

H N P D I S C U S S I O N P A P E R

A Best Practice Model of Harm Reduction in the Community and in Prisons in Russian Federation

Dave Burrows

April 2001



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COMMUNITY AND IN PRISONS IN RUSSIAN FEDERATION**

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Health, Nutrition and Population (HNP) Discussion Paper

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Health, Nutrition and Population (HNP) Discussion Paper

A Best Practice Model of Harm Reduction in the Community and in Prisons in Russian Federation

Dave Burrows^a

^aDirector, 3 Palms Consulting, Marrickville, Australia

This report was prepared to assist the World Bank and the government of the Russian Federation (RF) to define best practice in HIV prevention among injecting drug users in RF, and to recommend measures to be included in a proposed HIV/AIDS loan (or in activities directly funded by the government of the Russian Federation) that would lead towards best practice.

Abstract: A Best Practice Model of Harm Reduction in the community and in prisons in Russian Federation. Final Project Report is the result of a study commissioned by the World Bank in 2001 to examine best practice harm reduction for HIV prevention among injecting drug users (IDUs) in community and prison settings in the Russian Federation. The report is based on 26 surveys completed by needle and syringe exchange projects (NSEPs) in the Russian Federation, interviews with NSEP staff and key informants, and other research.

Results:

By early 2001, there were at least 48 NSEPs in RF. Key features of these NSEPs included:

- NSEPs surveyed were all funded, with an average funding of US\$28,000 per program.
- The average number of needles and syringes distributed in the previous month was 6258 per program.
- The mean regular reach (IDUs contacted in previous month as a percentage of the estimated number of IDUs in the area served by the NSEP) of the NSEPs was 0.74%.
- Main strengths of programs were considered to be: support from local authorities and institutions; caring attitude and pragmatic approach of NSEPs; international technical support and funding and peer education.
- Weaknesses cited included: insufficient funds to meet needs; low reach; management problems; patchy quality of services.

By early 2001, there were at least 6 prison harm reduction projects in RF. Key features of these programs included:

- Commitment at the highest levels.
- Training for senior prison authorities, middle management in prisons, custodial staff, medical staff and the prisoners themselves.
- Educational materials tailored to the needs of staff and prisoners, provision of peer education programs, and linkage between prisons and community programs.

This paper summarizes results of the research and provides recommendations for best practice for harm reduction in .

Keywords: HIV/AIDS; drug use; policy; program planning; prisons.

Disclaimer: The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

Correspondence Details: Dave Burrows, 3 Palms Consulting, 22 Francis St, Marrickville NSW 2204, Australia; Tel: (612) 9558-9396; Fax: (612) 9559-2964; Email: dbsyd@aol.com

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FOREWORD

As the AIDS epidemic entered its third decade, it had overtaken the bubonic plague as the biggest killer due to an infectious illness in history. By December 2002, there were 42 million people infected worldwide, and UNAIDS predicted that an additional 45 million would become infected by 2010, unless prevention efforts were strengthened and expanded.

Eastern Europe and Central Asia have the world's fastest-growing HIV/AIDS epidemic. In 2002, there were an estimated 250 000 new infections, bringing to 1.2 million the number of people living with HIV/AIDS. The Russian Federation and Ukraine remain at the forefront of the HIV/AIDS epidemic in ECA, but many other countries are now experiencing rapidly emerging epidemics. In recent years, the Russian Federation has experienced an exceptionally steep rise in reported HIV infections. In less than eight years, HIV/AIDS epidemics have been discovered in more than 30 cities and 86 of the country's 89 regions. Up to 90 percent of the registered infections have been attributed officially to injecting drug use, reflecting the fact that young people face high risks of HIV infection as occasional or regular drug injectors.

As shown around the world, one of the best ways to reduce the transmission of the epidemic is through harm reduction preventive programs that provide information about HIV/AIDS transmission, new sterile needles and syringes in exchange for used ones, and help minimize needle exchange sharing.

This paper by Dave Burrows was prepared as part of the preparation of the Russia Tuberculosis and AIDS Project approved in March 2003. The paper presents: (i) an overview of international best practice in harm reduction; (ii) the findings derived from a survey of harm reduction programs in Russia; (iii) best practice from these programs, including presentation of the Kazan model; (iv) findings from harm reduction programs in prisons; (v) a discussion on the level, breadth, effectiveness, reach and quality of services; and (vi) recommendations for the scaling up and improvement of existing programs.

Alexander S. Preker

Chief Economist, Health, Nutrition, and Population
World Bank

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EXECUTIVE SUMMARY

Background

- International and local groups have made a substantial, sustained attempt to increase the capacity of Russian Federation (RF) organisations to implement harm reduction programs for HIV prevention among injecting drug users (IDUs) since 1996.
- The RF HIV/TB Prevention Project, funded by World Bank loan, contains specific funding processes for increasing harm reduction activities.
- This report is based on 26 surveys returned by Needle and Syringe Exchange Programs (NSEPs) in RF, and interviews with NSEP staff and key informants, and other research.

International Best Practice in Harm Reduction

For community programs:

- At least 60% of IDUs in a city should be regularly reached with injecting equipment and appropriate education and information from NSEPs.
- Those IDUs at highest risk (especially women IDU/ sex workers) should be reached with sterile injecting equipment and information.
- Funding and operations should be continuous (no breaks or shutdowns).
- Programs should be located close to large numbers of IDUs.
- Outreach needed to access social networks, attract IDUs, deliver services.
- Peer education should be used to broaden the influence of NSEP to assist in reaching the maximum number of IDUs and change social norms.
- Peer support is used to involve active IDUs directly in the NSEP to more quickly change social norms around safer injecting and safe sex.
- NSEPs need to be linked with medical, other health and social services.
- NSEPs need to be embedded in the community, free to operate without harassment.

For prisons programs:

- Prisoners and prison staff need to be informed about HIV/AIDS and about ways to prevent HIV transmission, especially on likely risks of transmission within prison, and on the needs of prisoners after release.
- Information intended for the general public (through posters, leaflets and the mass media) should also be available to prisoners.
- Information should be made available in language and form that prisoners understand, and presented in an attractive and clear format.
- Harm reduction programs – such as NSEP and substitution therapy – available to IDUs outside the prisons should be available inside prisons.
- Peer education programs are needed – from prisoner to prisoner.
- Condoms and disinfectant need to be distributed to prisoners.
- Specific programs should be implemented for women prisoners.

Findings

- By early 2001, there were at least 48 needle and syringe exchange programs (NSEPs) in RF. Key features of these NSEPs included:
- Most have at least 1 fixed-site needle exchange and carry out outreach, and about one-third operate mobile services.
- Most are very young: 88% of respondents operating for less than 2 years.
- NSEPs surveyed were all funded: mean funding was \$27,982 /program.

- Of total NSEP funding in 2000, 70% was from international donors and 30% was from local funding sources.
- Staff at responding programs averaged 23 per program, of whom 34% are doctors; 20% are ex-IDUs; 15% are active IDUs; 8% are students; 15% are psychologists or otherwise qualified; 8% have other backgrounds.
- Responding NSEPs appear to be providing comprehensive services.
- Mean needles and syringes distributed in the previous month was 6258 per program. Secondary exchange (assisting or allowing IDUs to take needles and syringes to distribute to their friends or social contacts) accounted for 25% of all distribution.
- The number of clients seen by NSEPs in the previous month ranged from 10 to 760, with a mean of 148.
- Average level of primary exchange was 31 needles and syringes in 1 month or 372 in 1 year per NSEP client.
- The mean percentage of IDUs regularly reached by each NSEP is 0.74%.
- Main strengths of programs were regarded as support from local authorities and institutions; caring attitude and pragmatic approach of NSEPs; international technical support and funding; increasing use of secondary exchange and peer education.
- Weaknesses cited include: insufficient funds to meet needs; low reach; management problems; patchy quality of services.
- By early 2001, there were at least 6 prison harm reduction projects in RF. Key features of these programs included
 - Commitment at the highest levels.
 - Training for senior prison authorities, middle management in prisons, custodial staff, medical staff and the prisoners themselves.
 - Educational materials tailored to the needs of staff and prisoners.
 - Provision of peer education programs.
 - Linkage between prisons and community programs.
 - Links to international consultants and organisations.

Best Practice Harm Reduction in RF

For community programs, Kazan Model is an example. Its key features include:

- Effective distribution of a range of injecting equipment and educational resources suitable for the target population through two fixed sites, a mobile and outreach service (all of which are very friendly towards IDUs).
- Ratio of staff costs to cost of harm reduction and educational materials is more appropriate than many other services.
- Regular peer education training among IDUs and increasing reliance on peer support through involvement of active IDUs in a structured, constantly expanding system of secondary exchange.
- Maximum effectiveness of outreach staff through regular training and re-training; efficient use of outreach time and energy through close supervision, setting of daily and weekly goals, categorisation of tasks related to various stages of work with secondary exchangers, and use of standardised monitoring forms.
- Active referral of IDUs to other agencies to meet health and other needs.
- Use of feedback loop/ quality assurance to ensure NSEP activities match IDUs' needs and to change activities based on constant monitoring.
- Successful ongoing advocacy with key institutions.

For prisons programs, both the MSF-H and Nizhny Novgorod programs are examples. Their key features include:

- Commitment at the highest levels
- Training is vital: The five-tier training system provided by MSF-H involves workshops with senior prison authorities, middle management in prisons, custodial staff, medical staff and the prisoners themselves.
- Educational materials are tailored to the needs of each tier: involvement of prisoners or ex-prisoners and IDUs or ex-IDUs in developing specific literature for prisoners is vital, as is translation of key scientific and other documents into Russian.
- Provision of peer education programs: This can only take place effectively when all of the above steps have been carried out.
- Distribution of condoms and disinfectant.
- Linkage between prisons and community programs: Through quarterly regional round-tables, oblast multi-sectoral AIDS committees and developing good relationships with media.
- The role of international consultants and organisations has been extremely important to the development of the program.

Key recommendations include that:

Government of Russian Federation

- Address the two most important obstacles to expanding harm reduction as an emergency response to the HIV crisis in RF by amending relevant laws (recommended changes are outlined in Recommendation 1.1); and by ensuring that the Federal Ministry for Internal Affairs issues an unequivocal statement supporting harm reduction and introduces policies to demonstrate this support.
- Through the Implementation Group for HIV/TB Project, select at least the 34 territories where NSEPs already exist for the first year of the Project.
- Establish a National HIV/AIDS Committee at the highest level to oversee and co-ordinate harm reduction and all other activities related to HIV prevention, treatment, care and support.
- Ensure that the five-year National AIDS Plan is fully funded at the Federal level and harm reduction programs are prominent.
- Adjust Federal funding for Prisons Department of RF Ministry of Justice (GUIN) to assist oblasts to carry out HIV prevention work in detention facilities.
- Establish clearly defined goals for harm reduction in RF, and develop standardised monitoring and evaluation procedures to assess progress.
- Persuade/ assist territories at epicentres of the epidemic (Moscow City, Moscow and Irkutsk Oblasts) to urgently establish large-scale NSEPs.
- Ensure that all procurement steps (excluding the signing of contracts) are completed for the tendering process for the following goods:
 - Needles and syringes
 - Condoms
 - Sterile water
 - Alcohol swabs
 - Disinfectant (including sachets or bottles)

(Ways to determine numbers/ types of items detailed in Recommendation 3.1)

- Ensure all tendering steps (excluding signing of contract) are completed for implementation of the best practice prisons harm reduction program referred to in Section 6 for four oblasts beginning in Year 1 of the HIV/TB Prevention Project and a further three oblasts in Year 2.
- Ensure all steps for selection of oblasts are carried out for Year 1.

- Ensure the rapid completion of the Technical Assistance Operational Manual, and undertake widespread distribution of details of the Technical Assistance Program (TAP) and all steps of selecting initial funds recipients.
- Assist Dr Badrieva and her colleagues at Renewal NSEP in Kazan to write up (in Russian) the Kazan Model in great detail, and assist them to develop a training program based on this Model to be provided through the training programs funded through the HIV/TB Prevention Project.
- Ensure all tendering steps (excluding signing of contract) are completed for design, development and production, printing and distribution of educational materials for IDUs.
- If possible, complete all tendering steps (excluding signing of contract) for training on rapid assessment and response and interventions.
- If possible, complete all tendering steps (excluding signing of contract) for training programs to address the training topics detailed in Recommendations 5.8 and 5.9.

By end Year 1 of HIV/TB Prevention Project

- Sign the above contracts and begin disbursement of funds.
- Award contracts under Technical Assistance Program (by month 4).
- Ensure all tendering steps (including signing of contract) are completed for design, development and production, printing and distribution of training manuals on rapid assessment and response methods and harm reduction interventions; advocacy materials for harm reduction to local authorities; guide to starting and managing NSEPs.
- Ensure all tendering steps (excluding signing of contract) are completed for design, development and production, printing and distribution of educational materials for prisoners; training manuals on health promotion in prisons, HIV/AIDS counselling, care and support of prisoners with HIV/AIDS and training prison peer educators.

Oblast and Territory Governments

- Advocate at the Federal level for inclusion in the oblasts selected for Year 1 activities in the HIV/TB Project.
- Advocate for the Government of the RF to carry out the tasks above.
- Ensure that at least one large, user-friendly NSEP with multiple services (outreach, fixed-site and, where possible, mobile) is established in each territory to assist in starting other NSEPs, expanding distribution through other outlets, training staff, monitoring and evaluation, etc.
- Establish HIV/AIDS and drug use co-ordinating committees at oblast, city and rayon level.
- (Where possible) Provide oblast funding for harm reduction programs.
- (With NSEPs) Expand distribution of harm reduction materials to all rayons of the oblast.
- (With NSEPs) ensure integration of harm reduction programs with other HIV and drugs services (whether in government services or NGOs).
- (With prison programs) Expand prison harm reduction programs to ensure prisoners are reached in all detention facilities of the oblast.
- (Without NSEPs/prison programs) Advocate for inclusion in training and funding programs for NSEPs/ prison programs; reduce or eliminate obstacles to introduction of harm reduction programs; ensure co-operation between key institutions and NGOs; seek training for key staff and visits to oblasts with NSEPs/ prison programs.

Current NSEPs

- Undertake planning as quickly as possible to scale up current operations to distribute at least 5 times as many needles and syringes in 2002 as were distributed by each program in the past 12 months.
- Advocate at the oblast level for inclusion in the oblasts selected for Year 1 activities in the HIV/TB Project.
- Become familiar with the Technical Assistance Operational Manual of the HIV/TB Project, when it becomes available; attend briefings on the Technical Assistance Program; and submit proposals (when appropriate).
- Become familiar with the Kazan Model and other models of peer education and peer support such as that used by the Moscow outreach team and the Kolodets (Moscow) model of drug user organising. Begin implementing these models (in ways that suit local conditions).
- Undertake surveys and focus groups of NSEP clients to ensure quality of services (as detailed in Recommendation 5.5).
- As increased funding becomes available, ensure that condom, needle and syringe distribution is maximised especially to groups at highest risk of HIV infection, and across social networks, and increase distribution of sterile water, alcohol swabs and disinfectant.
- Before the HIV/TB Project begins, seek expansion of oblast funds and in-kind support to assist in expanding NSEP to all rayons of the oblast.
- Ensure that Program Managers and Co-ordinators are trained in the following topics:
- General and project management with emphasis on personnel management and structural methods to achieve a more democratic workplace; developing clear policies and procedures; managing change and expansion of services; delegation of authority; strategic and work planning; incentive and motivation techniques for managing volunteers; training staff and volunteers; establishment and maintenance of quality assurance processes; managing active and ex-IDUs; training and supervision of outreach workers (Kazan Model and international models); advocacy and working with police, administration officials, politicians, media and the community.
- Social aspects of drug use and changing group norms including designing, monitoring and adjusting peer education and peer support programs (Kazan Model and other Russian and international models); working on drug treatment and harm reduction as separate but linked issues; maintaining focus on harm reduction while establishing links with other services; care and support of HIV positive IDUs; and sensitisation to drugs and minority (especially Roma) issues.
- Ongoing situation assessment and intervention; sentinel surveillance monitoring; and program monitoring and evaluation.
- Ensure that NSEP workers, outreach workers and, increasingly, volunteers, receive training in the following topics:
- Basic HIV/AIDS and drug use information; educational messages; burnout and relapse prevention; and first aid: these training sessions need to be delivered as locally as possible several times each year to address high staff and volunteer turnover.
- Working with specific target groups: women IDUs who are also sex workers, IDUs of particular ethnicities (especially Roma), drug users in prisons and the military, street youth, gay and lesbian IDUs.
- Social aspects of drug use and changing group norms including follow-up training on peer education, peer support and secondary exchange and collection of clean injection equipment; and care and support of HIV positive IDUs.
- Distribution of disinfectant (bleach) and instructions on correct methods of disinfecting needles and syringes.

- Advocate at city and oblast level for expansion of distribution outlets for injecting equipment and HIV prevention educational materials.
- Advocate for greater acceptance for IDUs, people living with HIV/AIDS.
- Increase links between harm reduction and STI services; increase links with prisons programs.

Current Prison Programs

- Continue implementation in the 6 oblasts where programs are currently being implemented, expanding to cover all detention facilities in these oblasts as quickly as possible.
- Advocate for targeted education programs and other harm reduction programs to be allocated funds from oblast budgets.
- Work with community harm reduction programs to ensure consistency of educational messages on both sides of the prison gate.
- Continue to focus on both the prevention of HIV among prisoners and care and support of HIV positive prisoners.

Potential NSEPs and prisons programs

- Advocate at the oblast level for inclusion in the oblasts selected for Year 1 activities in the HIV/TB Project.
- Become familiar with the Technical Assistance Operational Manual of the HIV/TB Project, when it becomes available; attend briefings on the Technical Assistance Program; and submit proposals (when appropriate).
- (If already trained and ready to implement a program) Seek assistance from national and international organizations and current NSEPs to plan establishment, initial resource and budget requirements, and carry out initial advocacy for harm reduction programs.
- (If not yet trained) Seek training in Rapid Assessment and Response and Intervention Design.
- Seek funding at oblast and city level.

UNAIDS and members of UN Theme Group on AIDS

- Encourage the Government of RF to urgently carry out the above tasks.
- Advocate for additional funding from international sources to address the current HIV/AIDS crisis (especially for harm reduction programs), while the HIV/TB Prevention Project and other processes gradually build long-term capacity to deal with drugs and HIV/AIDS issues.
- Assist national and international NGOs to carry out the expansion of assistance programs below.

National and international NGOs

- Encourage the Government of RF to urgently carry out the above tasks.
- (Current donors of NSEPs) Continue to fund harm reduction programs for at least Years 1 and 2 of the HIV/TB Prevention Project to ensure continuity of services.
- (Current donors of NSEPs) Continue to fund government staff (where appropriate) in current NSEPs.
- (Current donors of NSEPs) As funding increases for goods (needles and syringes etc) under the HIV/TB Prevention Project, divert other international funding to staff costs, especially to increase outreach staff (where this is not covered by the Technical Assistance Program of the Project), and to training, establishment and government salary

- costs for starting new programs, especially in the 55 oblasts without any NSEPs.
- Where possible, expand networking, translation, training, technical assistance, development and distribution of educational and advocacy materials to meet the needs of current and potential community and prisons harm reduction programs throughout RF.
 - Continue and expand pilot projects of low-threshold drug treatment (such as the Yaroslavl program) and, when legal restrictions are lifted, trials of substitution therapy programs, including where possible both methadone and buprenorphine. Consider assisting pilot programs of needle exchange in prisons and care and support of HIV-positive IDUs, both in the community and in prisons.

I. INTRODUCTION

1.1 BACKGROUND

The Government of the Russian Federation (RF) has requested a loan from the World Bank which would, among many other activities, provide increased funding for harm reduction programs to prevent the spread of HIV among injecting drug users (IDUs). As part of the preparations for the loan, a study was commissioned of past and current harm reduction activities in the RF, both in the community and in prison settings.

These events have occurred in the context of a substantial and sustained attempt to increase the capacity of RF organisations to prevent HIV transmission among IDUs (Burrows and Weber 2001). These activities began in 1996 with needle and syringe exchange programs starting in Moscow and Yaroslavl, funded by International Harm Reduction Development (IHRD) of Open Society Institute (OSI) - as Russian projects are all exchange projects, the acronym NSEP is used in this paper for Needle and Syringe Exchange Programs. The Moscow NSEP was short-lived, as were locally funded efforts in Penza and Chuvasha in 1997. But, also in that year, the first mobile NSEP began operating in St Petersburg, funded by Médecins du Monde (MDM).

During 1997, other significant events included the opening of an Outreach program to IDUs on the streets of Moscow, funded by (MSF-H), the design of a training program on harm reduction also by MSF-H, the formation of Russia AIDS Prevention Initiative – Drugs (RAPID) with the involvement of IHRD, MSF, MDM, Open Society Institute – Russia (OSI-R), Interactive Drogenhilfe and the University of Connecticut. Also in 1997, the Russian Ministry of Health approved its AIDS Plan 1997-2000 without any activities directed towards harm reduction among IDUs as this group was not yet seen by the government as a major priority for HIV prevention efforts.

In 1998, the MSF-H Harm Reduction Training Program trained 89 individuals (from AIDS Centres, narcology centres and NGOs) from 32 cities in World Health Organisation Rapid Assessment and Response methods and designing harm reduction interventions. From the training, 29 rapid situation assessments of drug use and HIV infection were carried out. In Sverdlovsk oblast, a program began to start NSEPs, funded by the Department for International Development, UK. UNAIDS began a strategic planning process including harm reduction, and the Ministry of Health issued an order to all AIDS Centres that HIV prevention among IDUs was now a high priority.

By 1999, the HIV epidemic among IDUs in RF became the fastest-expanding HIV epidemic in the world. By the end of that year, 27 NSEPs were operating across RF (funded mostly by OSI-R), and a further 110 individuals from 29 cities were trained by the MSF-H program, resulting in a further 33 rapid situation assessments. Information, education and communication materials were developed with and for IDUs in Balakovo in the south of RF, funded by Population Services International. Harm reduction became part of the post-graduate training for narcologists at the Moscow Medical Academy, the Ministry of Health became publicly supportive of harm reduction in general and NSEPs in particular (for example, in interviews with the mass media), and the Ministry issued an order to all Ministerial bodies (at national, oblast and local level) to ensure the implementation of harm reduction programs as quickly as possible. Also in 1999, negotiations began for the HIV/TB project described below.

In 2000, MSF-H began a new program to provide ongoing technical assistance (through regular training and publications and Internet-based communications) for all NSEPs. International interest in the RF epidemic also increased as the UNAIDS Task Force for HIV Prevention among IDUs in Central and Eastern Europe set a target of 60% coverage for harm reduction programs in RF and other countries of the former Soviet Union, and there were special sessions and a one-day seminar dedicated to harm reduction in RF at the 11th International Conference on the Reduction of Drug-Related Harm in Jersey.

Also in late 2000 and early 2001, the RF Ministry of Health is finalising a five-year National Program on HIV/AIDS Control, which includes the development and financing of harm reduction programs (Goliusov 2001). By March 2001, 48 NSEPs (see Tables 2.1 and 2.2) were operating in RF (still funded mostly by OSI-R, but at least eight having substantial oblast or city funding), and eight of these NSEPs were also recently funded to provide additional harm reduction services to sex workers, and one was recently funded to provide harm reduction services to prisoners (all funded by IHRD).

