ISSN 1472-4863

# ARV4IDUs

ANTIRETROVIRAL TREATMENT FOR INJECTING DRUG USERS: A QUARTERLY BULLETIN

Volume 2 Number 1: English edition

October 2009

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Published by HIV i-Base

# *ARV4IDUs*

Antiretroviral Tretment for Injecting Drug Users: A quarterly bulletin

ARV4IDUs is a quarterly bulletin published in electronic format by HIV i-Base. As with all i-Base publications, subscriptions are free and can be ordered by fax or post using the form on the back page or directly from the i-Base website:

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ARV4IDUs is a not-for-profit community publication that aims to provide a review of the most important medical advances related to clinical management of HIV and its related conditions for injecting drug users, as well as access to treatments. Comments to articles are compiled from consultant, author and editorial responses.





HIV i-Base receives unconditional educational grants from Charitable Trusts, individual donors and pharmaceutical companies. All editorial policies are independent of funding sources.



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## EDITORIAL

Dear readers,

A warm welcome to our renewed edition of ARV4IDUs.

We would like to apologise for the gap from the last issue, which is related to a combination of both personal and organisational issues. We hope this issue is still useful as an overview from much of 2009 and we will now aim to return to our previous quarterly schedule. We would like to thank Open Society Institute for their decision to renew funding and their patience with our timeline.

Even if the information and studies on this particularly difficult, politically and legally challenging topic is still underrepresented in the majority of conferences, there were several studies worth taking a look at since the beginning of the year.

In this issue, you will find a coverage of three major conferences: The Conference of Retrovirus and Opportunistic Infections in Montreal, Canada (February 2009), The International Harm Reduction Conference in Bangkok (April 2009) and The IAS Conference on HIV Pathogenesis, Treatment and Prevention in Cape Town (July 2009).

In our next issue, we intend to cover the sessions of the EECAAC conference in Moscow (October 2009) and the European AIDS Clinical Society Conference in Cologne (November 2009).

We always like to encourage new writers and reviewers who would like to contribute to future issues. This can include research reports and overview articles. If you would like to contribute to future issues or have news to include, please email:

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ARV4IDUs is produced in English and Russian and is distributed by email and published on the i-Base website.


ARV4IDUs is produced as a supplement to the i-Base HIV Treatment Bulletin (HTB) and has been supported by a grant from the International Harm Reduction Development Programme of the Open Society Institute (www.soros.org).


Thank you for reading!

The editorial team

# CONFERENCE REPORTS

## 5th IAS Conference on HIV Pathogenesis, Treatment and Prevention

**19-23 July 2009, Cape Town**

## Introduction

The IAS conference did not have a lot of new research related to IDU, although one of the sessions did focus on IDU-related issues. We include the following reports in this issue:

- Influence of HIV infection on renal function among heroin users
- Risk of developing specific AIDS-defining illnesses in patients coinfected with HIV and HCV, with or without liver cirrhosis
- Response to first line antiretroviral therapy in patients with and without a history of IDU in Indonesia
- Screening, enrolment, and follow-up of IDUs in an HIV pre-exposure prophylaxis trial in Bangkok
- HIV, HCV and somatic comorbidity in a heroin maintenance centre in Switzerland - a case for an integrative medical approach to harm-reduction
- Performance of simple non-invasive scores to predict fibrosis in HIV/HCV co-infection in daily clinical practice
- Liver disease is associated with HIV/HCV co-infection and alcohol use among IDUs in Chennai, India
- Hunger and food insufficiency are independently correlated with unprotected sex among HIV-positive IDUs with and without HAART
- Drug and alcohol dependence special session

For the first time, webcasts of several sessions are available via the conference website together with searchable online abstracts and PDF files of many of the posters or presentations:

http://www.ias2009.org

The abstract database from the meeting is online at the same site.

## Influence of HIV infection on renal function among heroin users

**Svilen Konov, HIV i-Base**

A study by Gasiorowski and colleagues from the Wroclaw Medical University looked at the impact of HIV infection on renal function among heroin users. This study included 87 heroin users (23 HIV-positive and 64 HIV-negative) and 22 HIV-negative non-IDUs as a control group. None of the HIV-positive participants was on HAART at the time of the study. [1]

Previous research has highlighted that HIV-infection increases the risk of acute kidney injury and heroin use increases the risk of nephropathy. As routine serum creatinine can be an insensitive and/or non-specific test to diagnose kidney injury, the researchers suggested that new biomarkers may permit earlier and more accurate identification of acute kidney injury.

Using ELISA they measured the urine concentration of IL-18, NGAL, GST-alpha, GST-pi and beta-2M of all participants, and analysed results using Student T-test.

Although all the markers were higher in the heroin users compared to the control group, only the IL-18 was statistically higher (36.16±58.84pg/mL vs 9.8±3.72pg/mL).

They also reported a significantly higher increase of beta-2M concentration in the group of HIV-positive heroin users compared to HIV-negative heroin users (0.88±1.9mg/l vs 0.35±0.42mg/L, respectively).

Heroin dose and time of its use, sex, HBV, HCV, CD4 count and cocaine sporadic use did not have influence on kidney injury markers. However, NGAL and GST-alpha were statistically significantly higher in the group of the heroin users who were also amphetamine occasional users than in the group of heroin but non-amphetamine users (1.23±2.4ng/mL vs 0.49±0.8ng/mL for NGAL and 19.1±27.5ug/L vs 4.38±6.83ug/l for GST-alpha, respectively).

The researchers concluded that the 'results may suggest that HIV infection among heroin drug users may disturb kidney function and increase beta-2M urine concentration. Nonetheless, the heroin and amphetamine use may lead to kidney injury'.

References:

Gasiorowski J et al. Influence of HIV infection on renal function among heroin users.5th IAS Conference, 19-22 July 2009, Cape Town. Abstract CDB011.

http://www.ias2009.org/pag/Abstracts.aspx?AID=3357..

## Risk of developing specific AIDS-defining illnesses in patients coinfected with HIV and HCV with or without liver cirrhosis

**Svilen Konov, HIV i-Base**

An Italian study from the Sao Paolo Hospital in Milan looked into the correlation between the occurrence of different AIDS-defining illnesses (ADIs) and chronic HCV infection or HCV-related liver cirrhosis. [1]

There are few data concerning the risk of specific opportunistic diseases in patients with and without hepatitis C virus (HCV) infection.

The study was conducted in an Italian cohort of over 5000 HIV-positive patients, stratified into two groups: i) patients without HCV coinfection and with persistently normal aminotransferase levels and ii) patients with HCV coinfection. Coinfected patients were stratified according to liver cirrhosis. The incidence of new ADIs was calculated per 1000 person-years of follow-up by Poisson regression model and adjusted tor potential confounders.

The researchers observed 496 ADIs among 5397 patients over 25,105 person-years of follow-up, half of which were in coinfected patients. HCV coinfection was associated with an increased risk of developing an ADI (adjusted relative rate [ARR], 2.61; 95% confidence interval [CI], 1.88-3.61). Specific rates included, bacterial infection (ARR 3.15; 95%CI 1.76-5.67), HIV-related disease (ARR 2.68; 95%CI 1.03-6.97) and mycotic disease (ARR 3.87; 95%CI, 2.28-6.59), but not non-Hodgkin lymphoma (ARR, 0.88; 95% CI, 0.22-3.48).

HIV-monoinfected patients had a significantly lower rate of mycotic infection, bacterial infection, toxoplasmosis, and HIV-related ADI than among patients with HCV and cirrhosis. The risk among coinfected patients with cirrhosis was also greater than non-cirrhotic patients.

The researchers concluded that 'HIV-related bacterial and mycotic infections are strongly associated with positive HCV serostatus and HCV-related cirrhosis'.

They strongly recommended that these data should be considered when deciding when to start antiretroviral therapy in HCV-coinfected individuals.

References:

D'Arminio Monforte et al. Risk of developing specific AIDS-defining illnesses in patients coinfected with HIV and hepatitis C virus with or without liver cirrhosis. Clin Infect Dis. 2009 Aug 15;49(4):612-22.

http://www.ncbi.nlm.nih.gov/pubmed/19591597

## Response to first line antiretroviral therapy in patients with and without a history of IDU in Indonesia

**Svilen Konov, HIV i-Base**

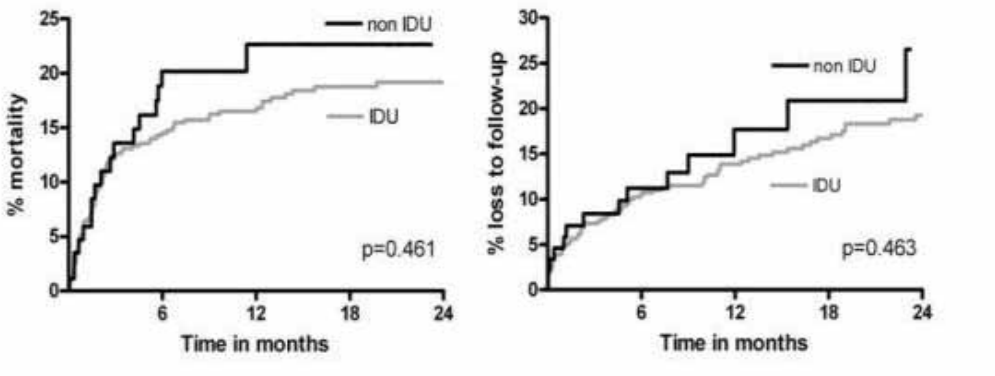
This study from Indonesia, reported during the IAS Conference in Cape Town, looked at the response to first line HAART in IDU and non-IDU patients as injecting drug use (IDU) is often associated with lower uptake, retention and success of antiretroviral treatment (ART).

The participants were all registered as HIV-positive between 1996 and April 2008 in a referral hospital. Data before January 2007 was collected retrospectively from medical records, with prospective questionnaires and blood results used subsequently.

