, HIV prevention programmes have been established, there remains a need to introduce public health technologies and strengthen existing capacity for rapidly assessing and responding to emerging HIV epidemics. This Harm Reduction Digest describes the spread of HIV among drug injectors in the region, existing harm-reduction responses and the application of Rapid Assessment and Response (RAR) as a strategy to further develop these. RAR is a methodology developed by the World Health Organization Programme on Substance Abuse to assist in rapidly assessing the individual, social and environmental factors related to HIV transmission among IDUs so as to develop appropriate public health responses. The authors of this Digest, who have all been centrally involved in this process, also describe as an example an HIV prevention training programme in the Russian Federation which aims to assist health professionals to respond to the developing crises of HIV/AIDS among IDUs.

SIMON LENTON

Introduction

An estimated 30 million people had been infected with HIV Infection world-wide by December 1997 [1]. Based on trends recorded in mid-1996, 60–70 million people are expected to be infected by the end of the year 2000 [2,3]. It is estimated that approximately 90% of infections occur in developing countries, particularly in the countries of sub-Saharan Africa and Eastern and South Asia. The spread of HIV is comparatively recent in Eastern Europe, yet the number of new infections continues to rise exponentially in many Eastern European countries [4].

HIV transmission associated with the shared use of contaminated injecting equipment and drug preparations is a pivotal determinant of HIV spread in many developing and transitional countries [5]. In Central, South and East Asia, for example, it is estimated that at least half of HIV infections are associated with injecting drug use in Malaysia, Myanmar, Vietnam, China and Kazakhstan [5]. The spread of HIV among IDUs has been rapid in many of these countries, and has often spread quicker than the time it has taken to develop appropriate research, assessment and HIV prevention interventions. Studies of the diffusion of HIV associated with drug injecting show that some cities reached an HIV prevalence of over 40% within 1 year of first identifying the presence of HIV [6].

The rapid spread of HIV associated with drug injecting has also been observed in developed countries, such as in the Southern European countries of Italy and Spain, and in Edinburgh, Scotland where HIV prevalence reached 40% within 1 year [7]. In New York, where HIV epidemics associated with drug injecting were first identified, it is estimated that HIV prevalence among IDUs increased approximately 10% a year in the late 1970s and early 1980s before stabilizing at around 50% after 1983 [8].

There is continued evidence of rapidly emerging HIV epidemics associated with injecting drug use. Despite over a decade of international experience on the reduction and prevention of HIV transmission among IDUs [9,10], new and explosive epidemics are still occurring, particularly in the Eastern European countries of the Ukraine, Belarus and the Russian Federation [5,11,12]. This highlights the need to develop public health technologies which have the capacity to rapidly assess and respond to emerging epidemics of HIV [12,13]. In this paper,

we outline recent evidence on rapidly emerging HIV epidemics associated with drug injecting in the countries of the Ukraine, Belarus, Moldova and the Russian Federation, and the development of HIV prevention activities in response. This leads us to consider the relevance of 'rapid assessment and response' methods as a mechanism for improving the efficiency and effectiveness of current HIV prevention responses. We conclude by providing a case example of a national training programme currently being undertaken in the Russian Federation which incorporates rapid assessment and response as a method of HIV prevention.

HIV associated with drug injecting in Eastern Europe

Estimates suggested, at the end of December 1997, that approximately 100 000 people were living with HIV infection in the Ukraine, as were 40 000 in the Russian Federation, and 9000 in Belarus [1]. While the diffusion of HIV infection is comparatively recent in these countries, it has been rapid and predominantly associated with injecting drug use. In the Ukraine, new HIV cases have soared from an average of about 47 per year between 1992 and 1994 to almost 1500 in 1995, and 12 228 in 1996, with just under 50% of all new infections reported among injecting drug users [11]. In 1997, the number of new HIV cases were reported to be 15 443, of which 7950 (51%) were reported as IDUs, and 2440 as prisoners for whom injecting drug use is also the most likely mode of transmission. [5]. Rapid spread has been most marked in the southern Ukrainian cities of Odessa and Nykolayev. Estimates of HIV prevalence among IDUs in Odessa rose from 1.4% in January 1995 to 13% in August 1995 and to 30% by January 1996 [11,14]. In Nykolayev, HIV prevalence among IDUs had reached 56% by January 1996 [14]. Rapid assessment reports indicate that transmission may be closely associated with modes of drug distribution, and in particular the distribution of 'himier' or 'chornie' (a domestically produced opiate from poppy straw) via ready-filled syringes and via 'front-loading' from the dealer's donor syringe [15].