Another important aspect of the context in which this report is written is the legal situation regarding drugs and harm reduction in RF. In January 1998, the Federal Law on Narcotic Drugs was signed by President Yeltsin. Illicit drug use had previously been in a legal limbo, although possession, supply, manufacture, traffic, and import were all offences. This law contains specific clauses outlawing the promotion of illicit drug use that NSEP managers feared could be used to close down harm reduction programs that encourage safer injection and to jail their staff. The law also prohibits methadone treatment and other forms of substitution therapy, and states that no non-governmental or private organization can carry out drug treatment that involves the prescribing of any drugs. In short, it places illicit drug use squarely within the purview of Internal Affairs (IA) and delineates only a small role for health agencies in working with drug users (Burrows et al 1999a).

Although OSI-R commissioned a review of all laws pertaining to harm reduction in RF (Poloubinskaya 1999), which showed that NSEPs were legally able to operate, their legality has not been confirmed by the Ministry of Internal Affairs of RF (at the time of writing). Despite the lack of confirmation, each NSEP has managed to come to an agreement with their local IA officials to allow the exchange to proceed. To support these efforts, a joint publication by MSF-H and OSI-R in Russian and English was developed in 2000 to explain the need for harm reduction programs and the role of police and Internal Affairs in helping to prevent HIV infection among IDUs (Burrows 2000a). This publication has been distributed to IA officers and departments throughout RF.

The HIV situation in RF in February 2001 was that 89,000 people had been officially registered as HIV-positive. WHO and UNAIDS believe this is an underestimate by 5-10 times: they estimate that the real number of HIV-positive people in RF is between 450,000 and 900,000 so that a HIV crisis is now occurring in RF. Around 90% of all infections are among IDUs.

Table 2.1. NSEPs in RF – March 2001

Region (number of cities with NSEPs)	Cities
Federal republic:	
Buryatia (1)	Ulan-Ude
Kalmykia (1)	Elista
Mordovia (1)	Saransk
Tatarstan (7)	Kazan, Bugulma, Almet'evsk, Zelenodolsk, Chisptopol, Naberezhnye Chelny, Nizhnekamsk
KRAY:	
Altai (2)	Biisk, Barnaul
Khabarovsk (1)	Khabarovsk
Krasnodar (2)	Novorossiysk, Sochi
Krasnoyarsk (1)	Krasnoyarsk
Primorski (1)	Vladivostok
Stavropol (1)	Stavropol
Oblast:	
Arkhangelsk (1)	Arkhangelsk
Astrakhan (1)	Astrakhan
Belgorod (1)	Belgorod
Kaliningrad (1)	Kaliningrad
Kemerovo (1)	Kemerovo
Lipetsk (1)	Lipetsk
Nizhny Novgorod (2)	Nizhny Novgorod, Bor
Novosibirsk (1)	Novosibirsk
Omsk (1)	Omsk
Penza (1)	Penza
Perm (1)	Perm
Pskov (1)	Pskov
Rostov-on-Don (1)	Rostov-on-Don
Sakhalin (1)	Yuzhno-Sakhalinsk
Samara (2)	Samara, Toliatti
Saratov (2)	Balakovo, Engels
Sverdlovsk (3)	Ekaterinburg, Pervouralsk, Verkhnyaya Salda
Tver (1)	Tver
Volgograd (1)	Volgograd
Vologda (1)	Vologda
Voronezh (1)	Voronezh
Yaroslavl (1)	Yaroslavl
<i>Federal city:</i>	
Saint Petersburg (3)	Saint Petersburg (2), Kolpino
Moscow (1)	

Contact details and other relevant information on each NSEP in RF is provided in Appendix 3.

Table 2.2. Sex work and prisons programs attached to NSEPs
Commercial Sex Workers Projects

Region	City
Saratov	Balakovo
Tatarstan	Kazan
Krasnoyarsk	Krasnoyarsk
Krasnodar	Novorossiysk
Penza	Penza
Sverdlovsk	Pervouralsk
Saint-Petersburg	Saint-Petersburg
Volgograd	Volgograd

Prison Project

Region	City
Pskov	Pskov

1.2 METHODS

The Terms of Reference for the development of this report required a harm reduction specialist to:

- Work with NGOs and Government officials to identify past, ongoing and proposed targeted HIV prevention projects for IDUs in RF
- Summarise key details of such projects, including but not limited to: source of funding, project duration, key interventions, strengths and weaknesses of the projects, etc. Identification of such projects to be undertaken for both the civilian and the prison populations.
- Based on such identification, evaluate the Russian experience with targeted HIV prevention projects for injecting drug users. Identify "lessons learned" and constraints with respect to the delivery of harm reduction services in the Russian context.
- Identify and evaluate differences required in the design and implementation of harm reduction projects in prisons, as compared to the civilian population. Develop a "best practice" model of HIV prevention among IDUs in RF (in both civilian and prison populations).
- Based on the best practices identified above, design two pilot harm reduction projects for one oblast in the Russian Federation: one for the civilian population and one for the prison population. Such design should include, but is not limited to: defining harm reduction objectives for the pilot programs, identification of key interventions of pilot program staff, identification of resource and training needs and gaps (including procurement needs for syringes, condoms, bleach, etc.); identification of appropriate mechanisms for the identification and inclusion of injecting drug users in the projects, and definition of mechanisms to monitor and measure project performance in meeting the harm reduction objectives.

From December 2000 until March 2001, three activities were undertaken to provide information on the above issues. The first was a key informant survey in person (in Moscow) and by email: this survey asked open-ended questions of 19 people who have worked on harm reduction in RF with more than one program, providing training and technical and/or other assistance, seeking

their views on the strengths and weaknesses of current programs and what elements are most needed for best practice in harm reduction in RF. Of these, 13 responded.

Secondly, a 38-question survey was translated into Russian and sent to the 42 community NSEPs across RF known at that time by OSI-R and the MSF-H Harm Reduction Infocenter (in the course of the study, a further six NSEPs were found). Of these 42 programs, 26 responded.

Third, responses from key informants and programs were summarised in English, and formed the major information source for a discussion paper. Because prison projects are still in a very early stage of development, key informant interviews and document searches were the only sources of data for the prisons sections of the discussion paper.

Feedback was sought on the discussion paper: it was provided in Russian or English both to the key informants mentioned above as well as all NSEPs in RF who are funded by OSI-R. It was also provided to representatives of the Ministry of Health of RF, Russian Healthcare Foundation, World Bank (both in head office and Moscow), UNAIDS, international NGOs, and as many other NSEPs (funded from sources other than OSI-R) as could be found.

As part of the feedback process, the consultant visited Moscow, Kazan and Nizhny Novgorod for further interviews and to view community NSEPs. During other work in the past 12 months, the consultant has also visited NSEPs in Pskov and Togliatti. Notes from these visits and interviews, as well as further research on international best practice in harm reduction, were combined with the information in the discussion paper to develop this final report.

II. INTERNATIONAL BEST PRACTICE IN HARM REDUCTION

2.1 COMMUNITY HARM REDUCTION PROGRAMS

Harm reduction

Harm reduction is one of the three complementary approaches to addressing drug issues, the others being supply reduction and demand reduction (Costigan et al 2000). Supply reduction includes seizing drugs through customs operations and assisting drug producers to stop growing, for example, opium poppies and substitute these with other, legal, crops. It also includes arresting drug traffickers and breaking up supply routes for illicit drugs. Demand reduction is a complex of measures, usually provided by social, education and medical services, to promote a healthy lifestyle free from drugs, and to assist drug users to stop using and achieve medical and social rehabilitation.

Harm reduction policies, strategies and activities aim to limit or reduce the nature and extent of adverse consequences of drug use, including:

- health: including HIV and other communicable disease transmission
- social: including social effects of (usually) young IDUs dying of AIDS
- economic: including costs of treating people with HIV/AIDS,
- legal: including detection, arrest and imprisonment of IDUs.

The harm reduction approach is based on a realistic acknowledgement that there are no known interventions for completely eliminating drug use or drug related problems in any city, community or country (Burrows et al 1998).

The principles of harm reduction work with IDUs include:

- Avoidance of increasing harm: for example, a law enforcement only-approach to illicit drug use may slightly decrease illicit drug use but increases the likelihood of HIV epidemics among IDUs
- Emphasis on short-term pragmatic goals (such as preventing HIV transmission in a specific circumstance) over long-term idealistic goals (such as overall reduction in drug use)
- Emphasis on the dignity and human rights of all members of a society, including drug users
- Establishment of a scale of means to achieving specific goals: eg a hierarchy of risks which states that the best method of avoiding HIV infection via drug use is to never start to use drugs or stop using drugs; the second best is to use drugs by any method other than injecting; if injecting, use a new needle and syringe for each injection; if a new needle and syringe cannot be acquired, use your own syringe and needle; and so on: this hierarchy is used to provide small, achievable steps which can be encouraged by harm reduction programs
- Use of multiple strategies to achieve goals
- Involvement of drug users in the planning and implementation of programs designed to address drug use and HIV/AIDS among drug users (Drucker and Clear 1999; Lenton and Single 1998; Burrows et al 1998).

The main type of harm reduction program used in the Russian Federation is needle and syringe exchange, together with counseling, outreach, peer education and support, and other activities connected with needle exchange. While there are many activities which can be used for HIV prevention among IDUs, NSEP is an essential component of effective prevention and will be the main focus of this section of the paper.

Needle exchange and distribution

The riskiest activity for HIV infection during injection is frequent sharing of injecting equipment with strangers (Ball 1998). Needle exchange or distribution prevents or reduces this practice. There are now 134 countries worldwide reporting the practice of injecting drugs for recreational or non-medical purposes. Of these countries, 114 have reported HIV infection among IDUs, with 46 countries implementing at least one needle and syringe provision or needle and syringe exchange program (Strathdee et al 2001).

Needle and syringe exchange programs (NSEPs) have been studied in many different countries and in great detail due to the controversy surrounding their introduction. US government reports (quoted in Lurie et al 1996) have found that, following the introduction of needle exchange to a city or country, there is:

- No increase in the number of drug injectors
- No increase in drug use.

No reports have contradicted these findings. An evaluation of Australian needle and syringe exchange programs found that these programs had saved an estimated 3000 lives in a single year at a cost of about US\$200 per life saved (Feacham 1995). The savings in HIV treatment costs were estimated to be about US\$150 million.

NSEPs have proven highly effective in preventing HIV transmission among IDUs (Lurie et al 1996; Lindesmith Centre 1997). A worldwide survey (Hurley et al 1997) found that in:

Cities **with** needle exchange: HIV seroprevalence among IDUs
reduced by 5.8% per year

Cities **without** needle exchange: HIV seroprevalence among IDUs
increased by 5.9% per year

Specific effectiveness studies have mainly been conducted in the USA, and have concentrated on the effects of NSEPs on both risk behaviours for HIV infection (especially the sharing of needles and syringes) and the effects of NSEPs on HIV incidence and prevalence. Among the first group of studies, findings include:

- Frequent use of a NSEP is associated with reduced needle sharing in studies from California, Maryland and NY: the NY study found the number of study participants who shared needles and syringes dropped from 26% to 8% after the first visit to a needle exchange, then to 3% after 8 months of attending the needle exchange (Watters et al 1997; Vlahov et al 1997; Paone et al 1999)
- The number of times a syringe is used was reduced by more than half after IDUs started attending NSEPs in three US cities (Heimer et al 1998)

Studies examining the effects of NSEPs on HIV incidence and prevalence among IDUs have found:

- The prevalence of HIV in syringes collected by a NSEP in Connecticut fell from 66% to

- 43% within three months of the opening of the NEP (a reduction of about 33%) (Heimer et al 1997)
- A 70% reduction in HIV incidence when comparing NSEP participants against non-participants in NY (Des Jarlais et al 1996); and a reduction in prevalence among NY IDUs from 50% to around 30%, believed to be mainly due to the effects of NSEPs (Des Jarlais 2001)
 - A 15% to 70% reduction in HIV incidence in a range of US cities, using three different mathematical models (the difference between these results may be largely explained by the level of reach of NSEPs – the greater the reach, the greater the likely effect on HIV incidence) (Lurie and Drucker 1997)
 - A reduction of HIV incidence from 4% to less than 2% nationally in Australia (where 50-60% of IDUs attend NSEPs) (Loxley et al 1997)
 - HIV prevalence among IDUs in Dhaka, Bangladesh (where NSEPs have reached around 80% of IDUs) remained below 5% despite rapid rises in many other cities in South Asia (Jenkins et al 2001).

Only two studies from Canada appeared to show little positive or even a negative impact of NSEP on HIV transmission (Bruneau et al 1997; Strathdee et al 1997). However, a recent review of all of the above evidence by several leading US epidemiologists showed that the Canadian results were most likely due to the NSEPs in Vancouver and Montreal not reaching sufficient numbers of IDUs at highest risk for HIV infection, or not providing sufficient equipment and other services to meet the varied risk reduction needs of their clients (Vlahov 2000; Des Jarlais 2000; Strathdee et al 1997).

Reach of NSEPs

The complex issue of the reach of NSEPs is becoming increasingly important around the world. In the USA, it has been accepted for some years that more than half of a city's IDUs need to be reached by NSEP services to have a substantial impact on a HIV epidemic. In the most recent paper on the situation in NY (the first city with a large epidemic of HIV among IDUs), it is suggested that at least 50% of IDUs in the city needed to directly participate in NSEP services to bring the epidemic there under control, though secondary exchange (assisting or allowing IDUs to take needles and syringes to distribute to their friends or social contacts) may also have been needed, and the level of secondary exchange needed to bring the epidemic under control is unknown (Des Jarlais 2001). (As noted in Section 2 of this report, the UNAIDS Task Force for HIV Prevention among IDUs in Central and Eastern Europe in 2000 set a target of 60% coverage for harm reduction programs in RF and other countries of the former Soviet Union.)

This problem has also been studied by examining the situation in Kathmandu Nepal, where a NSEP had been in operation for 10 years yet there was a sudden rise in HIV among IDUs. Reynolds (2000) found that Kathmandu IDUs were injecting on average 16 times a week or about 70 times a month, while they received only an average of five needles and syringes a month from the NSEP. This means that a sterile needle and syringe was only used for one out of every 14 injections. He found that this was the most likely reason for the rapid spread of HIV among IDUs in the city.

Other concerns have been expressed about the level of coverage that NSEPs have nationally. Wiessing (2001) found that most national NSEPs in the European Union are providing fewer than 100 needles and syringes per drug user per year, though the UK provides 556 per drug user per year (through a combination of NSEPs and pharmacies). Even this is not enough to meet the

current Western European target of a new needle and syringe for each injection. In France and UK, it was estimated that IDUs inject, on average, 2.2 times per day, meaning that a saturation program of needle distribution would need to provide (or provide access to) 803 needles and syringes per drug user per year.

In the UK, where the largest needle exchange exists, approximately 27 million syringes were distributed through NSEPs and pharmacies in 1997 but there were significant regional differences, with the number of syringes distributed per drug user in England and Wales about three times higher than in Scotland (Parsons et al 2001). NSEPs in the USA have grown rapidly in recent years, from 68 programs in 1994 to 131 in 1998 (the last year for which figures are available). By 1998, these programs were exchanging 19.4 million needles and syringes per year; and each program operated an average of 4.85 sites (fixed or mobile) per week for an average of 20.45 hours per program per week (McKnight et al 2001). Given that there are estimated to be 1.3 million IDUs in the USA, these programs are probably only reaching a small minority of the country's IDUs (Stimson and Choopanya 1998).

Changing social norms

As well as risks from sharing needles and syringes, there are added HIV transmission risks in drug preparation, manufacture and purchase (such as purchase of liquid drugs in syringes that may not be sterile). NSEPs and educational programs also need to address drug users' sexual behaviour through prevention education (use of condoms, negotiation of safe sex) and condom distribution. Focus groups, in-depth interviewing and the use of ethnographic methods such as observation (and the use of video for recording drug preparation and manufacture) can identify HIV transmission points and an understanding of the social nature of drug users' lives. NSEPs and educational programs also need to address drug users' sexual behaviour through prevention education (use of condoms, negotiation of safe sex) and condom distribution. On the basis of this information, education programs can develop appropriate prevention strategies (Ball 1998).

The goal of such strategies must be to change the social norms surrounding drug injecting and sexual behaviour (Friedman et al 1994). By encouraging a large percentage of injectors to switch to safer behaviours, HIV prevention becomes the norm. Accompanying a change in social norms, each individual drug user must decide to protect his/her health: many IDUs do not worry about HIV infection, despite the realisation that HIV infection will cause serious physical problems and will likely lead to death (especially in transitional and developing countries). This appears to be the result of internalisation of negative attitudes towards drug users expressed by parents, media, health care workers, militia and the general community (Burrows et al 1999b, Burrows 2000c).

Increasing NSEP effectiveness

Several features of NSEPs have been shown or are generally believed to increase their effectiveness. A properly organized NSEP unit, stationary or mobile, is the centre of access to a hidden group of drug users, who might never otherwise access medical or social services. Provision of sterile needles and syringes, collection of used needles and syringes, provision of sterile swabs, condoms, booklets and other explicit targeted education materials, contact information about relevant services, consultations on various questions (not only medical) are integral activities of exchange programs (Burrows 2000b).

The siting of NSEPs is important: locating the NSEP so that it is convenient to large numbers of IDUs may be critical for effective HIV prevention (Rockwell et al 1999, Burrows 2000b). Continuity of service is also important. An evaluation of Italian NSEPs found that continuity of

funding and service was vital to the programs' success in attracting and maintaining relationships with IDUs (Sabbatini et al 2001). Nigro et al (2001), looking at this same issue in the Italian province of Catania, made a similar observation as several NSEPs had begun in 1996, closed down later that year and re-opened in 1998. The researchers noted that each time a project was re-started, "a lot of energy, time and effort are dedicated simply to re-establishing old contacts and...rebuilding a relationship with previously contacted users". The closure of a NSEP can also have a serious impact on HIV risk behaviours among IDUs. When a US NSEP was closed in 1997, significant increases were found in the percentage of IDUs re-using syringes more frequently and sharing needles and syringes (Broadhead et al 1999).

Most NSEPs use outreach to ensure their activities extend throughout various social networks of IDUs. Outreach work has been extensively studied. Even without an attached NSEP, in Chicago, a large outreach program achieved a reduction in risky behaviours from 100% to 14% over four years and the rate of HIV infection fell from 5% to 1% per semester by the last six months of the study (Choi and Coates 1994). Under the National AIDS Demonstration and Research (NADR) project, the US National Institute on Drug Abuse (NIDA) funded outreach projects in 68 cities of the country. Published results of the outreach work in 20 cities found dramatic decreases in risky behaviour among program clients. For example, the proportion of clients judged to be at high risk of infection with HIV through shared injecting equipment fell from 62% prior to receiving outreach to 31% at a 6-month follow-up interview, and similar decreases (16% to 8%) were noted in the proportion of clients judged to be at high sexual risk (Sloboda 1998).

Outreach work is usually needed to identify networks of IDUs, introduce them to the NSEP's services, build up trust between NSEP staff and IDUs, (in some cases) distribute sterile injecting equipment and educational materials, and/or carry out research on the needs of IDUs. However, outreach work (whether or not it is connected to a NSEP) is unlikely to reach sufficient numbers of IDUs across a wide range of social networks in a short enough period to prevent fast-moving HIV epidemics. Social norms of injecting will only change with the active involvement of IDUs themselves (Friedman et al 1987; Friedman et al 1989; Burrows 2000b). This involvement can take many forms but most commonly at NSEPs, it involves peer education and/or peer support.

In peer education, active IDUs are trained to educate other IDUs about HIV risks, safer injecting and safe sex practices (Burrows 1995a). A study of Australian NSEPs found that peer education was regarded as an essential element in their work (Burrows 1998) and a European study of 2554 IDUs in Greece, France, Italy, Portugal and Spain found that educational materials were much better accepted by IDUs when they were distributed by "friendly contact" from another IDU, rather than from a counsellor or other professional (Volpicelli et al 2000).

In peer support, this process is broadened so that IDUs are involved in all aspects of defining what issues need to be addressed, what types of educational and other strategies should be employed, as well as carrying out the education and other processes and, in some cases, evaluating and reporting on their work (Burrows 1995b). Peer support programs began in the 1980s in the Netherlands and quickly spread to Germany, the UK, Norway, Denmark, France, Belgium, Italy, Spain, Australia and New Zealand (Burrows 1994). More recently, peer support groups are being established in the transitional and developing world in countries such as India, Brazil, Bangladesh, Slovenia and the Russian Federation (Francis 2001; Siqueira DJ 1999; Faruque et al 2001; van Dam and Grebenc 1999; Melnikov and Gouwe 2001). Fostering peer support is increasingly being regarded as an important part of effective NSEP practice.

Finally, there is a strong need to reach IDUs at highest risk for acquiring HIV. Specific programs may be needed to target women IDUs (especially those who are sex workers); gay and lesbian

IDUs; street youth (whether injecting or pre-injecting); and IDUs of specific ethnicities who are often marginalized such as Roma in Eastern Europe, Vietnamese in Australia, North African in France, etc.

Women IDUs who are also sex workers are increasingly regarded as the main nexus of injecting-related and sexually transmitted HIV epidemics. This group should be at least as high a priority as male IDUs, especially in those countries where a significant proportion of female IDUs are also sex workers (such as Eastern and Western Europe, North America and Australia, and some cities or countries in Asia and South America).

NSEP and the community

The experience of establishing and running NSEPs in many countries around the world has confirmed the vital importance of gaining – and maintaining – support from local authorities and communities. Research has shown that NSEPs are most likely to work effectively if they are well managed, sufficiently financed, free from police harassment and linked with health and other social services (Heimer 1998). Many techniques are used to ensure that the local community accepts the NSEP's services and, eventually, supports the program's work (Burrows 2000b).

However, in almost every country, there are serious difficulties between the operation of NSEPs and law enforcement activities directed towards preventing drug selling and buying and, in some cases, drug possession and use. This is a seldom-researched topic, though it is often discussed by NSEP practitioners. The research which has been done suggests that hostile police activities can have devastating effects on a NSEP's work: for example, client contacts fell by 40% in an Australian NSEP one month after a sustained police operation targeting drug users in the local area around the fixed-site NSEP (Fitzgerald et al 2000).

It is useful to note that needle and syringe programs can have an important impact on police behaviour towards IDUs. For example, Sikder et al (2001) evaluated an advocacy project by the SHAKTI NSEP in Dhaka, Bangladesh in which local police were targeted with orientation and advocacy materials. Prior to the project, 84% of NSEP clients had been arrested by the police (which fell to 12% after the project) and assaults on clients by police fell from 56% prior to the project to 30% afterwards.

Social factors, such as housing and employment, which lie outside the usual purview of NSEPs are also being seen as increasingly important. One study of IDUs who stopped injecting in Montreal (almost 20% of the 901 IDUs studied) found that the most important factors in ceasing injecting – either to switch to non-injecting drug use or ceasing drug use – were the IDU's belief that he/she could change behaviour, having fewer risky practices (such as needle sharing and unsafe sex), and stable housing. Recent involvement in drug treatment was not associated with ceasing injecting (Bruneau et al 2001).

Several programs in Asia provide work skills training and, sometimes, jobs for active drug users, believing that stable employment will assist IDUs to control, reduce and ultimately cease drug use. SHARAN and Mukti Sadan Foundation in India provide various pathways to work in its many HIV and drugs programs as well as assistance with computer training and finding other work (Kapoor and Samson 2001), while NorthNet Foundation in Chiang Mai Thailand has started a bakery to assist drug users to upgrade their skills and to generate income for their families (Zarina Mulla: Personal Communication 2001). Increasingly, NSEPs are becoming involved in many of these non drug-related aspects of their clients' lives.

