TREATMENT AND CARE FOR DRUG USERS LIVING WITH HIV/AIDS

Paper prepared for the UN Reference Group on treatment and care for drug users living with HIV AIDS

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Introduction

This report has been prepared in October-April 2004 by the Centre for Research on Drugs and Health Behaviours at Imperial College on behalf of the UN Reference on HIV/AIDS prevention and care among IDUs in developing and transitional countries. Its purpose is to examine the extent to which the international community's commitment to adequate and equitable care for those with HIV/AIDS has been translated into action in developing and transitional countries particularly when applied to injecting drug users[1]. The provision of effective treatment and care for all people with HIV/AIDS is now accepted as an integral component of a comprehensive and expanded response to the epidemic. All member states of the United Nations and partner international agencies are committed to reducing the gap between developed and developing countries and making treatment and care available to all who require it.

Antiretroviral drugs (ARV) which have been available in the developed world since the 1980s has been one of the great success stories in the fight against HIV/AIDS and has changed HIV into a manageable *health status* rather than a terminal illness or *death sentence* [2]. Between 1995-2001 for example as ARV treatment accelerated in the USA, HIV-related deaths declined by more than 83%. Although it is estimated that 5-6 million adults in developing countries are currently in need of ARV drugs, UNAIDS and WHO estimates that only about 300,000 people in low and middle income countries (800,000 worldwide) are currently receiving such therapies. However, the proportionate decrease in mortality and AIDS among IDUs has been less impressive. Much of the disparity in benefit has been a consequence of decreased access and receipt of potent antiretroviral combinations [3 4].

This report will focus on the provision of antiretroviral medication for the treatment of HIV/AIDS to injecting drug users.

The Impact of HIV/AIDS in Developing and Transitional Countries

UNAIDS (2003) [5] estimates that there are a total of 40 million people living with HIV/AIDS and that between 5-6 million adults in developing countries are in need of ARV. However, at the end of 2002 only about 300,000 people were prescribed these drugs. Moreover, just one country - Brazil- accounts for over 1/3 of those prescribed ARV in resource poor countries [6].

In seven out of ten regions around the world injecting drug use is a major vector for HIV/AIDS transmission [7] and as there are an estimated 10 million IDUs around the WORLD [8] representing a high proportion of those who have HIV and requiring treatment and care. It has been estimated that between 5-10% of all new HIV infections are as a direct result of injecting drug use [9]. As will become clear from the discussion below IDUs with HIV/AIDS encounter particular difficulties in accessing treatment and care. There are ongoing efforts to reduce their as yet prohibitive cost and WHO's target of 3 million people on anti-retroviral therapy by 2005[10] along with the increases in resource availability should provide an opportunity to develop better HIV/AIDS treatment and care programmes.

Part 1

Treatment and care for IDUs living with HIV/AIDS in developing and transitional countries

(1) Overview

To-date, there is consistent evidence that the recent dramatic decrease in mortality and morbidity from HIV/AIDS that has resulted from the introduction of antiretroviral medication is not reflected in drug user populations even in countries where access to ARV is theoretically available to all who need it. Data will be presented in this report showing that IDUs represent a minority of those receiving ARV in developing and transitional countries even though in some countries they constitute the majority of those infected. It is increasingly accepted that excluding past and current drug users from anti-retroviral medication is medically unsubstantiated and ethically unacceptable. The Panel on Clinical Treatment for HIV infection in the USA[11] state that "*No individual patient should automatically be excluded from consideration for antiretroviral therapy simply because he or she exhibits a behaviour or other characteristic judged by some to lend itself to non-adherence. Rather, the likelihood of patient adherence to a complex drug regimen should be discussed and determined by the individual patient and clinician before therapy is initiated".*

There is evidence that on the whole IDUs can benefit as much from ARV treatment as other groups and that there are no valid medical reasons to exclude them from such treatment groups' [12]. Even those who are co -infected with hepatitis B or C and who are prescribed ARV do not appear to be adversely affected (except for slightly poorer CD4 count response in HIV/ hepatitis C co-infected patients [13]). The WHO/ARV Treatment Guidelines indicates that provided that special attention to the needs of IDUs ARV treatment are highly effective [14].

The discussion below will focus on the factors that inhibit equitable ARV provision to IDUs, the factors that impact negatively on adherence to treatment and the options for overcoming these difficulties. Because developing and transitional countries have little experience in providing ARV to IDUs most of the research evidence below will be based on studies in developed countries though reference will be made to experiences in developing and transitional countries. Many of the findings from these studies will be applicable to developing and transitional countries however, local research will have to be undertaken to test their relevance and to identify specific factors that may impact on ARV access and adherence.