A year after the rapid spread of HIV was detected among IDUs in the Ukraine, similar reports emerged from Belarus. In May 1996 in the small city of Svetlogorsk, over 750 HIV infected IDUs were identified. In the South of Belarus, an 18%

HIV prevalence was found among IDUs in May/June 1996, yet by July 1996 prevalence was estimated to be 50% [16]. By the end of 1996, a total of 702 new HIV cases were identified of which 485 (67%) were IDUs [11]. More recent estimates in 1997 suggested that over 80% of HIV infections in the Ukraine were associated with drug injecting [17]. While evidence on the emerging epidemic in Moldova is less dramatic by comparison, it still suggests a sharp rise in prevalence among IDUs. Here reported HIV cases have risen from an average of under three per year between 1992 and 1994 to seven in 1995, and to 55 in 1996, of which 38 (69%) were among IDUs [11].

Until recently, the Russian Federation appeared to have avoided the rapid spread of HIV infection. However, evidence now suggests that rate of new HIV infections has entered a steep upward curve in some parts of the country. National statistics for HIV infections per 100 000 tests carried out increased among Russian military personnel from fewer than five in 1995 to 60 in 1996; and among Russian prisoners from two in 1995 to 60 in 1996. New infections attributed to unsafe homosexual and heterosexual sex have remained similar over the past 10 years, rising steadily from 8–10 per year in 1987 to 65–80 per year in 1996. Infections among children peaked at 110 in 1989 (primarily due to an epidemic of patient-to-patient transmissions among new-born babies at a hospital in Rostov), and have now settled to around two per year [18].

As in the neighbouring countries of the Ukraine and Belarus, the most dramatic increases in HIV cases in the Russian Federation have been among injecting drug users. Prior to 1995 there were no recorded cases. During 1995 there were three cases, rising to 3200 in 1996. There was a total of 1072 recorded HIV cases between 1987 and 1995. In 1996 alone 1535 HIV cases were recorded, of which the majority—62%—were among IDUs, 5% among heterosexuals and 5.6% among homosexual men (V. Povrovski, unpublished paper, 1998; [18]). New infections in 1997 had risen to 4337, of which 74% (3200) were among IDUs [1]. Reports suggest that the cities and regions most closely associated with rapidly emerging epidemics of HIV among IDUs during 1996 and 1997 are Kaliningrad, Krasnodar and Rostov, Tver, Nizhny Novgorod and Moscow (V. Povrovski, unpublished paper, 1998; [19]).

It is important to note that *at the same time* as rapid increases in HIV prevalence among IDUs in

these countries, there has also been rapid increases in the prevalence of sexually transmitted infections (STIs) in the general population. It is known that the presence of untreated STIs enhances the transmission of HIV, and that the prevention and control of STIs also has an HIV prevention impact [20]. The combination of high and increasing prevalence of STIs in the general population, and of high and rapid spread of HIV among IDUs, increases the likelihood of major sexually transmitted epidemics of HIV in the region [21].

Between 1990 and 1996 the notification of new cases of syphilis in the Russian Federation has risen over 48-fold [21], with STI prevalence particularly high in St Petersburg, where syphilis rates had risen to 172 per 100 000 population by 1995. The Russian syphilis epidemic (especially around St Petersburg) is closely related to the rapid rise in syphilis in Finland, and is thought to be associated with the increase in tourism from Finland to Russia and migration from Russia to Finland [22,23]. In the Ukraine, new rates of syphilis have jumped from 6 per 100 000 population in 1990 to 144 per 100 000 population in 1996. In Belarus they have jumped from 2.7 per 100 000 population in 1990 to 72.1 in 1994, to 147.1 in 1995 and to 210 in 1996. In Moldova, syphilis rates have risen from 116.3 per 100 000 population in 1994 to 173.6 in 1995.

International experience has shown that HIV can spread extremely rapidly given certain social and structural conditions [6]. Such conditions appear to exist currently in the Russian Federation, the Ukraine, Belarus and Moldova. As has been noted (A. Reynolds, unpublished paper, 1997; [12,24]), they include: the recent and rapid diffusion of injecting drug use; high levels of mixing between IDUs from different social networks; the regular sharing of injecting equipment among members of social networks and between networks; the injection of liquid drugs sold in syringes; the distribution of drugs through 'back-loading' and 'front-loading'; proximity to drug supply routes (for example, from Afghanistan through Central Asian Republics, Russia and Ukraine to Western Europe); and widespread unemployment, economic dislocation and social change.