2.2 PRISONS HARM REDUCTION PROGRAMS

By contrast to community harm reduction programs, “progress in reducing drug related harms in prisons has been painfully slow”, according to a recent overview of prison programs (Dolan 2001). The need for harm reduction programs is clear as, for example, an estimated 600,000 drug users enter the prisons of Western Europe annually and the figure is likely to be higher in the USA (Bijl 1999).

Research into specific harm reduction activities have mostly been confined to four activities:

- Peer education programs
- Disinfectant and condom provision
- Needle and syringe exchange
- Substitution treatment

As substitution treatment (the use of a substitute drug such as methadone or buprenorphine to treat opiate addiction, for example) of any type remains illegal in RF at the time of writing, this paper will concentrate on the first three activities. Peer education is by far the most widespread activity to try to prevent HIV infection among IDUs in prisons. An Australian evaluation of peer education programs found that they had been effective in attracting prisoners to education sessions, in providing information and education in ways the prisoners accepted and understood (Taylor 1994). The key features of prisons peer education programs appear to be the willingness of the prison authorities to allow the program to be implemented, the ability to create a “space of trust” in which drug users and peer educators can talk freely, and training of prison custodial and medical staff as well as prison peer educators. Peer education programs in countries such as Australia and the Netherlands are assisted by outreach workers from community organisations who can provide education, information or training on specific topics such as living with hepatitis C or HIV, overdose, etc.

Condom and disinfectant distribution is a common practice in West European prisons: logically, these measures should assist in preventing HIV transmission but their effectiveness has been little studied as yet (Dolan 2001). According to the World Health Organization, 23 of 52 prison systems surveyed allowed condom distribution as early as late 1991, and 16 of the 52 countries carried out disinfectant (bleach) distribution in prisons. Significantly, no system that has adopted a policy of making condoms or bleach available in prisons has reversed the policy, and the number of countries that make condoms and bleach available has continued to grow every year. For example, in a number of surveys undertaken in Europe, the proportion of prison systems that declared having made condoms available rose from 53 percent in 1989 to 75 percent in 1992 and 81 percent in 1997. In the most recent survey, condoms were available in all but four systems. Bleach distribution has followed a similar, though slower growth, with 11 of the 22 prison systems in Europe now providing bleach distribution (Canadian HIV/AIDS Legal Network 2001a and 2001b). Effective programs ensure that either all prisoners have access to condoms and disinfectant or that access is provided in such a way that the prisoner can remain relatively anonymous.

Needle and syringe exchange in prisons has only been implemented in 45 countries worldwide (Switzerland, Germany, Spain and Austria – Belarus also is believed to have such programs) because it is so controversial that very few countries will allow it. As it is such a new activity, its effectiveness is also little-known but practitioners involved in implementing the German and Swiss programs have reported an initial evaluation that found either no increase or a decrease in

abscesses in the prisons with needle exchange, no new HIV or hepatitis infections and a general improvement in the health of IDU prisoners (Jacob and Stover 2000). They also described several features which are important in the implementation of such programs, including the need for anonymity for NSEP clients, for prison staff to be involved in planning and decision making, and for the program to be accompanied by educational materials, visits by community-based drug service organisations and NSEPs, and training seminars for staff and prisoners on HIV/AIDS and hepatitis, safe sex and safer injecting.

Specific programs are needed for women prisoners (Canadian HIV/AIDS Legal Network 2001c). Female inmates often have more health problems than male inmates. Many suffer from chronic health conditions resulting from lives of poverty, drug use, family violence, sexual assault, adolescent pregnancy, malnutrition, and poor preventive health care. Women are often unaware of having been exposed to HIV by their sexual or drug- using partners and as a result often do not seek counseling, HIV testing, and care and treatment. Women are often less educated than men about HIV infection and AIDS and do not have the support structures they need.

2.3 SUMMARY: INTERNATIONAL BEST PRACTICE

In summary, best practice for community harm reduction programs involving needle and syringe exchange includes ensuring that:

- The NSEP has adequate reach so that at least 60% of IDUs in a city are regularly reached with sterile injecting equipment and appropriate education and information
- Those IDUs at highest risk for acquiring HIV – especially women IDUs who are also sex workers – are reached with sterile injecting equipment and information; this usually requires targeting these groups with specific strategies
- Funding and operations are continuous to prevent increases in risk behaviour (caused by NSEP closure) and inefficient use of staff time and funds (through closure and re-opening of NSEPs)
- Programs are appropriately located close to large numbers of IDUs
- Outreach is used to identify new social networks and to attract IDUs to services or deliver services to IDUs
- Peer education is used to broaden the influence of NSEP beyond giving out sterile injecting equipment and beyond active NSEP clients to assist in reaching the maximum number of IDUs
- Peer support is used to involve active IDUs directly in the NSEP and associated activities, and thereby to more quickly change social norms around safer injecting and safe sex
- NSEPs are linked with medical, and other health and social services providing assistance with psychological, legal, housing and employment problems
- NSEPs are embedded in the community and are free to operate without constant harassment of clients and/or staff by police.

Best practice for prisons harm reduction programs includes ensuring that:

- Prisoners and prison staff are informed about HIV/AIDS and about ways to prevent HIV transmission, with special reference to the likely risks of transmission within prison environments and to the needs of prisoners after release
- Information intended for the general public (through posters, leaflets and the mass media) is also available to prisoners
- Information is made available in a language and form that prisoners can understand and

- presented in an attractive and clear format
- Training is provided for staff on HIV transmission
 - Whatever harm reduction programs – such as needle and syringe exchange, peer education and substitution treatment – are available to IDUs outside the prisons should also be available inside prisons
 - Condoms are distributed to prisoners
 - Specific programs are designed and implemented for women prisoners.

III. FINDINGS - COMMUNITY HARM REDUCTION PROGRAMS

The findings presented here were derived from the programs survey and key informant study carried out in December 2000 and January 2001. The studies were done quickly (to meet the Bank's deadlines) so the results must be treated cautiously as only 26 of the 48 NSEPs in RF replied. The list of key informants that responded is provided in Appendix 1. The specific programs that responded are unknown, as the programs survey was anonymous, but the survey questionnaire sent to programs appears as Appendix 2. A full list of the 48 programs is provided as Appendix 3.

3.1 PROGRAM DATA

The 26 NSEPs that responded to the survey cover a wide range of organisational and service types: 11 are NGOs, 1 a collaboration between an NGO and government agencies (AIDS Centre and narcological dispensary), and 14 are government agencies: 5 AIDS Centres, 3 narcological dispensaries, and the remaining 6 are combinations of government agencies (mostly AIDS Centre and narcological dispensary working together).

Table 4.1. Program types

Non-government organisations (NGOs)	42%
Government organisations (GOs)	54%
NGO + GO	4%

The responding NSEPs are generally very young: most have been operating for one year or less, and only 3 have been operating for longer than two years.

Table 4.2. Age of programs

	N = 26	%
1-12 months	15	58
13-24 months	8	31
25-36 months	1	3
37-48 months	2	8

All responding NSEPs receive at least some funding with the total annual funding for 25 programs (1 did not answer the funding questions) in 2000 being \$699,551 or a mean of \$27,982 per program.

Table 4.3. Total funding per program

In US\$ equivalent	N = 25	%
Less than \$10,000	2	8
\$10,001 - \$20,000	3	12
\$20,001 - \$30,000	12	48
\$30,001 - \$40,000	5	20
\$40,001 - \$50,001	2	8
\$50,001 - \$60,000	0	0
\$60,001 - \$70,000	1	4

Of the total funds in 2000, 68% (\$480,840) were from OSI-R, with almost 2% (\$11,584) from other international donors, 12% (\$81,191) in roubles from city and oblast budgets, 13% (\$93,359) in kind support from city and oblast administrations, 0.16% (\$1175) from the Federal budget, and 5% (\$31,402) from private sources in the city or oblast. In total, 30% of funding or in kind support was derived from within RF.

Total staff of the 26 NSEPs is 600, or a mean of 23 per program: this includes staff paid a salary (mean: 14 staff out of 23), volunteers paid a stipend or incentive (mean: 3/23), and volunteers who receive no payment or stipend (mean: 6/23). Of the total, 34% are doctors; 20% are ex-IDUs; 15% are active IDUs; 8% are students; 7% are psychologists; 8% have other university qualifications (most commonly social workers and teachers); and 8% have other, miscellaneous backgrounds. Staff ratios vary across payment regimes, with the biggest changes occurring among doctors, IDUs and ex-IDUs. The number of doctors paid a salary ranges from 0 at 1 NSEP to 18 at each of 2 NSEPs.

Table 4.4. Staff ratios by payment category

Payment category	Doctors	IDUs	Ex-IDUs	Total
Salary *	143 (33%)	38 (10%)	58 (16%)	364
Volunteer on stipend *	27 (31%)	8 (9%)	29 (34%)	86
Volunteer (no stipend) *	32 (21%)	46 (31%)	30 (20%)	150
Total staff *	202 (34%)	92 (15%)	117 (20%)	600

* Does not add up to 100% as other occupation categories have been omitted.

Services provided

The responding NSEPs appear to be generally providing comprehensive services, with all NSEPs providing a range of needles and syringes to meet the specific needs of IDUs in their city, and many also providing other injecting equipment.

Table 4.5. Services provided

	N = 26	%
Distribute needles and syringes	26	100
• 1 ml needle and syringe (non-detachable)	17	65%
• 2.5 ml needle and syringe (in same pack)	15	58%
• 5 ml needle and syringe (in same pack)	20	77%
• Detachable 1 ml syringe alone	5	19%
• 2 ml syringe alone	4	15%
• 2.5 ml syringe alone	5	19%
• 3 ml syringe alone	2	8%
• 5 ml syringe alone	8	31%
• 10 ml syringe alone	12	46%
• 20 ml syringe alone	9	35%
• Needles (separate from syringes)	9	35%
Distribute condoms	25	96%
Distribute alcohol swabs	18	69%
Distribute disinfectant (bleach)	8	31%
Other injection equipment	6	23%

The “other equipment” in the above table includes sterile water for injection (distributed by 3 programs), cotton wool, filters, vitamins, bandages and medications (all distributed by 1 program each).

All responding NSEPs distribute information/ education/ communication (IEC) materials, of which 96% produce their own materials and 77% provide educational materials from other organisations. Of those NSEPs that produce their own educational materials, 32% involve active IDUs in writing and producing materials; 60% involve ex-IDUs; and 92% involve health professionals.

Table 4.6. Most common topics of IEC materials produced by NSEPs

	N = 26
General leaflets on HIV/AIDS	19
HIV prevention among IDUs	15
Hepatitis/ hepatitis prevention among IDUs	13
Program information/advocacy materials for harm reduction	9
Vein care	9
Overdose prevention	7
Drug treatment	7

The most commonly distributed educational materials from other organisations are MSF-H publications on hepatitis, vein care, safer drug use, legal information, overdose and safe sex.

As well as needle exchange and distribution of educational materials, a wide range of other services are offered by most NSEPs.

Table 4.7. Other services offered

	N = 26	%
Peer education/support:	16	62
• Peer education training of active IDUs	14	54
• Training of active IDUs on HIV prevention etc	16	62
• Meetings of active IDUs re HIV prevention etc	12	46
• All 3 peer education/support activities	12	46
HIV testing	15	58
HIV pre-test counselling	22	85
HIV post-test counselling	21	81
Psychological counselling on drug use	24	92
Counselling on non drug-related issues	22	85
First aid for abscesses etc	11	42
Medical care for people living with HIV/AIDS	13	50
Detoxification/ drug treatment	11	42
Other services	13	50

“Other services” in the above table include STI testing and counselling (offered by 5 NSEPs), hepatitis B and C testing (5), drug rehabilitation (3), Narcotics Anonymous groups (3) and working with parents and relatives of drug users (3).

Methods of operation

There is a good mix of service types represented among the respondents: all 26 programs (100%) provide outreach needle exchange; 25 have at least 1 fixed-site needle exchange; and 9 operate at least 1 mobile service. A large number of questions were asked about operating hours, sites visited by mobile and outreach teams, etc.

The number of sites visited by outreach workers ranges from 2 to more than 20 each day, with 65% (17/26) visiting 2-4 sites each day: 50% (13/26) visiting the same sites each day.

Table 4.8. Outreach

	N = 26
Provide outreach at least once each week	26
• Visit 2-5 places each day	17
• Visit 6-10 places each day	7
• Visit 11-15 places each day	0
• Visit 16-20 places each day	0
• Visit more than 20 places each day	2
Visit the same places each day	13*
Visit different places on different days	10*

* 3 programs did not answer this question.

Of those NSEPs with fixed sites, more than 50% (13/25) have multiple (2-4) fixed sites.

Table 4.9. Fixed sites

	N = 26
Operate at least 1 fixed site	25
• Operate 1 fixed site	12
• Operate 2 fixed sites	11
• Operate 3 fixed sites	1
• Operate 4 fixed sites	1
Fixed sites located in:	
• AIDS Centres	13
• Narcological dispensaries/ hospitals	8
• Hospitals (not narcological)	4
• Other government premises	6
• NGO premises	1
• Commercial/ shopfront	1
• Residential building	1
• Unspecified	7

Of those NSEPs with mobile services, most make 2-3 stops per day (6/9), and the same number (6/9) stop at the same sites each day.

Table 4.10. Mobile services

	N = 26
Provide mobile service at least once each week	9
• Visit 2 places each day	2
• Visit 3 places each day	4
• Visit 4 places each day	1
• Visit more than 4 places each day	2
Visit the same places each day	6
Visit different places on different days	3

Mean operating hours of fixed sites each week are 46 hours (with 39% operating on weekends); mean operating hours of mobile services each week are 23 hours (with 37% operating on weekends); mean operating hours of outreach services each week are 21 hours (with 63% operating on weekends).

Reach of services

As was discussed in the previous section, defining the reach of NSEPs remains a contentious issue. Here, we begin by looking at the number of needles and syringes distributed and brought in for disposal. The survey asked for data both for the previous month and for the previous 12 months, but the past year data was unusable, largely because so many NSEPs were less than one year old.

The total number of needles and syringes distributed in the previous month was 157,779 (for 25 programs); this figure ranged (per program) from 142 to 19,609 with a mean of 6258.

Table 4.11. Needles & syringes distributed previous month*

	N = 25	%
Less than 5000	11	44
5001 – 10,000	10	40
10,001 – 15,000	2	8
15,001 – 20,000	2	8

* As the survey was sent out in late December and returned during January, the month specified was either November or December.

1 program did not answer this question

Secondary exchange (assisting or allowing IDUs to take needles and syringes to distribute to their friends or social contacts) was used by 81% (21/26) of responding NSEPs. Of those who provide secondary exchange, estimates of secondary exchange range from 4% to 80% of all needles and syringes being distributed by the NSEP, with a mean of 30%.

Table 4.12. Percentage distributed through secondary exchange

	N = 21	%
Less than 20%	8	38
21-40%	8	38
41-60%	3	14
61-80%	2	10

The number of needles and syringes collected in the previous month ranged from 0 to 20,043 with a mean of 5872. Return rates varied from less than 70% to more than 100%, but the vast majority were within the range 90%-100%.

The number of primary clients seen by responding NSEPs in the previous month ranged from 10 to 760, with a mean of 148. In most cases, this does not reflect the number of clients reached through secondary exchange, but only those who personally visited a fixed site or mobile NSEP or were provided with injecting equipment by an outreach NSEP worker.

Table 4.13. Clients seen in previous month

	N = 26	%
0 – 100	12	46%
101- 200	6	23%
201 – 300	5	19%
301 – 400	2	8%
More than 400	1	3%

Average level of primary exchange was estimated for the responding NSEPs. An average of 6258 needles and syringes are distributed in 1 month (the mean across all responding programs), of which 25% is secondary exchange (the mean across all programs) and 75% is primary exchange; and mean number of clients in 1 month is 148. The average level of primary exchange is therefore $0.75 \times 6258 / 148 = 31$ needles and syringes per IDU in 1 month or 372 in 1 year.

The estimated number of IDUs in the cities in which the NSEPs are located range from 1200 to 60,000, with a mean of 16,333. (These estimates were assembled during the rapid assessments carried out prior to starting each NSEP).

Table 4.14. Estimated number of IDUs in city

	N = 24	%
0 – 5000	15	63
5001- 10,000	6	25
10,001 – 15,000	3	13
15,001 – 20,000	3	13
20,001 – 25,000	2	8
25,001 – 30,000	1	4
30,001 – 35,000	2	8
35,001 – 40,000	1	4
More than 40,000	1	4

For the purposes of this report, reach of the programs was calculated by taking the estimated number of IDUs in each city and dividing by the number of clients seen in the previous month to achieve a regular coverage rate, expressing this as a percentage (the percentage of IDUs regularly reached by the NSEP). This is likely to provide an under-estimate as the previous month was in winter and higher figures may be reached in summer; it also does not represent overall reach of the program but gives an approximation of the percentage of IDUs being reached regularly.

These statistics were only available for 23 of the 26 NSEPs that responded. Overall, it is estimated that there are 392,000 IDUs in the 23 cities, of whom 2914 were clients of the NSEPs in those cities in the previous month. The overall regular coverage rate is $2914 / 392,000 \times 100 = 0.74\%$. However, this refers only to those IDUs who are known to be clients of the NSEP and does not account for secondary exchange clients.

Of these 23 cities, the regular coverage rate ranges from 0.1% to 13.2%: 65% of the NSEPs have a regular coverage rate below 1% (15/23); all but one of the remaining NSEPs – 30% (7/23) – have regular coverage rates of 1% -5%, and 1 NSEP has a regular coverage rate of 13.2%.

Further analysis was carried out on the above data to determine whether there were significant differences between government organisations and NGOs. Data was re-analysed for several key questions but no significant differences were found.

3.2 BEST PRACTICE

This section summarises the most commonly expressed views about best practice from the NSEP survey and key informants, under the headings of strengths, weaknesses and what is needed to reach best practice in RF.

Strengths of programs

The most often mentioned strength, especially by the programs themselves, was the caring attitude and pragmatic approach of most NSEPs. Comments included: “there is a clear willingness at most programs to do something about the problem”; doctors at NSEPs often educate other health and medical staff about HIV/AIDS and drug use; greatest strengths are “commitment and activism”, “enthusiasm of involved people and high level of knowledge and understanding”; “enthusiastic and pragmatic responses of those working directly with the target group”.

Support of local authorities and institutions is also regarded as one of the greatest strengths by most respondents. While problems with police and other Internal Affairs officers remain one of the biggest obstacles to increasing the reach of NSEPs (see below), several respondents mentioned that there had been fewer problems with police than expected (particularly as some respondents had feared their NSEPs would be quickly closed given the lack of clarity about the legal status of needle exchange in RF). The best programs are regarded as those where the manager can keep all parties working on the same issues, including police, government, doctors, ex-users and IDUs. Some programs have received local financial and in kind support, which both key informants and program respondents believe is vital to long-term sustainability. Most NSEP respondents did not see major problems (except financial) in expanding their activities to regularly reach 60% of IDUs, (though several key informants felt there were other important issues which also need to be considered – see below).

The simple fact of there being 48 NSEPs is seen as a strength in itself: “by doing needle exchange work, they are advocating for needle exchange”; “(Kazan NSEP) has built up a lot of experience and is now helping other programs start in the Republic”; “they implement controversial interventions the government is reluctant to support”. International funding, especially from OSI-R, has been essential to starting the programs and slowly gaining interest from local authorities. Technical assistance and training from international organisations, especially MSF-H and Médecins du Monde (MDM) was also vital: “without training and help, it would have been a big mess”.

Rapid situation assessments have helped in advocacy for NSEP and in deciding on locations for fixed site NSEPs, whether mobile NSEP is needed, where outreach workers should concentrate their activities, etc. (A weakness is that the RSA results have not been followed by all NSEPs: many programs “open in a particular premises for political or other reasons, though the RSA shows it is not a very convenient place for a needle exchange”).

NSEPs are moving towards increasing secondary exchange and peer education; more active IDUs are being recruited as volunteers and outreach workers are learning to supervise volunteers. Respondents felt that peer programs can work well in RF: “because of the social nature of (injecting) drug use in Russia, peer strategies are theoretically a good fit, what I have observed in 5 Russian cities suggests that whether or not programs utilize/encourage peer strategies (such as secondary exchange, peer education, peer support etc.), IDUs engage in these (for example,

providing each other with clean needles)”.

There are examples of excellent work by individual NSEPs in outreach, secondary exchange, advocacy at the oblast/republic level, development of publications with input from active IDUs, peer education. (A weakness is that very few NSEPs have excellence in all these areas.) There has been ready acceptance of international evidence of good practice, together with tailoring of international knowledge and experience to local conditions.

Weaknesses of programs

Weaknesses were more often discussed by key informants than by program respondents. There was no single weakness talked of by most respondents, but all of the below were mentioned by several people.

Low reach is one of the biggest problems. Not enough IDUs are becoming clients of NSEPs and not enough IDUs beyond the NSEPs are being reached through peer education, educational materials, etc. “This may have structural causes: NSEPs worry about running out of funding for needles and syringes so they try to limit numbers of clients.” Also, distrust of programs and staff is a big problem: “many drug users avoid programs out of fear of police targeting programs and IDUs”. Many NSEPs are not places where IDUs want to spend any more time than necessary: this is another possible reason for low reach. “One program gives out skim milk as an incentive: it might attract kids but not IDUs”. Many key informants worry that the reach of current programs in RF will have no impact (or virtually no impact) on the HIV epidemic among IDUs.

A connected issue is funding: most NSEPs do not have sufficient funds to do the work required of them. As well as funds for harm reduction materials (such as needles, syringes, condoms), most NSEPs lack the funding to do appropriate numbers and types of educational materials. However, some programs use funds to pay staff who may not really be involved in the program – by re-organising work practices and staffing, some funds may be re-allocated towards harm reduction materials.

Next, there is a set of management issues. One key informant said that management problems were partly caused by the general underdevelopment of the NGO sector in RF. There is a reliance on doctors as NSEP workers, and this may be causing problems for programs trying to access increasing numbers of networks of IDUs in a city. “One bus has 6 outreach workers and doctors: it’s already crowded before the client gets in”. The historic division of labour between professions has hindered multidisciplinary work, and distinctions appear to be made in most NSEPs between health professionals (who are usually paid) and IDUs and ex-IDUs (who are often not paid). There is a widespread concept of NSEP as a medical intervention, a belief which some key informants believe may be harmful: NSEP should be considered as a public health intervention incorporating active and “real” involvement from the target community, drug users themselves. Many program respondents believe doctors have been integral to the success of NSEPs starting up in RF – “this would never have happened if chief doctors from AIDS Centres and Chief Narcologists had not been involved” – but some key informants believe the emphasis should now be on increasing non-medical staff.

Although relationships between staff are good in most NSEPs, with some programs providing burnout prevention education and support for staff and relapse prevention education for ex-users, there is also a tendency towards managing NSEPs along strictly hierarchical, “medical” lines. Key informants believe NSEPs “should be more democratic, and managers should stop being afraid of users”. The lack of democratic structure in NSEPs stems from “copying the authoritarian

way to run organisations, used by government services”. Organisational structures inside government may find it hard to hire active IDUs (even as volunteers).

Information provided to managers is often not passed on to workers: “we sent a booklet for outreach workers to all the managers: we asked at the next training how many outreach workers had seen it: 1 out of 20. They don’t pass anything on”. Outreach workers who want to produce publications are often not granted access to computers. Managers are sometimes “like mothers, they want to look after everyone, tell them what to do all the time”; “managers do everything, they delegate nothing”; “managers have the central position, decide what information other staff will get”.

