ARV4IDUs

HIV Treatment for Drug Users – A Realistic Goal

Satellite meeting

Date: Thursday, 15 July
Time: 18.00-20.00
Location: Room G

Availability of ARV For Injecting Drug Users: Key Facts

While exact figures are difficult to obtain, recent estimates suggest that there are over 13 million injecting drug users (IDUs) worldwide. More than ten million of these live in the developing world.[1] While data in many regions are incomplete, the number of countries reporting HIV among injecting drug users has more than doubled in the past decade, from 52 in 1992 to 114 in 2003.[2] Contaminated needles account for the largest share of new infections in China, Russia, Ukraine, Belarus and Moldova, all the Baltic States, all of Central Asia, most of Southeast Asia, North Africa, Iran, Afghanistan, Pakistan, Nepal, Indonesia, Portugal, and the Southern Cone of Latin America. UNAIDS estimates that IDUs represent as many as 10 percent of annual global HIV infections, and one of every three new infections outside Africa.[3] Individuals at greatest risk for HIV through injection include those already among society's poorest and most marginalized: ethnic minorities, migrants, unemployed youth, and those exchanging sex for survival.

Extremely limited supplies of antiretroviral therapy (ARV), and the suggestion that drug users cannot comply with or benefit from ARV, have been used in many countries to justify longstanding restrictions on provision of HIV treatment to IDUs. Recent developments, including the formation of the Global Fund to Fight AIDS, TB and Malaria, World Health Organization's (WHO) "3 by 5" initiative, and the manufacture of generic ARV for as little as $300 a month, are expected to sharply increase availability of ARV worldwide. Greater commitment to ensuring that IDUs receive treatment has not yet been demonstrated. In spite of data showing that they receive the same benefits from treatment as other patients and achieve high levels of adherence when offered appropriate social and medical support,[4] IDUs remain locked out of treatment even in countries where they are the vast majority of those infected.

IDUs are routinely excluded from ARV in industrialized countries

Excluded in North America

- In a 1998 study of 404 treatment-eligible IDUs in Baltimore, MD, half were receiving no antiretroviral therapy at all, and only 14% were receiving the triple combination therapy considered standard of care. Drug users not in a drug treatment program were three times less likely than non-drug users with HIV to receive ARV. A follow up study in 2001 found that less than a third of IDUs had received ARV. [5]
- A 1998 study of 177 IDUs eligible for free ARV in Vancouver, BC (Canada) found that fewer than one in five (18%) were receiving triple combination therapy.[6]

Excluded in Western Europe

- A 1999 study of 6,645 patients at 51 centres across Europe found that HIV-infected IDUs were significantly less likely than either heterosexual or homosexual non-IDUs to be offered ARV.[7]
- A 1999 Swiss study of 2,154 HIV patients demonstrated that IDUs, whether former or active, had a significantly higher risk of inadequate medical treatment.[8]
- A 1999 Italian study of 684 treatment-eligible patients with HIV found that those with a history of injecting drug use were significantly less likely to be prescribed ARV.[9]
- A 1999 study of 123 current and former French IDUs demonstrated that despite regular access to AIDS specialists, active drug user were three times less likely to be prescribed ARV.[10]

IDUs are routinely excluded from ARV in countries where they are the vast majority of those infected with HIV

Excluded in Central and Eastern Europe and Central Asia (CEE/CA)

- A 2002 study found that IDUs represented 82% of cumulative HIV cases in CEE/CA countries, but only 23% of those receiving any form of antiretroviral therapy, including monotherapy.[11]
- In Russia, where IDUs represented 90% of all HIV infections in 2002, AIDS service programs reported that none of those on "triple therapy" in St. Petersburg or Moscow were IDUs.[12] A 2004 survey found that active IDUs were still excluded from ARV in St. Petersburg. Chief physician of the City Health Committee Dr. Elena Vinogradova told researchers: "We know who can be trusted and who not."[13]
- In Ukraine, where IDUs were 69% of all HIV cases in 2002, they were only 20 percent of those on any form of ARV, including monotherapy. AIDS centres dispensing combination therapy reportedly treat children first, then non-drug users, and drug users last.[14]
- Of the eleven CEE/CA countries where IDUs represented 2/3 or more of registered cases, none provided ARV of any kind to more than 5% of those infected in 2002. This was true even in countries whose GDP was among the highest of the Newly Independent States (e.g., Estonia).[15]

