



HIV Treatment
for Drug Users –
A Realistic Goal

Satellite meeting

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

ARV For Injecting Drug Users: Key Facts on HIV Treatment Efficacy

Medical professionals and AIDS program administrators in many countries routinely exclude those who use illicit drugs from antiretroviral therapy (ARV), suggesting that drug users are less likely to adhere to treatment and less likely to experience virologic and immunologic response.¹ Reluctance to offer ARV to drug users includes not only injecting drug users (IDUs), but also extends to those on medically prescribed opioid substitution treatment such as methadone, users of non-injecting drugs, and former drug users.

In the absence of randomized controlled trials, beliefs that drug users are non-compliant or untreatable are based as much on prejudice as on data. A number of studies—many of which offered drug users no services tailored to their needs—have shown mixed results on IDUs adherence and virologic response to ARV. A growing body of evidence, however, demonstrates that with proper supports IDUs can receive the same benefits from treatment as other patients, and achieve high levels of adherence.

ARV treatment is clearly effective for IDUs

While large, randomized controlled trials are needed, cohort studies show clear clinical benefits for IDUs on ARV.

A 1999 study of 6,645 patients from 51 centres across Europe receiving ARV found no significant difference between IDUs and non-drug users in CD4+ or virologic response.²

A 2004 study of 1,522 patients in Vancouver, BC (Canada) found that drug users who adhered to ARV experienced the same increases in CD4+ count as adherent non-drug users.³

In a 2004 study of clients of a mobile syringe exchange program in New Haven, CT (USA), 77% of drug users offered peer support along with ARV achieved reduction of viral load to less than 400 copies/ml and a 25% increase in CD4+ after six months.⁴

IDUs demonstrate high levels of adherence to antiretroviral therapy

Even poor and homeless IDUs can adhere to ARV.

In a 2001 study of 673 mostly poor patients with HIV in Sao Paolo (Brazil), active drug use had no impact on ARV adherence in multivariate analysis. Overall adherence to ARV among participants was 69%.⁵

In a 2001 study of 796 inner city patients in Baltimore, MD (USA), active users achieved levels of adherence of 66% without any special supports. Former drug users in the study demonstrated *higher* levels of adherence (83%) than those who had never used drugs (76%).⁶

In a 2004 study among 72 HIV-infected clients of New Haven needle exchange site (USA), those receiving ARV together with peer support achieved adherence rates of 85% after six months. These rates were achieved even though 35% of the users in the study were homeless, and 74% were deeply depressed.⁷

A 2000 study of 164 French ARV recipients found that those on buprenorphine achieved *higher* levels of adherence (78.1%) than either former drug users (65.5%) or active IDUs not on buprenorphine (42.1%). Higher adherence was reported even by those patients who continued to inject illicit drugs while receiving buprenorphine treatment.⁸

A "one-stop shopping" approach sharply increases ARV treatment success and adherence among IDUs

Including as many health and social services as possible at a single site has been shown to improve both adherence and treatment outcomes for IDUs.

In a 2002 study of 39 patients offered ARV daily at a methadone clinic in Dublin (Ireland), 58% achieved optimal viral suppression (<50 copies/ml) in 48 weeks.⁹

In a 2003 study, a Buenos Aires (Argentina) hospital program providing food, public transport, and access to ARV helped drug users to decrease the severity of their drug use and achieve the same levels of adherence as other patients of similar economic status.¹⁰

Jumpstart, a program in New York (USA) serving large numbers of low-income drug users, offers intensive adherence education and support. In a 2003 study of 78 patients who had previously "failed" on ARV, 66% achieved undetectable viral load within one year and experienced CD4+ gains higher than a control group of patients starting ARV without such supports.¹¹

In a 2004 study among 286 patients in Baltimore, MD (USA), patients receiving ARV at their methadone clinic achieved viral suppression within six months at higher rates (58%) than non-drug users who were self administering ARV (39%).¹²

International guidelines support provision of ARV to IDUs

WHO's 2004 Protocols for HIV/AIDS Care state explicitly:

“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. All patients who meet eligibility criteria and want treatment should receive it, including IDUs, sex-business workers and other populations.”¹³

Clinical data and review of best practices suggest four key principles for effective ARV treatment for IDUs¹⁴

Key Principle 1: Care must be accessible

Services should be located in places that are accessible to IDUs and in facilities that are part of the general healthcare infrastructure.

Key Principle 2: Care must be comprehensive

Integration of ARV with substitution treatment or other substance abuse services, as well as with primary care, counseling and education, can greatly increase treatment success for IDUs.

Key Principle 3: Care should be offered to patients at whatever level they are able to utilize

Simpler interventions like opportunistic infection prophylaxis may offer a “bridge” to more complex care such as ARV for IDUs who are newly diagnosed or still actively using drugs.

Key Principle 4: Outreach strategies are a vital component of HIV care

The most effective programs offering ARV to IDUs have formed strong links with community-based organizations, and have utilized peer educators and counselors who have been directly impacted by injecting drug use.

- ¹ For details of IDU access to antiretroviral treatment, please see 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
- ² Mocroft, A., S. Madsen, 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.
- ³ Wood E, Montaner JS, Yip B, Tyndall MW, Schechter MT, O’Shaughnessy MV, et al. Adherence to antiretroviral therapy and CD4 T-cell count responses among HIV-infected injection drug users. *Antivir Ther* 2004;9(2):229-35.
- ⁴ 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.
- ⁵ Nemes M. Aderencia ao Tratamento por Anti-retrovirais em Servicos Publicos no Estado de Sao Paulo, Brasilia, DF. Sao Paolo: Ministerio da Saude do Brasil; 2000.
- ⁶ Lucas G, Cheever L, Chaisson R, Moore R. Detrimental Effects of continued illicit drug use on the treatment of HIV-1 infection. *J Acquir Immune Defic Syndr* 2001;27(251-59).
- 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.
- ⁸ Moatti JP, Carrieri MP, Spire B, Gastaut JA, Cassuto JP, Moreau J. Adherence to HAART in French HIV-infected injecting drug users: the contribution of buprenorphine drug maintenance treatment. The Manif 2000 study group. *J Acquir Immune Defic Syndr* 2000;14(2):151-5.
- ⁹ Clarke S, Kennan E, Ryan M. Directly observed antiretroviral therapy for injection drug users with HIV 2002; *The AIDS Reader* 12(305-7):312-316.
- ¹⁰ Moscatello G, Campello P, Benetucci JA. Bloodborne and sexually transmitted infections in drug users in a hospital in Buenos Aires, Argentina. *Clin Infect Dis* 2003;37 Suppl 5:S343-7.
- ¹¹ Open Society Institute. Breaking Down Barriers: Lessons on Providing HIV Treatment to Injection Drug Users. New York, International Harm Reduction Development Program, Open Society Institute; July 2004.
- ¹² Lucas, G. Directly administered antiretroviral therapy in an urban methadone maintenance clinic: a non-randomized comparative study. *Clin Infect Dis* 2004; June 1;38 Supl 5:S409-13.
- ¹³ WHO. WHO HIV/AIDS Treatment and Care Protocols. Geneva: World Health Organization; March 2004.
- ¹⁴ Ibid.

For reference: ARV For Injecting Drug Users: Key Facts on HIV 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

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).