Of the 773 adult HIV patients, just over 80% had a history of IDU. These patients presented with a lower CD4-cell (median 33 vs. 84 cells/mm$^3$) and a high prevalence of HCV-infection (88%). Uptake and adherence to ART, however, were not different between IDUs and non-IDUs. Importantly, IDUs and non-IDUs showed similar mortality and loss to follow-up (see Figure 1 below). After a median of 20 months ART, virologic failure was detected in approximately 12% of IDUs and 16% of non-IDUs (p=0.524).

These data are particularly important in the Indonesian setting, where IDU remains the main route and risk factor for infection.

**Figure 1: Mortality and loss to follow up by IDU status**




References:

R. Wisaksana et al. Response to first line antiretroviral therapy among HIV-infected patients with and without a history of injecting drug use in Indonesia. 5th IAS Conference, 19-22 July 2009, Cape Town. Abstract MOPEB060.

http://www.ias2009.org/pag/Abstracts.aspx?AID=3468

## Screening, enrolment, and follow-up of IDUs in an HIV pre-exposure prophylaxis trial in Bangkok

**Svilen Konov, HIV i-Base**

The Bangkok Tenofovir Study is an ongoing randomised, double-blind, placebo-controlled study using daily oral tenofovir to prevent HIV infection among injecting drug users (IDUs). Preliminary results on the trial status were presented at the IAS conference in Cape Town. [1]

The trial is being conducted in 17 Bangkok Metropolitan Administration drug treatment clinics. Eligible IDUs (n=2400) are randomised (1:1) to receive daily tenofovir 300mg or placebo. Participants choose follow-up either daily with directly observed taking of study drug (DOT) or monthly without DOT. HIV status and demographics are assessed at enrolment, blood chemistry and hematology for safety at enrolment and every 3 months, and HIV status and adherence every month.

Between 2005 and 2008, 3824 IDUs were screened and 2259 (59%) enrolled. Reasons for screen failure included HIV infection (10%), elevated ALT or AST (8%), and chronic Hepatitis B infection (6%). Median age of enrollees was 31 years (range, 20-59), 79% were male, and 87% had completed primary school or higher. Retainment was high with 85% of eligible participants completing the 12-month visit, 84% the 24-month visit, and 94% the 36-month visit. Participants reported taking study medication the day before 94% of monthly visits and 88% chose DOT follow-up.

The first efficacy and safety results are expected in 2010.

References:

Martin M et al. Screening, enrolment, and follow-up of injecting drug users in an HIV pre-exposure prophylaxis trial in Bangkok. 5th IAS Conference, 19-22 July 2009, Cape Town. Abstract WEPEC081.

http://www.ias2009.org/pag/Abstracts.aspx?AID=2200

## HIV, HCV and somatic co-morbidity in a heroin maintenance centre in Switzerland - a case for an integrative medical approach to harm-reduction

**Svilen Konov, HIV i-Base**

As somatic diseases in IDU is not well investigated, the centre for heroin maintenance centre KODA in Bern, Switzerland compared the effectiveness of heroin maintenance therapy for criminal and socio-economic harm-reduction to evaluate the somatic health status of patients on heroin maintenance therapy and to assess the need for improving on-site somatic care.

The researchers performed a cross-sectional survey of all 201 IDU treated in KODA and developed a database containing medical, laboratory and epidemiological information.

Of the 201 patients (72% male, median age 40.5 years), 26 (13%) were HIV-positive and 17 were on antiretroviral treatment. Of 9 untreated patients, 3 would qualify for ART according to treatment guidelines. Three-quarters of patients (151/201) were coinfected with HCV. Plasma HCV-RNA results were available for 121 individuals. In 41 patients, no HCV-replication was found,

suggesting a high spontaneous viral clearance rate of 27%. Of 80 patients with documented HCV-replication only 9 (9%) had formally been evaluated for interferon/ribavirin therapy, and 6 were treated (2 SVR, 3 non-responders and 1 patient currently on treatment).

Over 50% patients (113/201) had an additional somatic diagnosis: infection related (34%), pulmonary (24%), cardiovascular (22%), neurological (22%) and haematological (19%) disorders were the most prevalent. Only 16% patients (32/201) were regularly followed by a specialist in the field of somatic illnesses.

The researchers concluded that 'In this hard to reach population somatic co-morbidities are difficult to manage within existing health care structures. However, they are likely to have an impact on long-term mortality. Improved on-site care for somatic illnesses should be included in heroin maintenance programmes'.

References:

M.C. Thurnheer et al. HIV, HCV and somatic co-morbidity in a heroin maintenance centre in Switzerland - a case for an integrative medical approach to harm-reduction.5th IAS Conference, 19-22 July 2009, Cape Town. Abstract CDC 071.
http://www.ias2009.org/pag/Abstracts.aspx?AID=2880

## Performance of simple non-invasive scores to predict fibrosis in HIV/HCV co-infection in daily clinical practice

**Svilen Konov, HIV i-Base**

Liver biopsy is the current gold standard for diagnosis of liver fibrosis in majority settings. As an invasive procedure, many HIV-positive people have either postponed or even refused it, sometimes leading to delayed diagnosis monitoring and treatment.

Non-invasive tests to predict fibrosis in HIV/HCV coinfection have the potential to overcome some of the above-mentioned limitations. These include AST to platelet ratio index (APRI) and Forns index (FI) which have both been validated in coinfected patients. However, the diagnostic yield of these indexes outside validation studies might be lower. Based on this, the GRAFICO study group examined the value of APRI and FI to detect significant fibrosis in coinfected patients in real life conditions. [1]

The study was a cross-sectional evaluation of fibrosis and included 8490 subjects with detectable plasma HCV-RNA. Patients came from 95 Spanish hospitals. Data of the last visit were obtained. For patients who had undergone a liver biopsy within 24 months of the last visit (n=519), APRI and FI was measured by areas under the receiver-operating-characteristic curves (AUROC).

The diagnostic accuracy was tested by positive (PPV) and negative (NPV) predictive values.

Results showed that AUROC of APRI was 0.668 (95%CI 0.662-0.714) and of FI 0.665 (95%CI 0.619-0.712). The PPV of APRI was 79% and the NPV was 66%. The PPV of FI was 74% and the NPV 64%. Liver biopsy length was available and ≥15 mm in 120 individuals. In this group, the PPV of APRI and of FI was 85% and 81% respectively. Using these indices, 22% of patients could be spared from having a biopsy. Applying both models sequentially, 30% of patients could benefit from exclusion of biopsy, with a PPV of 83%.

These data show that the combined use of both indices to decide anti-HCV therapy may save a significant proportion of patients from LB in non-referral centres or centres with lower experience in performing liver biopsy.

Reference:

González-García J et al. Performance of simple non-invasive scores to predict fibrosis in HIV/HCV co-infection in daily clinical practise. 5th IAS Conference, 19-22 July 2009, Cape Town. Abstract WEPEB217.
http://www.ias2009.org/pag/Abstracts.aspx?AID=249

## Liver disease is associated with HIV/HCV co-infection and alcohol use among IDUs in Chennai, India

**Svilen Konov, HIV i-Base**

Few data on the effect of HIV and HCV coinfection in IDUs have been collected from developing countries. Treatment decisions have been made based on data from developed countries, where the possible risk factors may not necessarily reflect the situation in lower income settings.

A study from Mehta and colleagues addressed this by characterising liver disease prevalence associated with HIV/HCV in a cohort of IDUs in Chennai, India. [1]

During the study, a convenience sample of 1158 IDUs was recruited through community outreach (2005-06) who were then followed twice a year. In 2008, a liver panel and complete blood count were performed (n=463). AST to platelet ratio index (APRI) was used to estimate the prevalence of significant fibrosis (APRI>1.5). Prevalence ratios (PR) of significant fibrosis were calculated using Poisson regression analysis.

The median age of IDUs was 35 years, 21% were HIV-positive, 52% HCV-antigen positive (70% HCV RNA positive). 41% reported heavy alcohol use and 52% daily cannabis use. The prevalence of significant fibrosis was 7% overall. Group ratios by HIV and HCV status were: 4% HIV/HCV-negative; 3% HIV mono-infected (HCV RNA-); 11% HCV mono-infected (HCV RNA+); and 14% HIV/HCV co-infected ($p< 0.001$). In multivariate regression analysis, adjusted for age, years of injection, and drug/alcohol use, compared to HIV/HCV-uninfected people, those HCV RNA+ only (PR: 3.6) and those HIV/HCV co-infected (PR: 5.0) had significantly higher fibrosis prevalence; however, HIV+ (HCV RNA-) did not demonstrate a higher prevalence. Cumulative alcohol use over the previous three years was positively associated with fibrosis (PR: 7.4 for heavy use) and cumulative cannabis use was negatively associated with fibrosis (PR: 0.3 for daily use).

The results clearly show that there is an association of HIV/HCV co-infection with liver disease in a setting where HIV subtype C and HCV genotype 3a predominate. This may be a signal for policy makers and clinic managers to incorporate components of liver disease management in HIV treatment programmes in Chennai, India.

References:

Mehta SH et al. Sustained immunological response among HIV-infected patients enrolled in a cost-recovery programme in Chennai, India: an alternate approach to free rollout programs. 5th IAS Conference, 19-22 July 2009, Cape Town. Abstract TUPED082. http://www.ias2009.org/pag/PosterExhibition.aspx

## Hunger and food insufficiency are independently correlated with unprotected sex among HIV-positive IDUs both with and without HAART

**Svilen Konov, HIV i-Base**

Shannon and colleagues presented a study that looked at food insufficiency and risk taking in Canada. [1]

Previously, the data on these issues have nearly always been collected from resource-limited settings. The researchers examined longitudinally the relationship between food insufficiency and unprotected sex among HIV-positive injection drug users (IDUs) both with and without HAART.

Longitudinal analyses were restricted to HIV-positive IDUs who completed baseline and at least one follow-up visit in the ACCESS cohort between 2005 and 2008. The participants relied mainly on food banks and shelters to obtain food and were housed only occasionally. A multivariate logistic model using generalised estimating equations (GEE) and a working correlation matrix to assess an independent relationship between food insufficiency (eg. going hungry due to insufficient access to food or money to acquire food) and unprotected sex (inconsistent condom use for vaginal/anal sex) was constructed.