Barriers to ARV treatment for IDUs

Research has shown that in many international and national strategic plans to deal with the HIV/AIDS pandemic little attention is given to treatment and care for IDUs living with HIV/AIDS[15]. Restricted availability of ARV and the underlying inequities in access to treatment sometimes centre on questions about IDUs capacity to adhere to treatment and on whether they can benefit from ARV treatment if available. HIV infected IDUs often present with a complicated array of medical and psychosocial issues. It has been posited that treatment for drug use must precede or at the very least coincide with antiretroviral treatment to facilitate adherence.[16] Thus in order to enable access to ARV

many developing and transitional counties require IDUs to be abstinent prior to entering treatment. However, when ARV is only prescribed on condition of abstinence it may cause serious difficulties to active drug users who are unwilling or unable to become abstinent. Relapse into drug use thus becomes associated with non-adherence – i.e. failure in ARV treatment. In selecting patients suitable for ARV certain biases have been identified Those IDUs infected with HIV who were not receiving ART tended to be active drug users with no clinical symptoms who have less contact with health providers [17]. Younger and less educated IDUs and those with a history of incarceration [18] Women too are less likely to be on any form of antiretroviral therapy [4].

However, research in the USA and elsewhere indicates that IDUs attending methadone maintenance treatment clinics are often the most likely to be prescribed ARV –For example a study in St. James hospital Dublin in Ireland [19] found that the primary factor associated with both acceptance and adherence to HAART was regular and stable attendance for methadone therapy. This finding can be extended to attendees in other treatment programmes such as needle and syringe programmes and clients contacted through outreach[3]. Experience from Brazil [20] where most substance dependent are cocaine users, for whom no substitution therapy exists and hence no obvious suitable base for the delivery of ARV, indicates that social and community support, enables patients to adhere to ARV treatments. However, IDUs are frequently stigmatised and experience discrimination.

(2) Adherence to treatment

Adherence to treatment has been widely researched in developed countries. Overall it was found that IDUs can and do adhere to treatment and enjoy clinical outcomes equal to other HIV+ patients provided they are given the necessary ancillary and support services and suitable ARV regimen is implemented.

Factors that negatively impact on adherence

A number of studies sought to identify the major difficulties encountered by drug users in adhering to ARV, thus pointing specifically to the areas with which IDUs require special help. Studies use different definitions and measures of adherence rates and are therefore not strictly comparable. Some studies use self-reported data or data from pharmacy records others use data is obtained in trials that employ Directly Observed Therapy (DOT).

Continuing drug use is one of the major behavioural features that impact negatively on adherence [21,22]. A study in Sao Paulo Brazil [23] indicated that IDUs have lower rates of adherence to ARV therapeutic regimen than non- users or non-injectors whereas ex IDUs did not differ substantially from non-users, injectors were significantly less adherent. Current injection drug users were less likely to achieve HIV-1 suppression compared with non-drug users [24]. Others [21] have determined that attendance in drug maintenance treatment will enhance adherence to HAART only if it is successful at reducing injecting. A study of 764 HIV infected patients [22] indicated that 44% of active drug users failed to utilise HAART compared with 22% of ex drug-users and 18% of non-drug users. Furthermore [22] researchers observed that switching from non-drug use to substance abuse was strongly associated with worsening antiretroviral therapy adherence. Alternatively switching from substance abuse to non-use was strongly associated with improvements

in antiretroviral therapy adherence compared to those persisting with substance abuse but for ex-IDUs non-adherence is associated with social instability [21]. Studies show that psychiatric morbidity among patients receiving ARV is associated with poor adherence[25] though the use of alcohol and other drugs does not necessarily impact negatively on adherence. [26]

The use of crack cocaine is particularly problematic [27]. Investigators at the Montefiore Medical Centre in New York [28] studied adherence to HAART in 85 current and former drug users, and found that of all the risk factors for non- adherence *cocaine use was the most strongly linked with poor adherence* with only 27% of cocaine users maintaining adherence over the six months of the study, compared to 68% of people who did not report cocaine use. Studies of women drug users [27, 25] found that women IDUs who smoked crack were less likely than non-IDUs to be responsive and adherent to ARV treatment. Some studies found that gender impacts on adherence and that females are less likely to adhere

A number of other factors impact negatively on adherence. These include a lack of social stability [21] (unstable housing, the lack of social support, homelessness) psychiatric problems, major life events and crisis, as well as the severity of the HIV related medical problems. Severe illness makes it difficult to adhere for this group of patients. In North American studies, ethnicity [29] was found to impact on adherence as does in gender: Women injectors and or crack smokers are less likely to adhere to treatment [30, 27,31,32]

