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GLOBAL PROGRAMME ON AIDS

HIV PREVENTION FOR PEOPLE WHO INJECT DRUGS

PLANNING AND COORDINATING AN HIV PREVENTION STRATEGY

GUIDE FOR AIDS PROGRAMME MANAGERS

WORLD HEALTH ORGANIZATION

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THE PURPOSE OF THIS GUIDE

This guide is designed to assist programme managers in assessing the potential spread of HIV infection through injecting drug use and in designing a strategy for the prevention of HIV infection in people who inject or might inject drugs. The scale and type of the strategy will depend on the actual level of drug use by injection, or the potential spread of drug use by injection. Where relevant, HIV prevention activities for injecting drug users should be included in national AIDS plans.

It is designed to assist in the three main stages involved in planning and coordinating an HIV intervention strategy to control the spread of HIV infection through injecting drug use:

Stage 1. The **preliminary situation analysis** of whether there is a potential or actual risk of HIV transmission through injecting drug use; and if so

Stage 2. **Planning an HIV prevention strategy**, which involves identifying possible sites for activities, target groups and target problems, identifying a range of possible intervention activities appropriate to the problems identified, and identifying the resources available to undertake them; and

Stage 3. **Coordinating the development and implementation of the strategy**, which involves recruiting and managing the local field managers who will be responsible for planning and conducting local intervention activities, setting performance targets, and guiding and overseeing the ongoing development of the strategy.

This guide is supplemented by the *Guide for implementing local interventions* which provides more detailed information on how to undertake a local assessment of drug use, select and design specific local activities, and implement and monitor them.

1. RESPONSIBILITIES OF THE AIDS PROGRAMME MANAGER

The AIDS programme manager is normally responsible for assessing AIDS problems at a national, provincial or state level, and for ensuring that strategic decisions are made regarding HIV prevention and the resources needed for this. Responsibility for the planning and conducting of HIV intervention activities at a local level will normally be the responsibility of a local field manager (see the supplementary guide).

BACKGROUND

1. DRUG INJECTION AND HIV INFECTION

The global AIDS pandemic is an aggregate of micro-epidemics in terms of time, geography and population. Interventions for high-risk behaviours such as injecting drug use are important in an overall prevention strategy: while the numbers of people at risk may appear small, their role in the epidemic may be large.

When the virus is present among drug injectors, and when unsterilized injection equipment (needles, syringes and other paraphernalia, including for example, bottle caps in which the drug is heated, cotton wool used as a filter) is shared, the spread of HIV infection can be very rapid indeed. In Milan, Edinburgh and New York, the prevalence of HIV infection (the percentage of people with HIV) among drug injectors grew rapidly, with 50% or more infected within a few years of the first appearance of the virus in these populations.

This explosive spread through populations of injecting drug users has occurred elsewhere. In Bangkok, prevalence rose to over 40% in the space of a few months at the beginning of 1987, probably due to an outbreak of infection within the prison system. In Manipur, in rural India, over 50% of drug injectors are now HIV-positive and high levels of infection have been identified in all states bordering the area.

HIV infection associated with the injection of drugs has now been identified in all global regions: it has been found in places with markedly different patterns of economic and political development, and corresponding resources for prevention and treatment. This includes countries as diverse as Brazil, Bahrain, Canada, China, Malaysia, Nigeria, Spain, Thailand, and Viet Nam.

Drug injectors are the second largest and in some places the fastest growing group of AIDS cases in developed countries. In some countries injecting drug use is the most important factor for the spread of HIV infection. Rapid spread of HIV infection in people who inject drugs may continue to occur unless appropriate preventive interventions are introduced. Given the role that drug injection plays in the transmission of the virus, not only among drug injectors but to the larger non-drug-using population, it is imperative to develop HIV prevention strategies which specifically target this group.

2. DRUG INJECTING IN DIFFERENT PARTS OF THE WORLD

The United States of America and Canada have the longest history of injecting, starting in the nineteenth century, with intravenous injecting developing from the late 1920s and spreading in the 1930s. The National Institute of Drug Abuse conservatively estimates that over 700 000 people in the United States of America injected drugs in 1990. Prevalences

are extremely high in some localities: in the Bronx, a borough of New York City, it is estimated that 17% of all men aged 25-44 are injectors and that between 5% and 13% of this age group in the Bronx are HIV-positive.