Summary of HIV prevention activities

National governments in Eastern Europe have recently recognized the seriousness of the threat posed

to public health by HIV epidemics through reflecting this in either national policies and strategies or through national statements of concern. In Russia, for example, the Duma has accepted a report on the need for action, the National Ministries of Health, Education, Internal Affairs and Defence are working with UN agencies on plans for national assessment and activities, and the Ministry of Health has designated at least one position at each of its regional AIDS Centres to focus on HIV prevention among drug users.

In the Ukraine, whereas the first (1992–94) and second (1995–97) National Strategic Plans on HIV/AIDS did not specifically address the issue of HIV/AIDS among IDUs, the third National Strategic Plan (1998–2000) has a specific focus on injecting drug use in recognition of its critical role in the HIV epidemic in the country. In March 1998, the 1991 law on 'Prevention of AIDS and Social Protection of Populations' was amended to enable 'harm reduction' approaches to be implemented in the country, including needle and syringe exchange programmes. With the technical support of UNAIDS, the United Nations Development Programme (UNDP) and the World Health Organization (WHO), the Ukrainian National Committee for the Prevention of AIDS and Drug Abuse has been working towards the development of public health policies and strategies targeting IDUs since 1996 (L. I. Andrushchak, unpublished paper, 1998).

Recently, there have been considerable efforts to develop HIV prevention activities targeting IDUs in the region. Needle and syringe exchange and distribution programmes have been established in Belarus, the Russian Federation and the Ukraine, as well as in other countries in the region including Bulgaria, the Czech Republic, Slovakia, Hungary, Kazakhstan, Lithuania and Poland [5]. Rapid assessment of the drug use situation in Svetlogorsk, Belarus during 1997 indicated that the needle and syringe exchange, which is located in the centre of the city, had contacted approximately a fifth of the estimated IDUs in Svetlogorsk [25].

In St Petersburg, needles and syringes have also been distributed by a mobile outreach bus since early 1987 (O. Toussova, personal communication, 1998). The Needle Exchange Bus is operated by a Russian non-governmental organization (NGO) called Renaissance, in collaboration with Médecins du Monde of France. During 1986, there was also a short-lived

needle exchange established by an individual in Moscow with assistance from the AIDS Prevention Action Network and funding from The Lindesmith Center. Yet recent moves to make changes in the Russian Law on Narcotic Drugs (1998) have led to fears among health professionals that the development of new needle and syringe exchanges may be impeded.

In addition to needle and syringe exchange, a pilot intervention to distribute condoms, bleach and information on the cleaning of injecting equipment is currently being implemented in three prisons in the Ukraine [5]. It is the first of its kind in a prison setting in Eastern Europe. Rapid assessment undertaken in Belarus indicates that needles and syringes are sold without restriction in pharmacies, although there is a scarcity of bleach available, even in some hospitals [26].

There is also evidence of outreach in these countries. In the Russian Federation the Moscow Outreach Programme, in which former drug users provide leaflets, condoms and verbal information and advice, is operated by Médecins Sans Frontières (MSF). The programme also provides onwards referral to services offering HIV testing, treatment for dependence and treatment for infectious diseases. In addition to distributing sterile injecting equipment, the Jaroslavl needle exchange in Russia is a 'peer-driven intervention' and aims to encourage peer support within drug user networks. Modelled on the East Connecticut Health Outreach (ECHO) Project [27], drug users contacted by the exchange are encouraged, through the use of coupons redeemed for cash, to participate in intensive education sessions and to educate and recruit their peers to these sessions. This project is jointly operated by the Russian NGO Friends Helping Friends and the University of Connecticut ECHO Project with funding provided by The Lindesmith Center/Open Society Institutes.

The provision of opioid agonist pharmacotherapy and treatments, including oral methadone, is also taking place in a number of Central Eastern European countries, including Bulgaria, Estonia, Hungary, Latvia, Lithuania, the Republic of Macedonia, Poland, the Slovak Republic and Slovenia [5]. While methadone substitution is emerging as a key component of treatment services provided in Slovenia and Lithuania, this is not the case in other countries where small, often pilot, programmes are in operation. There are no methadone substitute

programmes in the Russian Federation. Substitute treatments other than methadone (for example, codeine and methylmorphine) are provided in the Czech Republic and Slovakia [24,28]. Despite the introduction of low-threshold treatment programmes in many Eastern European countries, treatment detoxification in hospital settings and, to a lesser extent, out-patient rehabilitation, remains the predominant form and treatment services are often scarce outside of capital cities.