There is a patchy quality of services, depending on individual managers. NSEPs are “limited by their reliance on charismatic leaders or particular personalities and right connections to the government and other decision-makers and opinion leaders”. If a manager is interested in drug treatment, that becomes a major focus of the NSEP, if the interest is HIV treatment, that becomes the focus. An evaluation of 30 programs’ educational materials found that 80% were re-written MSF-H brochures, 10% were original, “excellent” publications and 10% were “very bad, anti-drugs stuff”. “Workers know very little about drug users and drug use in some agencies: there is a very low skill base amongst all agencies with no skills in therapies such as motivational interviewing.” Difficulties of access to health care for IDUs and to HIV treatments remain problems in some areas. There are “still some tensions with local government and other stakeholders – this could be improved through local committees and joint activities”.

There is also a confusion about the aims of the program in some cases: to reduce harm from drug use or to stop drug use. Programs in narcological dispensaries may have greater problems with maintaining a clear focus on harm reduction, and may have greater difficulty attracting clients. “There is a tendency to try to do rehabilitation and needle exchange together: when this happens, not as much attention is paid to needle exchange.” Abstinence ideologies sometimes hinder HIV prevention objectives: “professionals are very early in the learning curve on drug use and policy issues: in a way the latter is both a weakness and a strength: that is, interventions are not always well targeted or thought through, but it also makes the professionals involved more open to peer strategies”. Educational materials often contain anti-drugs propaganda, which is likely to turn IDUs away. However, some programs are working well with narcologists, and with NSEPs located inside narcological dispensaries: again, the difference appears to be based on individual managers.

There is little interest in investing time and money in educating volunteers: “we are constantly shocked that outreach workers attending MSF-H training know so little basic information on HIV and drug use”; “good outreach workers require training but there seems to be no training at the local level”; “outreach workers often have limited skills in outreach and counselling”; “new knowledge is not provided: if training is done, it’s done once”; outreach workers have low status in the organisation and society. High staff turnover means a larger investment is needed in training: this may also be caused by the lack of (or low) salaries. There is a lack of “frustration tolerance” among staff.

There is a lack of understanding about the need for long-term responses: “managers think it’s a 2 year project then they’ll stop”; there is a “need for some programmes to move away from single issue needle-syringe programming to provide a more comprehensive service and better integration with existing (particularly government) services”.

There is a poor understanding/experience of monitoring and evaluation: “complex rapid situation assessment programs have given some good research skills and base line knowledge in certain situations but little appears now to be happening on a local level with the RSA’s”.

Finally, networking is seen to be poor. NSEP managers are unused to working with similar colleagues in other cities, and feel insecure about letting their staff contact staff of other projects; “their only opportunity to meet is at MSF-H trainings”. There are “difficulties of networking with certain partners due to lack of knowledge, lack of money, rivalries”.

What is needed for best practice

The first point all respondents agreed on was that increased funding is needed to carry out the below activities. Also, as most of these programs are funded through short-term grants, their employees tend to feel themselves insecure about their job prospects. Also, due to various legal and organisational inconsistencies these staff are sometimes left without medical insurance, pension plans and other benefits. Thus, extending the time horizon within which harm reduction projects operate through longer-term grants and integrating these projects into legal frameworks should contribute to their ability to create a more supportive environment for their employees. One key informant suggested financial support should be dependent on good management, especially more democratic management and quality assurance (measuring the effect and impact of activities and altering programs in the light of this ongoing monitoring and evaluation). There also needs to be better co-ordination between donors and “agreed hand-over of funding responsibilities from international consortium to Russian agencies”.

The regular coverage rate of NSEPs needs to increase to 60% through:

- Scaling up programs as quickly as possible, increasing the number of IDUs served and providing outreach/subsidiary services – for example, satellite programs in outlying communities/towns and mobile services. Proliferation of harm reduction programs is essential (more than 1 per city), as is a greater involvement of NGOs. Most NSEP respondents felt the 60% target could be achieved through opening more fixed sites, operating more mobile services and hiring more outreach workers.
- Peer education to reach beyond clients: “MSF-H peer education program has been very successful, and should be replicated at all NSEPs”. Peer support needs to be trialed carefully: stable organisations with access to appropriate networks should start drug user organising, assisting IDUs to describe their circumstances and advocate for their interests. Outreach services need to be improved, and accreditation/ professionalisation of outreach work would be useful. A strong network of skilled outreach workers is needed.
- Mainstreaming of programs, incorporating HIV prevention interventions targeting IDUs into already existing structures/services, including dermatovenereology services, GUM clinics, HIV centres, narcology dispensaries, polyclinics, pharmacies, etc.
- However, at least 1 program in each oblast should be a specific needle exchange program with user-friendly policies and staff: this program should train and provide technical assistance for those doing NSEP at all other sites: “there should be at least one ‘model’ program in each region that can stimulate the development and support of further programs”.

Technical assistance and training continues to be needed at the national level, and training centres need to be developed in many parts of the country: “assistance to programs needs to be in Russian

from Russians and needs to be separate from funding processes because programs will hide problems from people connected to funders”; “well-developed and expanded training and technical support program - to build local capacity/expertise - best if this were to be integrated within existing training structures and institutions”.

Ongoing training needs include:

- Situation assessment and intervention, and sentinel surveillance monitoring; program monitoring and evaluation
- General and project management with emphasis on personnel management and structural methods to achieve a more democratic workplace, managing change and expansion of services, maintaining focus on harm reduction while establishing links with other services, delegation of authority, strategic and work planning, incentive and motivation techniques for managing volunteers, training staff and volunteers, establishment and maintenance of quality assurance processes
- For both managers and staff, social aspects of drug use and changing group norms including follow-up training on peer education and peer support and network distribution (secondary exchange) and collection of clean injection equipment; also, care and support of HIV positive IDUs and sensitisation to drugs and minority (especially Roma) issues
- For outreach workers and other non-managerial positions: Specific training programs on outreach techniques, basic HIV and drugs information, educational messages, burnout prevention and enhancing frustration tolerance (how to tackle the problems encountered, especially in outreach work, and the frustrating policies under which NSEP work is carried out) need to be delivered as locally as possible several times each year to address high staff and volunteer turnover.

One of the most important areas of need is that of policy and other national and local support for harm reduction. This needs to be strengthened through:

- Clearly defined short-, mid- and long-term goals and standardised monitoring and evaluation to assess progress towards these goals
- Effective and committed national level co-ordination and support across all government and NGO sectors; development of political consensus on harm reduction, at federal, oblast and city level; “local and oblast level co-ordinating committees are needed to ensure multi-sectoral collaboration, sustainability and ownership of the harm reduction work”.
- Directives from the highest levels to give clear instructions to the local authorities; good advocacy materials to convince policy/decision makers and other stakeholders: “increasing the effectiveness of harm reduction projects requires their recognition as a part of the Russian public health system”.
- Intersectoral co-ordinating committees/ mechanisms at oblast/city level to ensure all relevant government structures and NGOs work together to implement harm reduction programs
- A community approach: “drug use (and thereby care, treatment and harm reduction for drug users) is not only a responsibility for drug services but for everybody (youth organisations, schools, unemployment services, religious organisations, parents, etc.), focusing on shared responsibility (it is not only the authorities’ responsibility)”.
- Legislative and policy reform to reduce barriers and facilitate access to services for IDUs: “Further development of HIV/AIDS policy is needed, which must also include a (re)consideration of drug policies”.
- Training of all levels of all Internal Affairs forces, as well as guidelines on non-interference with NSEP activities.

- Continuing the mainstreaming of harm reduction in universities and technical colleges: results of existing programs should be included in official training curricula.

Substantial capacity building is needed at NSEPs. Policy development is urgently needed: most NSEPs operate at the whim of the current manager. A range of clear policy and program guidelines, based on evidence, are needed to enable organisations to develop and evaluate programs with minimal external technical support. Russian derived models of good practice and professional guidelines are needed for workers (especially in new occupations, such as outreach work). There also needs to be a change in the hierarchical/ authoritarian management structures in governmental bodies and governmental health organisations to allow multi-disciplinary co-operation between professions at an equal level.

Ancillary services also require upgrading. Voluntary HIV pre and post test counselling needs to be improved, as does the relationship between NSEPs and and IDU/ sex worker friendly STI treatment services to ensure adequate treatment of STIs among IDUs. Referral to anonymous and free medical treatment is needed, especially care and treatment for HIV-positive IDUs.

Networking is another major issue: existing program networks such as the MSF-H Infocenter and training program need to be upgraded in size to improve networking, provide technical assistance and "peer" support for programs. The incorporation of Russian harm reduction programs and ideas into the international harm reduction movement needs to continue at a faster pace.

Monitoring and evaluation also require upgrading: a regular monitoring system of local situations should be established using rapid assessment and response (RAR) and sentinel surveillance monitoring. Local rapid ethnographic studies are needed of drug settings, including acquisition (preparation) and use patterns. Good quality standardised rapid assessment and sound epidemiology (such as capture /recapture studies) are needed to assess numbers, trends and patterns of drug use at local and oblast level.

Finally, the concept of harm reduction needs to be widened beyond NSEP:

- Methadone and other substitution programs are urgently needed to encourage IDUs to reduce or stop injecting. These should be medical programs connected to NSEPs and should be implemented on a large enough scale to meet demand
- Low-threshold drug treatment (such as the Yaroslavl drug treatment pilot project) should be implemented on a large scale across RF
- Detoxification and drug treatment needs to be improved, including long-term psycho-social support, especially for HIV-positive IDUs
- Adequate programs are needed to target marginalised populations and high risk settings such as prisons, military, street youth - this requires outreach programs and agreement with relevant ministries (e.g. Internal Affairs, Justice, Defence).

3.3 KAZAN MODEL

One of the aims of this project was to develop a Model of Best Practice of Harm Reduction in RF. However, during talks with key informants and a subsequent visit to Kazan, it became clear that such a model already exists. As it was developed in that city, it is called here the "Kazan Model".

Kazan, 800km south-east of Moscow, with a population of 1.8 million, is capital of the Republic of Tatarstan, one of the 89 territories of the Russian Federation. The drug using situation in

Kazan is a typical example of a “closed scene” in RF. While in Western Europe and North America, there are often ‘open scenes’, where drugs are bought and sold fairly openly on the streets or in some other public area, most Eastern European cities (with the exception of Moscow and St Petersburg in RF and cities such as Odessa and Zhitomir in Ukraine), have closed drug scenes in which drugs are bought, sold and used very secretly. Drug sellers may work with pagers or mobile phones and drug buyers must be introduced to sellers by people the seller trusts. Sales may only be made at certain street corners or certain apartments or other specific places which change quickly due to police activities. In the Kazan Rapid Situation Assessment, it was estimated the city had about 20,000 IDUs in this closed scene.

Gaining access to IDUs in closed scenes, establishing trusting relationships and expanding needle and syringe distribution is usually very slow and this has been one of the biggest problems faced by NSEPs in RF. The Renewal NSEP started in Kazan in May 1999. It was started within the Republican AIDS Centre by the doctor in charge of the centre’s polyclinic, Dr Larissa Badrieva, who is now Project Co-ordinator for the NSEP. Initially, the program had three activities:

- Outreach to distribute needles and syringes and educational materials (mostly from the MSF-H outreach program in Moscow) to IDUs in the city’s infectious diseases hospitals (where drug users were receiving treatment, usually for hepatitis)
- Establishment of a fixed-site NSEP at the Republican AIDS Centre
- Training of IDUs in vein care, safer injecting practices, HIV and hepatitis prevention, and other topics of interest to IDUs.

Outreach began in the infectious diseases hospitals because these are part of the health system (and therefore able to be accessed by doctors from the AIDS Centre after appropriate approvals had been sought) and are places where IDUs come for treatment: that is, a usually hidden population can be found there. Also, these hospitals, catering for a large city, bring together IDUs from many scattered social networks. Having won the trust of IDUs in these hospitals, “snowball” techniques – asking each drug user to introduce outreach workers to his or her friends – were used to penetrate social networks throughout the city.

Later, the program began to produce its own educational materials, most notably a series of small cards with a single, simple message and graphic on each card, which are given out with injecting equipment. In addition, to increase the reach of the service within Kazan, a structured method of expanding needle and syringe exchange and education was implemented to increasing numbers of hidden networks of apartment-based IDUs.

Use of tusovkas

Dr Badrieva and her staff outlined the methods they used. First they categorised sites related to drug use as follows:

- Drug user
- Middleman
- Dealer
- Hang-out (tusovka)
- Den of users (priton).

“Drug user is an IDU to whose apartment friends come and there they can talk to outreach workers. Middleman (or running man) is an IDU to whom people come and ask to assist in buying drugs. Dealer is a merchant: people come to his house aiming to buy drugs. Tusovka is a place (not necessarily apartment) where IDUs get together to hang out rather than buy drugs. Priton is an apartment where one can buy drugs, use them, and where sexual intercourse may

take place.”

Within this system of drug-related sites, the outreach staff (four outreach workers) and management decided that those sites which are too closely related to drug buying and selling were dangerous for outreach workers to visit regularly due to the likelihood of police actions there. However, drug users’ apartments might not be visited by sufficient numbers of IDUs to make them worthwhile targets for outreach workers’ time and energy. “We do not have many outreach workers and a limited number of information materials. Therefore, we have to make sure that each brochure and each syringe that we distribute are effective and lead us to the goal – changing IDUs’ behaviour.” It was decided that tusovkas were the most appropriate and least dangerous places to try to reach IDUs.

The tools used to encourage IDUs to reduce their risk of acquiring HIV are harm reduction materials (including needles and syringes, condoms and alcohol swabs) and information about safer behaviour. “Harm reduction materials by themselves do not lead to behavioural changes of IDUs, especially after we stop distributing them. Information without materials (especially in the very beginning of work with IDUs) is also not effective. The approach should be as follows: information should be backed up by materials.”

To carry out this task, a system of secondary exchange has been established, using volunteers at tusovkas. Outreach and fixed-site NSEP workers are involved in constantly seeking for addresses of tusovkas (which of course are carefully hidden from police and other authorities) and introductions to the tusovka “host”: this person may be the owner of an apartment or simply the most respected person in the place, the “leader”.

Once access has been gained to the tusovka, outreach workers try to persuade the “host” to participate as a volunteer in the NSEP’s activities. This process of persuasion has 3-5 stages:

- opening
- development,
- support,
- secondary development,
- closing.

Opening is the beginning stage that aims to win the trust of a site host. At this stage, outreach workers are asked to fill out Kazan Model Form 1 (see over page). This form allows the Outreach Manager to decide whether it is worthwhile going ahead to the development stage, and which outreach workers would best be able to assist in its development. The **Development** stage aims to involve the site in NSEP activities: in this stage, outreach workers spend many hours trying to gain personal contact with all visitors of the site, working out what activities take place at the site and what harm reduction materials and information would be most useful, persuading the host to allow harm reduction activities to be carried out at the site (including introducing outreach workers to all people connected with and visiting the tusovka, needle and syringe exchange, distribution of leaflets, collection of used equipment, allowing training sessions to be provided for visitors to the site), receiving information about new sites. During these stages, the Outreach Manager requires that any outreach workers attending tusovkas fill out a form that charts the opening and development process (see Kazan Model Form 2).

Through this form, the outreach worker in daily briefings with the Outreach Manager and weekly team meetings (together with the Outreach Manager and other members of the Outreach team – see below), states what point the site host has reached in his/her willingness to act as a volunteer

for the program, and what point the outreach workers have reached in “covering” all visitors and others at the site with information and harm reduction materials.

Once it is felt that the host is working well as a volunteer, and all or almost all visitors to the site have been met by outreach work, the site moves into the **Support** stage, in which information and materials are provided for distribution at the site, and occasional educational/training sessions are provided by outreach workers. This requires much less involvement from outreach workers in short visits from time to time. Volunteers also fill out simplified versions of the NSEP’s monitoring forms so the program can check how many harm reduction materials and leaflets are going out through each site. At the time of writing, this outreach model had been in existence for about 20 months: in that time, 101 sites had been opened in the city and the program had reached 7700 IDUs (about 35% of the city’s IDUs), though only around 322 clients visit the NSEP each month. Unfortunately only 35 sites still operate, mainly because of continued police activities around tusovkas.

The final two stages only apply to some sites. **Secondary development** – this stage is only used when there are many new visitors at the site: when this occurs, the development process is repeated to ensure the new visitors are all covered by outreach workers. **Closing** is the last stage: this usually occurs because of a change in host, decreased interest by the volunteer or external reasons (such as problems with police).

During a visit to a tusovka, “hosted” by young woman named Olga in a residential building in central Kazan, I was impressed by the obvious friendliness between Olga and the outreach workers. Her apartment is one of the places where IDUs tend to come to hang out. All her family are involved with alcohol, drugs, and/or sex work so there is no objection to IDU friends dropping in. When asked why she had become a volunteer, Olga said: “I was so surprised that the outreach workers were friendly. Normally we are treated with disgust. I was happy to give out the syringes and leaflets as they asked.”

Volunteers who remain involved in the program for some time receive small benefits. Within the program’s budget, there is an allocation for small gifts (of up to US\$5 each) to up to 50 volunteers. But to receive them, volunteers must show their passport, state their address, submit medical insurance certificate and pension card. “These are drug users and dealers” said the Project Co-ordinator. “They don’t want to be involved in all this”. So the project provides small incentives of use to the volunteers but without requiring any of the above information. In addition, volunteers are issued with certificates once they have undergone sufficient training and are involved at an appropriate level. “These certificates state that they are a volunteer for the needle exchange program. It is not of much use when the police call – they still get arrested very often. But the volunteers love these certificates.”

Kazan Model Form 1

The opening of the location

General information

1. The date when the questionnaire is filled out
2. Who has provided the information
3. The coded ID of the location host
4. The area of the location

Relationship with the project

5. The date of the work beginning
6. Which staff members have worked at this location
7. Via whom the access to this location has been obtained
8. The level of trust of the host (give the examples)
9. Personal characteristics of the host
10. Which staff members are allowed to visit the location by the host
11. Does the host allow the project staff to communicate with him\ her for a long time (1-2 hours) at his\her location and if not why
12. The cumulative number of primary contacts
13. Average number of IDUs per visit

Relationship with the external world

14. Who is the host of the location living with?
15. Can these people he\she lives with hamper or facilitate the work (who in particular)?
16. What days and what time is it easier to find the host at home?
17. Can the police hamper the work and how?
18. Can other people hinder the work (neighbors etc.)

Movement

19. The category of the location
20. Approximate number of the host's permanent clients who are not covered with work and their category
21. The possibilities of getting access to other locations
22. What days and when during the day do the host's permanent clients visit him \her?
23. Where is it possible to communicate with the host's clients?
24. Where is it possible to watch risky behavior of the host's clients?
25. What do the host and his clients usually use?

Outreach workers requests

26. Who wants to work at this location?
27. How many times a week (what days)?
28. What working hours?

Supervisor's decision about the development

29. The following person is delegated to be responsible for the work at the location
30. A partner of the responsible person will be
31. The number of the site visits per week
32. Working hours at the location

Kazan Model Form 2

ID of the location host:

The category of the location:

Area:

Date				
The working stage with the location				
Outreach worker				
The time of arrival at the location- the time of departure from the location				
The number of repeated contacts				
The number of primary contacts				
The number of other IDUs related to the host				
The number of other IDUs: visitors				
Collected syringes (from the host \visitors)				
Distributed syringes (to the host \visitors)				
Distributed harm reduction materials (to the host \visitors)				
Distributed condoms (to the host \visitors)				
Provided services				
Referrals given				
Distributed information materials (to the host \visitors)				
Survey				
Characteristics and extent of the host's involvement				
Characteristics and extent of the visitors' involvement				
Behaviour change of the host				
Behaviour change of the visitors				
The number of uncovered visitors on the stage of development. Appearance of new visitors at the stage of support.				
Other notes				

Note: real form is larger than this with 8 empty columns, one for each day of the week and one for weekly totals and summaries.

Model of constant expansion

While there are many important aspects of the Kazan Model, which will be discussed in the next Section, here it is necessary to concentrate only on four features: the constant expansion built into the model, the need for advocacy, peer support and the management techniques used to ensure quality assurance.

Because outreach workers are constantly in a process of identifying new sites or tusovkas, opening and developing them where possible, then moving to the support stage as soon as possible, the time and resources devoted to outreach work are used in the most efficient way. After the necessary investment of time and energy in development, only short visits are needed during the support stage, which can continue for as long as the site host remains interested in assisting the NSEP. As outreach time is freed up by moving to the support stage, workers are available to open more new sites. This enables the NSEP to constantly expand the number of sites it reaches.

Even with a stable number of outreach workers, this process has enabled the NSEP to reach into over 100 hidden networks of IDUs. With a simple addition of outreach workers and sufficient harm reduction equipment to supply all of these networks, the program should eventually be able to reach into almost every hidden network in the city, thus assuring near 100% reach of information and education and at least 60% coverage with harm reduction materials. The Kazan Model of outreach and secondary exchange is an excellent method of assisting to change the social norms of IDUs around safer injecting and safe sex, and other issues.

However, it needs to be noted that this model will not work everywhere in RF immediately. While the Kazan NSEP avoids drug selling sites, if possible, outreach workers are still often in hazardous situations, especially if police decide to raid a tusovka where outreach workers are present. In addition, the RF Criminal Code has such severe penalties for possessing such small quantities of drugs that the tusovka hosts face substantial jail sentences for collecting used needles and syringes to give to the outreach workers. In addition, the Code contains a criminal offence of allowing premises to be used for a crime to be committed and this provision is regularly used to arrest tusovka owners. For these reasons, advocacy is needed at the highest levels (see below) to ensure that all sectors of society agree that HIV prevention is a higher priority than arresting drug users.

Another important aspect of the Kazan Model is its involvement of IDUs to assist and educate other IDUs. This is the key element of peer support. Although other types of peer support are possible and are starting in other parts of RF (see Section 6), the Kazan Model involves and fully integrates active IDUs in its work, which is the hallmark of effective peer support programs. By doing this (even to the point of giving certificates to these volunteers), the program ensures that IDUs become committed to harm reduction and to changing social norms. The fact that volunteers continue to provide needle and syringe distribution and collection despite the danger of imprisonment also shows that active IDUs can be courageous and altruistic in assisting their friends to prevent HIV transmission.

Training and management of outreach workers is another critical issue. In a recent report, the management of the NSEP noted that 22 training sessions had been provided for outreach workers in the previous nine months. Only through this constant upgrading of skills can outreach workers face the multitude of problems likely to crop up in their work. This investment in outreach workers is vital.

The Outreach Manager, using the forms shown earlier, sits with each outreach worker each morning to discuss the goals of the day: this is made easier because each step of opening and development has been specified and indicators are provided for workers to assess the feasibility of opening or the stage of development. Each outreach worker meets again with the Outreach Manager at the end of each day to discuss the progress made with each site. This daily supervision addresses one of the major problems with outreach worldwide – the possibility that outreach workers are simply “hanging out” with their friends, rather than working towards the goals of the program.

An extra layer of supervision is the weekly team meeting on Saturdays. At this meeting, each outreach worker discusses with the Outreach Manager his/her performance in the previous week, whether all goals were met, problems encountered, etc. and the individual goals for the following week. This is done in a group, and the other outreach workers are encouraged to comment. From this process, decisions are also made about secondary development and closure of sites, when necessary, and the Outreach Manager can easily compare the performance of outreach workers and identify specific problems for further individual supervision.