Europe and Australia saw the diffusion of drug injecting from the late 1960s. In Europe injecting was initially adopted by minority creative groups (such as jazz musicians), and there was a rapid spread to other social groups in the early 1970s with an illicit market served by heroin from South-East Asia. During the 1980s, heroin smoking and injecting expanded to poorer and more disadvantaged social groups. Such diffusion - from middle-class innovators to poorer groups - has been encountered in other parts of the world.

Europe, Australia and North America continue to have new recruits to drug injecting. And there is also a diffusion of newer patterns of injecting: for example, occasional amphetamine injection may be as widespread as heroin injection in some countries.
Drug injecting is likely to spread to new areas and social groups, for example in eastern Europe and the former Soviet Union. It is estimated that there are upwards of 75 000 injectors in the United Kingdom, and 100 000 each in Italy and Poland.

In Asia, heroin injecting has been found in Hong Kong since the 1950s, and there was widespread injecting of amphetamine in Japan between 1946 and 1956, continuing on a lesser scale through to the present day. In Thailand, heroin injecting increased significantly in the early 1960s, followed by a more rapid increase between 1967 and 1975. Drug injecting is a recent arrival in many countries in Asia. Injecting drug use appeared only from about the mid-1980s in Myanmar, Sri Lanka, Viet Nam, India, southern China, Laos, Malaysia and Nepal.

In South America, cocaine injecting has been reported from Argentina, Brazil (extensive in Rio de Janeiro and Santos) and Venezuela and to a lesser extent in Chile and Paraguay. In the Caribbean and Central America injecting on a small scale is reported from a number of countries including the Dominican Republic and Honduras. In Puerto Rico (which has a high rate of HIV infection) it is linked with injecting populations in New York.

Injecting appears to be uncommon in African countries - but it has been reported recently from Nigeria, Senegal, South Africa and Tunisia. There was a major spread of heroin use in the 1980s in Mauritius, connected with the use of the island as a drug transit country.

Drug injecting is now occurring in countries which are mostly poor, and are often either in drug-producing areas or along drug trans-shipment routes.

3. PATTERNS OF DRUG USE AND DRUG INJECTION

Drug injection is found in all social classes, although in some countries it is more commonly associated with social deprivation. It is a rural as well as an urban phenomenon.

Many, but by no means all, drug injectors live in poor social conditions. In the United States of America, poor income and area of residence are correlates of HIV infection and AIDS, and areas with high HIV seroprevalence (such as the South Bronx in New York) have high levels of other social problems such as poor housing, unemployment and lack of social and health services.

> In Chicago and New York, many drug injectors are homeless or in unstable accommodation, and homeless drug injectors are more likely to report behaviours which put them at risk of HIV infection.

In many countries, heroin is the main drug that is injected. But other drugs may be injected including cocaine, amphetamines, tranquillizers, and barbiturates. Some of these drugs are illicitly manufactured while other are legitimately produced pharmaceutical drugs which have been obtained licitly from doctors or illicitly from other drug users.

> In Madras, many drug users inject buprenorphine, which is obtained in ampoules on prescription from local doctors.

The pattern of drug use may change over time in response to changes in drug control legislation, shifts in the location of illicit drug production, changes in prescription practices of doctors, the introduction of new drugs, and changes in local drug use.

> Thailand experienced a change in drug use from opium smoking to heroin smoking, and then to heroin injecting. Thai injectors tend to confine their drug use to heroin.

Drugs may be injected with medical syringes (insulin or other plastic disposable syringes, or reusable ones), or with a variety of improvised equipment such as eye droppers or plastic tubes with needles attached. In one prison, drug injectors devised makeshift syringes using ball-point pens.

People who inject drugs often share drug injecting equipment, whether by force of circumstance (as when new or clean equipment is not available) or by local custom. When a syringe or other equipment is used for drug injection, small quantities of blood are usually left in the implement. This is especially the case if drug injectors are in the habit of drawing blood back into the syringe during the process of injection. If this blood contains HIV, then the next person to use the syringe is likely to become infected with HIV. The transfer of blood that occurs when syringes are shared is an extremely efficient means of transmission of HIV infection and other bloodborne diseases such as hepatitis B and C, and malaria.

> The earliest syringe-transmitted epidemics among drug injectors were recorded in Egypt in 1928 and in New York in 1932, when there were outbreaks of malaria resulting in many deaths among drug injectors.