Among 436 HIV-positive IDU, the median age was 42 years (IQR: 36-47) with 42% female. Food insufficiency over the follow-up period was reported by 67% of participants. In multivariate GEE, younger age (AOR 0.96; 95% CI 0.93-0.99), being married/cohabitating (AOR 4.56; 95%CI 3.01-6.87), and food insufficiency (AOR 2.68; 95%CI 1.49-4.82) independently correlated with unprotected sex among HIV-positive IDU (adjusting for binge drug use, HAART, RNA viral load suppression and other potential confounders).

These results indicate that improved access to free and low-cost food among HIV-positive IDU as a secondary prevention strategy, including interventions that account for the potential competing resource demands of acquiring drugs and food.

References:

Shannon K et al. Hunger and food insufficiency are independently correlated with unprotected sex among HIV+ injection drug users both on and not on HAART. 5th IAS Conference, 19-22 July 2009, Cape Town. Abstract WPDEC101. http://www.ias2009.org/pag/Abstracts.aspx?AID=3310

## Drug and alcohol dependence: new advances and ongoing challenges in HIV treatment and prevention

**Sinead Delany-Moretlwe for IAS**

It is commendable that the 5th IAS conference included a special session on IDU and dependence issues. It is unfortunate though that the session was poorly attended. Below is the report of the conference rapporteur Sinead Delany-Moretlwe.

The session highlighted the importance of treating drug addiction for HIV prevention. Advances in understanding brain metabolism, functional pathways and the expression of specific receptors have enhanced the understanding of the interactions between genes, biology and environment which can result in addiction in some people.

Methamphetamine use (MA) was shown to be strongly associated with an increased risk of HIV infection, and progression of HIV disease. Effective behavioural and medical intervention strategies are available to treat MA addiction, and this can be used either alone or in combination.

Data from a published meta-analysis of 20 studies in Africa was presented which showed a 57% increased risk of HIV acquisition among alcohol drinkers compared to non-drinkers after controlling for other factors. A crude dose response was observed with heavy drinkers having a greater risk of HIV acquisition than moderate drinkers. Interventions are needed to address the increased risk of HIV acquisition in alcohol users.

The achievements and challenges of delivering methadone substitution treatment (ST) programmes in Eastern Europe and Central Asia were presented. Some advances have been made in some countries to secure funding for ST programmes, to integrate ST programmes in HIV/TB treatment programmes, and to develop policies for the management of HIV in injecting drug users (IDU). However, significant social, political and regulatory obstacles to the acceptance and integration of ST programmes into general medical care still remain common.

This has lead to the abrupt closing and withdrawal of treatment programmes in several countries with severe consequences for the people in these programmes.

An evaluation from a supervised injecting facility (SIF) in Vancouver, Canada was also presented. In this programme reductions in public disorder and HIV risk behaviour were observed, with no increases in harmful behaviour such as increased initiation into drug use. Despite these successes there are political challenge to the expansion of this programme beyond the pilot phase, highlighting the stigma and lack of political will that many harm reduction programmes face, despite the evidence of success.

Throughout the session, strong arguments were made that addiction is a chronic disease, which should be managed as other chronic diseases. Treatment for drug addiction was seen as the best strategy for HIV prevention in drug using populations.

References:

Drug and alcohol dependence - new advances and ongoing challenges in HIV treatment and prevention. Tuesday 21July. Special Session TUSS3. http://www.ias2009.org/pag/PSession.aspx?s=2383

# CONFERENCE REPORTS

## International Harm Reduction Conference (Harm Reduction 2009)

**20-23 April 2009, Bangkok**

## Introduction

A PDF file of the abstract book from the Harm Reduction 2009 is now available to download free from the conference website.

The site also links to a searchable database of conference abstracts

http://www.ihra.net/Thailand/ProgrammeAbstracts

## Reflections on the politics of harm reduction and the global response to HIV

**Craig McClure**

**Executive Director, International AIDS Society**

The following transcript is the keynote closing address from the conference.

Sawa dee Kap. Good afternoon.

Distinguished, compassionate and determined fellow harm reduction advocates, let me first thank the organisers, and Professor Gerry Stimson in particular, for providing me the opportunity to make some reflections on the politics of harm reduction and the global response to HIV.

Five years ago this week I became the Executive Director of the International AIDS Society. It was just three months before the International AIDS Conference in Bangkok, and the IAS was about to relocate to Geneva and restructure its operations, staff and strategic vision. Needless to say, things were somewhat of a mess, and believe me, I was terrified, despite having worked in HIV for close to 15 years at the time.

On July 11, the conference opened in Bangkok, the first time the meeting had ever been held in South-East Asia. Close to 30,000 people had registered, and, as the Asian bird flu epidemic had only recently been contained, I sighed with relief that the conference

was not cancelled. I'm sure Gerry can relate that feeling to this week's conference! Though bird flu was under control, the war against drug users in Thailand was not. It was estimated that thousands had been killed as part of then-Prime Minister Thaksin Shinawatra's attempts to rid the country of drugs. The dead were mostly individual drug users and small-time dealers, certainly not the powerful mafia that control the production and distribution of illegal drugs in Thailand. They remained of course untouched.

At the opening session, Prime Minister Thaksin, former-UN Secretary General Kofi Annan, and, who could forget, Miss Universe, made strong commitments to the fight against AIDS. Dignitaries and celebrities were falling over themselves to say how much they cared.

And then it was time for the substantive part of the opening session – a global overview of HIV epidemiology and the current response, and a passionate call for humanity and harm reduction by one of Thailand's bravest and strongest HIV-positive drug user activists Paisan Suwannawong. Paisan, if you are in the room today, I pay tribute to you. Inexplicably, the dignitaries, led by Prime Minister Thaksin, ceremoniously filed out of the stadium before the substantive discussions began. Paisan was left on the stage with a dwindling audience that, having seen all the dignitaries leave, thought the opening was over, and emptied the hall.

Needless to say, there was an outcry. Behind the scenes over the following days were angry meetings between the IAS and community leaders, and difficult meetings between the IAS and Thai government representatives. I realised that the IAS had made a mistake in allowing Paisan's talk to be scheduled at the end of the programme, even though we did not know that the Prime Minister would leave early. I learned that it was not considered appropriate for a Thai Prime Minister to listen to a drug user. I learned a lot of things that week.

In the end, Paisan was given the opportunity to speak again, this time at the Closing Session, but the damage was done.

One of the many things I learned from that experience, that has been compounded over the past five years in the work I have done related to drug use, harm reduction and HIV, is the enormous fear that underpins the world's approach to drugs, drug use and people who use drugs.

At the end of this year I will be leaving the IAS, after six IAS conferences and some dramatic progress in the response to HIV. I'd like to offer three observations I have made related to the response to HIV as it relates to drug use and harm reduction.

All three are about fear.

**The person who uses drugs as "other"**

My first observation is how all of us continue to talk about people who use drugs as "other". We use terms like "drug abuser", "drug user" and even "person who uses drugs" as if some of us do not use drugs. But which one of us does not use a drug that alters our mood, our consciousness of pain, our physical or emotional state? A joint, a dab of speed, a line of coke, a tab of ecstasy, a shot of heroin. Even the last three Presidents of the United States between them have admitted using some of these. A pint of beer, a glass of wine, a shot of whisky. A cigarette. A cup of coffee or tea. A pain relieving medication, an anti-depressant, a valium, a sleeping pill.

We are all people who use drugs. Our refusal to acknowledge this is all about our fear that "we" might become, or be seen as, one of "them".

Throughout history human beings have been people who use drugs. We will always be people who use drugs. As human beings we strive to develop the knowledge and technologies to control our environment and to manage our circumstances. The drug user, the person who uses drugs, is not the "other". She or he is you and me.

It seems to me that what we really need to focus on is the difference between drug use and drug addiction or dependency. Global drug policy continues to focus efforts primarily on the substances alone. This is wrong.

Of course, the harms associated with some drugs are worse than others. Sometimes these are due to the degree of addictiveness of a particular drug. But most of the harms are due to the way that a particular drug is acquired (for example in a dark back alley versus from a pharmacy) the way in which it is used (as a pill, for example, versus smoking, snorting or injecting), and, even more importantly, the way in which society treats people who use drugs. The vast majority of the horrific harms associated with drug use – crime, HIV and other infections, violence, incarceration, death – are clearly fuelled by the drug policies our governments pursue. It doesn't take a rocket scientist to show that criminalizing drugs and drug use leads to a dramatic increase in drug-related crime, and that controlling and regulating the production and distribution of all drugs would go a long way towards reducing that crime.

If we are all people who use drugs then the critical questions seem to me to be:

- Why is it that some people who use drugs go on to have problematic drug use?;
- How we can prevent that from happening?;
- How we can help those that already have dependence problems? and
- How can we change the social and economic conditions that drive many people into drug dependence?

The reasons for drug use per se seem at least fairly well-characterised. We use drugs out of curiosity, to feel good, to feel better, to do better, or to manage physical, emotional or psychological pain. One might add to dance better, to have sex better, to relax more, to switch off, to switch on or to escape from the misery of social and economic deprivation. As to why some people go on to become drug dependent, the answers are less clear. There is some evidence, though still weak, that genetic factors, including the

effects of our environment on gene expression and function, may contribute to vulnerability. People with mental health problems are at greater risk for drug dependency. This is not surprising, considering the generally pathetic state of mental health services around the world that drive people to self-medicate, and the neglect of the poor and the marginalised. How and why some people become drug dependent and not others and how we can prevent drug dependency is an area that still requires much research. But no reason should be used to blame or belittle anyone who is drug-dependent.

So long as we continue to define the drug user as "other" and define the drug itself as the problem we will be trapped in our misguided and harm-inducing programmes and policies.

**The wilful denial of evidence and the abuse of medical authority**

My second observation relates to the wilful denial of evidence by policy makers throughout the world and the abuse of power by some members of the medical profession who support this denial.