The need for rapid assessment and response

While the above summary of HIV prevention activities in Eastern European countries highlights the emergence of an integrated and community-based response to reducing the public health harms associated with drug injecting—including syringe and needle exchange, community outreach, peer intervention and drug treatment services—conventional research and intervention approaches are often inefficient in rapidly responding to new public health problems. With new and explosive epidemics of HIV associated with drug injecting often emerging faster than conventional research and intervention approaches can be developed or completed, there is the need for a public health technology which is *rapid, pragmatic* and *cost-effective* [12,13].

As a result, there has been increasing interest, particularly among international development agencies, in developing methods of rapid assessment and intervention response as a means of reducing or preventing HIV infection associated with drug injecting. It has been recognized increasingly that there is a need to integrate such assessment as part of the process of developing pragmatic intervention responses. In our view, the effectiveness of rapid assessments can be judged by their practical outcomes. Envisaged as a method for undertaking local assessments *in order to develop* local responses—and not merely as a means for generating knowledge—we are interested in building on existing expertise in rapid assessment [29–31] to develop a method of ‘rapid assessment and response’ (RAR) [12,13].

In recognition of the need for rapid assessment and response methods in the field of HIV prevention, the World Health Organization Programme on Substance Abuse (WHO/PSA), in collaboration with UNAIDS and The Centre for Research on Drugs and Health Behaviour, University of London, have developed the *Rapid Assessment and Response*

Guide on Injecting Drug Use (IDU-RAR) and the *Rapid Assessment and Response Guide on Sexual Behaviour Associated with Substance Use (SEX-RAR)* [32,33]. These *Guides*, which to date have been piloted in the Ukraine, Kazakhstan, the Russian Federation, Colombia and Nigeria, aim to provide the methods necessary to undertake rapid assessments and intervention developments at the local or regional level.

RAR is an action research approach which consists of three main components: assessment methods and sources of data; key areas of assessment; and the development of action plans for intervention implementation. The *Guides* outline the use of multiple methods (both qualitative and quantitative, including approaches to sampling, key informant interviews, focus groups, observations and focused surveys) in conjunction with multiple data sources (including a variety of existing data sources) to undertake assessment of the city and country context, the extent and nature of drug injecting, the extent and nature of health consequences and risk behaviour associated with drug use, the situational and contextual factors influencing risk reduction and the need for public health intervention and policy development. The implementation of the RAR instrument, and its final evaluation and field-testing, is likely to take place in approximately 15 developing and transitional countries, but it is also designed to be used and field-tested in a variety of both ‘developing’ and ‘developed’ country settings.

Building on existing expertise on rapid assessment in anthropology, sociology, public health and community development, RAR represents an attempt to formalize and, to some extent, standardize methods of rapid assessment and response as part of community participatory intervention initiatives [5]. The principles underpinning the ‘rapid assessment and response’ approach borrow from conventional action-orientated research approaches, but place greater emphasis on the use of multiple methods and data sources; community participation in the assessment and response; the development of cost-effective and pragmatic methods; and on explicitly linking rapid assessment and intervention development as part of the ongoing process of ‘assessment–response–assessment’ at the local level [13].

The piloting of the RAR instrument suggests that the principles underpinning the approach distinguish it from conventional methods of research and assessment [13]. First, by explicitly connecting rapid

assessment with rapid response, a departure is made from research approaches which do not feed directly or rapidly to practical outcomes. Secondly, its focus on 'triangulation' across multiple methods and data sources, and its 'inductive' approach, distinguish it from 'single-method' approaches and allow for findings to be cross-checked throughout the assessment (designed to last between 3 weeks and 3 months) and for validity to be confirmed. Thirdly, its multiple methods approach, and its use of existing data sources, aim to maximize data output in relation to resource input thereby increasing its cost-effectiveness. Fourthly, its 'investigative' approach and its use of qualitative data allow for investigation at many levels of society which includes consideration of the social, cultural, religious, political and economic context. Finally, its focus on community participation, and the integration of assessment and response as part of community organizing initiatives, aims to strengthen local capacity rather than relying on 'outside' expertise.