Wherever there is the use of drugs by injection, it is highly likely that HIV transmission will occur. *An HIV prevention strategy should be implemented even if HIV has not yet been identified locally.* This is important, because the spread of HIV infection among drug injectors can occur more rapidly than the time it takes to implement prevention activities.

In some countries drug injecting is still uncommon. However, changing patterns of drug use may make drug injection more attractive to some people. For example, many towns and cities that are on drug trafficking routes soon find that they have a local drug problem.

> Both Mauritius in the Indian Ocean and Malta in the Mediterranean are small islands that have been used as trans-shipment routes for heroin from Asia to Europe and the United States. In both countries local drug injecting soon occurred.

Where drug injecting does not occur, it is important to develop interventions to discourage its occurrence.

HIV prevention activities should therefore target both current and potential injectors. The national AIDS programme should include activities which help current injectors to reduce their risks of HIV infection and/or give up the use of drugs by injection and discourage potential injectors and the general population from taking up the habit.

4. HIV PREVENTION ACTIVITIES

A wide variety of measures have been introduced to try to reduce or limit the spread of HIV infection through drug injecting, and from drug injectors to their sexual partners.

The objectives of such interventions are:

(a) to promote safer drug injecting and sexual behaviour in current injectors to reduce the risk of transmission of HIV through drug injecting or sexual behaviour; and

(b) to discourage the use of drugs by injection.

A public health approach to drug use recognizes that interventions must be developed for people who are currently injecting and are unable or unwilling to stop injecting. These activities help them change their behaviour to reduce the risk of infection from HIV to themselves and to others. The objective is to help people avoid sharing syringes, to decontaminate syringes where sharing cannot be avoided, and to use condoms for penetrative sexual intercourse. In the interests of public health, it is important to discourage drug use generally, and drug use by injection in particular.

HIV prevention activities should:

(a) make contact with target populations (by developing services and programmes in the community and by making services more attractive); and

(b) develop interventions that are acceptable to people who inject or might inject drugs.

Experience in many countries has shown that it is possible to work with this often hidden and hard-to-reach part of the population to reduce the risk of transmission of HIV. To do this it is necessary to gain their trust by providing services or establishing outreach programmes that respond to the needs of the individual or group, as identified by them.

There is considerable evidence that people who inject drugs may be helped to change their behaviour in order to reduce their own risk of infection with HIV, or the risk of transmitting it to others. But people cannot be forced to change their behaviour, and coercive measures may serve to marginalize them further from the wider community. Interventions need to be developed in a way that gains the support of the target groups.

Many interventions have been developed rapidly in response to urgent epidemic, or potentially epidemic, situations. They have included:

- mass media and social marketing - national and local information campaigns;
- local media and advertising;
- information, education and counselling - the provision of advice, information and counselling about risk behaviours and protective strategies;
- providing condoms to drug users;
- increasing the availability of needles and syringes;

- syringe decontamination - providing information about syringe decontamination and providing supplies of suitable decontaminants;
- outreach programmes;
- drug abuse treatment - improving access to, and effectiveness of, treatment for drug problems.

There is evidence that many of these interventions, alone or in combination, can help people who inject drugs to change their behaviour and reduce their and their sexual partners' risk of infection with HIV.

5. INJECTING DRUG USE AND NATIONAL AIDS PLANS

The potential for the rapid spread of HIV infection among drug injectors makes it imperative to include HIV prevention for injecting drug users in national AIDS plans. National AIDS plans should address the needs of people who inject drugs, and also the needs of others with whom they associate, including their sexual partners.

In countries where drug injecting is not currently found, national AIDS plans should take into account the possibility that it may start to become a problem. Experience worldwide has shown that drug use and drug injecting is a dynamic and rapidly changing social phenomenon.

PLANNING AND COORDINATING AN HIV PREVENTION STRATEGY FOR INJECTING DRUG USERS AND THEIR SEXUAL PARTNERS: A SUMMARY OF ACTIVITIES

Planning and coordinating an HIV prevention strategy for drug injectors involve three stages. Programme managers will need to:

Undertake a preliminary situation analysis (Stage 1)

They will collect information from a variety of sources to assess whether there is a potential or actual risk of HIV infection through injecting drug use in the country.