This meeting also has the main features of a quality assurance system:

- Services are continuously monitored to search for problems and new issues which are not currently being addressed: these are brought up and discussed at team meetings
- Outreach Manager and outreach team decide on changes to work practices or involvement with sites, based on the above information
- Decisions on ways to address problems or new issues are implemented quickly (usually the week following the team meeting)
- Ongoing monitoring continues to check whether the new ways of working are effective or whether new issues are again emerging: through the following team meetings.

Kazan and beyond

As well as the outreach process outlined above, the Renewal program includes two fixed-site NSEPs and a recently-started mobile service that specifically targets street sex workers with harm reduction materials, increasing the program’s ability to reach and educate female IDUs who are also sex workers. In addition, the program provides training sessions for IDUs (10 in the past nine months) on overdose, safe sex and disinfection of needles and syringes. Consultations with infectionists, testing for HIV, hepatitis and STIs, and medical treatment are also arranged for NSEP clients.

In addition, during 2000, the Project Co-ordinator and outreach workers visited the following other cities in Tatarstan: Bugulma, Almet’evsk, Zelenodolsk, Chishtopol, Naberezhnye Chelny and Nizhnekamsk. In these visits, they supervised harm reduction implementation (Bugulma and Naberezhnye Chelny) and carried out a situation assessment and designed responses based on these assessments (in the other cities). They met with the co-ordinators and potential implementers of harm reduction activities, visited city administrations, met with IDUs and delivered 20 seminars on harm reduction, in which more than 500 medical specialists participated from throughout Tatarstan. A further 28 people from the above cities were brought to Kazan and trained in NSEP work, and reduction materials are now being provided to all of these cities.

The Project Co-ordinator has also been successful in ensuring that a Prikaz (order) has been issued to 10 polyclinics and other medical centres in Kazan, requiring them to become fixed site NSEPs. These programs will be supplied with harm reduction materials, and their staff will be

trained, by Renewal

Due to the advocacy efforts of the managers of the Kazan NSEP, and the interest of the Tatarstan President and his Ministers in youth and health affairs, the Republic of Tatarstan has instituted a multi-sectoral response to HIV/AIDS, of which harm reduction is a key activity. The Republican AIDS Committee represents many sectors of Tatarstan society, is chaired by the Deputy President and has as its Secretary the Head Doctor of the Republican AIDS Centre. The committee, through the Head Doctor of the AIDS Centre, is responsible for co-ordinating activities and relations between various government and non-government organizations.

Following the establishment of the Republican AIDS Committee, a general AIDS action plan has been agreed with all 45 territories of Tatarstan and similar committees have been established in each territory (chaired by the Deputy Governor of each territory in charge of social issues) to co-ordinate local activities. Since 1999, harm reduction has been an official part of these plans and activities. Mr Burnashov, Advisor to the Prime Minister, told me that the outcome of harm reduction work in cities such as Kazan had been very positive and convincing. "Initially, it was planned that there would be two programs: one on harm reduction and one on AIDS control," Mr Burnashov said. "Now it has been decided that harm reduction will be the main focus of AIDS control so that, of the 10 million roubles planned to be used for AIDS control (over the two years 2001-2002), 6 million roubles will be used for harm reduction."

An interview with the Health Minister of Tatarstan, Dr Ziyatdinov, confirmed that harm reduction is supported at the highest levels of the Republican government. "We managed to develop and introduce the idea of harm reduction vertically. The request was made to start a harm reduction program in Kazan, and a request was made for funding. This led to many debates and the program managers convinced us they are right and their program is right. Already Tatarstan had shown its interest in health issues: we are the second territory in RF in terms of health care spending per capita after Moscow. Tatarstan considers the health of its people the most important treasure of the nation."

The Minister believes harm reduction needs to be part of a comprehensive approach targeting the health of young people. A schools health program has begun and separate programs work to encourage young people into sports and other recreational activities to prevent drug use. He said much work had been done with the police to assist them to understand their role in these activities. "The President has set police the goal of protecting the physical territory of the republic, analysing the structure of the illegal drugs trade, and preventing drug trafficking." This has helped to ensure that IA officers target drug dealers rather than drug users, which is vital for NSEPs to work effectively.

3.4 OTHER RESEARCH

Prior to finalising this report, the author was provided access to the draft version of a UNDCP/UNAIDS Case Studies Booklet – *Lessons learned on drug abuse and HIV/AIDS: Central and Eastern Europe and the Central Asian Republics*. While this booklet covers the whole CEE/NIS region, its main points echo the above findings. The booklet finds that the following challenges must be overcome if measures to prevent the spread of HIV among IDUs are to be successful:

- *“Comprehensive coverage of the entire targeted populations is essential.”* For prevention measures such as NSEPs to be effective in changing the course of the epidemic in a country, it is essential that as many individuals in the at-risk populations as possible are reached. No single approach can be acceptable to all drug users, as indicated by the coverage rates cited in the case studies (estimated rates vary between 2 and 33%). In order to reach a substantial part of the population, a wide availability of services is needed.
- *“Drug abuse treatment needs to be easily available to contribute to preventing HIV infection.”* Longer retention in treatment, as well as completion of treatment, are correlated with reduction in HIV risk behaviours or an increase in protective behaviours. But, to reach their target population, treatment services need to be readily available and flexible. Treatment applicants can be lost if treatment is not immediately available or readily accessible. Treatment systems need to offer a range of treatment alternatives, including substitution treatment, to respond to the different needs of drug abusers.
- *“Capacity building in HIV prevention and treatment needs to be encouraged within the existing system of health services.”*
- *“Systematic project planning, monitoring and evaluation need to be further strengthened.”*

Also, initial data was released from several projects that are evaluating the introduction of NSEPs in RF. Grund et al (2001) provided preliminary data from a large evaluation undertaken in 1999/2000 of NSEP clients in Nizhny Novgorod, Pskov, Rostov-on-Don, St Petersburg and Volgograd. This data showed “substantial reductions in previously identified injection risk behaviors, such as needle sharing, from the time prior to using the exchanges and generally low rates of the same behavior while using the exchanges. The percentages of respondents reporting receptive syringe sharing - perhaps the most widely used measurement in judging the effectiveness of (NSEPs) - are comparable to those in effective syringe exchange programs in other countries. Based on these data we recommend that syringe exchange and other HIV prevention programs in Russia should be expanded.” However, the authors also found that some risk behaviours remained unchanged after the opening of NSEPs.

Specifically, the study looked at behaviours in a 30-day period prior to the NSEP opening (called “prior” below) and in a 30-day period several months after the exchange opened (called “NSEP” below). A total of 1076 IDUs were interviewed for the study, which found that, on average across the five cities:

Table 4.15. IDU Behaviour in 5 RF Cities before and after attending NSEP

Behaviour	Prior	NSEP
Daily injection of at least 1 drug	53%	53%
Receiving a used syringe (receptive syringe sharing)	38%	11%
Injected at an anonymous injecting venue	45%	28%
Bought drugs in syringe	12%	3%
Used blood in preparation of drugs	8%	4%
Saw others use blood in drug preparation	27%	8%
Injected in a group	91%	86%
Shared utensils (eg, vial)	82%	73%
Syringe mediated drug sharing (SMDS) – use of syringes to share drugs between several syringes in group injecting	58%	48%

The authors pointed out that these final three behaviours are tied closely to the group preparation of liquid drugs. It is yet to be determined how the widespread introduction of heroin to RF cities will affect these behaviours. Grund et al also recommended increasing use of secondary exchange of needles and syringes, finding that, on average, 44% of the clients interviewed were already involved in passing on new injecting equipment to their friends.

Preliminary data from a study in Sverdlovsk oblast showed similar results. Power (2001) carried out a baseline survey (IDUs I; n = 663) prior to the opening of NSEPs in Sverdlovsk, then compared this data with two groups: those IDUs who had been attending an NSEP for at least three months (NSEP IDU; n = 241) and those who had never attended a NSEP (IDUs II; n = 122). Some preliminary results are below:

Table 4.16. IDU Behaviour in Sverdlovsk before and after attending NSEP

Behaviour	IDUs I	IDUs II	NSEP IDU
Only use own syringe	32%	33%	72%
Only use own needle	40%	32%	75%
Only use own filter	37%	38%	69%
Only use own drug solution	36%	26%	68%
Purchase ready-made drug	17%	11%	13%
Syringe mediated drug sharing	65%	52%	32%

Power found that purchasing ready-made drugs was virtually unchanged by NSEP attendance, and that the effects of the NSEP on numbers of IDUs adding blood to drug solution was the opposite of the intended effect. Again, this is likely to change due to changes in drug use patterns, but this finding echoes Grund et al's statement that NSEPs need to concentrate on the social nature of drug preparation and use. Power also found little effect on condom use among NSEP clients, suggesting that further work is needed to reduce sexual transmission among IDUs.

In addition, the results of an important survey carried out in 1999 by the All-Russian Centre for Public Opinion Research were released, showing that attitudes of most Russians had changed slightly (since previous surveys in 1994 and 1989) to become more liberal towards sex workers, gay men and people living with HIV/AIDS. However, the attitude of Russians towards drug users continued to be increasingly negative with 29% of those surveyed believing that drug users should be "eliminated". In addition, the researchers found 24% of those surveyed believes that drug users must be segregated from society. These results led the researchers to fear that stricter drug policies (as opposed to harm reduction policies) will be implemented in RF in the coming years (Oleinik et al 2001a).

Finally, MSF-H and OSI-R released a list of 11 cities which had been trained in the MSF-H RAR training program in 1998-1999, and had carried out rapid situation assessments, stated their desire to start NSEPs, but were unsuccessful in being funded due to a restriction on the number of programs that could be funded through OSI-R, and few other donors willing to fund harm reduction programs in RF at present. MSF-H and OSI-R staff believe these cities should be considered first when funding for new programs is established, and have provided additional training to these cities in December 2000 to assist them in program design, budgeting and fundraising.

Table 4. 17. Cities completed MSF-H training, wanting funding for NSEP

Region	City
Republics	
Bashkiria	Ufa
Chuvashia	Cheboksary
Karelia	Petrozavodsk
Mari-El	Ioshkar-Ola
Sakha-Yakutia	Mirny
Oblasts	
Bryansk	Klintsy
Chelyabinsk	Chelyabinsk
Irkutsk	Irkutsk
Kaluga	Kaluga
Khanty-Mansi District	Nizhnevartovsk
Kurgan	Kurgan
Kursk	Kursk
Tomsk	Tomsk
Vologda	Cherepovets

If the above 14 programs were to be funded, a further 13 oblasts and republics would have at least 1 NSEP, bringing the total number of oblasts and other territories with NSEPs to 47 or more than half the territories of RF. OSI-R has also been approached to fund two other NSEPs by NGOs in Moscow, one of the epicentres of the HIV epidemic in RF.

IV. FINDINGS – PRISONS HARM REDUCTION PROGRAMS

There are very few HIV prevention programs among IDU prisoners in RF, and all of the programs discovered during this investigation have started within the past two years. The biggest prison harm reduction program is currently being developed by MSF-H, together with external agencies and GUIN (Prisons Service) of the RF Ministry of Justice. This program works with prisons in four oblasts. Other programs are in Nizhny Novgorod, where the NGO “Anti-AIDS Foundation” and Nizhny Novgorod Prison Administration are carrying out an education and training project (with support from Penal Reform International, funded by OSI and increasingly from local sources); and in Pskov, where the NSEP has recently received additional funding from OSI-R to do prisons work. The information in this section is derived from key informant interviews with staff from the Nizhny Novgorod and Pskov projects as well as MSF-H staff, and reading relevant documents. Contact details and other relevant information for the six prison programs are in Appendix 3.

Single oblast programs

The Pskov program was only funded in early 2001, so it is very early in its implementation. Pskov NSEP plans to establish a condom and disinfectant distribution program, together with a trial of needle and syringe exchange in prison. The prison NSEP would follow the model used in Schklov in Belarus where harm reduction materials (including injecting equipment) are provided to authorised inmates in each unit of the prison each evening to deal with first aid needs during the night. In the morning, used equipment is collected. At the time of writing, planning for the Pskov project was under way, as were negotiations with prison and other authorities (Personal communication: Irina Sivacheva, Pskov Anti-AIDS Initiative, February 2001).

The Nizhny Novgorod project started in May 1999 with the implementation of activities to improve prevention of HIV transmission and management of HIV positive inmates. The project has five main components (Reyes and Bollini 2000):

- Agreement from prison authorities of the city to the planned activities.
- Training of staff from various prisons as trainers to provide training to staff at all levels, as well as peer education training among prisoners. Training materials developed included several videos and radio programs and two leaflets: one for staff, and one for inmates. Two study visits to Ukraine and the Krasnodar region were conducted in September 1999 for key representatives from the project, NGOs and prison authorities.
- Providing the means of preventing HIV transmission: Disposable syringes and gloves were made available to prison staff, bleach was made available in the toilets, and instructions on how to disinfect razors were provided (as instructing prisoners in disinfecting injecting equipment was regarded as unethical). A limited number of condoms were also made available for long-term family meetings.
- Improvement of living conditions of HIV positive prisoners, with a new wing being built for HIV positive prisoners in one colony, quarters for family visits made available in two other colonies, a yard for walking and sports in the sectors for HIV positive inmates in the male colonies, and a fenced recreation yard set aside for HIV positive women inmates.
- Sociological survey on knowledge of HIV transmission and attitudes towards HIV positive prisoners, conducted on a sample of prison guards and inmates from colonies where HIV positive prisoners were held, and a community sample.

An evaluation of the project was carried out by two international consultants in September 2000 (Reyes and Bollini 2000). The evaluation found that:

- a) Enormous changes had occurred since the beginning of the project in the attitudes of the prison administration towards HIV infection: the administration “changed its cognitive framework and consequently its response to the epidemic, from passive epidemiological control to proactive provision of information and better care”.
- b) Study visits to Ukraine and Krasnodar assisted prison authorities’ to understand the magnitude and consequences of HIV infection in prison.
- c) The project influenced the knowledge of prison staff and prisoners concerning HIV transmission and risk involved with dealing with HIV positive prisoners.
- d) The educational pamphlets issued by the project contained all the relevant information needed by both staff and inmates, were tailored to these two distinct target audiences, and were illustrated accordingly, so as to attract the readers.
- e) The project conspicuously improved the living conditions of HIV positive inmates.
- f) HIV positive male and female prisoners’ comments on the new developments were very favourable.

A visit to the project by the author in February 2001 confirmed the evaluation’s findings. Project staff stated that the project had led to a complete change of thinking in the GUIN in Nizhny Novgorod oblast. “Health staff attitudes in prisons are absolutely different from what they were two years ago. Our first reaction was to isolate prisoners with HIV. Now we encourage all staff to treat all prisoners as if they were HIV positive”, they said.

Funding for the program has continued from PRI, as well as various sources of local funds, including charities. Funding for all health programs in prisons normally is Federal funding provided to GUIN in Moscow and then to GUIN at the oblast level. This funding has no allocation for the production of HIV education materials, so funding for these must come from other sources. The only government funds likely to be used for this type of work are targeted program funds at the oblast level.

Project staff said that needle exchange in prison was an interesting idea and felt that it would be very easy to implement. “However, we have not seen the need for it yet. The level of drug addiction among prisoners here is low, and the number of inmates who inject on a regular basis is very low,” they said.

Multi oblast program

The MSF-H program started in July 1999 after the organisation carried out an extensive assessment of prison conditions related to the spread of HIV infection as well as a survey of international best practice on preventing HIV transmission in prisons (Bijl 1999). The program directly involves 3000 staff and 15,000 inmates (and indirectly 80,000 inmates) in Moscow, Krasnodar, Penza and Omsk oblasts.

The three-year pilot project has completed its preparatory phases and is now developing specific interventions. The program includes:

- Signing a Memorandum of Understanding (MOU) between GUIN of the Ministry of Justice of RF and MSF-H: this was followed by a recommendation from the senior levels of the Ministry that project educational materials be distributed at all prisons in RF.
- Initial training workshops involving senior national and regional decision-makers on approval for the program, strategy, and materials and activities to be used, as well as the steps to program implementation. International consultants, harm reduction NSEP staff, program staff and others assisted decision-makers in these processes. A guideline for all RF prisons on management of HIV prevention is being drafted as a result of this process.
- Specific HIV/AIDS management training was provided by international consultants to middle management of the selected prisons, who now act as regional contacts and trainers for other staff in their regions. Similar work was done by a Russian NGO on pre- and post-test counselling training for selected prison medical staff who are now regional trainers on these topics. Custodial staff were trained in preventive and occupational health, drug treatment, HIV prevention, drug and harm reduction, peer support, roles of custodial and medical staff, etc. in a similar way to become regional trainers.
- With support from international consultants and regional health services, inmates have been trained as peer educators in three regions (the 4th region will be covered this year). Training takes place over five days and covers a wide range of relevant topics.
- Future plans include ongoing training of the various groups (custodial and medical staff and prisoners) over the next two years. Quarterly regional round-table meetings on HIV prevention in prisons are being held between municipal and prison authorities. The project team provide a media conference each time they visit each region and the roundtable meetings also include media representatives.
- The program has translated 22 key documents and scientific papers on HIV prevention among prisoners into Russian. A booklet for prison officers was adapted into Russian from the West European Prison Peer Education Program; leaflets have been produced about the program and about research activities; booklets for male and female prisoners have been developed, with ex-prisoners involved in developing these materials, and focus group testing with current prisoners; training manuals are being developed (with international consultants) on health promotion in prisons, HIV/AIDS (for prison doctors), counselling, and training prison peer educators. All of these materials will be approved by federal and regional prison authorities before being distributed.
- Participating regions and prison sites were provided with computers, modems, email access and a list server to enhance communications between participating prisons. Prisons are also receiving condoms and bleach for distribution to prisoners.
- Epidemiological surveillance is being used to support the development of educational materials, and to measure program impact, and a monitoring system has been implemented on the health situation of HIV positive prisoners. A baseline survey was carried out in August 2000 of about 1200 inmates across the four oblasts.

In interviews with key informants, all the above features of the MSF-H program were considered as strengths. An additional strength is the readiness of prisoners to be educated and informed on these topics: “they’re bored by prison life so they are very interested in what we have to say”. The biggest weakness is the size of the prison population in RF, combined with the current workload on overworked and under- or unpaid staff, and the dilapidated state of most prison facilities.

V. DISCUSSION

5.1 BEST PRACTICE NSEP IN RUSSIAN FEDERATION

This rapid evaluation of the work of community harm reduction programs in RF has discovered several, very positive findings. When harm reduction work began in RF in 1996, few people working on the issue would have believed that there would be 48 functioning needle and syringe exchange programs (NSEPs) operating across RF less than five years later.

From the key informants, there appear to have been both internal and external factors at work in this success. Internally, the most important factor seems to have been a core group of caring and pragmatic people (mostly doctors, usually epidemiologists, infectionists or narcologists) who became involved in the difficult field of HIV prevention among IDUs, learned about effective approaches to this issue, and undertook the many steps needed to carry out a rapid situation assessment, design a program, gain funding, start and maintain a NSEP. Another internal factor has been the attempt (not always successful) to bring a multidisciplinary approach to this issue, not just among doctors but among many different professionals working together with IDUs and ex-users. Support from local administration officials has also been crucial to the establishment and operation of NSEPs.

Externally, training from MSF-H and MDM, and funding by OSI-R were regarded as the most important factors. Training on rapid assessment and response (RAR) methods was important, as was the use of rapid assessments as both program development and advocacy tools. Program development, through training and technical assistance from various sources, assisted in enlisting the support of local authorities, including police, and in building capacity of government and non-government organisations to carry out all the tasks associated with NSEP work.

It also needs to be remembered that NSEPs in RF are generally very young with the great majority operating for less than two years. This means that the way these programs are judged must be different to the way that similar programs might be evaluated in countries where NSEPs have been operating for 15 years.

The program data show that most NSEPs are offering a wide range of harm reduction materials, educational materials and services. As a way of considering what services are provided and how they are provided, the following will be examined below:

- a) Level of services: for example, numbers of needles and syringes provided for each client
- b) Breadth of services: for example, types of syringes available, and types of referral available for health services
- c) Effectiveness of services: for example, whether IDUs' behaviours are changing after NSEP is introduced
- d) Reach of services: for example, how many clients access the services
- e) Quality of services: for example, how clients feel about services

Level of services

The types of NSEP service delivery, based on the program survey, seem generally appropriate, especially for such young programs. All responding NSEPs use outreach workers, all but one have at least one fixed site (with more than half of these having more than one fixed site), and more than one-third operate mobile services. This is a good mix of service delivery types and

shows a willingness to expand to meet the needs of clients. Operating hours are low by comparison to many other countries, especially on weekends. As noted in Section 3, operating hours on average at NSEPs in the USA are also low, but many countries provide access to needles and syringes through a variety of delivery mechanisms 24 hours a day, 7 days a week. This must become the aim in RF as well. (This does not mean that access must always be through the NSEP – see Reach below.)

The numbers of needles and syringes distributed and collected – when viewed on a per-client basis – is high. While questions were not asked about the numbers of alcohol swabs, condoms, bottles or sachets of disinfectant and other harm reduction materials provided, observations by key informants are that these also appear to be appropriate (where they are provided), except where funding restrictions cause shortages of these items.

The key figure – that each primary exchange client of the responding NSEPs receives, on average, 31 needles and syringes in 1 month or 372 in 1 year – approaches the needle and syringe distribution figures in leading countries such as UK, The Netherlands, Germany and Australia. This does not mean the level of needle and syringe distribution should be reduced: a higher level of service should mean a higher likelihood of NSEP clients using a new needle and syringe for every injection and hence reduced chances of NSEP clients contracting HIV or hepatitis B or C infection. It is also likely that some of this primary exchange is hidden secondary exchange – that is, clients saying they are using all the syringes themselves when they are really distributing them to friends.

However, the overall number of needles and syringes provided is quite low (see Reach below) with 84% of responding programs saying they distributed fewer than 10,000 needles and syringes in the previous month. Needle and syringe collection appears to be generally well organised with most responding NSEPs having return rates of between 90-100%.

Funding will be examined below in relation to reach. Here, it is important to note that the overall expenditure (from all sources) by responding NSEPs was \$699,551 in the previous year, or \$58,296 per month (assuming that the funds were spread evenly over 12 months). As the figure for needles and syringes distributed in the previous month was 157,779, the cost per needle and syringe delivered is calculated as \$0.37. This is substantially higher than the comparable figure for Ukrainian harm reduction programs which have been operating for several years. However, the figure for RF is likely to be an overestimate (due to some missing data), the responding NSEPs generally provide a wider range of services than Ukrainian harm reduction programs, and the youth of the RF programs make the figure acceptable at present. Over time, this figure should reduce to 2-3 times the cost of a needle and syringe (\$0.12-\$0.18): this normally happens (in the Ukraine for example) when much larger volumes of needles and syringes are distributed (above 10,000 per month for example). The increasing use of secondary exchange will assist in lowering this figure.

Several respondents also said they were careful not to expand their delivery of needles and syringes beyond specific limits, due to fears about funding. As the NSEPs know how much they will receive from OSI-R (their chief funding source) but are unsure what other funding may be available, once they become successful at attracting IDUs, they calculate how many needles and syringes are being distributed and project these calculations for the remainder of the year to see if their current funding will cover these expenses. Most NSEP managers are aware of the dangers of running out of supplies and (at worst) closing the NSEP, so they try to be careful with distribution of all materials. This obstacle to expansion can be addressed very quickly through expanding NSEPs' access to all injecting equipment and condoms.