The need for such a public health technology is most acute in developing and transitional countries where cost-effective methods of assessment and response are required. As has been noted, the use of rapid assessment has played a critical role in settings where existing data are inadequate for the planning of interventions and policies [5,30]. This is also the case in Eastern European countries, where rapid assessment has enabled the collection of multiple sources of data, using multiple methods, in a comparatively short space of time, where previously only inadequate data existed [5,15,28,34]. Such assessments have proved pivotal in understanding the local complexity of risk behaviours associated with drug injecting to inform the development of appropriate community-based public health and harm reduction initiatives [12,14,17,34,35].

The rapid spread of HIV associated with drug injecting highlights the concomitant limitations in current applications of public health methods and the need for methods of rapid assessment and response. It is for this reason that the RAR methodology has been developed, and that we view rapid assessment and response as appropriate to the development of HIV prevention activities among IDUs [12]. Since 1997 there has been a dramatic increase in the use of rapid assessment methods in Eastern Europe, including in Belarus, the Czech Republic, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Macedonia, Romania, Slovenia, the Ukraine and

Uzbekistan [5,14,15,17,28,34–38]. Throughout this period, rapid assessment—and the *WHO IDU-RAR Guide*—has also been used in HIV prevention training and capacity building initiatives in a variety of countries, including over fifteen cities in the Russian Federation [39–44]. This highlights the use of the *RAR Guides* as a training as well as an assessment and intervention tool. We describe this intervention below.

HIV prevention and rapid assessment training in Russia: a case example

After a situation assessment in the Russian Federation in 1995–96, Médecins Sans Frontières—Holland (MSF–H) recommended that the development of an effective HIV prevention strategy among IDUs required three main activities. First, there was the need for the training of several hundred Russian doctors, government officials, non-government organization staff and former drug users in HIV prevention methods which have proved successful in preventing or controlling HIV epidemics among IDUs in other countries. Secondly, there was the need to establish HIV prevention interventions among IDUs in cities and regions throughout the Federation. Thirdly, there was the need to ensure government and policy support for these initiatives.

To assist in achieving these objectives, in September 1997 MSF–H began a project to provide training and support for HIV prevention among IDUs in the Russian Federation [40,41]. MSF–H worked with several national and international organizations to develop appropriate activities, including the Ministry of Health of the Russian Federation, through its Infectious Diseases and Narcology Departments, the Trimbos Institute (the Netherlands Institute on Mental Health and Addiction), UNAIDS and the World Health Organization.

From the assessment carried out by MSF–H in 1995–96, it was determined that a national training programme was required to ensure that Russians working on HIV prevention among IDUs have a combination of skills. These included the skills and capacity to: (a) undertake community outreach, and communicate effectively, with current and former IDUs; (b) undertake rapid assessments to determine the extent and nature of drug use (especially injecting drug use) and associated HIV risk behaviour and infection in their city or region; (c) plan interventions which are effective in reaching IDUs and in

encouraging them to adopt and maintain behaviours which protect against HIV transmission; (d) develop proposals to acquire funds and other resources to develop these plans; and (e) train their colleagues and others in their city or region in the above skills.

In response, an extensive training programme has been developed. At the beginning of the training cycle, all participants are provided with a Russian-language copy of the WHO *Rapid Assessment and Response Guide on Injecting Drug Use (IDU-RAR)* [32,33], the *European Peer Support Manual* [45], a set of training guidelines and selected articles from scientific journals, translated into Russian. The training cycle takes place over a period of 4 months, beginning with a 12-day training programme at Zvenigorod outside Moscow. This is followed by 12 weeks' work by participants in their cities to assemble a rapid assessment team and undertake a rapid assessment (where possible technical support is provided from MSF-H staff and consultants). The training cycle concludes with a 6-day training programme in Zvenigorod to discuss the processes and outcomes of each city's rapid assessment, and to use these results for initial programme planning. The first day of the 6-day return training coincides with the last day of the initial training course for the next wave of participants, to allow new participants to learn from the experiences of the returning group. Four training cycles are scheduled for each year in 1998 and 1999. The principles underpinning the

design and implementation of the training programme are summarized in Table 1.