The most obvious example of wilful denial of evidence is of course the fact that methadone remains illegal in Russia, thereby preventing the introduction of substitution therapy for people dependent on opioid drugs. The International AIDS Society has made the issue of access to methadone in Russia and throughout Eastern Europe and Central Asia a policy priority. Across the region, over 3.7 million people inject drugs, with over two million people injecting in Russia alone, the highest per capita in the world, with four times the overall global prevalence of injecting drug use. Close to 70% of all HIV infections in Russia are linked to injecting drug use, versus 30% globally outside of sub-Saharan Africa.

We all know that there are decades and decades of research showing that opioid substitution therapy is the most effective intervention to reduce injecting and prevent HV infection among people dependent on opioids, particularly if delivered as part of a comprehensive package of harm reduction interventions, including education and counseling, needle and syringe exchange programmes, provision of condoms, HIV diagnosis and treatment and TB and STI diagnosis and treatment.

But in Russia methadone remains illegal, and the Russian government maintains that there is no evidence that it works to prevent HIV infection or reduce the harms associated with injecting opioids. This denial of evidence is so profound that the government even dares to boldly distort the facts in international fora, such as at the high level meeting of the Commission on Narcotic Drugs in Vienna last month.

This kind of blatant and wilful denial of the evidence can only be based on deep-seated fear. Remember, this is a society steeped in denial due to fear. For decades the horrors of Stalin's regime were denied by not only the Russian government but ordinary Russian citizens, until long after the death of Stalin, and despite the disappearance of tens of millions of people.

But this kind of denial of the evidence is by no means limited to Russia. Even in my own home country of Canada, a supposed bastion of democracy and human rights, there is a concerted and organised state-supported campaign to deny evidence related to harm reduction. For a number of years now a number of studies in the Downtown Eastside of Vancouver have struggled against the odds to scientifically determine the impacts of a number of harm reduction interventions, including a supervised injection site and heroin maintenance therapy. These studies have been dogged by government interference since their inception, including unwarranted attempts to shut trials down, spending of public funds on harm reduction-denialist organisations to write negatively about the trials, misrepresentation of the evidence of the studies' results, and interference in the peer review process.

Fear drives the global war on drugs. Otherwise how could such clear evidence of the failure of the past ten years' international drug policy be so blatantly denied? How could billions of dollars be wasted on a global anti-drugs programme that fuels violence, harms individuals, families and communities, strengthens organised crime and punishes sick people with prison sentences rather than providing them with the treatment, care and dignity that they need?

Fear also drives the abuse of people who use drugs by doctors and others in the medical system. In particular, I'm referring to the continuing use of forced detention and isolation, electro-shock therapy, forced participation in medical experiments and other abuses of people who use drugs that many of us might refer to as "torture". Doctors who administer these abuses under the guise of "drug treatment" are not just wilfully denying the evidence, they are violating human rights and the Hippocratic Oath. And make no mistake, as a membership association of health care professionals and researchers working in HIV, the International AIDS Society abhors and condemns these unethical and inhumane practices.

Fear drives the denial of evidence. I have seen it in the denialists who claim that HIV does not cause AIDS and the denial of the evidence that antiretrovirals work to control HIV.

Fear can induce denial of any evidence we throw at it.

**The need for common ground between the Harm Reduction and Anti-Drugs movements**

My third and final observation relates to the seemingly vast gulf of irreconcilable differences between those of us advocating for harm reduction approaches to drug use and those in the anti-drugs movement.

Recently I visited the INSITE supervised injecting site in the Downtown Eastside of Vancouver. It was late afternoon, a very busy time at the centre. There was actually a queue of people outside the door over 15 people deep, each waiting impatiently for his or her chance to inject in one of the supervised cubicles inside. I spoke with a few individuals. These were not happy people. They were skinny, undernourished, bruised and cut, in tattered clothing, scared, twitchy, and desperate. There was a hint, a glimmer, of hope in the eyes of one or two, but not much. The road ahead for these people looked bleak to me. God knows how it looked to

them. Using the supervised injecting site was just one small but significant notch above sharing a needle and syringe in the alley up the road. Homeless and hungry, their lives pretty much devastated by the harms associated with drug use and the failure of the Canadian health and social systems. This is the reality of a supervised injecting site, an entry point to reduce harm amidst a sea of neglect.

To bridge the gap between the harm reduction and anti-drugs movement we harm reduction advocates must not be coy about the horrific problems that can be associated with drug use – their effects on the individual, the family, the community and humanity. Individuals in the anti-drugs movement are motivated too by their experience of the worst harms associated with drug use. Discussing these experiences openly and without prejudice could be the beginning of a common language we share. If we are not able to reach out to these groups and find common ground then our evidence will never overcome their fear.

Most importantly, our own fear that we might weaken the argument of our evidence that harm reduction works if we acknowledge and talk openly too much about the ugly side of drug dependency must also be overcome. If we let the chasm between us and the anti-drugs movement get too great then we will have to fight this battle far longer than necessary. We are not, after all, "pro-drug", we are not "encouraging drug use". We must reach out for dialogue consistently, with passion and compassion if we are to make further gains.

**Conclusion**

Next year, in July 2010, the International AIDS Conference will be held in Vienna, Austria. This will not be a repeat of the recent meeting in Vienna that has so angered us all. The conference will have a major focus on injecting drug use and human rights. There will be a special sub-focus on Eastern Europe and Central Asia, using Vienna in its historical role as a bridge between East and West. Let's work together to ensure that Vienna in 2010 helps confront the fear that was rampant at the Commission on Narcotic Drugs in Vienna in 2009.

Fellow people who use drugs, let us all continue to dig deep within ourselves to face our own fears about the drugs we use, how we use them, how we can continue to be curious, to feel good, to feel better and to do better. Let us continue to consider how we can prevent or reduce any harm we might cause ourselves, our families, our communities and society. Let us stop HIV infection in people who use drugs and treat, care and support those that are living with HIV. Let us move towards a unified voice where public health and human rights are two sides of the same coin. Let us fight for a more just and equitable society for all people in all places.

Finally, let us continue to search for common ground with those who are not yet on what Michel Kazatchkine referred to earlier this week as "the right side of history"? Let us find the passion and compassion to talk to our so-called enemies, show them the way, and help them overcome their fear. Because as Nobel Laureate and human rights warrior Aung San Suu Kyi said:

"Fear is not the natural state of civilised people."

Thank you.

## Michel Kazatchkine discusses funding shortfall in harm reduction programmes

Michel Kazatchkine - executive director of the Global Fund To Fight AIDS, Tuberculosis and Malaria - at the opening of the Harm Reduction 2009 conference in Bangkok, Thailand, discussed the Global Fund's budget shortfall and efforts to curb the spread of HIV among injection drug users. According to Kazatchkine, the Global Fund faces a shortfall of $4 billion next year. The Global Fund has requested $2.7 billion from the US, which typically contributes about 30% of the organisation's budget. He added that the Global Fund is uncertain about how much the US and other wealthy nations will contribute because of the economic downturn. He added that the global financial crisis could undermine years of progress in addressing HIV/AIDS and providing treatment access. "The financial crisis obviously is affecting the rich countries, and, therefore, I am very concerned about their ability to keep up development aid commitments," he said, adding, "In global health, it is a slow slope to make progress, it takes you time to actually see the gains. If the efforts are not sustained, we will lose a lot of gains that we have made in the last six to eight years".

The Global Fund is the leading multilateral donor of harm-reduction initiatives-including methadone substitution, needle-exchange programmes and antiretroviral drug access-for IDUs worldwide. During his address to the conference, Kazatchkine said that drug use should be decriminalised to help curb the spread of HIV. "I am talking about decriminalisation of drug users," he said, adding, "I am not talking about decriminalisation of drug trafficking, there should not be any misunderstanding. Drug users have been looked towards as criminals, they are arrested, harassed, they are imprisoned, they have no access to services, they are not respected in the very basic human rights perspective".

Pratin Dharmarak, Thailand's country representative for Population Services International, said that about 30% to 40% of the country's estimated 200,000 IDUs are living with HIV. "Services for [IDUs have] been overlooked," Pratin said. Thailand this year received $100 million from the Global Fund for HIV/AIDS efforts, some of which will be allocated to harm-reduction efforts among IDUs. However, because of next year's funding shortfall, such programmes in the region likely will see reductions.

Source: kaisernetwork.org [21 April 2009]
http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=1&DR_ID=58114

## Taiwan Harm Reduction programme for IDUs praised

Taiwan's harm reduction programme for injection drug users, which has reduced the number of new HIV cases among the group by about 50% over a three-year period, recently received praise at the International Harm Reduction Association's 20th International Conference in Bangkok, Thailand.

Taiwan's HIV incidence declined to 1,752 new cases in 2008, compared with more than 3,300 in 2005 - nearly double the number recorded in 2004. Sheng Mou Hu, the country's health minister at the time, said the success in reducing the number of new HIV cases can be attributed to the approach that "harm reduction should be based on human rights."

The programme was launched in 2006 and includes elements like enhanced screening and monitoring of HIV-positive IDUs, a needle-exchange programme and methadone replacement initiatives. As a result, IDUs in Taiwan are presented to the public as "patients" who required medical attention rather than criminals.

Ton Smits, executive director of the Asian Harm Reduction Network, said, "No other country in Asia can match Taiwan's achievement in launching and sustaining this harm reduction program." He said that in most Asian countries, policies relating to drug control "are in direct conflict with HIV-related policy, undermining harm reduction programmes in the region." He also noted that 3% of IDUs in Southeast Asia have access to harm reduction services and that such programmes are "facing a financial crisis," with a 90% resource gap in 2009. Only 2% to 3% of all available resources for HIV/AIDS is spent on harm reduction strategies.

Some encouraging signs have been seen in other Asian countries - such as China, Malaysia, Thailand and Vietnam - that are beginning programmes similar to Taiwan's that treat IDUs through public health approaches rather than law enforcement measures. IDUs still are listed as one of the most vulnerable groups in the region. According to IHRA, there are close to 16 million IDUs in 158 countries worldwide. Information released at the conference said that some estimates place the number of HIV-positive IDUs at three million, while others place it at more than 6.6 million.