Excluded in Asia

- In China, where IDUs account for more than 60% of the estimated one million cases of HIV, a 2004 survey found that IDUs are excluded from most medical care services.[16] A 2003 study in Yunnan, among the Chinese provinces with the highest number of HIV-infected IDUs, found that some of the forced detoxification centers to which drug users were sent performed HIV tests on detainees, but do not inform them of the result or offer them treatment. AIDS clinics in the province were empty and padlocked.[17]
- In Malaysia, where IDUs are 75% of all registered HIV cases, prisons and forced treatment centers test detainees for HIV, segregate those who test positive, but offer them no treatment. In the leading HIV clinic in Kuala Lumpur, where the government pays for one antiretroviral and asks patients to pay for the other two, former IDUs were only 20% of those receiving treatment in 2003. No active drug users were among those receiving ARV.[18]

- In Vietnam, four of five forced treatment centers surveyed in a 2001 study forced detainees to take HIV tests, but did not offer any treatment to the 40-80% who tested positive.[19] The Ministry of Social Evils has launched recent campaigns to institutionalize tens of thousands of drug users in Ho Chi Minh City, and to extend to five years the period of mandatory "rehabilitation" that human rights groups have termed forced labor.[20] The recently adopted National Strategy of HIV/AIDS Prevention and Control in Vietnam for 2005-2010, however, has committed to full inclusion of IDUs in HIV prevention and care services, including access to ARV treatment.[21]
- In Thailand, widely praised for the manufacture of generic ARV, government guidelines for years listed drug users among the "high risk" groups ineligible for ARV. That recommendation was withdrawn in 2004, though a national "drug war," including widespread blacklisting and arrests of people allegedly involved with drugs, has made many afraid to seek drug treatment or HIV services. IDUs represent virtually none of the 30,000 people on ARV in the country in 2004.[22]

Excluded—though less so—in Latin America and the Caribbean

- A 2004 survey found that three of the four Latin American countries for which information on HIV prevalence among IDUs is available—Brazil, Uruguay, and Chile—offer ARV to eligible patients with HIV regardless of past history. The fourth, Argentina, offers ARV to former IDUs who were abstinent from drugs.[23]
- IDUs had no access to ARV in the remaining 18 Latin American and Caribbean countries surveyed, including those like Columbia with as many as 8,000 HIV patients already on ARV.[24]
- Even when IDUs are included in national treatment protocols, such as Uruguay and Brazil, research indicates that provider prejudice against IDUs can make it difficult for them to access ARV, whether in entire regions of a country or in particular clinics.[25]

Expert guidelines offer rhetorical support on ARV to IDUs, but little monitoring

- WHO guidelines are clear that there should be no categorical exclusion of injecting drug users from any level of care. They state: "All patients who meet eligibility criteria and want treatment should receive it, including IDUs, sex-business workers and other populations."[26]
- Treatment guidelines issued by the U.S. Department of Health and Human Services note that that "No individual patient should automatically be excluded from consideration for antiretroviral therapy simply because he or she exhibits a behavior or other characteristic judged by some to lend itself to non-adherence."[27]
- In practice, however, IDUs continue to be excluded from treatment. Neither WHO's "3 by 5" initiative nor the application requirements of the Global Fund to Fight AIDS, TB and Malaria, include specific requirements that IDUs be included among those receiving ARV, even in countries where they are the vast majority of those infected with HIV.

[1] Aceijas, C., G. Stimson, et al. (2004). Global overview of injecting drug use and HIV infection among injecting drug users. London, Centre for Research on Drugs and Health Behavior, Imperial College.

[2] Strathdee, S. and K. Poundstone (2003). The International Epidemiology and Burden of Disease of Injection Drug Use and HIV/AIDS. Reducing the risks, harms and costs of HIV/AIDS and injection drug use (IDU): A synthesis of the evidence base for development of policies and programs. J. Rehm, B. Fischer and E. Haydon. Toronto, Health Canada.

[3] UNAIDS (2002). Report on the Global HIV/AIDS Epidemic. Geneva, The Joint United Nations Programme on HIV/AIDS.

[4] For a summary of research on adherence to and efficacy of ARV among IDUs, see ARV for Injecting Drug Users: Key Facts on Treatment Efficacy (2004), Coalition ARV4IDUs. Satellite meeting "HIV Treatment for Drug Users – A Realistic Goal". XV International AIDS Conference. Bangkok July 15, 2004. www.ceehrn.org

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[6] Strathdee, S. A., A. Palepu, et al. (1998). "Barriers to use of free antiretroviral therapy in injection drug users." JAMA 280(6): 547-549; Wood, E., M. W. Tyndall, et al. (2001). "Unsafe injection practices in a cohort of injection drug users in Vancouver: could safer injecting rooms help?" CMAJ 165(4): 405-410.

