

Antiretroviral Treatment for Injecting Drug Users

INJECTING DRUG USERS (IDUS) COMPRISE THE LARGEST SHARE OF HIV CASES in at least 20 nations of Asia and the former Soviet Union, including China and Russia.¹ Yet as these countries move to make HIV treatment more available, IDUs remain disproportionately less likely to have access to antiretroviral (ARV) treatment.² Reasons for this inequality include misconceptions about the impact of drug use on treatment adherence, denial of basic supports such as methadone that would facilitate HIV treatment, stigma in health care settings, and emphasis on incarceration and punishment of IDUs rather than on their care.^{3,4,5,6,7,8}

HIV Treatment Shortfalls: Gaps in ARVs for IDUs

Though nearly one in three HIV cases outside Africa is attributed to injecting drug use, ARV treatment systems continue to exclude IDUs.⁹

- ▶ In Eastern Europe and Central Asia, IDUs represent more than 80 percent of HIV cases, but only 14 percent of the total number of people receiving ARVs.¹⁰
- ▶ In Russia, where approximately 83 percent of total HIV cases are IDUs,¹¹ as many as 70,000 people are in need of ARV treatment. Only 30,000 receive it. ARV stockouts are an ongoing problem in Russia.¹²
- ▶ In Thailand, where more than 80% of people in need of ARV treatment receive it, the country has failed to systematically extend treatment to drug users; some providers openly deny drug users treatment.¹³
- ▶ In China, Malaysia, and Vietnam, IDUs are interned for months or years in forced detoxification and rehabilitation centers. Though many IDUs are HIV-positive, few centers offer ARVs.^{14,15,16}
- ▶ In Malaysia, IDUs comprise 75 percent of all HIV cases but only 5 percent of those receiving ARV treatment.¹⁷

HIV Treatment Benefits: Clinical Efficacy of ARVs for IDUs

Medical providers are often reluctant to treat IDUs, claiming that their lives are too chaotic for them to adhere to antiretroviral treatment or that multiple illnesses make treatment too difficult.^{18,19} While active drug use has been linked to problems with access and adherence to ARV treatment, IDUs offered appropriate supports can achieve adherence

and treatment outcomes comparable to those of other patients.^{20,21}

- ▶ A 2006 study in France determined that a history of injecting drug use had no significant effect on adherence to ARV treatment.²²
- ▶ A 2004 study of patients in Vancouver (Canada) found that drug users who adhered to ARV experienced the same increases in CD4+ count as adherent non-drug users.²³
- ▶ In a 2000 study in Sao Paulo (Brazil) active drug use had no impact on ARV adherence; 69 percent of patients achieved adherence levels of over 80 percent, though most were poor, had limited education, and were unemployed.²⁴
- ▶ A 1999 study of patients receiving ARV treatment from 51 centers across Europe found no significant difference between IDUs and non-drug users in CD4+ or virologic response.²⁵

HIV Treatment Tool: Opiate Substitution Therapy and ARVs for IDUs

Prescribed medications such as methadone or buprenorphine are the best studied and most effective form of treatment for opiate dependence.²⁶ Substitution therapy allows patients to stop or reduce illicit drug use and injection, improve their health, stabilize their lives, and adhere to ARV regimens.²⁷ The World Health Organization added methadone and buprenorphine to its list of essential medicines in 2005.

Despite its effectiveness, opiate substitution therapy remains strikingly limited. Of 6 and a half million IDUs estimated to live in countries where contaminated needles are the main source of HIV infections, only 130,000 have access to substitution therapy.²⁸ In Russia, with more than 2 million IDUs, opiate substitution therapy is illegal.²⁹