If the analysis shows that there is a problem of injecting drug use, or there is the potential for injecting drug use to develop, programme managers will need to:

Plan an HIV prevention strategy (Stage 2)

They will:

- identify possible sites for intervention activities, target groups and target problems;
- identify a range of potential intervention activities appropriate to the problems identified; and
- identify available resources (agencies, people and money) for undertaking the HIV prevention strategy.

Programme managers will then need to:

Coordinate the development and implementation of the HIV prevention strategy (Stage 3)

They will:

- recruit, manage and/or support those responsible for planning and conducting local HIV interventions; and
- guide and oversee the ongoing development of the strategy.

STAGE 1: UNDERTAKING THE PRELIMINARY SITUATION ANALYSIS

In order to plan for an HIV prevention strategy, programme managers will assess the need to conduct a situation analysis at the local level. This will involve examination of available information from a variety of sources to assess whether there is a potential or actual risk of HIV infection through injecting drug use in the country. While at the local level the actual situation analysis will be conducted by the local field managers (see the *Guide for implementing local interventions*), programme managers will conduct a preliminary assessment at the national level. This will involve examination of:

- the extent and location/setting of drug use and drug injecting;
- the extent of HIV infection, hepatitis and STDs in drug users including drug injectors; and

- factors that may constrain or facilitate HIV prevention activities for injecting drug users.

1. COLLECTING INFORMATION FOR THE SITUATION ANALYSIS

A comprehensive preliminary situation analysis conducted to inform the planning of an HIV prevention strategy requires an assessment of the following three key factors:

(a) *What is the extent and location/setting of drug use and drug injection?*

More specific questions include:

- Is injecting drug use occurring in any parts of the country, and, if so, to what extent?

- Are drugs being used but not injected (e.g. by smoking) which have the potential for injection? For example, is heroin being smoked, is cocaine being inhaled, are tranquillizers or methaqualone being used?

> In Pakistan, heroin is smoked and there is little evidence that it is injected. However, it is common for doctors to inject medical drugs when treating patients, and where injection is culturally accepted, it could be adopted by drug users.

- If there is little evidence of current drug use or injection, are drugs which could be injected likely to be or become available? Are there indications that drugs are being transported through any area of the country? If so, it is likely that local drug use will develop.

> Heroin bought in South-East Asia is often shipped illegally through Nigeria *en route* to Europe and North America. Nigeria now has a local problem with heroin use.

(b) *What is the extent of HIV infection, hepatitis and STDs in drug users and drug injectors?*

The questions that need to be considered include:

- What information is there on levels of HIV infection, hepatitis B and C, and sexually transmitted diseases (STDs) among drug injectors?

- What test data are available and how much of the country do they cover?

(c) *What are the factors that constrain or facilitate prevention activities?*

The questions that need to be considered include:

- What is the legal position regarding drug possession and the sale of drugs? What are the enforcement practices and how rigorously are the laws enforced?

- What is the legal position regarding the sale, distribution or possession of syringes?

> In many cities in the U.S.A., "drug paraphernalia laws" prohibit the sale and possession of syringes for drug use. Prevention projects have therefore focused on training drug injectors in cleaning syringes using bleach.

- How is drug use viewed by society? Are drug users marginalized as a result of law enforcement activities and driven underground? How does this affect the ability of prevention services to reach them?

> In some countries it is not illegal to sell syringes to drug injectors; indeed they may be bought in certain shops. In some countries the possession of drugs for personal use is not penalized, and drug injectors therefore do not have to hide themselves from police surveillance.

Sources of information

Various information sources can be used to provide answers to the above questions for the situation analysis. Other factors and/or questions that need to be examined to assess the situation will require detailed examination at the local level by the field managers rather than at the national level. The programme managers, however, will examine the availability of information on the following matters, while the field managers will conduct the actual situation analysis:

- the characteristics of drug injectors and their place in the community and society;
- the nature of drug use and drug injecting behaviour;
- the locations and venues used by drug injectors;
- the sexual behaviour of injectors and their partners; and
- current levels of HIV/AIDS awareness among drug users.

Drug treatment programmes exist in many countries and they have information about the numbers and characteristics of people coming for treatment.

STD clinics and/or the HIV surveillance system should be able to provide information on the prevalence of HIV infection, hepatitis and STDs among injectors.

General hospitals, psychiatric hospitals and psychiatrists are often approached by drug injectors or their families for help. In most cities there is a doctor who specializes in the treatment of people with drug problems.