Breadth of services

The responding NSEPs appear to be generally providing comprehensive services. Responding services were a mix of organisational types: 11 are NGOs, one a collaboration between an NGO and government agencies (AIDS Centre and narcological dispensary), and 14 are government agencies: five AIDS Centres, three narcological dispensaries, and the remaining six are combinations of government agencies (mostly AIDS Centre and narcological dispensaries working together). There was no evidence that a program operating from a particular organisational type was any better or worse than any other program: for example, there was no evidence that programs run by narcological dispensaries were necessarily less effective than those run by NGOs.

The distinction between government and NGO services in RF is also less clear than in many other countries. Most NGOs working in the HIV and drugs field in RF are hybrid structures (for example, an NGO based in a narcological service or AIDS Centre using government and non-government staff). Successful programs seem to depend less on organisational type and more on the strategies used to embed harm reduction activities in the local community. A community approach is needed whereby drug use and related HIV infection are not only the responsibility of a single organisation, but are shared by narcological dispensaries and hospitals, AIDS Centres, infectious diseases hospitals, youth organisations, schools, welfare services, religious organisations, parents groups and so on. A recommended way to ensure this occurs is the establishment of intersectoral co-ordinating committees or mechanisms at oblast and city level to ensure all relevant government structures and NGOs work together to implement harm reduction programs.

The provision of a range of different needles and syringes (with substantial differences between programs based on local needs) and the high percentage of programs providing condoms, are good indicators of the breadth of harm reduction materials provided. In conversations with NSEP managers, however, it appears that condom distribution may have been higher than usual during the past few months, due to a large donation of condoms by Population Services International. As this donation may not be regularly repeated, additional attention is needed to ensure that all programs are supplied with appropriate numbers of condoms to meet the needs of IDUs including, especially, female IDUs who are also sex workers.

The number of NSEPs providing alcohol swabs (69% of programs) is disappointing as these swabs are an excellent harm reduction tool for preventing abscesses, and are a talking point for NSEP and outreach workers to broach other issues related to safer injecting. Given the quality of tap water in many parts of RF and the problems of homeless or “street” drug users finding appropriate water for injecting powdered drugs such as heroin, it is also recommended that all programs provide sterile water, at least to heroin-using clients.

The provision of disinfectant continues to be a difficult issue globally. It has been shown that disinfecting needles and syringes with bleach does not prevent hepatitis C transmission, but it appears to have some role in reducing (though not preventing) HIV transmission. For this reason, many NSEPs in other countries do not distribute disinfectant. But, after much research and discussions with drug users in Australia, the decision has recently been made in that country to begin distributing disinfectant and instructions on its use as there are many situations where a drug user cannot use a new needle and syringe or be sure that no one else has used his or her needle and syringe. Disinfectant provision and education in its use should become a standard part of RF NSEP work.

The distribution of educational materials seems to be widespread, and these materials cover a large number of relevant topics, though concerns have been expressed about the quality of these materials (see Quality below).

As well as needle exchange, a wide range of other services are offered by most NSEPs. Most of the services offered are medical, which is valuable as one of the goals of harm reduction programs is to attract drug users into regular contact with health services. Strangely, relatively few responding NSEPs provide first aid for abscesses, etc. yet this is a very valuable tool for attracting drug users to NSEP services: all NSEP and outreach staff should be trained in first aid. Also, few programs concentrate on working with sexually transmitted infections (STI) clinics to ensure that IDUs with STIs receive prompt treatment, and that transmission of STIs and sexual transmission of HIV is addressed: working with STI clinics can also assist in bringing NSEP staff into closer contact with a key target group, women IDUs who are also sex workers. There is also a focus on drug treatment services by many NSEPs, which may be appropriate if it does not lead to a confusion of goals (see Quality of services below).

However, medical and drug services may be less useful to many IDUs than other services such as legal and social assistance. There is little evidence that clients are being asked what services they need (apart from the types of needles and syringes they require), and that NSEPs are adjusting their operations to meet these needs. Both level and breadth of services should be constantly monitored through various means – surveys, focus groups, structured involvement in advising the NSEP managers – to ensure that IDUs' highest priority needs are either met within the program or appropriate referral mechanisms are put in place. By meeting clients' greatest needs wherever possible, the NSEP becomes more valuable to IDUs and NSEP staff are more likely to have a greater influence in assisting IDUs to change their behaviour.

It is excellent that almost two-thirds of responding NSEPs provide training of active IDUs or meetings of active IDUs to discuss HIV prevention and other issues. All NSEPs should carry out this work when appropriate levels of trust have been built up with drug users, when staff have appropriate skills, and when suitable premises can be found. It is encouraging that key informants detected an increasing emphasis on peer education and on working closely with active IDUs – that active IDUs comprise 15% of the total workforce of the responding NSEPs was also a surprise. Over time, this figure should increase but such a substantial level of involvement of active IDUs was not expected at this stage of the NSEPs' development.

Unfortunately, peer education and peer support programs in RF are too young to be evaluated yet, and these techniques are little researched worldwide. As was mentioned in Section 3, despite the lack of research evidence for the effectiveness of peer strategies, they have increasingly become a vital part of practice for NSEPs in other countries, as they appear to be the only method that can quickly lead to a change in social norms around IDUs' risk behaviours.

The Kazan Model (Section 3) is one excellent model of peer support. Other models in RF have grown out of other RF harm reduction programs. First, the MSF-H outreach team has developed a successful Russian-language training program for IDUs in peer education. The five-day program has been run eight times in Moscow with, by January 2001, 60 graduates of whom 20 have become volunteers and seven have become outreach workers at the MSF-H outreach program. The program includes sessions on practical methods of reducing drug-related harm, contacting peers, history and philosophy of harm reduction, overview of infectious diseases (HIV, hepatitis), overdoses, vein care, safer drug use and safe sex, non-injecting drug use, disinfection of injection equipment, detoxification, drug treatment and legal aspects of drug use. Participants are provided

with educational leaflets, a training manual and certificate for completing the course, and are encouraged to pass on their knowledge to 10 of their friends (Kobzev and Kruglikova 2001). If all graduates reach this goal, around 600 people have been reached so far with this method.

Oleinik et al (2001b) reported on NSEP activities in Penza including an outreach model which has similarities to the Kazan Model and the beginning of drug user organising for mutual support. This latter topic was also the subject of Melnikov and Gouwe's (2001) paper on Kolodets, the first drug user self-organisation to start in RF. Kolodets began in Moscow in June 2000 and regular meetings have been held to discuss the issues on which its members will work. In April 2001, the group published a booklet in Russian and English explaining their existence and their plans to represent the health, public, legal, economic and social interests of drug users and their relatives.

These three models all appear to be successful ways to increase involvement by active IDUs in NSEP work. All programs in RF should be using at least one of these processes and, where possible, all three models should be implemented.

A point that was made by the key informants on harm reduction in prisons is that NSEPs and other relevant municipal bodies need to be working closely with prisons peer education activities. The role of NGOs and municipal bodies should be to share responsibility for training of prison peer educators with prisons harm reduction program staff, providing counselling to IDU and ex-IDU prisoners, and ensuring that there is a consistency of educational messages and prevention strategies across both prisons and community harm reduction programs. NSEP outreach staff should become involved in training of prison peer educators, but they will need to be trained in the specific nature and limits of prisons work prior to their involvement.

The concept of harm reduction also needs to be widened beyond NSEP to include the establishment of methadone and other substitution programs on a large enough scale to meet demand, as well as low-threshold drug treatment and improved detoxification and drug treatment, including long-term psycho-social support, especially for HIV-positive IDUs.

For these new activities, there are many lessons to be learned from current initiatives in RF and Ukraine. In Yaroslavl, a pilot project began in late 2000 to implement drug counselling and social rehabilitation as basic elements of a comprehensive drug treatment program: the project is being implemented by Trimbos Institute of the Netherlands with Yaroslavl Narcology Clinical Hospital, funded by Dutch government agency Matra. The project is only about half-complete, but already there are indications that narcologists are finding these techniques useful (Personal Communication: Franz Trautmann, February 2001). If this program evaluates well, NSEPs should encourage the widespread use of these techniques to assist in addressing the broader issues of drug use and HIV/AIDS.

In Ukraine, a program of non-medical care and support for HIV-positive IDUs was recently begun by MSF-H. The program is based on a needs assessment which found that the change in social norms of IDUs around HIV prevention had to include attempts to increase IDUs' self-esteem so that they would become more motivated towards HIV preventive behaviours (Burrows et al 1999b). The first steps in the program were the publication in English and Russian of an overview of treatment, care and support of HIV-positive IDUs (Burrows 1999b); a national survey of the needs of HIV-positive Ukrainians including IDUs and ex-IDUs (Leonchuk and Shapoval 2000: also published in Ukrainian); and a training program on non-medical care and support of people with HIV/AIDS in Ukraine, with specific emphasis on IDUs (McCallum and Burrows 2000). This training program will be trialled in Kiev and Odessa in mid-2001 and, if

successful, should be considered for use in RF.

Effectiveness of services

It was beyond the scope of this brief study to prove the effectiveness or otherwise of NSEP as an intervention to prevent HIV transmission among IDUs in RF. However, preliminary results from Grund et al (2001) and Power (2001) clearly demonstrate that NSEPs are having a similar effect in RF to the effects observed in other countries. Individual behaviour change among IDUs is strongly related to attendance at a NSEP. Reduction of risk behaviours such as the sharing of needles and syringes is likely to have a major impact on HIV transmission, if it becomes the social norm among IDUs across RF.

These researchers also point out where some problems may lie for effective HIV prevention among IDUs. Both studies have found that social behaviour of IDUs, especially in the preparation or manufacture of liquid home-made drugs, is not changing at the same rate as individual behaviours. This is a powerful argument for increased reliance on peer strategies such as peer education and peer support (see Breadth above).

In addition, there are techniques that non-IDU NSEP staff can use to try to influence group norms. NSEP staff and outreach workers should start with small changes which may have a significant impact on HIV transmission. For example, in Astrakhan, it was observed that many IDUs used their syringes to draw up their liquid drug from a common pot or vial. The NSEP gives out a syringe with a thick intramuscular needle (which cannot be easily used to inject liquid drugs) and an additional thin intravenous needle. Staff recommend to every drug user to draw up the solution using their own sterile intramuscular needle, which serves as an additional barrier to HIV spreading during the “sharing out” of liquid drugs: the intramuscular needle is then replaced with the intravenous needle before injecting.

A more difficult change is recommended by US authority on microbiology and HIV transmission among IDUs, Dr Robert Heimer, who recommends that NSEPs attempt to encourage IDUs to use smaller syringes with fixed needles rather than the separated needles and syringes which are commonly used. Dr Heimer estimates that the blood left in the former is around one-tenth of the amount of blood left in the latter after an injection and, consequently, HIV transmission is far more likely when sharing separated needles and syringes (Personal communication: Robert Heimer, April 2001). This recommendation needs to be carefully considered in light of IDUs’ preferred practices. If IDUs will not come to the NSEP for fixed needles-and-syringes because they prefer them separated, the NSEP fails to reach and access hidden networks of IDUs. It is therefore recommended that the current range of needles and syringes continue to be offered to IDUs, but that NSEP and outreach staff, together with volunteers and people involved in peer strategies, work together to encourage the gradual adoption of fixed needles-and-syringes.

Reach of services

The level and breadth of services offered by NSEPs in RF are adequate or good, but there are serious problems with the reach and quality of services. NSEPs working at their current coverage rate in RF will have little or no effect on the HIV epidemic in RF.

It is not surprising that the overall regular coverage rate of NSEPs responding to the survey was 0.74%. As was mentioned in Section 4, this is likely to be an underestimate for various reasons. Also, it is possible that numbers of IDUs in some cities were over-estimated in the earlier rapid situation assessments. Because injecting has increased so quickly in RF, many injectors are young and have not been injecting for a long time: so there is also a possibility that many IDUs are not injecting every day (for example, Grund et al found that 47% of IDU respondents were injecting less than once a day), so the need for needles and syringes may be lower than in Western Europe, where it is estimated that each IDU injects on average 2.2 times a day (see Section 3).

However, even if the average regular coverage rate were 10 times higher than the rate derived from the survey, this would be around 7%, still a long way short of the 60% coverage recommended as a target for NSEP in RF. Also, this coverage rate only refers to those cities where a needle exchange exists. As was mentioned in Section 2, there are 48 NSEPs in total in 34 oblasts and territories, yet there are 89 territories in RF: this leaves a further 55 territories where NSEPs need to begin operating immediately to build an effective national network of prevention programs.

In essence then, there are two goals for increased reach. First, in the cities where they exist, NSEPs need to increase access to their programs (and to needles and syringes outside their programs) as quickly as possible. Second, NSEPs need to open in other cities in each oblast where one NSEP now works, as well as in the 55 territories with no programs.

The reach of existing NSEPs must increase by a very large amount, in most cases by at least 10 times and in some cases up to 100 times their current level. Achieving a regular coverage rate of 60% must occur as quickly as possible. Most NSEP respondents felt the 60% target could be achieved through opening more fixed sites, operating more mobile services and hiring more outreach workers, if additional funding is provided for these services).

Methods of calculating coverage remain controversial, and several respondents asked “60% of what?” This issue was discussed in some depth at the 12th International Conference on the Reduction of Drug-Related Harm in Delhi, India in April 2001. While no definitive form of calculations was agreed on, I believe the following is an appropriate way to consider “60% coverage”.

- In every city where there are estimated to be, for example, 10,000 IDUs, NSEPs and other programs should aim to reach (over 3-4 years but faster if possible) 80-90% (that is, 8000-9000) IDUs at least once with education and specific information: this needs to be either face-to-face communication or through explicit, detailed educational materials designed specifically for IDUs with active IDUs involved in their writing and design.
- In addition, NSEPs need to attempt to reach around 60% (that is, 6000) IDUs with sterile needles and syringes, other injecting equipment and condoms on a regular basis (for example, so that, on average each of these 6000 IDUs is receiving at least 2-3 needles and syringes per week – this can be done through a variety of methods – see below).

- However, if this group of 6000 IDUs simply all come from the same social networks, and are male and not from any of the other high-risk groups of IDUs, the coverage will still be insufficient: the target should be 60% of IDUs in 100% of rayons in the city, and at least 60% among highest-risk groups (see below).
- For oblasts and the whole of RF, the same guidelines apply. If there are 100,000 IDUs in a territory with 60,000 in one city and 40,000 in several smaller cities, it is not enough just to address the largest group (in fact, the history of the RF HIV epidemic contains numerous examples of HIV outbreaks in small cities leading to major problems for entire territories).

As several respondents have pointed out, this process is very hard to monitor and evaluate. First there is the issue of the estimated number of IDUs in each city and territory. Even with rapid situation assessments carried out in 61 cities, there are doubts about the accuracy of the estimates used by some programs. Secondly, if secondary exchange is expanded, keeping track of numbers of clients being reached and the regularity of their contact with the program becomes increasingly difficult. The Kazan Model, with its standardised forms filled out by volunteers and outreach workers, overcomes this problem to a degree. But innovative research methods will need to be developed to assist programs to calculate reach and coverage: these methods are currently being developed and discussed through the Global Research Network on HIV and drug use.

The level of funding for NSEPs is one of the key problems to expanding services to reach appropriate numbers of clients. But it is unlikely that funding can be found quickly to increase reach adequately to reach the 60% target. Increased short-term funding is needed as soon as possible to remove obstacles to expansion of injecting equipment distribution, and long-term funding is needed to carry out many of the above activities but this funding should be dependent on good management increasing the quality of NSEP services (see below).

In addition, the experience of several NSEPs in achieving substantial funding from local donors should be expanded. Advocacy is needed for allocations to harm reduction programs from oblast, city and rayon budgets, where this is possible. In addition, businesses and charities should be approached and educated about the need for harm reduction services and for funding for expansion of these services.

Measures must also be found to increase the number of needles and syringes distributed and education provided to ever increasing groups of IDUs, but at a lower cost than present operations. The techniques that offer the most promise are, again, peer strategies. The Kazan Model for example is a constantly expanding program, using active IDUs as volunteers: the constant expansion built in to the Model and its outreach training and management processes ensure that outreach workers' time is used as efficiently as possible, and that injecting equipment and information are supplied regularly within many hidden social networks throughout the city. This is likely to lead to reduced costs while rapidly increasing the program's reach: already, the cost per needle and syringe delivered in Kazan is below \$0.27, almost 10c below the average across responding programs.

However, there are some serious drawbacks to establishing the Kazan Model in every city in RF. The first is the attitude of police and other Internal Affairs officers (dealt with in more detail below). A second problem has been identified by several programs: by increasing secondary exchange, the NSEP decreases its level of control over the provision of needles and syringes and other equipment to IDUs. There have been reports of NSEP clients taking large amounts of equipment and selling needles and syringes, not just to IDUs but to diabetics and others. This is a serious concern and must be addressed in setting up secondary exchange programs and involving

active IDUs (many of whom are poor, are also active criminals and are tempted to steal and sell injecting and other equipment).

The best method of addressing these issues lies at the heart of the Kazan Model: the emphasis on training and close supervision of outreach workers. By working closely with outreach workers and assisting them to understand the importance of needle and syringe exchange as a public health intervention, they can pass on this information and the motivation to assist friends and relatives to the active IDUs they meet. In turn, the active IDU volunteers also pass on this information and motivation to their social networks. An added benefit of involving active IDUs in needle exchange work is that they tend to know very quickly if someone in their network is stealing and selling equipment, and are able to implement social sanctions to ensure that the social network shows its disapproval of such behaviour.

Another point made by several programs is that it is hard to work with active IDUs, that they have no discipline, will not work proper hours, are unmotivated etc. It is interesting to note that Renewal NSEP at Kazan originally employed mostly active IDUs, but these have now been replaced by mostly ex-IDUs and non-IDUs. If it is true that active IDUs are incapable of certain types of work, then certainly they should not be employed for such work. But most NSEPs worldwide find that some active IDUs are capable of a wide variety of tasks. The most important point is to involve active IDUs as much as possible in NSEP work.

To establish secondary exchange, as well as to become a focal point for NSEP services throughout a territory, each oblast must implement at least one NSEP that is “user-friendly”, carries out effective outreach, peer education and peer support programs, and assists in setting up other needle exchange services by training workers in these services, providing technical assistance and assisting them in monitoring and quality assurance.

After such a program is well-established and has started to win substantial support at the city and oblast level, the methods of needle and syringe delivery should be widened so that aptekas, polyclinics, infectious diseases hospitals, dermatovenereology services, GUM clinics, AIDS centres, narcology dispensaries, NGOs working on other issues and many other structures throughout each city and, ultimately in each rayon of the oblast, become sources of injecting equipment and information. In smaller cities and rural areas, it is probably more effective to use health providers, with occasional visits from outreach workers from larger programs, because it may not be cost-effective to start specific NSEPs in every rayon.

As well as increasing overall reach, NSEPs need to specifically focus on those IDUs at highest risk for acquiring HIV. These groups at highest risk usually include women IDUs who are also sex workers, IDUs of particular ethnicities (especially Roma), drug users in prisons and the military, street youth, gay and lesbian IDUs. To do this successfully will usually involve the starting of specific programs targeting each group. This has begun in RF with the IHRD-funded add-on projects addressing sex workers and prisoners which have started in 9 NSEPs. Other models for targeting specific populations of IDUs, developed in other countries, are described in Burrows 2000b.

Like their international counterparts, one of the most significant obstacles to increasing the reach of programs and a major obstacle to opening programs is hostility by police towards NSEP operations and mistreatment of IDUs by police, causing them to stay hidden. Grund et al's (2001) study of NSEP clients in five RF cities in 1999/2000 found “the activities of law enforcement agencies present a serious impediment to pragmatic HIV prevention efforts, such as needle exchange”. The study quoted a NSEP staff member: “The relations with the police are tense.

Police and Program aims are opposite. The laws are not satisfactory. They negatively influence drug abuse morbidity. Drug users in Nizhny Novgorod are educated enough in questions of safe drug use, disinfecting rules. But the situation itself forces them to infringe on safety rules.” Grund et al concluded that the Internal Affairs department should be targeted by intense advocacy and education efforts.

One key informant from a program responded: “We tell people it’s anonymous if they come to the fixed-site (NSEP – located at city AIDS Centre), but people still think there are probably video cameras, that we provide information to the police. This fear comes from the time when narcologists had to report all registered drug users to the militia.” Harassment of IDUs by police have also been reported as a major problem at the NSEPs in St Petersburg and Sakhalin, (Tsekhanovich and Dughin 2001; Mokienko and Mokienko 2001); as well as being discussed as a problem across the whole RF, with 100,000 arrests under the Law on Narcotic Drugs in 1998 alone, 75% for possession without intent to supply (Levinson and Khachatryan 2001).

The role of police becomes even more important if NSEPs wish to implement a model such as that used in Kazan. The constant expansion of secondary exchange can be seriously hampered, or stopped altogether, unless very clear understanding are reached with the police. However, even with the good relationship that exists between the Renewal program and Kazan Internal Affairs Department, significant difficulties continue to be caused by the Law on Narcotic Drugs which allows volunteers to be arrested while they are assisting the NSEP (see below).

But, also like their colleagues elsewhere, RF NSEPs have found ways to reduce problems related to law enforcement. In St Petersburg, active advocacy by the Medecins du Monde NSEP with local police was carried out to alert police to the risks of HIV infection from NSEP clients to police, and to inform police about harm reduction. Close contact was formed with the Psychological Service of the Department of Internal Affairs which led to further contacts with militia units. At the request of the department, a leaflet was written by NSEP staff for militia (printed from the militia budget), which is now being widely distributed to police in the city. Initial evaluation of the activities via polls of NSEP clients indicate that the number of unreasonable persecutions of IDUs has decreased and the harassment of IDU sex workers has been virtually eliminated (Tsekhanovich and Dughin 2001).

One very material way that police can assist a program’s success is by either approving, or understanding and working with, an identification system for NSEP clients. Some NSEPs in RF already use specific cards which state that the user is a client of a specific NSEP. In 1999 a new NSEP in Novorossiysk was finding it difficult to attract IDUs to the service. Then police searched a user who showed them a card from the AIDS Centre inviting the user to the NSEP: the police, who had been trained in the new NSEP’s operating procedures and ordered by their chief not to interfere with the program’s work, allowed the user to go without any further hassles. Two days later, the NSEP had attracted many new clients (Burrows 2000b).

The most effective way to develop police liaison with NSEPs and other harm reduction programs is to meet at a senior level with the directors of the program(s) to ensure that there is an agreement between senior police and health officials about the ways in which the program(s) will operate. This will usually mean that a document is signed to the effect that police support the program’s operation, or at least that the program can operate without interference from the police.

There also needs to be a mechanism to deal with problematic situations. These often occur when the high-level agreements about police policy are not communicated to (or are communicated but misinterpreted by) officers on the street who may harass, for example, NSEP workers and clients.

The usual mechanism is to arrange regular meetings at a senior level between police and health (and possibly city) officials or an agreed process to call meetings at short notice if problems arise. If possible, these arrangements should be agreed in writing. The benefit for the police in such a mechanism is that it can be used to raise any problems they have with the program as well as any problems the program has with police behaviour.

Much care is needed in balancing a program's relationship with the police and its relationship with drug users. Evidence of collusion or collaboration with the police by a harm reduction program can cause enormous credibility problems with a program's clients. Communications of this type should always be carried out by an identified person within the harm reduction program (usually the program manager) who has to judge the optimum relationship with the police according to local conditions (Burrows 2000b).

Effective co-operation between NSEPs, police and other sectors working on HIV and drugs issues in RF will require increased attention to policy. Two processes are vital. First, a community approach is needed so that many different sectors of society see drug use and HIV related to drug use as an issue they need to work on, including youth organisations, schools, unemployment services, religious organisations, parents, and so on.