A major cause for non-adherence is the *interaction between antiretroviral medications and drugs used by IDUs.* The side effects from HAART are being investigated in relation to a large number of medicines and reported drug interactions particularly with methadone is increasingly believed to be a critical factor in determining adherence. A review of the literature [33] indicated that many classes of recreational drugs including benzodiazepines, amphetamines and opioids that are metabolised by the liver could potentially interact with anti-retroviral drugs. However, most antiretroviral-opioid interaction studies reported to date involve methadone. Controlled studies of interactions are not available but clinically significant interactions have been observed in a number of case reports. The review concluded that adverse drug interactions might be associated with serious clinical consequences.

Methadone: Best-documented studies of interaction are between nevirapine and methadone. Nevirapine [34, 35] is known to reduce the level of methadone in the blood. Patients who do not increase their dose of methadone when taking nevirapine experience withdrawal symptoms that can be corrected when the methadone dose is increased or nevirapine is stopped. The experience of unexpected withdrawal by patients in methadone has been dramatic and painful and has tempted some to drop out of anti-retroviral treatment. Observations from a pilot study of 5 methadone maintained patients [36] showed that 4 of 5 participants reported opiate withdrawal symptoms while on HAART within 2 weeks of beginning ARV treatment. The discomfort caused by unexpected withdrawal symptoms goes some way in explaining non-adherence in certain circumstances. At the same time it was found that opiate drugs can also decrease the level of antiretroviral agents in the blood thus rendering the ARV treatment ineffective and necessitating increased doses of HIV medicines. It is clear that these complex interactions require further explorations so that drug users for whom attendance at a drug treatment facility is generally seen as enhancing adherence do not exclude themselves from treatment because they are experiencing many unpleasant symptoms.

Buprenorphine[37] and cocaine [38] have shown no adverse interactions with ARV although cocaine use per se has been found to speed up the cell-to-cell spread of the virus by up to 200 times [39]. For *Marijuana* there is only limited and inconclusive data on interaction of marijuana and antiretroviral therapy.

(3) Facilitating adherence

Concerns about providing ARV to IDUs persist. Research [40] found that IDUs had markedly lower rates of virological suppression and higher rates of virological rebound, and that much of the differences in virological response were explained by IDUs lower levels of adherence to HAART. A further note of caution was raised recently [41]with indications that those IDUs who receive ARV are more likely than others to engage in unsafe sexual practices suggesting a 'harm reduction' fatigue.

However, it has been demonstrated that simplifying treatment regimens (e.g. by providing DOT [directly observed therapy] in conjunction with drug treatment) and promoting patient participation in designing and determining the ARV medication regimen does facilitate adherence. (A large study of 8580 AIDS patients in 27 clinical settings in Brazil[23] concluded that the major factor effecting adherence was the quality of the medical services).

Also important is to ensure that IDUs receive adequate treatment of concurrent conditions including psychiatric and physical problems. In addition it is important to use advocacy in order to create enabling environment within which treatment can be provided to IDUs living with HIV/AIDS. A study in Nigeria concluded that '*Advocacy is also urgently needed to address the poor state of service availability and accessibility for drug users in general, particularly those infected with HIV… In addition to alerting the relevant authorities on the emerging problem of injecting drug use and the associated health consequences, the advocacy package should be geared towards stimulating discussion on, and effecting major changes in policy and practice as they relate to the care of drug users in general and HIV infected ones in particular'* [42].

*Service delivery factors h*ave been shown to impact adherence [43] and it is argued that changes are needed to the HIV/AIDS care delivery systems including substantial increase in the provision of drug treatment programmes and revision of drug policies that create barriers to health care. Substance dependent people living with HIV/AIDS have multiple treatments and care needs. In order to meet these needs a number of models of treatment delivery have emerged. These include services that target drug use and include treatment of addiction and its medical consequences (e.g. hepatitis) but although some provide testing for HIV they refer those who are HIV+ to specialised units once addiction treatment is completed. Some services provide treatment for HIV/AIDS regardless of how the infection was contracted and thus include IDUs among their patients. Finally there are integrated drug abuse and HIV/AIDS treatment and encompass medical, psychiatric, social care and substance abuse treatment.