Source: kaisernetwork.org [Apr 28, 2009]

http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=1&DR_ID=58234

# CONFERENCE REPORTS

## UNGASS Commission on Narcotic Drugs (CND)

**11-13 March 2009, Vienna**

A High Level Segment of the Commission on Narcotic Drugs (CND) was dedicated to the evaluation of the implementation of political declaration and action plans of the UN General Assembly Special Session (UNGASS) held in 1998. The evaluation started in 2008 and will determine international drug policy for the next decade. Allan Clear from HRC reports.

## Victory for Maintaining the Status Quo

**Allan Clear, Harm Reduction Coalition**

The High Level Segment (HLS) of the Commission on Narcotic Drugs (CND) ended mostly unobserved and unnoticed. The United Nations Office on Drugs and Crime (UNODC) is the operational arm of CND. In 1998, a UN General Assembly Special Session (UNGASS) on drugs was held in New York. Rallied by the slogan "A drug free world, we can do it", the meeting set a number of targets to be achieved over the following 10 years. The March High Level Segment in Vienna was the culmination of a review of the last 10 years. The lead-up to the meeting saw the most rancorous debate ever experienced at a CND meeting. The HLS of CND culminated in the passing of a Political Resolution that was ostensibly achieved by consensus, but with 26 countries objecting to the omission of the words 'harm' and 'reduction' in paragraph 21 of the resolution, consensus was clearly a mockery.

The Political Declaration will be in place for the next decade. It is a non-binding document important in 2 ways. Without harm reduction being named in the Political Declaration, no approach is identified for working with active drug users, and there is no serious intent to include the views of drug users in the development of global drug policy. Preventing people from starting drug use, helping people end their drug use, and reintegrating them into mainstream society appear in the document, but absent is the most important population: people who use drugs. Secondly, many countries, the majority from the developing and transitioning world, are drafting national drug plans. The Political Declaration can serve as a blueprint for national governments, but with harm reduction 'delegitimised' by its omission, harm reduction practice and philosophy will remain absent from national plans also.

Many governments argued vociferously for inclusion of harm reduction in the Political Declaration but were opposed and undermined by the United States in collusion with Russia and Japan. However, the United States made one major concession by reversing its longstanding opposition to needle exchange. The US government has finally accepted the abundant science that needle exchange is an effective intervention to stop the spread of blood-borne HIV among drug injectors. This appears to be one area where the

new administration refuses to play politics with people's lives. During his election campaign, President Obama publicly endorsed the removal of the congressional ban preventing the use of federal funds to support needle exchange*. In a February 12, 2009 letter signed by US Ambassador Geoffrey Pyatt to the presiding Chair of the UNODC meeting in Vienna.

However, needle exchange does not appear in the Political Declaration.

In making its position known, the United States issued a statement supporting needle exchange but objecting to harm reduction on the grounds that the term is ambiguous. There was no corollary complaint that anti-corruption, drug prevention or drug treatment are also ill-defined in the Political Declaration. One can only be suspicious that this was a purely political manoeuvre.

Ten years ago, demand reduction was the controversial issue. This year it was accepted that demand for drugs needs to be addressed on par with the supply of drugs. Perhaps in ten years time, people who use drugs and harm reduction will also be accepted on an equal footing.

References:

http://www.whitehouse.gov/agenda/civil_rights/

Links:

http://www.ungassondrugs.org/

FAQ on the 2009 review of the 1998 UNGASS:
http://www.harmreduction.org/article.php?id=876

* In a historic move, the U.S. House of Representatives voted on July 24 to remove a 21 year old ban that has restricted the use of federal funds being used to support needle exchange programs. However the Senate retained the complete ban in its version of the budget. The possible removal of ban also has implications for U.S. support of needle exchange programmes in other countries. The vote was a surprise to some who had despaired after President Obama failed to remove language retaining the ban in the 2010 budget he submitted to Congress. The White House also removed President Obama's campaign support for removing the ban from its website. In reality though, the win was thanks to the relentless efforts of harm reduction advocates in the United States, who worked district by district to mobilize constituents to lobby their representative.

Though the House of Representatives vote is a promising first step, the battle is not over. The ban contains a problematic provision prohibiting federal dollars from being used to fund programmes that operate within 1,000 feet of schools, daycare centers, universities, pools, parks and video arcades. While, on the face of it this may sound innocuous, in many districts, particularly in urban areas, this would stop needle exchange programmes from operating where services are needed most.

U.S.-based advocates are working to convince Congressional members to remove this provision when the bill goes to "conference" - the time when the House and Senate meet to iron out differences between the two versions of the bill, something that will likely happen in late 2009. Until that time, the ban remains in place.

# CONFERENCE REPORTS

## 16th Conference on Retrovirus and Opportunistic Infections (CROI)

**8-11 February 2009, Montreal**

**Introduction**

Abstracts and webcasts can be accessed via the conference website at the following link: http://www.retroconference.org

The following reports from the conference are included in this issue of ARV4IDUs:

- Waning of virological benefits following directly administered ART among drug users: results from a randomised, controlled trial
- Effect of substance abuse on ART pharmacokinetics
- HIV among IDU in Almaty, Kazhakstan: driving forces and implications for HIV treatment – a personal view

## Waning of virological benefits following directly administered ART among drug users: results from a randomised, controlled trial

This study, conducted in New Haven, Connecticut, looked into the sustainability of the HAART results among IDUs after transition to self-administration of the therapy post DAART (Directly Administered Anti Retroviral Therapy).

The study had a very innovative and interesting design. It was a community-based, prospective, randomised controlled trial of 6 months of DAART compared with self-administered therapy.

The primary endpoint was the proportion of participants with a virological suppression after 6 months post intervention, defined as achieving either a ≥1.0 log reduction from baseline or HIV-1 RNA <400 copies/mL. Secondary endpoints included change in CD4 count.

The DAART group (n=88) was more likely to have a virological success (70.5% vs 54.7%, p=0.02), mean reduction in HIV-1 RNA level (-1.16 vs -0.29 log copies/mL; p=0.03) and a change in CD4 count (+58 vs –24 cells/mm3; p=0.002).

After further 6 months, however, when all subjects received HAART as self-administered therapy, the DAART (n=82) and self-administered therapy (n=52) arms did not differ on virological success (DAART 58% vs self-administered therapy 56%, p=0.64), mean reduction in viral load (–0.79 vs –0.31 log copies/mL, p=0.53), nor mean change in CD4 lymphocyte count (+60 vs –15 cells/mm3, p=0.12). Statistically, in the multivariate analysis, only high levels of social support significantly predicted virological success.

Researchers suggest that "a longer DAART duration or incorporation of self-efficacy or social support components, which may provide durability to this otherwise effective intervention" may be necessary to improve the clinical outcomes among HIV-positive IDUs.

References:

Smith-Rohrberg Maru D et al. Waning of Virological Benefits following Directly Administered ART among Drug Users: Results from a Randomised, Controlled Trial. 16th CROI, 2009, Montreal. Abstract 579.

http://www.retroconference.org/2009/Abstracts/35670.htm

## Effect of substance abuse on ART pharmacokinetics

**www.hiv-druginteractions.org**

This study looked at a group of 275 patients, 47% of whom were active users of at least one substance (heroin 2%; cocaine 7%; marijuana 13%; tobacco 43%; alcohol 22%; prescription opioids 14%). It was found that a significantly higher proportion of substance users had antiretroviral trough concentrations below the therapeutic range (23% vs 9%, p=0.048). The proportion of patients with an unfavourable treatment outcome (HIV RNA >75 copies/ml) was significantly higher in the substance user group than in the non-user group (40% vs 28%, p=0.044). However, when adjusted for race, substance abuse was no longer associated with virological response.

References:

Ma Q, et al. Comparison of ART pharmacokinetics and clinical monitoring parameters in HIV-infected patients with and without substance abuse. 16th CROI, Montreal, 2009. Abstract 698.

http://www.retroconference.org/2009/Abstracts/35802.htm

## HIV among IDU in Almaty, Kazhakstan: driving forces and implications for HIV treatment

**Nabila El-Bassel, Columbia University Global Health Research Center in Central Asia**

I'm taking you to a different part of the world, to Kazakhstan in Central Asia. Before I begin, I want to say that there are not much data in the region and I worked very hard to get data to present at this conference, although I have been working there for almost 6 years. As you see from this map, Kazakhstan is in Central Asia and it has borders with China, Russia, other Central Asian countries and with Afghanistan, which produces the drugs I'm going to talk about. Kazakhstan has 15 million people and a territory of 2.7 million kilometers. It's really the largest country in central Asia and in fact is the 9th largest country in the world. What I'll be doing in this presentation, I'll talk about HIV epidemic in Kazakhstan and I'll highlight two cities, Almaty and Temirtau, greatly affected by the HIV epidemic. I'll talk about the forces that drive the HIV epidemic in Central Asia and specifically Kazakhstan and finally, I'd like to talk about what needs to be done in the region to deal with the epidemic.

Let me begin by saying that Kazakhstan as a country has a relatively low prevalence rate of HIV, however, in the past several years, Kazakhstan has been experiencing a very high incidence of HIV and is one of the fastest growing epidemics of HIV in the world. As you see from this figure, the rate of HIV in 2002 was 0.05% and in 2007 is greater than 1%. The number of people living with HIV in Kazakhstan as of 2007 is 12,000. However, it's tripled since 2001. As you see in this figure, every year, there are more and more cases of HIV in Kazakhstan and I'd like you to pay attention to 2005, when there were less than 1000 cases and it's doubled in 2007 as you see here 1979 cases. The good news about Kazakhstan is the increased number of people who are tested for HIV. If you look at 2005, there were less than 1 million people tested for HIV. In 2007, 12% of the population (1.8 million) in Kazakhstan have been tested for HIV. Recent data shows that the number is closer to 2 million.

It says that there are 350 people who've died from AIDS but the estimates vary; elsewhere it says 600 people have died from AIDS. What I'd like to focus on is drug use. As you see from this figure, drug use accounts for more than 73% of HIV cases in Kazakhstan. According to data, there are 53,000 individuals registered to be DU. But this number is in fact not true. It's estimated that there are 120-200,000 drug users in Kazakhstan, and it's further estimated that the rate of HIV varies between 1-4% of the population.