HIV Treatment Needs: Integrated, Comprehensive Care for IDUs

Drug use is often linked to other factors that may affect HIV treatment, including poverty, psychiatric illness, and infection with hepatitis C or tuberculosis. Offering multiple services at a single site and creating strong links between HIV, TB, and drug treatment providers can

increase accessibility and effectiveness of ARVs for IDUs. Keeping programs open late, situating them in areas convenient for drug users, and including peer outreach workers and counselors in treatment provision also increases the effectiveness of health care for IDUs.^{30,31,32,33} Directly administered antiretroviral therapy (DAART), in which program staff supervise delivery of ARV treatment, can also increase adherence.^{34,35}

► A New York City program offered patients peer education and counseling, support in disclosing HIV status to family members, and referrals to drug treatment and housing services. The caregiving team included a social worker and a nurse as well as a physician. New patients received prefilled pillboxes and counseling every week. In a 2004 study of the program, nearly nine in ten (86 percent) achieved an undetectable viral load after one year. Only one in three patients who did not receive such support achieved the same result.³⁶

► A 2004 study of a program in New Haven (USA) found that 77 percent of drug users who were offered peer support and DAART at a mobile health clinic achieved an undetectable viral load. Adherence among these IDUs was 85 percent despite the fact that 35 percent were homeless and 74 percent were depressed.³⁷

► A 2005 study in Baltimore (USA) showed that IDUs who received DAART in methadone clinics were significantly more likely to adhere than patients who self-administered their ARV, including IDUs on or off methadone and non-IDUs.³⁸

“Access to HIV treatment should not be artificially restricted due to political or social constraints. Specifically there should be no categorical exclusion of injection drug users from any level of care.”³⁹

World Health Organization, *Protocols on HIV/AIDS Treatment and Care for the Commonwealth of Independent States, 2004*