Second, effective and committed national, oblast and rayon level co-ordination and support are needed across all government and NGO sectors. One pilot project which should be closely monitored is the TACIS Intersectoral Development project in St Petersburg (described in Simbirtseva and Spirin 2001), in which newly instituted democratic processes in that city are being used to focus on alcohol and drug prevention and health promotion generally. Similar processes – involving both politically elected and appointed officials together with NGOs to develop appropriate and effective policies – should be encouraged throughout RF. Intersectoral co-ordinating committees are needed at the oblast, city and rayon level, and decision-making by NSEPs and these local structures needs to be informed by the results of a regular monitoring system of local situations using rapid assessment and response (RAR) and sentinel surveillance monitoring.

There also remain national issues which urgently need to be addressed. The Law on Narcotic Drugs is rapidly emerging as the major structural threat to the expansion of NSEP in RF. The law needs to be reviewed as soon as possible, emphasising its negative impact on HIV prevention programs such as NSEP and outlawed substitution programs. Specific provisions that urgently require alteration (possibly by regulation rather than a change to the law) are the punishments provided for possession of tiny amounts of illicit drugs (which can be used to arrest secondary exchangers who have collected several dirty syringes), and the ban on substitution programs involving methadone and buprenorphine therapies. In addition, the Federal Ministry of Internal Affairs needs to issue an unequivocal statement that NSEP activities are legal, and that all Internal Affairs staff must assist in their implementation and expansion to address the country's rapidly worsening HIV crisis.

Some respondents felt there is a need for increased capacity in many NSEPs in advocating for harm reduction to police and other potentially obstructive groups. A policy and advocacy program for harm reduction, currently being implemented by International Harm Reduction Development (IHRD) of Open Society Institute across all countries of Central and Eastern Europe and the Newly Independent States, should assist in capacity development on these topics.

In addition, there should be widespread distribution of advocacy materials such as *Starting and Managing Needle and Syringe Programs* published in Russian and English by IHRD (Burrows

2000b), and its first chapter (available separately for use specifically for advocacy for NSEP), and the [Newsletter of Harm Reduction in Russia](#), published in Russian by the MSF-H Infocenter, which also contains many articles useful in advocacy and informing various community sectors about harm reduction.

The media can be a very important ally in advocacy processes – for example, the Press Club founded by Vozvrastchenie NSEP in St Petersburg attracts journalists to its regular meetings to hear talks by specialists in various medical disciplines, social policy, law, as well as ex-IDUs, people with HIV, etc; after these talks, journalists organise various activities to reduce stigma towards IDUs and people living with HIV and to inform the general public about drugs and HIV/AIDS (Ostrovskaya 2001).

In terms of advocacy goals, one key informant suggested there were three distinct stages:

1. The authorities do not interfere while you set up a NSEP
2. The authorities approve and begin to promote the NSEP
3. The authorities start to fund the NSEP.

The informant suggested that almost all programs had quickly attained the first stage. Fewer had attained the second and only a small minority had reached the third stage. The task over the next months is to bring many new programs to the first stage, while assisting existing programs to all move to the third stage.

For all of the above activities, technical assistance and training continues to be needed at the national level, and training centres need to be developed in many parts of the country.

Quality of services

At the same time that a rapid expansion is under way of NSEPs in RF, greater attention needs to be paid to the quality of the services being provided. From many of the results of the studies for this report, it appears that many clients are not attending NSEPs because they do not like some aspect of the service there. In addition, many key informants feel that there are significant problems in the management of many NSEPs, especially in personnel management and specifically in managing outreach or “non-professional” staff.

NSEPs need clearly defined short-, mid- and long-term goals and standardised monitoring and evaluation methods to assess progress their progress towards these goals. Some key informants have expressed concern about the confusion of intentions of NSEPs in RF. Only three of the responding NSEPs are managed by narcological services but several more include a narcological dispensary as one of the 2-3 agencies managing the NSEP. There is no reason why narcological services should not be involved in NSEPs and there is no evidence that NSEPs managed by these services are of lower quality than other services. In fact, some programs believe the involvement of narcologists has had a positive impact on both the needle exchange activities (as narcologists are experienced at communicating with drug users and can assist other staff to better understand IDUs) and on drug treatment services (for example, by narcologists participating in a mobile services, they can provide narcological assistance to IDUs as an outreach service without requiring attendance at a dispensary).

But the main goals of narcology services are different to the main goals of NSEPs. Most narcologists see their role as assisting IDUs to stop taking drugs and to prevent young people from starting to take drugs. NSEPs are designed to prevent HIV transmission among IDUs. NSEPs should not require IDUs to be “counselled” or harassed about their drug use when they access NSEP services. The two activities (needle exchange and narcological services) need to be

separate but linked. Referral mechanisms between the services need to operate efficiently and staff of both types of services need to understand each other's work. But often the same person (or the same service) cannot do both drug education/treatment and NSEP work. From the results of these surveys, it appears that this confusion exists in some RF NSEPs. Given the massive HIV epidemic sweeping RF at present, priority must be given to attracting IDUs into NSEP services and HIV prevention education, even if this is at the expense of talking to IDUs about their drug use.

Another, and possibly related, issue is the concern by some key informants that needle exchange is seen as a "medical" intervention. This is reflected in the numbers of doctors involved in NSEP in RF (far higher than in most other countries), the number of medical services offered together with NSEP (at the expense of other services that IDUs might find more attractive), the preponderance of doctors involved in preparing educational materials, the concern that NSEPs may be unfriendly places where IDUs want to spend any more time than necessary, and the concern that NSEPs tend to be hierarchical, "medical" organisations. In most countries, doctors have no or very little involvement with the establishment and management of NSEPs: characteristics of the RF health system and society led to the involvement of many doctors in NSEPs, and it is likely to be true that, without the involvement of doctors, most NSEPs would not have been able to start in RF.

Doctors should continue to be involved in starting NSEPs in the 55 territories which currently have no NSEPs, and in the many cities and towns across RF without NSEP services. In addition, doctors can still play an important role in expanding NSEPs by assisting with embedding NSEP activities within the public health programs in each territory, and by providing or organising links to medical services. However, those NSEPs with 5 and more doctors employed by the NSEP need to consider whether there are more efficient ways of spending scarce staff funds to reach the maximum number of IDUs, and a gradual shift should occur towards the employment of more ex-IDUs and (if appropriate in the local circumstances) active IDUs.

Another important issue is the patchy quality of services, depending on individual managers. There appear to be few policies or work guidelines prepared for most organisations. Also, non-managers (and especially outreach workers) appear to be deprived of information and education, though some programs have pointed out that restrictions on use of the Internet and email are often caused by slow Internet servers and telephone lines resulting in the NSEP's only computer being tied up for several hours for simple Internet-related tasks: in these cases, more than one computer may be needed and this may often be achieved through local fundraising. Respondents said that if training occurs, it happens only once with no refresher courses, ongoing training, encouragement of ongoing learning by staff, or training of new staff. The high staff turnover means that a larger investment is needed in training. Training needs to be regular and needs to be repeated often. Training topics should include those mentioned in Section 4 and above in Reach.

NSEPs must be realistic about the work they ask from outreach staff. Staff need clear job descriptions and a clear understanding of what is expected of them. NSEPs also need to provide positive feedback when staff are doing their jobs well and clear processes of support (such as use of a psychologist's services) when staff are experiencing difficulties, as well as well-understood and transparent processes for discipline and dismissal for the situations when these are needed. Concrete and realistic goals for each week and month (and, if possible, each day) should be set so that staff can know when goals have been achieved, increasing their sense of personal accomplishment.

Staff also appear not to be involved in decision-making in many NSEPs. Managers need to use more “democratic” management methods because bringing a range of staff viewpoints to concentrate on problems is more likely to lead to appropriate solutions. In particular, the views of active IDUs need to be regularly sought to ensure that the organisation is meeting client needs. Team meetings should be used not only to exchange information, but as part of a quality assurance loop. A quality assurance system should be developed for each NSEP so that:

- All services are continuously monitored to search for problems and new issues which are not currently being addressed: team meetings are the usual venue for discussing these issues
- Regular reports on this monitoring feed into management at an appropriate level for decision-making, but managers need to involve team members (and active IDUs, where possible) in this decision-making
- Management decisions on ways to address problems or new issues are fed back to staff and are implemented quickly
- Ongoing monitoring continues to check whether the new ways of working are effective or whether new issues are again emerging: through the following team meetings.

This circular process is now regarded as international best practice as it ensures an ever-growing evidence basis for each activity and an ongoing improvement in services.

Quality of educational materials was a concern of some respondents. Some NSEPs have involved active IDUs in developing education and information leaflets and posters, and these have been successful in attracting and educating other IDUs. Many other NSEPs have simply used publications from MSF-H, AIDS Infoshare and others, or rewritten these materials as their own leaflets. There have been some structural reasons for this, such as the general lack of OSI-R funding for educational materials, but there also seems to be a reluctance by NSEPs to become involved in this type of work. While I remain committed to the notion that local development of educational materials is an excellent way to involve active IDUs in NSEP operations (Burrows 2000b), the decision that the HIV/TB Prevention Project will fund massive production and distribution of IDU educational materials appears to be justified. These materials will need to be very explicit to be effective, but they will ensure consistency of messages across RF and should prove very useful when distributed together with locally produced educational materials.

Finally, networking between programs needs to be improved. The MSF-H Infocenter and training program should be increased in staff and resourcing to play a key role in this process. While translation is constantly being carried out of key scientific papers on harm reduction, this process needs to increase to ensure that a wide range of materials (and summaries of evidence in the Newsletter of Harm Reduction in Russia, AIDS Round Table, On Narcology or similar publications) on community drug education, various types of drug treatment, HIV prevention among IDUs, advocacy strategies for harm reduction, and HIV/AIDS and drugs policies of other nations are available in Russian for a wide audience. Further measures are needed to encourage NSEPs use email and Internet services to connect with each other. Bilingual staff at the MSF-H Infocenter should be encouraged to expand their role as focal links between Russian NSEPs and global harm reduction networks.

An example of Best Practice Harm Reduction community programs in RF is the Kazan Model. Important features of this model are:

- Effective distribution of a range of injecting equipment and educational resources suitable for the target population (including resources produced locally with involvement of active IDUs, and specific educational resources and extra condoms for women IDUs)

- who are also sex workers) through two fixed sites, a mobile and outreach service (all of which are very friendly towards IDUs): preliminary evidence from RF studies suggest these activities will dramatically reduce individual risk behaviours among IDUs
- Ratio of staff costs to cost of harm reduction and educational materials is more appropriate than many other services: small staff of 10 includes only 2 doctors (employed part-time), 3 with other professional backgrounds and 5 NSEP or outreach staff with drug use background or interest
 - Regular peer education training among IDUs and increasing reliance on peer support through involvement of active IDUs in a structured, constantly expanding system of secondary exchange: use of these strategies should have a major impact on social factors affecting HIV transmission among IDUs
 - Maximum effectiveness of outreach staff through regular training and re-training, and through supervision, and efficient use of outreach time and energy through close supervision, setting of daily and weekly goals, categorisation of tasks related to various stages of work with secondary exchangers, and use of standardised monitoring forms
 - Active referral of IDUs to other agencies to have health and other needs met
 - Use of feedback loop and quality assurance process to ensure NSEP activities match IDUs' needs and to change activities based on constant monitoring
 - Successful ongoing advocacy with Internal Affairs, Administration and other influential groups at city and Republican level, including gaining financial support for both expansion of activities in Kazan and starting NSEP in other cities
 - Ongoing advocacy for substitution programs and low-threshold drug treatment programs, and for the whole community to participate in addressing in drugs and drug-related HIV issues (for example, through working with the Ministry of Health of Tatarstan on drug prevention issues as well as harm reduction promotion).

5.2 PRISON PROGRAMS

Although there has been little work to date on HIV prevention in prisons, the work has been of an extremely high quality. Both the Nizhny Novgorod (NN) project and the MSF-H program meet international best practice guidelines for this type of work. As the Pskov program has only just begun, it is too early yet to judge its work.

Information is so far incomplete but the following features of a model of best practice for HIV prevention among IDU prisoners can be observed:

- a) Commitment at the highest levels: The MSF-H program has achieved this at the highest level possible with the GUIN in Moscow, and the NN program has agreements with GUIN at the oblast level.
- b) Training is vital: The five-tier training system provided by MSF-H involves workshops with senior prison authorities, middle management in prisons, custodial staff, medical staff and the prisoners themselves: similar processes are used in the NN program.
- c) Educational materials need to be developed, tailored to the needs of each tier: both programs have provided a variety of literature for prisoners, and MSF-H is preparing training materials packages for each tier. The involvement of prisoners or ex-prisoners and IDUs or ex-IDUs in developing specific literature for prisoners is acknowledged as vital by the MSF-H program. The translation of key documents into Russian is an important step in building scientific understanding of HIV prevention among prisoners.

- d) Provision of peer education programs: While this is only now starting in the prisons covered by the MSF-H program, both programs place great emphasis on the use of peer education of prisoners by prisoners. This can only take place effectively when all of the above steps have been carried out.
- e) Distribution of condoms and disinfectant: both programs ensure that distribution of the means of prevention among prisoners is a key element.
- f) Linkage between prisons and community programs: This appears to be the greatest lack so far. The NN program has some links to the NSEP in that city but these links could be strengthened through more collaborative work. The MSF-H program is too young to enable these links to be fully established yet but it sees the clear need for linking these programs, and the quarterly regional round-tables bringing these groups together is an excellent start to broader co-operation. In addition, the MSF-H program actively promotes oblast multi-sectoral AIDS committees to ensure community and prison programs work together. Media are kept informed of the goals of these programs and the usefulness of prevention for the whole community, not just for prisoners.
- g) The role of international consultants and organisations has been extremely important to both programs though they are reducing the need for international consultants by increasing capacity among Russian staff and organisations.

There are few obvious ways that such programs can be improved. One question that needs to be answered is: should best practice harm reduction in RF prisons necessarily include needle exchange? At this stage in the development of harm reduction programs in RF, needle exchange in prisons is increasingly being discussed. This type of intervention only exists in four developed countries worldwide (Switzerland, Germany, Spain and Austria), but the news (still unconfirmed in the scientific literature at the time of writing) that needle exchange programs are now under way in at least one prison in Belarus has led to such programs being considered in RF.

If the RF authorities are willing to trial this intervention (as looks likely in Pskov), this should be encouraged because needle exchange inside prisons may, long-term, be a very effective tool in preventing HIV transmission but, given the current social circumstances in RF, needle exchange in prisons does not need to be part of a best practice model.

Funding is another issue which must be addressed. More than 90% of funding for the prisons programs in 6 oblasts comes from international sources. Federal GUIN funds are difficult to use for HIV prevention activities. At present, oblast funding appears to be the most likely way to increase local funding, but oblasts do not appear to be convinced yet of the public health and general community benefits of providing funds for targeted HIV education and prevention programs in prisons. The current prisons programs need to advocate for the introduction/expansion of oblast funding for this type of work.

There seems to be little evidence yet about the specific ways that linkages between municipal and prisons harm reduction services will work. The suggestion (above) that community NSEPs begin to seek training and to define their role in working with prisons programs is a first step. Prison authorities should also ensure that municipal authorities invite NSEPs (where they exist) to the quarterly regional round-table meetings. Information provided by the MSF-H Infocenter and training programs should include information on prisons, especially on training prison peer educators and counselling in prison settings.

Finally, there is the question of whether current prisons programs can effect changes both to HIV prevention in prison and to the treatment of HIV positive prisoners. The Nizhny Novgorod

program showed that both could be achieved, though the cost of physical rehabilitation of buildings and amenities is likely to be prohibitive when applied across RF. The MSF-H approach – providing training, scientific papers and training materials on management of HIV/AIDS to prison medical staff, and promoting links between municipal services such as AIDS centres and the prisons – seems likely to lead to better understanding and at least improved medical treatment of prisoners with HIV/AIDS. But the physical surroundings of HIV-positive prisoners will continue to need to improve (as do the conditions of all prisoners in RF) and prisons harm reduction programs need to continually advocate for these improvements.

VII. RECOMMENDATIONS

No recommendations are provided here for specific steps to assist one oblast to reach best practice in harm reduction in both the community and prisons (though the appropriate steps are listed in recommendation groups 5 and 6). At this point in the HIV crisis in RF, with up to 1 million people likely to be infected with HIV in the country by the end of this year and up to 2 million expected to be infected by 2003/2004 (Pokrovsky 2000), what is needed immediately is a massive, rapid expansion of effective harm reduction programs both in the community and prisons simultaneously in many oblasts and territories. For these reasons, the below recommendations have been formulated to assist the World Bank, Government of RF, and existing and potential harm reduction programs to urgently scale up harm reduction activities.

(Note: all terms used in this section relating to procurement such as International Competitive Bidding, National Shopping etc are explained in full in the HIV/TB Project Operational Manual – Russian Healthcare Foundation 2001 – available in Russian or English from the World Bank office in Moscow).

It is recommended that:

1. Government of Russian Federation

- 1.1 Address the two most important obstacles to expanding harm reduction as an emergency response to the HIV crisis in RF: amend the Criminal Code and the Law on Narcotic Drugs to ensure that secondary exchangers (active IDUs and others who assist NSEPs by distributing and collecting injecting equipment) cannot be arrested for participating in NSEP activities (through regulatory change, if feasible, of the penalties for small-scale possession of illicit drugs and the offence of keeping premises where drug use occurs) as well as removing or amending those provisions that prevent the use of substitution therapy (such as methadone and buprenorphine); and ensure that the Federal Ministry for Internal Affairs (IA) issues an unequivocal statement supporting harm reduction, provides training to its staff at all levels on the need to work with health agencies to address the current HIV crisis in RF, and orders all IA departments throughout RF to facilitate the expansion of harm reduction services.
- 1.2 Through the Implementation Group for HIV/TB Project, re-consider the limited number of oblasts to participate in community harm reduction programs in the first year of the HIV/TB Prevention Project. Given the extent of the epidemic, reaching 10-15 oblasts in the first year is not sufficient. The number of oblasts selected for the first year should at least include the 34 territories where NSEPs already exist and, if possible, should also include the 13 oblasts where trained personnel are ready to start NSEPs.
- 1.3 Through the Implementation Group for HIV/TB Project, decide on oblasts selected for Year 1 activities (both for community and prisons harm reduction programs).
- 1.4 Establish a National HIV/AIDS Committee at the highest level to oversee and co-ordinate harm reduction and all other activities related to HIV prevention, treatment, care and support. In addition to its ongoing co-ordination work, this committee should undertake a review of laws and policies that hinder the introduction of harm reduction programs (including substitution therapy programs) and amend these to create a supportive environment for harm reduction work.

- 1.5 Ensure that the five-year National AIDS Plan is fully funded at the Federal level; ensure that harm reduction programs are prominent in activities under the Plan; and ensure that activities under the new Plan are co-ordinated with activities funded through the HIV/TB Prevention Project.
- 1.6 Adjust Federal funding for GUIN to assist oblasts to carry out HIV prevention work in detention facilities.
- 1.7 Establish (together with UNAIDS, World Bank, and international NGOs) clearly defined short-, mid- and long-term goals for harm reduction in RF, and develop standardised monitoring and evaluation to assess progress towards these goals.
- 1.8 Persuade and assist those territories at the epicentres of the HIV epidemic in RF (Moscow City, Moscow and Irkutsk Oblasts) to establish large-scale NSEPs and other harm reduction programs as quickly as possible.
- 1.9 Ensure that all procurement steps (excluding the signing of contracts) are completed for the tendering process for the following goods (using International Competitive Bidding procedures):
- Needles and syringes
 - Condoms
 - Sterile water
 - Alcohol swabs
 - Disinfectant (including sachets or bottles)
- The numbers and types of each item should be determined as follows:
- a) A census of all NSEPs be conducted in July 2001 to determine exact numbers of each type of needle and syringe (both fixed and separated) distributed by all programs in the previous 12 months (if this is difficult for RHCF to implement, UNAIDS together with national and international NGOs should be approached for their assistance in this process). This number multiplied by 5 (in each category of needle and syringe) should form the initial contract for Year 1 of the HIV/TB Prevention Project: if it is determined that a two-year contract is more efficient, then the census numbers should be multiplied by 12.
 - b) The above census should also ask NSEPs how many condoms were provided during the previous 12 months: this figure should be multiplied by 10 for a one-year contract or by 25 for a two-year contract (as programs increasingly reach sex working IDUs, the level of demand for condoms is expected to increase dramatically).
 - c) In the above census, all syringes of all types should be added together with the number of fixed needles and syringes to provide a total for syringe distribution: this figure multiplied by 4 should be the figure for a one-year contract for both alcohol swabs and sterile water (this will be around 80% of the total syringes ordered for the year); for two-year contracts for alcohol swabs and sterile water, the total number of syringes should be multiplied by 10.
 - d) Disinfectant for one year, if in sachets, should be 2.5 times the total syringe count from the previous year; or 6 times this figure for a two-year contract.
- 1.10 Ensure all tendering steps (excluding signing of contract) are completed for implementation of the best practice prisons harm reduction program referred to in Section 6 for four oblasts beginning in Year 1 of the HIV/TB Prevention Project and a further three oblasts in Year 2: these

oblasts should be in addition to the five oblasts in which the MSF-H and Nizhny Novgorod programs are currently working (and Pskov should be considered favourably for inclusion in Year 1 if the relevant oblast is selected). Selection Based on Consultants' Qualifications should be undertaken for this contract. This should not be done as part of the Agreed Procedures on Training Procedure Procurement as this procedure would limit the funds able to be used by the program, and the best practice prisons program incorporates many non-training activities together with training activities.

1.11 Ensure all steps for the selection of oblasts are carried out for Year 1 programs, including: advertising of the criteria for selection, assisting oblasts to understand the funding programs which make up the HIV/TB Prevention Project (through the same tours mentioned in 3.4), receiving and commenting on applications and sending them to the Implementation Group for HIV/TB Project for their decision.

1.12 Ensure the rapid completion of the Technical Assistance Operational Manual, and undertake widespread distribution of details of the Technical Assistance Program (TAP), including tours of RF to explain the program and train potential applicants for TAP funds. These steps should also include development of evaluation and selection criteria, generation of applications and selection of TA funds recipients.

1.13 Assist Dr Badrieva and her colleagues at Renewal NSEP in Kazan to write up (in Russian) the Kazan Model in great detail, and assist them to develop a training program based on this Model to be provided through the training programs funded through the HIV/TB Prevention Project.

1.14 Ensure all tendering steps (excluding signing of contract) are completed for design, development and production, printing and distribution of educational materials for IDUs. The number to be produced should be 2.5 times the total syringe count (in 3.1 above) for a one-year contract or 6 times this figure for a two-year contract. As this will involve very large printing and distribution costs, it is recommended that this work be contracted separately from the design, development and production work: printing and distribution should be tendered using International Competitive Bidding procedures; while the other work should form a consultancy awarded through Selection Based on Consultants' Qualifications procedures as there are few organisations with the skills or experience needed to carry out this latter work.

1.15 If possible, complete all tendering steps (excluding signing of contract) for training on rapid assessment and response and interventions to allow immediate implementation of this program in early Year 1 of the Project (as the process from beginning of training to implementation of programs takes 13 months on average: Burrows and Weber 2001). This contract should be established through Selection Based on Consultants' Qualifications as part of the Agreed Procedures on Training Procedure Procurement.

1.16 If possible, complete all tendering steps (excluding signing of contract) for training programs to address the topics in 5.8 and 5.9 below. This contract (or these contracts) should be established through Selection Based on Consultants' Qualifications as part of the Agreed Procedures on Training Procedure Procurement.