When you talk about Almaty, the former capital of Kazakhstan, affected greatly by HIV as well as Temirtau, in the north of Central Asia and it's a factory city. Almaty has 1.3 million people, has 8,000 registered drug users and has an estimated 30,000 drug users not only registered but total. There are HIV drug users around 1,500 and the rate of HIV among drug users is 5%. Temirtau has 170,000 people, 650 registered drug users (4700 estimated RDU), HIV+ drug users is 1677 and the rate of HIV among drug users is 19%.

Here I'd like to share with you the prevalence rate of HIV among drug users in Kazakhstan, both in Almaty and Temirtau. As you see in this figure, the rate of HIV in country in 2005 was 3.4% and in 2007 it became 3.9%. And if you look at Almaty, it started at 2.1% in 2005 and moved to 5% in 2007. In Temirtau in 2005, as you see here, it was 17% and moved to 19.3% I don't know what happened in 2006.

Prevalence rate of syphilis among DU is quite high in K, A, and T. AS you see here, the country prevalence rate of syphilis is 11%, in Almaty 8.2% and Temirtau 12%x percent. Also the prevalence rate of HCV among drug users is quite high. In the country, that rate is 66%, 77.1% in Almaty and 76% in Temirtau. Coinfection. Kazakhstan has the highest incidence of TB in the world (CDC 2008), especially for multi-drug resistance. In 2007, the incidence rate was 132 per 100,000 and TB mortality rate was 18.2 per 100,000. 14% of all new cases are MDR (CDC 2006). I'd like to share with you data showing that coinfection is low but more research needs to be done about this issue. As you see from this figure, there are 220,904 TB patients, among whom the HIV coinfection rate is .5% Among 9379 HIV+ patients, coinfection rate is 11%. The data doesn't reflect what's happening because TB is a serious issue in Kazakhstan. TB and HIV coinfection rate likely to rise as drug use continues; coinfection requires immediate attention.

Here it shows that access to ARV started in 2005. According to recent data showing that in 2005, 25% of people who needed treatment received it. In 2006 it increased to 31%. In 2007, 41% of those who needed treatment received it. There is a debate around this data and there is another story that the percentage is a lot lower than what I've presented here. Overall, 422 people received treatment for HIV in 2007 (Republican AIDS Center), also data showing that 50% of those treated are drug users (205) and national data showing that adherence to treatment showing between 50-70%. I would like to also comment on this data, I looked hard to find this data because adherence, or definitions to adherence, are not well defined. For this kind of data, adherence means that someone stayed in treatment for one year (UNAIDS 2008).

Now I want to move to talk about the forces that drive the HIV epidemic among drug users in Kazakhstan:

- Availability of drugs that come from Afghanistan
- Drug trafficking in Central Asia and particularly in Kazakhstan.
- Limited access and barriers to drug treatment as well as to HIV prevention

Drugs come to Kazakhstan from 10 different routes from Afghanistan. Drugs get easily to the region and is heavily affecting the HIV epidemic in the region. I want to give you a sense of what I mean; if you look at this figure, you see that in 2007, 93% of global drugs comes from Afghanistan and 50% traffick through Central Asia and heavily through Kazakhstan. If you look at this figure and this sad story, in 2001, 12% of global drugs came from Afghanistan whereas you see here in this figure of 2007, 93%. If also you look at opium production in metric tons, you'll see that in 2007, 8200 metric tones of opium produced; compare it even with 2005, it was 4100 metric tons. And you see how the region is affected by drugs. This is another way to give you a sense of the opium cultivation in Afghanistan. In 2007, almost 200,000 hectares were cultivated of opium; this represents a 17% increase even from the previous year (if you look at the data, it tells you a story of what's happening in the region). Also, data that was really fascinated with the findings; it is estimated that 100-120 tons of drugs was trafficked through Kazakhstan in 2006. Usually, 11% of drug trafficked through the country stays in Kazakhstan, which means it is estimated that 10-12 tons of drugs remain in Kazakhstan and used by the people there.

Another reason I want to talk about why we still see the HIV epidemic increasing among drug users. There is a low number of needle exchange programmes in the region. Overall, 146 in the whole country but most are housed in medical facilities where IDU don't feel comfortable going; they're stigmatised, not respected, not treated well. Only 29% of IDUs in Kazakhstan attend needle exchange programs. There are other problems in SEPs that prevent people from going there. SEP have difficulty obtaining a regular supply of syringes and there is no formal protocol for syringe collection in those programs. Sadly, there is limited distribution of HIV prevention services, even condoms, you don't see them in needle exchange programs.

Drug users really have one option, which is to go to detoxification. No drug rehabilitation, no substation therapy, very limited access to HIV prevention. One other thing we need to understand when we talk about the epidemic among drug users is that DU are repeatedly subjected to arrest by the police and forced to go to detoxification unit. If you look at the number of prisoners who are drug users in Kazakhstan, it has been increasing tremendously. There is data showing that of the 100,000 prisoners in Kazakhstan, 60% are drug users. Another thing we need to look at in context of HIV prevention is that drug users are required to register. Anyone who has attended drug treatment or arrested must register. Registrations lead to restrictions in employment and prevent them from accessing any kind of treatment. Also, there is harsh penalties for possession of very small amount of drugs. Recently, I was talking to a drug user serving a 3-year prison sentence for carrying less than 1 gram of heroin.

So what do we need to do to deal with this huge, growing epidemic in the region? Clearly, there is a need to increase drug treatment programs. We need to focus on substitution therapies and promote 12-step programs. I met with some drug users recently who are really looking forward to starting 12 step programmes because they believe in the concept that it can help them to stay health. Also, there's a need to increase the number of needle exchange programmes and make them accessible to drug users in the country and ENSURE distribution of condoms and other HIV prevention services. It is sad to see how drug users in the country would like to get access to condoms and no access to condoms, even in NEP where we expect drug users to have access to them.

Adherence to treatment – there's so much to be done! As I presented earlier, I personally do not believe much in the numbers I presented. I would say that a lot of research should focus on understanding access to treatment as well as adherence to treatment. We talk about scaling up HIV prevention and this is a place where we really need to focus on prevention strategies like peer education and psychosocial HIV prevention strategies. Given that the epidemic is a concentrated one among drug users and clearly, the transmission from DU to their sexual partners is huge, I would like to recommend – and I have been talking about – this approach of working with the couples. It's very important to come up with HIV prevention intervention that addresses the couple as a unit and focus prevention on that unit; concurrently develop interventions for sex workers. Another issue I'd like to focus on, and needs to be done immediately in Kazakhstan, is the elimination of the registration of drug users. I mentioned earlier that registration is a HUGE barrier that will prevent drug users from accessing treatment. Secondly, eliminate the punitive approaches used by the police against drug users. One point I'd like to make is the need to scale up HIV prevention in prison. Prisoners are in and out; the HIV prevention strategies in prisons are very rare, almost nothing is happening in prisons for drug users.

And I want to mention something I don't have here, when I was looking at how the epidemic is concentrated in Kazakhstan, among which population and you see all the research that it's limited – it's about drug users, about sex workers (60,000 and 2/3 are drug users and no treatment and no approach to HIV prevention for this population) and the third group that I was looking for data on is men who have sex with men. According to the data from K, there is 100,000 MSM – when I was looking at the rate of HIV among this population, the response was 0 percent prevalence. A lot needs to be done not only in scaling up research and treatment but also research to better understand precisely what's happening in the region.

References:

El-Bassel N and Terikbeyeva A. HIV among IDU in Almaty, Kazhakstan: driving forces and implications for HIV treatment. 16th CROI, 2009, Montreal. Abstract 60. http://www.retroconference.org/2009/Abstracts/36541.htm

This presentation is available online as a webcast as part of the symposium: A Tale of 4 Cities held on Monday 9 February 2009, 4pm. http://www.retroconference.org/2009/data/files/webcast.htm

## INTERVIEW

# During first 45 days post HAART initiation patients hospitalised most often for non-AIDS-defining infections: an interview with Stephen Berry, MD

**Bonnie Goldman, theBody.com**

My name is Steve Berry, and I'm with Johns Hopkins University. I'm presenting the results of a prospective observational study showing the reasons for hospitalisations in HIV-infected patients after HAART initiation.

We looked at 2,000 people in our centre in Baltimore, Maryland who were previously naïve to antiretrovirals. All of them initiated HAART between 1996 and 2005. We looked at their hospitalisation rates within six months prior to starting HAART, and then looked at all hospitalisations over time in that first year after starting HAART.

What we have done now, which is new from what was presented in October was to look at the reasons for all the hospitalisations, based upon separating them into 18 categories, which are roughly by organ system, and then also looking specifically for immune reconstitution inflammatory syndromes, which was done by chart review, rather than using ICD-9 categories.

### The major findings

Number one, was that all-cause hospitalisations remain high for the first 45 days.

However, by 45 to 90 days, and then out through one year after starting HAART, they are statistically less significantly than prior to starting HAART.

Then we looked just at the baseline characteristics of our group. The group is about 66 percent men. The median age for starting HAART was 39. The group was about 75 percent African-American. About 45 percent have injection drug use as a risk factor for HIV infection. The bulk of the people's HAART initiation events that we studied were actually occurring prior to 2000, with a large number, 54 percent, being 1996 to 1998 - shortly after HAART came out.

When we look at all the categories for reasons for hospitalisation, the top category was actually not AIDS-defining illnesses, but were non-AIDS-defining infections. This included episodes of pneumonia; this was bacterial endocarditis; this was cellulitis - as the top types of infections in that category.

The next category for hospitalisations was AIDS-defining illnesses, where PCP [pneumocystis pneumonia] was top, accounting for 25 percent of those; Cryptococcus was next; candidal esophagitis was next.

Psychiatric illness was actually the third most common reason for hospitalisation in this overall period, accounting for about 11 percent of all admissions. Gastrointestinal and liver causes were next and then endocrine nutritional, metabolic and immunity,

as one combined category. The bulk of that was hypovolemia as a reason for admission; then reno- and genito-urinary; and then cardiovascular, to round out the top seven categories for most common reasons for admission.