Nongovernmental organizations working in slum areas or running facilities for youth or specifically for drug users may provide valuable information.

> During a situation analysis in an Indian city, contact was made with drug injectors through a community-based treatment project. Doctors invited in active drug users who described how they injected drugs. Other drug injectors were met at a church-based slum project. Within three days, 20 drug injectors had been interviewed.

Social scientists or medical researchers in universities or independent institutions may provide information.

The police, prison authorities, customs, courts and other law enforcement agencies can normally provide information on arrests, convictions and drug seizures. Because of the illegal character of drug use in most countries it is important to establish contacts with the police and prison staff to offer them general information about proposed HIV interventions.

> An anonymous survey of prisoners in Spain found that over a third of prisoners had injected drugs before going to prison, and that many continued to inject whilst in prison.

Court staff such as **probation officers, parole officers, social workers** and **lawyers** are not likely to have information on the numbers of people seen with drug problems, but are an important source of information about local drug use patterns, and drug users' characteristics.

To obtain more detailed data on drug users and drug using behaviours, the local field managers will examine other sources of information (see the *Guide for implementing local interventions*).

The way forward

The most fruitful way forward for the preliminary situation analysis will be first to identify key agencies, individuals and NGOs in various sectors who have information, such as those mentioned above, and/or to call meetings of experts at various levels in different parts of the community. Use the three questions listed above as a checklist to see what information the experts can initially provide. Making contact with these groups will also provide an opportunity to explain the importance of HIV prevention and recruit their help for interventions at a later stage. These groups can also be used to contact others who might be able to provide relevant information.

It should be remembered that although they form a population that is largely unseen, some injecting drug users have contact with medical, legal and other institutions. Because of the often covert nature of drug use, information gathered by these institutions is likely to be limited and partial. Agencies and individuals vary in their perspectives on drug use: for example, treatment agencies are likely to come into contact with problematic drug users rather than those who are managing their drug use without problems. The police see those who have come to the attention of law enforcement authorities rather than those who escape detection. Programme managers must weigh the evidence from different sources carefully, and make sure that official statistics are supplemented with local investigations.

How much information is required for the preliminary national situation analysis?

The right amount of information is that which is sufficient in order to identify possible intervention activities. Do not try to attempt such a thorough analysis that the development of interventions is unnecessarily delayed.

In practice, ideas for possible interventions will be developing at the same time that the analysis is being undertaken. It will also be necessary to re-assess the situation periodically.

STAGE 2: PLANNING AN HIV PREVENTION STRATEGY

If the preliminary situation analysis shows that drug injection is ongoing or imminent in some or several parts of the country, it will be necessary to develop an HIV prevention strategy (comprised of various intervention activities), and to identify the resources available to undertake the work. Developing such a strategy involves: identifying sites, target groups and target problems for intervention activities; identifying, at a broad strategic level, which interventions will be most appropriate; and mobilizing adequate resources.

1. IDENTIFYING POSSIBLE SITES, TARGET GROUPS AND TARGET PROBLEMS FOR INTERVENTION ACTIVITIES

The information collected in the situation analysis will enable the programme manager to identify:

- **sites for activities**, such as areas, towns, villages;

- **target groups**, such as non-injecting and/or injecting drug users, urban dwellers, rural farmers, fishermen, drug users in and out of treatment, prisoners, occasional and recreational injectors or frequent and compulsive injectors, sexual partners of drug users; and

- **target problems,** such as low levels of knowledge of HIV and AIDS among injectors, lack of drug treatment facilities, behavioural norms that sustain syringe sharing, stigmatization of drug injectors, legal constraints that impede prevention activities such as legislation that prohibits the sale or free distribution of syringes to injectors.

> Focus group interviews with drug injectors and results of HIV surveillance testing in Manipur, India, showed that most drug injectors lived along the main road through the state, but not in the neighbouring countryside. This led the investigators to hypothesize that drug use would also be found on this route in neighbouring states, and to target these areas for preventive actions.

2. SELECTING A RANGE OF POTENTIAL HIV INTERVENTION ACTIVITIES APPROPRIATE TO THE PROBLEMS IDENTIFIED

The next stage is to identify, at a broad strategic level, which interventions will be most appropriate. The design of a national (e.g. mass media) or local intervention is likely to require further detailed assessment, usually in the form of a **local situation analysis** conducted at a later date by a local field manager (see the *Guide for implementing local interventions*). But at this point it is the responsibility of the programme manager to take the strategic lead, and to identify in broad terms which activities will be most effective in preventing the spread of HIV among drug injectors.