In order to sustain prevention activities which will emerge from the training programme, MSF-H formed a strategic alliance called the Russian AIDS Prevention Initiative-Drugs (rapid), with the Open Society Institute/The Lindesmith Center (OSI/TLC) of Russia and the United States, and Médecins du Monde (MDM) of France. After completing training, participants are encouraged to develop proposals for funding from The Lindesmith Center for assistance with full programme planning (by Programme Developers from the United States, France, Germany and The Netherlands), and for programme funding through the Open Society Institute-Russia, as well as applying to local and international sources for funding for their programme proposals.

By April 1998, MSF-H had completed the first training cycle with 26 participants from 13 cities, as well as the initial training course for a further 21 participants from eight cities. Participants have included: drug treatment experts; AIDS centre staff; and others, including behavioural scientists. First training cycle participants attended from the following cities: Moscow; Tver; Nizhny Novgorod; Novorossisk; Samara; Kazan; Kaliningrad; Rostov-on-Don; Pskov; Belgorod; Ryazan; Orel; and Bryansk.

While the programme may still be considered in

Table 1. Principles of the MSF-H training programme

-
- The training is one element in an integrated strategy to prevent HIV and other blood-borne infections among IDUs in the Russian Federation
 - Selection of training participants is vital to the success of the project. While some participants are drawn from the staff of AIDS centres, drug treatment centres and other groups working in the Russian health system, others include former drug users, and people working in non-government organizations
 - Where possible, between three and four participants are funded to participate from each city to begin the process of assembling a team to carry out rapid assessments and local networking
 - Emphasis is placed on the use and implementation of the WHO *Rapid assessment and response guide on injecting drug use (IDU-RAR)*, and the value of combining this with outreach intervention approaches. The establishment of contacts via the combination of the rapid assessment and outreach is useful for setting up prevention activities at a later stage
 - The training uses an adult learning approach
 - Site visits, consultations with drug users (where possible), former drug users and other health professionals involved in outreach work and other interventions are important features of the training course
 - Information-sharing is included to allow participants who already have some experience of HIV prevention and support work among drug users to talk about their experiences
 - Where possible (and increasingly with each training course), examples used are drawn from the Russian Federation and countries of Eastern Europe to maximize their relevance to participants' work situations
 - The training course and subsequent work follow the steps of the MSF-H training cycle [46].
-

its early stages, evaluation is ongoing throughout. To date, the evaluation instruments completed by participants indicate that over 95% indicated that they found the training course had: stimulated them to plan an HIV prevention programme targeting drug users; provided them with new information and skills regarding programme planning; and led them to feel capable of developing an HIV prevention programme among drug users in their city or region. In addition, over 90% of participants indicated that the training course had stimulated them to work with rapid assessment; provided them with new information and skills regarding rapid assessment; led them to believe that rapid assessment methods could be useful in their work; and led them to feel capable of undertaking a rapid assessment in their city or region. Finally, 80% of participants agreed that the course had stimulated them to do more outreach work.

At the beginning of the final training workshop, participants and facilitators were given verbal reports of the outcomes of participants' attempts to undertake rapid assessments in their cities. Ten of the 13 cities represented in the course either completed a rapid assessment or almost completed an assessment within the 12 weeks between the initial and return training courses. In addition, most participants had used the WHO *Rapid Assessment and Response Guide on Drug Injecting* creatively, discovering ways to use and triangulate multiple sources of data, including locally available existing data and statistics with the findings from surveys. Some participants used less conventional techniques outlined in the *Guide* such as capture-recapture methods for estimating prevalence, and focus groups and unstructured interviews to gain a deeper understanding of the local determinants of HIV transmission and of possible prevention activities among drug users in their city or region.

At the time of writing, in four cities—Novorissk, Kazan, Pskov, Ryazan—participants have already used the findings from their rapid assessments to begin negotiations with city or *oblast* (district) officials about developing HIV prevention programmes. Some had already begun prevention programmes, such as training IDUs in HIV and hepatitis prevention, resuscitation techniques (to assist in overdoses), vein care and abscess prevention. Participants from all other cities indicated a willingness to develop HIV prevention programme among drug users.

In the final workshop, participants were encouraged to formulate programme plans and budgets, and write draft applications for funding these programmes. By June 1998, seven Letters of Intent (LOIs) had been received by The Lindesmith Center from groups of training participants seeking funding for specific programmes to prevent HIV transmission in their cities. Four LOIs were immediately accepted and assigned to Programme Developers (in the cities of Kazan, Pskov, Novorissk and Belgorod), while other LOIs are currently under consideration. All participants will be contacted by the training programme staff before the end of 1998 to discover whether programmes are implemented as a result of these or other processes.