What we did next was to look, for each of those categories, over time after starting HAART: what happens to admission rate within each of those categories?

So, for the two reasons for admission which were most common-the non-AIDS-defining infections and AIDS-defining illnesses-we see the pattern-which is what we see for all-cause admissions, and what was presented in October-that for the first 45 days, admission rate remains quite high.

Then it seems that, at 45 to 90 days, the real immune recovery has kicked in and is operating, and you see decreases for all these manner of infectious illnesses.

Next, looking at psychiatric reasons for admission, there's also a statistically significant drop-off. This drop-off occurs immediately after starting HAART, and remains constant out through one year.

When we look at all of those other categories for admission-GI [gastrointestinal], liver, endocrine metabolic, renal and cardiovascular-there doesn't appear to be any change after starting HAART. Admission rates within those categories remain flat across time.

We did multivariate analysis of admission rates for the top three categories - so, for non-AIDS-defining infections, AIDS-defining illness and psychiatric illness. And here, as you would probably expect, for AIDS-defining illnesses-CD4 count, baseline CD4 count, is the largest driver. But the decay over time is not at all affected in multivariate analysis. Still, after 45 days, you see this decrease in admission rate.

**And the greatest risk was ...? I see you had a lot of patients with below 50-cell CD4 count at baseline.**

Definitely. In that risk group, there was an incidence rate ratio of infection of over 10, if you had less than 50 cells/mm3, compared to having over 200 cells/mm3 when you started HAART.

**And did you track the rise in their CD4 count, and correlate it with hospitalisations?**

We didn't have a chance to do that. We didn't track that.

**Are there plans to do that?**

We may look at that. In fact, we may look at that especially, as well, because there's a lot of interest now in looking at some of these non-AIDS defining illnesses over time, after starting HAART, and even after starting and restarting HAART, looking at cardiovascular events, for example, and risk of heart attacks, in particular. So, using CD4 rebound in that analysis would be something interesting to do.

**Could you talk about the psychiatric illnesses? Because it's not something one thinks about when predicting reasons for hospitalisations for HIV-infected patients.**

Sure. I think the first major finding is that they represent a significant burden of illness. Overall, they represent 11% of reasons for admission. They do have that drop-off in admission rate right after starting HAART. What's interesting here is that we can't tell from these data whether the decrease in psychiatric admissions actually causes people to start HAART, or whether HAART, and getting better from HIV, leads to a decrease in mental illness. I actually would suspect it's the former. My suspicion is that people who are getting admitted for depression within the six months prior to starting HAART: a lot of them are getting engaged in care, and they are getting better. As part of that getting engaged in care, their providers are recognizing these patients have low CD4 counts and that HAART is indicated. So then they're starting HAART. So it's hard to tell in this case which came first.

One little piece of corroborating evidence is that the drop-off in admission rate for psychiatric illness happens immediately in the first 45 days after starting HAART. I think that makes me suspect that it's actually improvement in mental illness is preceding the HAART initiation.

**And the most likely patient to experience psychiatric hospitalisations?**

The most likely patient, we can see here. It's going to be someone who's been using injection drugs. Women were also more likely in multivariate analysis to be admitted for psychiatric reasons. Interestingly, younger age, rather than older age, was also significant in multivariate analysis for being admitted for psychiatric reasons.

**Have these numbers been corroborated in other studies that you know of? In terms of the psych? Psychiatric illnesses are very interesting. I haven't really heard that before.**

In terms of psychiatric illness itself, I don't know the literature. But we know that for overall reasons for admission, injection drug users [IDUs], women, African Americans, are all more likely to have admission, and are also more likely to die.

**But the difference is very striking here. I mean, for psychiatric illness admissions, it's really almost double, even between women and IDU.**

Well, we do see for non-AIDS-defining infections, there's also, similarly, a higher risk for women and a higher risk for IDU. It's logical for IDU, because substance abuse correlates very strongly with depression. In these admissions, overall admissions for psychiatric illness: recurrent major depression was the number one cause; depressive disorder not otherwise classified was the second one; and drug-induced depression was the third one. So I think a lot of what we're seeing here is comorbid illness with substance abuse and depression.

**Do we know what sort of drugs the IDU were using?**

Primarily heroin. Cocaine is often combined, injected at the same time.

**But actually, this is a good story, as well as a bad story. The good story is that there's a lot of difference within 45 days.**

Exactly. So 45 days is a period that clinicians may want to keep in mind. It represents a period of the time when you really need to be quite concerned. But then after 45 days, making it through that high-risk period, we see great improvements across the board.

**Great. What are your next steps?**

The next steps for this would be, as mentioned earlier, looking at people who are not naïve to antiretrovirals, looking at people who are starting and stopping HAART, and looking for causes of admission in those groups, maybe paying particular attention to some of the non-AIDS-defining illnesses. Looking at psychiatric illness again, for example, looking at cardiovascular illness, looking at renal illness.

Source: thebody.com

http://www.thebody.com/content/confs/croi2009/art50557.html

References:

1. Berry SA, Gebo KA, Moore RD, Manabe YC. A high risk of hospitalization immediately follows HAART initiation. In: Programme and abstracts of the 48th Annual ICAAC/IDSA 46th Annual Meeting; October 25-28, 2008; Washington, D.C. Abstract H-2292.
2. Berry SA, Manabe YC, Moore RD,. Reasons for Hospitalization that Occurs after HAART Initiation. In: Programme and abstracts of the 16th Conference on Retroviruses and Opportunistic Infections; February 8-11, 2009; Montréal, Canada. Abstract 711.

# GLOBAL NEWS

## German vote on use of medical heroin opens door to EU consensus on drug treatment

**OSI press release**

On 4th June 2009 the Open Society Institute issued a press statement in support of the decision by the German Parliament to approve medical heroin to treat dependence on opium-based drugs. This development comes only six months after Swiss citizens voted to include heroin as a possible form of treatment for drug users.

Carefully monitored studies have proven that making medical heroin available to severely dependent people is a sound public health intervention. In both Germany and Switzerland, pilot projects demonstrated clear benefits for drug users, their families, and their communities. The main benefits include overall improvement in the health of drug users, fewer HIV infections, and a significant reduction in crime.

"Addiction is a chronic disease," said Kasia Malinowska-Sempruch, director of OSI's Global Drug Policy Program. "People with chronic illnesses need ongoing, tailored treatments to control their disease and improve their quality of life. Addiction is no different. After the Swiss referendum, the German parliament's vote now shows that the consensus in Europe is moving towards recognising this truth."

In the UK, politicians and the media still demonise drugs and drug users. A recent example is the reclassification of cannabis to class B—which substantially increases the penalty for possession—against the advice of government-appointed experts.

To combat damaging stereotypes, Release, a UK-based advocacy group, sent a fleet of double-decker buses sporting the message "Nice people take drugs" to the streets of London this week. The reality, Release said, is that all sorts of people take drugs - and it is time policy focused on treatment, rather than punishment.

"The attempt by some politicians to cast drug users as morally weak is deeply disturbing and misses the point," Ms Malinowska-Sempruch added. "With proper treatment, drug users no longer run the risk of overdosing or getting infected with HIV or hepatitis C.

Source: OSI Press Release on the approval of medical heroin for use in treatment of dependence on opium-based drugs by the German parliament

## Iran estimates 20,000 people with HIV/AIDS: 78% related to IDU

At least 19,435 HIV cases have been reported in Iran, with more than 1,000 cases recorded since December 2008, according to a report recently released by the country's Ministry of Health. Of the 19,435 cases, 1,875 cases have progressed to AIDS. The health ministry estimates that about 80,000 people are living with HIV in the country - or four times the number of reported cases - and that limited testing facilities and stigma are preventing people from accessing testing or reporting their status. The highest HIV burden at 40.2% of recorded cases was among people ages 25 to 34, while 93.3% of cases were recorded among men.

The report found that the most common mode of transmission was injection drug use, accounting for more than 77.5% of reported

cases, followed by sexual contact, which accounted for about 13.1% of cases. In addition, mother-to-child transmission accounted for 0.9% of recorded cases. The health ministry said that there is concern that the sexual transmission of HIV could reach an epidemic level because about 60% of the country's almost 71 million population is under age 30, according to the 2006 national census.

Health Minister Kamran Bageri Lankarani in December said that Iran aims to address the growing number of HIV/AIDS cases with an approach that includes harm reduction among injection drug users; a sexually transmitted infection education programme for young people; and counselling and therapy programmes.

Source: kaisernetwork.org [05 May 2009]
http://www.kaisernetwork.org/daily_reports/rep_hiv.cfm#58392

## IRIN News examines HIV/AIDS awareness levels among IDUs in Myanmar

IRIN News recently examined how the "thousands" of injection drug users in Myanmar have "little or no awareness of the risks" associated with the practice, including an increased risk of HIV/AIDS. The government reports that the number of registered IDUs in the country is around 70,000, with a majority of newly registered IDUs using heroin.

However, many IDUs do not register, which is required when seeking treatment, for fear of persecution - meaning that the number of IDUs likely is much higher. Injection drug use, which accounts for about 30% of all new HIV infections in Myanmar, is the main mode of HIV transmission in the country after heterosexual sex. The United Nations Office on Drugs and Crime estimates that up to 300,000 people may be addicted to injection drugs in the country.

The government estimates that HIV prevalence among IDUs is about 35% and up to 80% in some areas. Sun Gang, country coordinator for UNAIDS, said, "HIV prevalence among injecting drug users is pretty high in this country. One in three injecting drug users is infected with HIV/AIDS." Willy de Maere, country coordinator with the Asian Harm Reduction Network, said that HIV/AIDS awareness among IDUs is critical, adding, "You cannot get behavior change unless you have the correct knowledge."