[7] Mocroft, A., S. Madge, et al. (1999). "A comparison of exposure groups in the EuroSIDA study: starting highly active antiretroviral therapy (HAART), response to HAART, and survival." J Acquir Immune Defic Syndr 22(4): 369-378.

[8] Bassetti, S., M. Battegay, et al. "Why is highly active antiretroviral therapy (HAART) not prescribed or discontinued? Swiss HIV Cohort Study." J Acquir Immune Defic Syndr 21(2): 114-119.

[9] Murri, R., M. Fantoni, et al. "Intravenous drug use, relationship with providers, and stage of HIV disease influence the prescription rates of protease inhibitors." J Acquir Immune Defic Syndr 22(5): 461-466.

[10] Carrieri, M. P., J. P. Moatti, et al. (1999). "Access to antiretroviral treatment among French HIV infected injection drug users: the influence of continued drug use. MANIF 2000 Study Group." J Epidemiol Community Health 53(1): 4-8.

[11] CEE-HRN (2002). Injecting Drug Users, HIV/AIDS Treatment and Primary Care in Central and Eastern Europe and the former Soviet Union: Results of a Region-wide Survey. Vilnius, Central and Eastern European Harm Reduction Network.

[12] Ibid. p. 12.

[13] Human Rights Watch (2004). Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation. Moscow/New York, Human Rights Watch. p. 45.

[14] CEE-HRN (2002). Injecting Drug Users, HIV/AIDS Treatment and Primary Care in Central and Eastern Europe and the former Soviet Union: Results of a Region-wide Survey. Vilnius, Central and Eastern European Harm Reduction Network. p. 10.

[15] Ibid. p. 12.

[16] Asian Harm Reduction Network (2004). Scaling up provision of anti-retrovirals to injecting drug users and non-injecting drug users in Asia. Melbourne, Asian Harm Reduction Network.

[17] Human Rights Watch (2003). Locked Doors: The Human Rights of People with AIDS in China. New York, Human Rights Watch.

[18] Wolfe, D. and K. Malinowska-Sempruch (2004). Illicit Drug Policies and the Global HIV Epidemic: Effects of UN and National Government Approaches. New York, Open Society Institute.

[19] Vu Doan Trang (2001). Harm reduction for injecting drug users in Vietnam: A situation assessment. Report for Macfarlane Burnet Centre, Victorian Public Health Training Scheme. Melbourne, Australia.

[20] Wolfe, D. and K. Malinowska-Sempruch (2004). Illicit Drug Policies and the Global HIV Epidemic: Effects of UN and National Government Approaches. New York, Open Society Institute.

[21] National Strategy of HIV/AIDS Prevention and Control in Vietnam up to 2010 with a Vision to 2020. Government Office of the Socialist Republic of Vietnam; March 2004.

[22] AIDS Division Bureau of AIDS, TB and STIs Department of Diseases Control Ministry of Public Health, Thailand (2004), www.aidsthai.org.

[23] Latin American Harm Reduction Network (2004). WHO strategy to support the scale up of anti-retroviral treatment (ARV): The role of regional harm reduction networks in capacity building, Rede Latinoamericano de Reducao de Dano (RELARD).

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[25] Ibid. p. 3.

[26] WHO. WHO HIV/AID Treatment and Care Protocols. Geneva: World Health Organization; March 2004.

[27] US Department of Health and Human Services (2000). Panel on Clinical Practices for Treatment of HIV infection. Guidelines for the Use of Antiretroviral Agents to HIV-infected Adults and Adolescents. Washington: Department of Health and Human Services.

For reference: Availability of ARV For Injecting Drug Users: Key Facts (2004). Coalition ARV4IDUs. Satellite meeting "HIV Treatment for Drug Users – A Realistic Goal". XV International AIDS Conference. Bangkok July 15, 2004. www.ceehrn.org

Coalition ARV4IDUs includes the following organizations: Central and Eastern European Harm Reduction Network (CEE-HRN), International Harm Reduction Development Program of the Open Society Institute (IHRD/OSI), European AIDS Treatment Group (EATG), Gay Men's Health Crisis (GMHC), Thai Drug Users' Network (TDN) and Thai AIDS Treatment Action Group (TTAG).