By end Year 1 of HIV/TB Prevention Project

1.17 Sign the above contracts and begin disbursement of funds as quickly as possible.

1.18 Award first round of contracts under Technical Assistance Program (by month 4).

1.19 Ensure all tendering steps (including signing of contract) are completed for design, development and production, printing and distribution of training manuals on rapid assessment and response methods and harm reduction interventions; advocacy materials for harm reduction to local authorities; guide to starting and managing NSEPs. Numbers of these to be determined by asking current NSEPs how many copies they need and multiplying this number by 3 (as rapid expansion is expected in NSEPs during the next two years). As this will involve very large printing and distribution costs, it is recommended that this work be contracted separately from the design, development and production work: printing and distribution should be tendered using International Competitive Bidding procedures; while the other work should form a consultancy awarded through Selection Based on Consultants' Qualifications procedures as there are few organisations with the skills or experience needed to carry out this latter work.

1.20 Ensure all tendering steps (excluding signing of contract) are completed for design, development and production, printing and distribution of educational materials for prisoners; training manuals on health promotion in prisons, HIV/AIDS counselling, care and support of prisoners with HIV/AIDS and training prison peer educators. Numbers of these to be determined by asking current prisons programs how many copies they need and multiplying this number by 20 (as many of these training manuals can be used by GUIN staff in regular staff training already funded through Federal and oblast budgets). Contract processes should be the same as in 3.11.

2. Oblast and Territory Governments

2.1 Advocate at the Federal level for inclusion in the oblasts selected for Year 1 activities in the HIV/TB Project.

2.2 Advocate for the Government of the Russian Federation to carry out the tasks in 1 above.

2.3 Ensure that at least one large, user-friendly NSEP with multiple services (outreach, fixed-site and, where possible, mobile) is established in each oblast and territory to assist in starting other NSEPs, expanding distribution through other outlets, training staff, monitoring and evaluation, etc.

2.4 Establish HIV/AIDS and drug use co-ordinating committees at oblast, city and rayon level (where these have not yet been established) to ensure all relevant government structures and NGOs work together to implement harm reduction programs in both community and prison settings. Increase links between harm reduction and STI services, and harm reduction programs in prisons and the community (see 5.12).

2.5 (Where possible) Provide oblast funding for harm reduction programs, especially for salaries for government staff involved in harm reduction, premises and vans for NSEP, and targeted education programs and educational materials development for prisoners.

2.6 (With NSEPs) Expand distribution of harm reduction materials as quickly as possible, using a variety of outlets, to ensure that IDUs are reached in all rayons of the oblast.

- 2.7 (With NSEPs) ensure integration of harm reduction programs with other HIV and drugs services (whether in government services or NGOs).
- 2.8 (With prison programs) Expand prison harm reduction programs to ensure prisoners are reached in all detention facilities of the oblast. Consider pilot programs of low threshold drug treatment programs, substitution therapy (when this becomes legal) and needle exchange.
- 2.9(Without NSEPs/prison programs) Advocate for inclusion in training and funding programs for NSEPs/ prison programs; reduce or eliminate obstacles to introduction of harm reduction programs; ensure co-operation between government Health, Internal Affairs and Justice institutions and NGOs; seek training for key staff and visits to oblasts with NSEPs/ prison programs.

3. Current NSEPs

- 3.1 Undertake planning as quickly as possible to scale up current operations to distribute at least 5 times as many needles and syringes in 2002 as were distributed by each program in the past 12 months.
- 3.2 Advocate at the oblast level for inclusion in the oblasts selected for Year 1 activities in the HIV/TB Project.
- 3.3 Become familiar with the Technical Assistance Operational Manual of the HIV/TB Project, when it becomes available; attend briefings on the Technical Assistance Program; and submit proposals (when appropriate).
- 3.4 Become familiar with the Kazan Model and other models of peer education and peer support such as that used by the Moscow outreach team and the Kolodets model of drug user organising. Begin implementing these models (in ways that suit local conditions).
- 3.5 Undertake surveys and focus groups of NSEP clients to discover what they like and do not like about current services including location and operating hours of NSEP, other services provided, types of injecting equipment and other goods provided, etc., and adapt services (where possible) to meet clients' expressed needs and to make services as friendly as possible towards IDUs to increase access and reach. Examine attitudes to fixed needles and syringes and gradually encourage IDUs to switch to this type of equipment, if possible. Examine social nature of drug use and develop specific techniques to address issues such as HIV transmission during the "sharing out" of drugs.
- 3.6 As increased funding becomes available, ensure that condom, needle and syringe distribution is maximised, especially to groups at highest risk of HIV infection, and across social networks, and increase distribution of sterile water, alcohol swabs and disinfectant: careful and continuous monitoring (such as that used in Kazan) will be needed to ensure injecting equipment and other goods are not stolen and sold, and to try to track levels of client contact (to evaluate reach and coverage).
- 3.7 Before the HIV/TB Project begins, seek appropriate funding at oblast and city level for all government staff employed by NSEPs (as the wages of government staff are generally not able to be funded under the Technical Assistance Program, or under the Project as a whole) as

well as expansion of oblast funds and in-kind support to assist in expanding NSEP to all rayons of the oblast.

3.8 Ensure that Program Managers and Co-ordinators are trained in the following topics:

- General and project management with emphasis on personnel management and structural methods to achieve a more democratic workplace; developing clear policies and procedures; managing change and expansion of services; delegation of authority; strategic and work planning; incentive and motivation techniques for managing volunteers; training staff and volunteers; establishment and maintenance of quality assurance processes; managing active and ex-IDUs; training and supervision of outreach workers (Kazan Model and international models); advocacy and working with police, administration officials, politicians, media and the community.
- Social aspects of drug use and changing group norms including designing, monitoring and adjusting peer education and peer support programs (Kazan Model and other Russian and international models); working on drug treatment and harm reduction as separate but linked issues; maintaining focus on harm reduction while establishing links with other services; care and support of HIV positive IDUs; and sensitisation to drugs and minority (especially Roma) issues.
- Ongoing situation assessment and intervention; sentinel surveillance monitoring; and program monitoring and evaluation.

3.9 Ensure that NSEP workers, outreach workers and, increasingly, volunteers, receive training in the following topics:

- Basic HIV/AIDS and drug use information; educational messages; burnout and relapse prevention; and first aid: these training sessions need to be delivered as locally as possible several times each year to address high staff and volunteer turnover.
- Working with specific target groups: women IDUs who are also sex workers, IDUs of particular ethnicities (especially Roma), drug users in prisons and the military, street youth, gay and lesbian IDUs.
- Social aspects of drug use and changing group norms including follow-up training on peer education, peer support and secondary exchange and collection of clean injection equipment; and care and support of HIV positive IDUs.
- Distribution of disinfectant (bleach) and instructions on correct methods of disinfecting needles and syringes.

3.10 Advocate at city and oblast level for expansion of distribution outlets for injecting equipment and HIV prevention educational materials, especially through government health services at first, eventually expanding to all relevant government and NGO facilities; also encourage aptekas to sell injecting equipment to IDUs and, if possible, provide education materials.

3.11 Advocate for greater acceptance for IDUs and people living with HIV/AIDS, both at the institutional level (starting with health institutions and staff) and in the community.

3.12 Increase links between harm reduction and sexually transmitted infection (STI) services to address sexual transmission of HIV among IDUs and from IDUs to their non-injecting sexual partners; specific programs will be needed to address groups at highest risk, such as women IDUs who are also sex workers; increase links with prisons programs (in the 6 oblasts where these operate) to ensure consistency of approaches in prisons and the community, and to assist in prison peer educator training.

4. Current Prison Programs

4.1 Continue implementation in the 6 oblasts where programs are currently being implemented, expanding to cover all detention facilities in these oblasts as quickly as possible .

4.2 Advocate for targeted education programs and educational materials development for prisoners to be allocated funds from oblast budgets; and for widening the concept of harm reduction in prisons to include low threshold drug treatment programs, substitution therapy (when this becomes legal) and needle exchange.

4.3 Work with community harm reduction programs to ensure consistency of educational messages on both sides of the prison gate.

4.4 Continue to focus on both the prevention of HIV among prisoners and care and support of HIV positive prisoners.

5. Potential NSEPs and prisons programs

5.1 Advocate at the oblast level for inclusion in the oblasts selected for Year 1 activities in the HIV/TB Project.

5.2 Become familiar with the Technical Assistance Operational Manual of the HIV/TB Project, when it becomes available; attend briefings on the Technical Assistance Program; and submit proposals (when appropriate).

5.3 (If already trained and ready to implement a program) Seek assistance from national and international organizations and current NSEPs to plan establishment, initial resource and budget requirements, and carry out initial advocacy with local administration, police and key institutions about the need for harm reduction programs. Undertake surveys and focus groups of IDUs to discover what they would like in a NSEP, and how to make the service as friendly as possible towards IDUs to increase access and reach. Examine social nature of drug use and develop specific techniques to address issues such as HIV transmission during the “sharing out” of drugs.

5.4 (If not yet trained) Seek training in Rapid Assessment and Response and Intervention Design methods (to be conducted as part of the HIV/TB Prevention Project).

5.5 Seek appropriate funding at oblast and city level for any government staff to be employed by NSEPs, and as much funding and in kind support as possible towards program costs.

- 5.6 Ensure that as many relevant staff as possible participate in the training programs supported by the government, the Bank and other donors.

6. UNAIDS and members of UN Theme Group on AIDS

- 6.1 Add their influence to efforts by other agencies and national organisations to encourage the Government of Russian Federation to urgently carry out the tasks in 1 above.
- 6.2 Advocate for additional funding from international sources to address the current HIV/AIDS crisis (especially for harm reduction programs), while the HIV/TB Prevention Project and other processes gradually build long-term capacity to deal with drugs and HIV/AIDS issues.
- 6.3 Assist national and international NGOs to carry out the expansion of assistance programs in 7.5 and 7.6.

7. National and international NGOs

- 7.1 Should encourage the Government of Russian Federation to urgently carry out the tasks in 1 above.
- 7.2 (Current donors of NSEPs) Continue to fund harm reduction programs for at least Years 1 and 2 of the HIV/TB Prevention Project to ensure continuity of services while new funding mechanisms are being implemented and oblast selection is increasing.
- 7.3 (Current donors of NSEPs) Continue to fund government staff (where appropriate) in current NSEPs where such staff will not be appropriately reimbursed by oblast or city governments.
- 7.4 (Current donors of NSEPs) As funding increases for goods (needles and syringes etc) under the HIV/TB Prevention Project, divert other international funding to staff costs, especially to increase outreach staff (where this is not covered by the Technical Assistance Program of the Project), and to training, establishment and government salary costs for starting new programs, especially in the 55 oblasts without any NSEPs: first priority should be given to funding program applications from groups trained by MSF-H (prior to March 2001) who have prepared funding applications (see Section 4).
- 7.5 Where possible, expand networking, translation, training, technical assistance, development and distribution of educational and advocacy materials to meet the needs of current and potential community and prisons harm reduction programs throughout RF.
- 7.6 Continue and expand pilot projects of low-threshold drug treatment (such as the Yaroslavl program) and, when legal restrictions are lifted, trials of substitution therapy programs, including where possible both methadone and buprenorphine. Consider assisting pilot programs of needle exchange in prisons and care and support of HIV-positive IDUs, both in the community and in prisons.

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APPENDIX 1

The following key informants participated in interviews in person, by phone or by email:

Larissa Badrieva, Program Co-ordinator Renewal NSEP, Kazan, RF (and staff)
Murdo Bijl - Research and Development, MSF-H, Moscow, RF
Ruben Burnashov, Advisor to the Prime Minister of Tatarstan, Kazan, RF
Oksana Chernenko - Trainer, Regional HR Training Program, Harm Reduction Initiative Russia, MSF-H, Moscow, RF
Larissa Dementieva, Co-ordinator, HIV/TB Project, Russian Healthcare Foundation, Moscow, RF
Niyaz Galiullin, First Deputy to Health Minister of Tatarstan, Kazan, RF
Jean-Paul Grund, Consultant, DV8 Consulting, Frankfurt, Germany
Alek Khachatryan - Resource Centre Manager, Harm Reduction Initiative Russia, MSF-H, Moscow, RF
Dr Mikhail Narkevitch, Medical Director HIV/TB Project, Russian Healthcare Foundation, Moscow, RF
Isabelle Perivier - Coordinator, Harm Reduction Initiative Russia, MSF-H, Moscow, RF
Robert Power PhD, Senior Lecturer, University College London UK
Elena Pyckovskaya, Head of Methodological Department and Co-ordinator of NSEP, Nizhny Novgorod Oblast AIDS Centre, RF
Tim Rhodes, Senior Lecturer, Centre for Research into Drugs and Health Behaviour, London, UK
Gena Roshupkin - Material Development Coordinator, Prison Program, MSF-H, Moscow, RF
Anya Sarang - Lead Trainer, Regional HR Training Program, Harm Reduction Initiative Russia, MSF-H, Moscow, RF
Boris Sergeev, Consultant to MSF-H Harm Reduction Training program, Toronto, Canada
Beatrice Stambul, Medecins du Monde, Marseilles, France
Alexandre Tchourine, Head of Medical Department, Ministry of Justice, Prison Department, Nizhny Novgorod oblast
Franz Trautmann, International Programs, Trimbos Institute, Utrecht, The Netherlands
Urban Weber - HIV/Aids, Project coordinator, MSF-H, Moscow, RF
Colin Wisely, Lifeline International Projects Manager, Manchester, UK
Vitaly Zhumagaliev, Co-ordinator, Public Health Program, Open Society Institute – Russia, Moscow, RF
Kamil Ziyatdinov, Health Minister of Tatarstan, Kazan, RF

APPENDIX 2

Survey of Harm Reduction Programs in Russian Federation (English version)

Informed Consent

Please read the following and, if you are willing to take part, signify your agreement to participate in this survey.

The Government of the Russian Federation is currently negotiating a loan from the World Bank which would, among many other activities, provide increased funding for harm reduction activities to prevent the spread of HIV among injecting drug users (IDUs).

As part of the preparations for the loan activities, a study has been commissioned of past and current harm reduction activities in the Russian Federation. The project is being carried out by a Consultant to the World Bank, Dave Burrows.

The study will examine:

number and characteristics of programs that have been undertaken, are under way or planned
details of current programs including funding levels and sources, program activities, problems faced and overcome
strengths and weaknesses of programs
specific characteristics which contribute to best practice of harm reduction programs in the Russian context

This survey will lead to the compilation of a report on harm reduction programs in Russian Federation which will be used to assist the introduction of World Bank loan activities. It will describe a model of best practice of harm reduction in the Russian context, and will be used to develop specific steps to achieve best practice among programs in RF.

Responses to the survey will be anonymous. Because of time constraints, you are asked to return the completed survey by email or fax as quickly as possible. When received, the results will be translated and coded for analysis.

Please signify your agreement to participate in this survey.

Harm reduction activities

1. Is your harm reduction program operated by:
 - a) Non-governmental organization
 - b) Government AIDS Centre
 - c) Government narcological centre
 - d) Other government agency: please specify:.....
 - e) Other organisational type: please specify:.....

2. Does your harm reduction program provide needle and syringe distribution?

- a) Yes
- b) No

IF NO, GO TO Q. 25

IF YES,

3. When did your organization begin distributing needles and syringes?

- a) Month:.....
- b) Year:.....

4. Does your needle and syringe program (NSP) operate from a fixed site?

- a) Yes
- b) No

IF NO GO TO Q.11

IF YES

5. How many fixed site NSPs are operated by your program?

- a) 1
- b) 2
- c) 3
- d) more than 3: please specify:.....

6. In what type of premises is your fixed site NSP located?

- a) Government AIDS Centre
- b) Government narcological dispensary
- c) Government hospital: please specify type:.....
- d) Other Government building: please specify type:.....
- e) NGO premises
- f) Rented commercial premises (shopfront)
- g) Rented commercial premises (other): please specify:.....

7. What are the opening hours of your largest fixed site NSP?

- a) Monday.....
- b) Tuesday.....
- c) Wednesday.....
- d) Thursday.....
- e) Friday.....
- f) Saturday.....
- g) Sunday.....

8. If you have more than one fixed site NSP, are the opening hours of the other fixed sites:

- a) the same as in Q. 6
- b) different to the above site: please specify.....

9. At the largest fixed site, how many staff and volunteers are usually employed?

- a) Staff.....
- b) Volunteers (paid stipends).....
- c) Volunteers (without stipends).....

10. If you have more than one fixed site NSP, are the staff numbers of the other fixed sites:

- a) the same as in Q. 8
- b) different to the above site: please specify.....

11. Does your NSP operate from a mobile service or from specific “points” (eg street corners, under bridges) where staff or volunteers stay at the same point for 1-2 hours?
(PLEASE NOTE: THIS QUESTION DOES NOT REFER TO OUTREACH. SEE Q. 16)

- a) Yes
- b) No

IF NO, GO TO Q. 16

IF YES

12. How many stops does the mobile service make or how many points do staff or volunteers visit (on average) each day:

- a) 2
- b) 3
- c) 4
- d) 5
- e) 6
- f) more than 6: please specify

13. Are the same sites visited/stopped at each day?

- a) Yes
- b) No: please specify the places where stops/visits made each day:.....
.....
.....

14. What are the operating hours of your mobile/"point" service? (PLEASE NOTE: THIS REFERS TO THE HOURS SPENT ACTUALLY AT THE SITES OR ON THE MOBILE SERVICE, NOT TIME SPENT IN THE OFFICE)

- a) Monday.....
- b) Tuesday.....
- c) Wednesday.....
- d) Thursday.....
- e) Friday.....
- f) Saturday.....
- g) Sunday.....

15. In your mobile/"point" service, how many staff and volunteers are usually employed?

- a) Staff.....
- b) Volunteers (paid stipends).....
- c) Volunteers (without stipends).....

16. Does your NSP operate an outreach team (visiting apartments, houses, areas of drug using and buying)

- a) Yes
- b) No

IF NO, GO TO Q. 20

IF YES

17. How many places do staff or volunteers visit (on average) each day:

- a) 2
- b) 3
- c) 4
- d) 5
- e) 6
- f) more than 6: please specify

18. Are the same places visited at each day?

- a) Yes
- b) No: please specify the places where stops/visits made each day:.....
.....
.....

19. What are the operating hours of your outreach service? (PLEASE NOTE: THIS REFERS TO THE HOURS SPENT ACTUALLY DOING OUTREACH, NOT TIME SPENT IN THE OFFICE)

- a) Monday.....
- b) Tuesday.....
- c) Wednesday.....
- d) Thursday.....
- e) Friday.....
- f) Saturday.....
- g) Sunday.....

20. In your outreach service, how many staff and volunteers are usually employed?

- a) Staff.....
- b) Volunteers (paid stipends).....
- c) Volunteers (without stipends).....

21. During NSP, what types of equipment are provided to clients?

- a) 1ml fixed needle and syringe
- b) 2.5ml syringe (with needle in same package)
- c) 5ml syringe (with needle in same package)
- d) 2.5ml syringe (alone)
- e) 5ml syringe (alone)
- f) needles (alone): Please specify type(s):.....
- g) Other needles and syringes: please specify.....
- h) Alcohol swabs
- i) Disinfectant
- j) Other equipment

22. How many needles and syringes did your organization distribute in:

- a) the past month?.....
- b) the past year?.....

23. During NSP, what educational/informational materials are distributed to clients?

- a) Educational materials developed by your organization: please specify topics.....
.....
.....
- b) Educational materials developed by other organizations: please specify organizations and topics:.....
.....
.....
.....
.....

24. How many clients (PLEASE NOTE: THIS REFERS TO CLIENTS. NOT NUMBER OF VISITS) attended your organization's NSP service in:

- a) The past month?.....
- b) The past year?.....

25. Apart from NSP, what services are offered by your organization? (PLEASE NOTE: THIS REFERS ONLY TO SERVICES OFFERED WITHIN YOUR ORGANISATION, NOT SERVICES AT OTHER ORGANISATIONS REFERRED TO BY YOUR STAFF)

- a) Production of educational materials involving active IDUs
- b) Production of educational materials involving ex IDUs
- c) Production of educational materials involving health professionals
- d) Meetings of active drug users to talk about HIV prevention issues
- e) Training of IDUs on HIV prevention and other issues
- f) Training of IDUs as peer educators
- g) Pre-test counselling for HIV test
- h) HIV testing
- i) Post-test counselling for HIV test
- j) Psychological counselling on drug issues
- k) Psychological counselling on other issues
- l) First aid (dealing with abscesses etc)
- m) Medical care for people with HIV/AIDS
- n) Drug treatment (detoxification etc)
- o) Other services: please specify:.....
.....
.....

26. What is the composition of paid staff of your organization?

- a) Doctors: number and specialisations:
.....
.....
- b) Psychologists: number:.....
- c) Other university educated staff: number and qualifications:
.....
.....
- d) Ex-IDUs: number:.....
- e) Active IDUs: number:.....
- f) Students: number:.....
- g) Others: number:.....

27. What is the composition of volunteers (paid stipends) of your organization?

- a) Doctors: number and specialisations:
.....
.....
- b) Psychologists: number:.....
- c) Other university educated staff: number and qualifications:
.....
.....
- d) Ex-IDUs: number:.....
- e) Active IDUs: number:.....
- f) Students: number:.....
- g) Others: number:.....

28. What is the composition of volunteers (who are not paid stipends or salary) of your organization?

- a) Doctors: number and specialisations:
.....
.....
- b) Psychologists: number:.....
- c) Other university educated staff: number and qualifications:
.....
.....
- d) Ex-IDUs: number:.....
- e) Active IDUs: number:.....
- f) Students: number:.....
- g) Others: number:.....

29. What is the annual funding provided to your organization for **harm reduction activities** by:

- a) Open Society Institute: US\$:.....
- b) Other international donors (please specify donors and amounts):
US\$:.....
.....
- c) City administration budget (actual funds): US\$:.....
- d) City administration budget (in kind support): US\$:.....
- e) Oblast administration budget (actual funds): US\$:.....
- f) Oblast administration budget (in kind support): US\$:.....
- g) Federal budget: US\$:.....
- h) Local private donors (actual funds): US\$:.....
- i) Local private donors (in kind support): US\$:.....

Statistics

30. What is the population of your:
- a) city.....
 - b) oblast.....
31. What is the estimated number of **injecting** drug users in your:
- a) city.....
 - b) oblast.....
32. How many cities (apart from your city) in your oblast have populations of:
- a) more than 1 million:.....
 - b) 500,000 to 1 million.....
 - c) 250,000 to 500,000.....
 - d) 100,000 to 250,000.....
 - e) 60,000 to 100,000.....
 - f) 30,000 to 60,000.....

Best practice

33. What are the most important characteristics of effective harm reduction work in the Russian Federation?
34. To reach 60% of IDUs in your **city** on a regular basis, what would your organization require? Please be as specific as possible (eg, if you say “funding”, what specific goods, services, salaries need to be funded?).
35. To reach 60% of IDUs in your **oblast** on a regular basis, what would your organization require? Please be as specific as possible (eg, if you say “funding”, what specific goods, services, salaries need to be funded?).

Thank you for participating in this survey.

APPENDIX 3

Contact details for NSEPs in RF

Contact details for prisons programs in RF



HEALTH, NUTRITION,
AND POPULATION



HUMAN DEVELOPMENT NETWORK

THE WORLD BANK

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THE WORLD BANK

1818 H Street, NW
Washington, DC USA 20433
Telephone: 202 477 1234
Facsimile: 202 477 6391
Internet: www.worldbank.org
E-mail: feedback@worldbank.org

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