Additional HIV/AIDS efforts in the country include needle-exchange programmes. However, some experts say that because of the high prevalence of injection drug use, existing treatment and rehabilitation services fall short of what is needed. UNODC and its partners - such as AHRN and the Myanmar Anti-Narcotics Association, a local nongovprogramsernmental organisation - are working to curb the spread of HIV among IDU populations by providing HIV/AIDS information, clean needles and condoms through drop-in centres and outreach programmes. In addition, they are providing medical care for opportunistic infections and general health care and providing referral services for counseling and testing; prevention of mother-to-child HIV transmission; treatment for HIV, tuberculosis and sexually transmitted infections; and detoxification and methadone treatment.

Source: kaisernetwork.org [Mar 11, 2009]

http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=1&DR_ID=57412

## US CDC report examines high-risk behaviors associated with HIV among IDUs

A new report from the US CDC 'HIV-Associated Behaviors Among Injecting-Drug Users' is available to download in PDF format.

Researchers used data from the National HIV Behavioral Surveillance System collected from May 2005 to February 2006 in 23 U.S. cities with high AIDS prevalence to assess trends associated with HIV risk behavior, testing and prevention services among injection drug users.

The report found that 31.8% of IDUs had shared needles, 62.6% had unprotected vaginal sex, 71.5% had been tested for HIV, and 27.4% had used an HIV behavioral intervention service. According to the authors, the findings "underscore the need to continue current public health strategies" aimed at preventing HIV transmission and expand efforts to provide "effective behavioral interventions that focus on HIV risks of sharing syringes and other injection equipment and engaging in high-risk sexual behavior".

Source: kaisernetwork.org [14 April 2009]
http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=1&DR_ID=57988
Link to download report: http://www.cdc.gov/mmwr/PDF/wk/mm5813.pdf

# OTHER NEWS

## Thai activists Paisan Suwannawong and Karyn Kaplan receive international award

On 30 March 2009, the John M. Lloyd Foundation announced that AIDS advocates Paisan Suwannawong and Karyn Kaplan of the Thai AIDS Treatment Action Group have been selected as the co-recipients of the $100,000 annual John M. Lloyd AIDS Leadership Award.

Paisan Suwannawong, a native of Bangkok, has been living with HIV for 18 years. A former injecting drug user and graduate and former staff of Rebirth Drug Treatment Center in Ratchaburi, Thailand, Suwannawong is one of Thailand's leading harm reduction advocates. He is the co-founder of the Thai Drug Users' Network (TDN), founding chairman of the Thai Network of People Living with HIV/AIDS (TNP+), and, with award co-recipient Karyn Kaplan, co-founder of the Thai AIDS Treatment Action Group (TTAG) which strives to build leadership and advocacy capacity among people living with or at high risk for HIV. Suwannawong serves as TTAG's executive director.

Karyn Kaplan, a native of New Jersey, has been involved with fighting the AIDS pandemic in the US and Thailand for over 20 years. In the US she worked with the International Gay and Lesbian Human Rights Commission (IGLHRC), and in Thailand she has campaigned for harm reduction and conducted drug policy advocacy with the Thai Drug Users' Network (TDN), including helping to secure a historic US $1.3 million grant to drug user groups from the Global Fund to Fight AIDS, TB and Malaria (GFATM) for the country's first peer-driven harm reduction project in 2003. Kaplan is the co-founder and Director of Policy and Development for the Thai AIDS Treatment Action Group (TTAG) in Bangkok.

"Their outspoken courageousness is undeniable and humbling for all of us," said Robert Estrin, President of the John M. Lloyd Foundation.

"This award is given with the Foundation's admiration and respect for all that Paisan and Karyn have accomplished, and with the hope that it will help them to achieve even more success as leaders in the AIDS advocacy community."

"It is such a huge honour for us to receive this recognition, and you have no idea how much this means to our organisation in terms of its sustainability," said Karyn Kaplan. Paisan Suwannawong added, "This is an honour not just for us, but for all of the activists working so hard in Thailand to fight AIDS and the discrimination around it."

Leading AIDS experts applauded the selection of Suwannawong and Kaplan for the second annual John M. Lloyd AIDS Leadership Award.

The John M. Lloyd AIDS Leadership Award was established in 2008 to recognise, support and empower effective leaders in AIDS advocacy. There is no application process for the award – the selection is made by the board of the John M. Lloyd Foundation. The award will be split among Paisan Suwannawong, Karyn Kaplan and the Thai AIDS Treatment Action Group as an unrestricted gift to help build leadership capacity.

The John M. Lloyd Foundation was established in 1991 by John Musser Lloyd (1948-1991) to seek creative, compassionate, and courageous solutions to the root causes of the AIDS epidemic. Each year, the foundation awards approximately $400,000 in mostly small grants.

Source: www.johnmlloyd.org

## JOB VACANCY

## ARV4IDU EDITORIAL ASSISSTANT

HIV i-Base are looking for a freelance assistant editor to help produce ARV4IDUs.

Essential requirements include:

- active interest in IDU advocacy and access to HIV treatment
- good written English and editorial experience
- self motivation and good ability to work independently
- ability to plan and adhere to publication schedules
- interest in developing working involvement of the editorial board
- interest in supporting and developing new activist writers

This post is part-time and the successful applicant will be able to work remotely, though daily internet access is essential.

For further details please contact Simon Collins with a brief outline of your interest and experience.

simon.collins@i-Base.org.uk

# ON THE WEB

## Web resources

The following organisations all include web resources about ARV4IDUs:

http://www.drugtext.org/library/legal/eu/default.htm

http://www.harmreduction.org

http://www.erowid.org

http://www.union.ic.ac.uk (see health and well-being section)

http://www.dancesafe.org

http://unaids.org

http://who.org

http://unodc.org

http://www.soros.org/initiatives/issues/health

http://www.ihra.org

http://www.hit.org.uk

http://www.opiateaddictionrx.info

## Abstracts from IHR conference in Bangkok

A PDF file of the abstract book from the Harm Reduction 2009 is now available to download free from the conference website.

The site also links to a searchable database of conference abstracts

http://www.ihra.net/Thailand/ProgrammeAbstracts

## CATIE publication

Learning from each other: enhancing community-based harm reduction programmes and practices in Canada

The Canadian Harm Reduction Network and the Canadian AIDS Society collaborated on a project to identify and document effective and innovative harm reduction programmes and practices, and to disseminate this information in order to enable organisations across the country to draw on each other's experiences and successes.

http://orders.catie.ca/product_info.php?products_id=25188 PDF version or printed copies through the ordering centre

## New OSI Report

### At what cost: HIV and human rights consequences of the global war on drugs

• Human Rights Toolkit, Authored by Karyn Kaplan, available online:

• First set of Guidelines for Prescribing Opioid Pain Medication published in February 2009

Earlier this year, the Journal of Pain released the first set of suggested guidelines released in the U.S. to advise clinicians on the use of prescription opiates for pain management. February 2009: http://www.sciencedaily.com/releases/2009/02/090206135315.htm

The International Harm Reduction Development Programme of the Open Society Institute has released a new guidebook that we would like to share with you: Human Rights Documentation and Advocacy: A Guide for Organisations of People Who Use Drugs. Written by veteran activist Karyn Kaplan, it is available at this link:

http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/hrdoc_20090218

People who use illicit drugs face daily harassment, discrimination, and abuse—incidents that often go unreported, due to fears of reprisal and other harmful physical, mental, social, or legal consequences. Investigations into rights violations against people who use drugs or efforts to bring perpetrators to justice are rare. Often law enforcement and the society-at-large do not recognise

the basic rights of people who use drugs, and blame the victim for any human rights abuses endured as a result of their drug use. Moreover, some government laws and policies directly violate the rights of people who use drugs or create the conditions for violations to occur.

*Human Rights Documentation and Advocacy: A Guide for Organisations of People Who Use Drugs* aims to help activists recognise human rights abuses that are systematically conducted and condoned by state and non-state actors and silently suffered by people who use drugs. The guidebook provides activists with the tools necessary to develop a human rights advocacy plan, particularly by documenting abuses against people who use drugs.

The guidebook includes the following topics:

- Starting human rights documentation
- Guidelines for documenting human rights violations committed against people who use drugs
- Guidelines for conducting interviews
- Monitoring legal systems

The guidebook is being printed in English and Russian. For copies please email Roxanne Saucier

rsaucier@sorosny.org

http://www.soros.org/initiatives/health/focus/ihrd

## HIV/AIDS Surveillance in Injection Drug Users (through 2006)

http://www.cdc.gov/hiv/idu/resources/slides/index.htm

## HIV i-BASE

HIV i-Base is an HIV-positive led treatment information service. We produce information both for clinicians and other health workers and for people with HIV.

Our publications are used and have been adapted in many countries and settings.

Our fully searchable website is designed to be fast to access, easy to use, and simple to navigate.

All i-Base publications are available online.

http://www.i-base.info

i-Base produce five non-technical treatment guides, which are available online as web pages and PDF files.

http://www.i-base.info/guides

- Introduction to combination therapy
- A guide to changing treatment
- Avoiding & managing side effects
- HIV, pregnancy & women's health
- Hepatitis C for People living with HIV

The site also includes a web-based Q&A section for people to ask questions about treatment:

http://www.i-base.info/questions

Recent questions include:

- Is it OK to take probiotic cultures with HIV meds?
- Is d4T+3TC+EFV good enough?
- Can I take these supplements with my HIV treatment?

We have also posted online a set of generic clinic forms, developed with the Royal Free Centre for HIV Medicine, which may be a useful resource for other hospitals.

http://www.i-base.info/clinicforms

# HIV i-Base

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**Guide To Avoiding and Managing Side Effects** *(May 2008)*

**1** ☐ **5** ☐ **10** ☐ **25** ☐ **50** ☐ **Other** _____ _____ _____

**Guide to HIV and Hepatitis C coinfection** *(March 2009)*

**1** ☐ **5** ☐ **10** ☐ **25** ☐ **50** ☐ **Other** _____ _____ _____

*Earlier versions of many treatment guides are available in other languages as PDF files on the website*

**Adherence planners and side effect diary sheets - In pads of 50 sheets for adherence support**

**1 Sheet** ☐ **1 pad** ☐ **5 pads** ☐ **10 pads** ☐ **Other** ☐ _____ _____

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