Conclusions

The continued rapid spread of HIV infection among IDUs emphasizes the need for developing methods of rapid assessment and response. In the past 2-3 years, the rapid spread of HIV associated with injecting drug use has occurred in the Ukraine, Belarus and the Russian Federation, and conditions are such that there is potential for rapid HIV spread among IDUs in Moldova. Recent evidence suggests similar rapid spread in Kazakhstan [5,36]. While there exists over a decade of international experience in developing assessment and intervention methods to monitor and describe the diffusion of HIV associated with drug injecting and to reduce, reverse or prevent HIV epidemics among IDUs [9,10,47], there remains a need to build on this expertise to develop public health technologies and responses to reduce drug-related harm which are *rapid, pragmatic* and *cost-effective* [12,13].

Available evidence on HIV transmission among IDUs in Eastern Europe highlights the pragmatic and cost-effective benefits of early intervention. Not only is there an urgent need to develop rapid assessment and responses in countries where HIV infection is already apparent, such as the Ukraine, Belarus, Moldova, Kazakhstan and the Russian Federation, it is also necessary to consider the use of rapid assessment and response methods to introduce or strengthen HIV prevention strategies in cities and countries where new epidemics of HIV have not occurred as yet [12]. Rapid assessment and response methods may not only provide the technology for rapidly responding in the light of new evidence, but they also provide the technology for monitoring

situations by providing ongoing rapid indicators of public health problems where existing data collection systems are limited.

We have outlined the rationale underpinning rapid assessment and response methods and, in particular, the development of the WHO and UNAIDS *Rapid Assessment and Response Guides on Injecting Drug Use and Sexual Behaviour Associated With Substance Use* [32,33]. These *Guides* have been piloted in a number of developing and transitional country settings, and it is planned to systematically field-test and evaluate their implementation in at least a further 15 countries. However, the preliminary indications are that these *Guides* provide the public health tools necessary for undertaking rapid assessments and for developing appropriate public health interventions at the local level [13].

We have described here how rapid assessment and response methods have been used in the context of a national HIV prevention training intervention in the Russian Federation. This, we believe, gives a preliminary indication of the utility of rapid assessment and response methods as both a training and intervention development tool. The experiences gained from the MSF-H training have highlighted how rapid assessments can lead to the development of HIV prevention programmes at the city or regional level. In a situation where the immediate development of HIV prevention initiatives faces an array of obstacles, the RAR has been found to offer tasks and techniques which can be carried out immediately so as to begin working towards programme development. RAR has been found to be a politically useful tool in demonstrating the need for prevention interventions among IDUs, and in assisting with negotiations towards intervention developments at the local level. In addition, in a context where existing data collection systems are often limited, the rapid assessments undertaken by participants have been found to be useful in gathering basic indicators on the extent and nature of the drug use situation, and may operate as pilot studies for planning future epidemiological and behavioural studies.

The precise content and focus of the training programme will continue to be developed in the light of evaluation and feedback from participants. To date, we have found the training to be useful in assisting participants of Russian government and non-government organizations to strengthen their expertise in the skills and methods of rapid assessment, HIV prevention and intervention develop-

ment. We have also discovered that practical outcomes from the training, and in particular the implementation of rapid assessments, are most likely when one or more participants from a city has expertise in both drug treatment (or 'narcology') and HIV or infectious disease prevention. This has led us to include three or more participants from each city who have a combination of experiences in narcology, HIV/AIDS treatment or prevention, and non-governmental organizations. We also recognize the importance of involving participants from both government and non-governmental organizations in the training, as well as other community members in rapid assessment and response developments. The emphasis of the RAR approach on integrating assessment and response as part of community participatory initiatives at a number of levels is welcomed.

In summary, we believe that the rapid emergence of adverse health consequences associated with drug injecting demands a rapid public health response. The development of 'rapid assessment and response' methods may provide the means for rapidly initiating pragmatic and cost-effective HIV prevention among IDUs. The combination of rapid assessment and response methods, with the type of training provided by the MSF-H programme, within a strategic framework which also includes technical assistance and funding, appears to be an effective approach to assisting countries in Eastern Europe to respond to HIV among IDUs. The approach may also have application in other parts of Central and Eastern Europe, as well as other areas of the world.

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