An HIV prevention strategy will generally consist of:

- **risk reduction** intervention activities targeted at current drug injectors in order to help them reduce their risk, or the risk to others, of HIV infection.

  Activities to reduce risk of HIV infection among current drug injectors include mass-media education; local information campaigns; providing advice, information and

counselling about risk behaviours and protective strategies; improving the supply and return of needles and syringes; providing information about syringe cleaning and providing supplies of suitable decontaminants such as bleach; developing outreach services to hard-to-reach populations; providing health care in such a way as to attract target groups; introducing peer education within local drug-using communities; and condom promotion.

- intervention activities designed to **discourage injecting**, targeted at potential drug injectors and current drug injectors in order to reduce the injecting of drugs.

  Activities to reduce drug injecting include mass-media-based education for drug users, outreach and peer education to drug users who do not inject; outreach and peer-education to drug injectors; improving availability of, access to, and utilization of drug treatment for those who wish to modify their drug use.

(See the *Guide for implementing local interventions* for more details of intervention activities.)

A successful HIV prevention strategy needs to provide:

- **knowledge** - education and information about HIV transmission;
- the **means** to change behaviour; and
- the **skills** to make changes in behaviour.

Intervention activities are generally a mix of the above three factors. For example, a programme might provide injectors with information about preventing HIV transmission by cleaning needles and syringes (**knowledge**), provide them with bleach to decontaminate needles and syringes (**means**), and teach them how to use the bleach effectively (**skills**). A drug treatment programme might advise injectors to cease injecting to reduce risk of HIV infection (**knowledge**), provide access to treatment (**means**), and teach ways to control drug use (**skills**).

Single interventions are unlikely to be useful: programme managers will therefore need to identify the appropriate **combination** of interventions.

3. IDENTIFYING AVAILABLE RESOURCES

The programme manager will need to assess which **existing resources** (agencies, people and money) may be mobilized for HIV prevention activities. What effective programmes already exist for HIV prevention, and which (e.g. drug rehabilitation projects) can be adapted to HIV prevention? For example, many STD programmes may already have drug injectors among their clients. A slum project may already have contact with drug users.

Resources may include national and local media (television, newspapers, magazines), drug treatment programmes, family planning, STD clinics, police, NGOs, slum projects, schools and institutions for higher education.

Which organizations should be involved?

In order to decide which organizations should be involved in the HIV prevention strategy, the following basic questions must first be considered:

- Which institutions (e.g. hospitals, prisons, NGOs) already have contact with drug users, or might be able to contact them?
- Is there a system for the treatment of drug users, and which drug users use it?
- Which institutions have the capacity to innovate and develop a flexible and creative response?
- Which community, academic, and other resources might be coopted to help?
- What gaps exist in current resources, how might they be filled, and what new projects may have to be launched?
- What are the medical, health and social resources and structures that might determine who can undertake interventions, and how they might be undertaken?
- What interventions are likely to be acceptable, and therefore used, by drug injectors? Which agencies are trusted by drug users?
- What are the training needs for staff?

The obvious agencies are not always the most appropriate. For example, drug treatment facilities are well placed to educate patients about HIV risks, but a drug treatment programme may be available and accessible to only a minority of drug injectors. An abstinence treatment approach may make it difficult for them to give advice about safer drug use. These programmes have an existing clientele, but may not have expertise in contacting drug users in their own locales. Drug users who come to treatment may be a special and distinct population.

The police have many contacts with drug users, and can use these opportunities to pass on HIV prevention information, or information about HIV projects. But their role may make it difficult for them to advise about safer drug use because of possible conflicts with their duty to uphold the law. Only certain types of drug injectors come into contact with police.

Contact with workers in other countries

It will be helpful to contact workers in other countries who have expertise in HIV interventions. Many countries have produced national and local strategic plans, developed specific interventions, and produced information and resource packs for workers and drug injectors. Many will be willing to make their products available. It is unlikely that these resources can be adopted without modification: rather, they can be used to help develop

local ideas and material for interventions. Managers should investigate resources available from international sources. Twinning arrangements with other countries and cities may be useful for the exchange of advice and expertise.

Finance

Programme managers will be responsible for mobilizing financial resources for intervention activities, allocating them as appropriate, and assisting others to identify and mobilize their own resources.