NOTES

- IHRD (2008). *Harm Reduction Developments 2008: Countries with Injection-Driven HIV Epidemics*. New York: International Harm Reduction Development Program (IHRD) of the Open Society Institute, p. 11.
- Aceijas, C., E. Oppenheimer, et al. (2006). “Antiretroviral treatment for injecting drug users in developing and transitional countries 1 year before the end of the ‘Treating 3 million by 2005. Making it happen. The WHO strategy’ (‘3by5’).” *Addiction* (0), doi:10.1111/j.1360-0443.2006.01509.x.
- International Treatment Preparedness Coalition (2007). *Missing the Target*. <http://www.aidstreatmentaccess.org/itpc5th.pdf>
- UNAIDS (2006). Report on the Global AIDS Epidemic. Geneva: UNAIDS.
- Human Rights Watch (2006). “Rhetoric and Risk: Human Rights Abuses Impeding Ukraine’s Fight Against HIV/AIDS. New York: Human Rights Watch. <http://hrw.org/reports/2006/ukraine0306/>
- Human Rights Watch (2003). *Locked Doors: The Human Rights of People with AIDS in China*. New York: Human Rights Watch.
- Bobrova N, Rhodes T, et al (2006). “Barriers to accessing drug treatment in Russia: a qualitative study among injecting drug users in two cities.” *Drug and Alcohol Dependence* (82 Suppl 1). S57-63.
- Wolfe, D. and K. Malinowska-Sempruch. (2004). *Illicit Drug Policies and the Global HIV Epidemic: Effects of UN and National Government Approaches*. New York: International Harm Reduction Development Program (IHRD) of the Open Society Institute.
- UNAIDS, op cit.
- IHRD (2008). *Harm Reduction Developments 2008: Countries with Injection-Driven HIV Epidemics*. New York: International Harm Reduction Development Program (IHRD) of the Open Society Institute, p.63.
- IHRD (2008). *Harm Reduction Developments 2008: Countries with Injection-Driven HIV Epidemics*. New York: International Harm Reduction Development Program (IHRD) of the Open Society Institute, p. 37.
- International Treatment Preparedness Coalition, op cit.
- Human Rights Watch (2007). “Deadly Denial: “Barriers to HIV/AIDS Treatment for People Who Use Drugs in Thailand.” New York: Human Rights Watch
- Human Rights Watch (2003). op cit.
- Wolfe, D. and K. Malinowska-Sempruch, op cit.
- Vu Doan, T. (2001). *Harm reduction for injecting drug users in Vietnam: A situation assessment*. Report for Macfarlane Burnet Centre, Victorian Public Health Training Scheme. Melbourne, Australia.
- Aceijas, C., E. Oppenheimer, et al., op cit.
- Human Rights Watch (2004). “Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation.” New York: Human Rights Watch. <http://hrw.org/reports/2004/russia0404/>
- Human Rights Watch (2006), op cit.
- Peretti-Watel P, Spire B et al. (2006). “Drug use patterns and adherence to treatment among HIV-positive patients.” *Drug and Alcohol Dependence* (82 Suppl 1). S71-9.
- Wood E, Montaner JS, et al. (2004). “Adherence to antiretroviral therapy and CD4 T-cell count responses among HIV-infected drug users: implications for program replication.” *Clin Infect Dis* 2004;1 (38 Suppl 5):S376-87.
- Peretti-Watel P, op cit.
- Wood E, op cit.
- Nemes, MIB (2000). “Aderencia ao Tratamento por Anti-retrovirais em Servicos Publicos no Estado de Sao Paulo,” Brasilia, DF. Sao Paolo: Ministerio da Saude do Brasil.
- Mocroft, A., S. Madge, et al. (1999). “A comparison of exposure groups in the EuroSIDA study: starting highly active antiretroviral therapy and CD4 T-cell count responses among HIV-infected injection drug users.” *Antivir Ther* 2004;9(2):229-35.
- Institute of Medicine (1990). *Treating Drug Problems, vol. 1*. Washington, DC: National Academy Press; 187.
- Palepu A, Tyndall MW et al (2006). “Antiretroviral adherence and HIV treatment outcomes among HIV/HCV co-infected injection drug users.” *Drug and Alcohol Dependence*. In press.
- IHRD (2008). *Harm Reduction Developments 2008: Countries with Injection-Driven HIV Epidemics*. New York: International Harm Reduction Development Program (IHRD) of the Open Society Institute, p. 72.
- IHRD (2008). *Harm Reduction Developments 2008: Countries with Injection-Driven HIV Epidemics*. New York: International Harm Reduction Development Program (IHRD) of the Open Society Institute, p. 76.
- Kazatchkine, M and Lert F (2004). “France: Meeting the Needs of Injecting Drug Users in HIV Care.” In IHRD, *Breaking Down Barriers*. New York: International Harm Reduction Development Program (IHRD) of the Open Society Institute.
- Broadhead RS, Heckathorn DD et al. “Harnessing peer networks as an instrument for AIDS prevention.” *Public Health Reports*. 1998, 113 Suppl 1: 42-57.
- Kerr T, Small W et al. “Harm reduction by a “user-run” organization.” *Int J of Drug Policy*. 2006, 17: 61-69.
- Grund, JP, Blanken P et al. “Reaching the unreachable.” *J of Psychoactive Drugs*. 1992, 24(1): 41-7.
- Altice F, Mezger J, Hodges J, Bruce R, Marinovich A, Walton M, et al. Developing a directly administered antiretroviral therapy intervention for HIV-infected drug users: implications for program replication. *Clin Infect Dis* 2004; 1 (38 Suppl 5):S376-87.
- Lucas GM, Weidle PJ, Hader S and Moore RD (2004). “Directly Administered Antiretroviral Therapy in an Urban Methadone Maintenance Clinic: A Nonrandomized Comparative Study.” *Clin Infect Dis*, 38:S409-13.
- Dobkin, JF (2004). “New York: Antiretroviral treatment for multi-problem patients.” In IHRD, *Breaking Down Barriers*. Op cit.
- Altice F, op cit.
- Lucas GM, op cit.
- WHO (2004). *HIV/AIDS Treatment and Care Protocols for Countries of the Commonwealth of Independent States*. Geneva: World Health Organization.