STAGE 3: COORDINATING THE DEVELOPMENT AND IMPLEMENTATION OF THE HIV PREVENTION STRATEGY

The next task for AIDS programme managers will be to coordinate the development and implementation of the HIV prevention strategy. This will involve: recruiting, managing and/or supporting those responsible for planning and conducting local HIV interventions; and guiding and overseeing the ongoing development of the strategy.

Often, responsibility for managing a local intervention will be placed with the public health authority, a local AIDS programme, or a local drug programme.

In some countries, the drug treatment programme can take on responsibility for HIV prevention with input from the AIDS programme. Areas of collaboration would be testing of blood samples, training of drug workers on routes of transmission, sharing experiences on counselling, and collaboration on public information campaigns on AIDS to ensure relevance for drug users.

1. RECRUITING AND MANAGING LOCAL FIELD MANAGERS

Programme managers will need to recruit a number of local field managers or organizations, each of whom will have responsibility for planning and conducting HIV interventions in a specific geographical area (for instance, the whole or part of a large city, town or rural district). Programme managers must decide how best to subdivide the country or region for which they are responsible.

If there is to be one or more nationwide intervention (e.g. a mass-media information campaign or an HIV testing programme) the programme manager may wish to delegate responsibility for such interventions to field managers.

The local field managers recruited will be responsible for:

- undertaking a **local situation analysis** where there is a potential or actual risk of HIV transmission through injecting drug use; and if so
- selecting **local intervention activities** aimed at specific **target groups** in particular **locales**; and
- **implementing prevention activities,** which includes project development, the setting of project targets, project management and the monitoring and evaluation of activities.[1]

Local field managers will need to be clear about what, in broad terms, the interventions are expected to achieve and what their own responsibilities are.

Management structures must be set in place, and there must be clear instructions about who reports to whom, how often, and about what. Programme managers must liaise closely with the field managers, particularly when a decision is being made about the choice of specific local interventions: all activities must be in accordance with the overall HIV prevention strategy.

Performance targets

Performance targets should provide an overall goal and a sense of purpose; they should be challenging, explicit, and achievable over a specified period of time. A set of indicators should be decided on to monitor the targets.

Some of the targets will indicate the success in **implementing** activities, for example the number of staff trained, the number of bleach bottles distributed, the number of shops selling syringes, the number of people passing through the drug treatment system or the numbers of AIDS information leaflets distributed to drug users.

> A prison AIDS programme decided to give an AIDS education kit to each prisoner before release, containing information about HIV risk from injecting and sexual behaviour. The target set was that each prison institution should make the kit available within 12 months, and that within 18 months 95% of prisoners would receive one.

[1] See the *Guide for implementing local interventions.*

Other targets will indicate the successful **impact** or outcome of the activities, for example, the proportion of injectors routinely using bleach, the proportion regularly using condoms or the proportion sharing syringes.

Targets should take the following form:

> "By (date), *x*% in the target population will be able to cite at least two acceptable ways of protecting themselves from HIV infection."
>
> "By (date), *x* pharmacies will be supplying injecting equipment to injecting drug users (IDUs) on request."
>
> "By (date), *x* IDUs will be receiving treatment at treatment sites."

Information systems and surveillance

The need for improved information and surveillance systems will become apparent, and in many cases it will be appropriate for AIDS programmes to commission or promote routine collection of data on drug users and injectors which may be complemented by in-depth studies of drug use practices and the risk of HIV infection amongst drug injectors. Establishing better systems of surveillance is also a way of raising professional awareness of drug injection among, for example, police, emergency room staff, and other workers.

2. GUIDING AND OVERSEEING THE ONGOING DEVELOPMENT OF THE STRATEGY

HIV prevention for people who inject drugs is a long-term endeavour, and one which demands much effort, commitment and innovation from the people involved. It is likely that over time the HIV prevention strategy will need to be modified in response to changes in the levels of drug use by injection and behaviours of drug injectors. The strategy must therefore be flexible and be able to assimilate new information, change priorities and allow for the development of new interventions or the modification of existing ones.

Programme managers will therefore need to prepare guidelines on the evaluation of each intervention, use the results to make an informed judgement about which activities are most effective in preventing the spread of HIV among drug injectors and the local community as a whole, and modify the HIV prevention strategy as appropriate.

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