What seems to be needed are 'innovative approaches to enhance adherence' thus in the Guidelines for a Public Health Approach (WHO April 2002) [44] the following is recommended:

'that innovative approaches to enhance adherence to ART be developed, due to the lifelong nature of this treatment. Strategies to enhance adherence include minimising pill counts and dosage frequencies by preferentially using combination pills on a once or twice daily basis. A number of fixed dose combination products contains two or three ARV drugs are currently marketed that can be used twice a day. However, while a number of ARV drugs have now been approved for once daily administration, relatively few three or four drug daily regimens have been rigorously tested in clinical trials. Other approaches which might facilitate adherence include enlisting the assistance of family or community members to support patients in taking their medications on a regular and timely Basis; extensive counselling and patient education; and directly observed' therapy. Psychosocial issues that can also contribute to low adherence to therapy need to be taken into consideration especially for injection drug users and other vulnerable populations'

Some innovative models of care have been developed in the USA and these include *linked* and *managed* care. These may include the location of the treatment service, opening hours, accessibility, ambience as well as the relation between clinical staff and clients. Also crucial is the way in which the treatment is managed and co-ordinated, initially addressing active substance abuse, stabilising housing and social and nutritional support. Ensuring effective health monitoring, and treating active medical and psychiatric conditions, providing clear information and education to clients about their medication and encouraging clients to participate in determining their own treatment. Furthermore the lack of ancillary services such as reliable access to primary medical care, social support that helps clients deal with issues of domestic violence, stigma and discrimination. Most crucial is the treatment regimen decided upon and the manner in which it is implemented. Note that few examples of such innovative approaches have been identified in developing and transitional countries.

In order to enhance adherence to ARV [45] it is necessary to ensure coordination and collaboration between treatment providers and develop pragmatic approaches to treatment and care. Additionally services should ensure adequate coverage, access and quality and be prepared to adapt services and programmes to local needs. Services to drug users living with HIV/AIDS should not be contingent upon a drug user's agreement to enter drug treatment programme and that ARV treatment should no not be withheld or refused simply because a person with HIV/AIDS is a drug users. Overall, treatment and care for IDUs living with HIV/AIDS must be adapted to the needs of the drug user and where needed, they should be offered assistance to adhere to ARV treatment.[46]

Part 2

Methods of data collection used in the preparation of this report

The data used in the preparation of this paper is derived from multiple sources.

- Personal communications to key field workers, researchers and policy makers, NGO personnel, UN agencies world wide - via e-mail and telephone. An e-mail letter explaining the purpose of the study was sent to 273 colleagues and key respondents from a wide range of agencies and organisations worldwide requesting assistance in identifying services and programmes that offer treatment and care to drug users who are living with HIV/AIDS enquiring whether ARV was generally available in the country and whether substance dependent people received this medication and under what circumstances. Respondents were asked to estimate the number of drug users receiving ARV and to identify studies/ reports or policy statements on IDUs living with HIV. Altogether 310 such letters were written to individuals and about 160 replies were received. 26 documents were appended to the replies and on one occasion a report was specifically prepared in response to our enquiry.

- UNAIDS (epidemiological data sheets), WHO (Geneva, Copenhagen PAHO), UNODCC (country profiles), UNDP, UNICEF, ECCMD. CDC, CICAD, FHI, World Bank, CIA, Harm Reduction Networks (AHRN, CEEHRN), MSF, Medicine du Monde, International coalition of PLWHA, International HIV Treatment Access Coalition. These sources were extensively used to determine the epidemiological situation in respect of IDUs, and HIV/AIDS in the countries covered in this report and to determine what treatment is available to IDUs living with HIV/AIDS.

- An extensive review of the literature was undertaken using scanning of key Addiction and HIV/AIDS Journals, Medline, Aidsmap. A large number of key words were used to search the literature and databases, in multiple combinations. These include drug users, substance users, IDU, HIV/AIDS, ARV, ART, antiretroviral medication, Treatment, treatment services, methadone treatment, Cocaine, Crack Cocaine, adherence, compliance, HIV infection, mental health services, primary health care, alcohol, methadone, hepatitis B, C, Co-infection, ARV Availability, HAART, DOT, Anti-HIV agents, HIV infections, substance abuse intravenous

- In addition conference reports and abstracts were examined: Barcelona XIV International AIDS conference (July 2002), XIII International AIDS Conference, Durban South Africa (July 2000), 11th International conference on the Reduction of Drug Related Harm Jersey (April 2000), 14th international conference on the Reduction of Drug Related Harm, Chiang Mai, Thailand (April 2003), 5th International congress on Drug therapy in HIV infection, Glasgow, Scotland (October 2000), The 6th International Congress on AIDS in Asia and the Pacific (2002)

- Reports tabled at the WHO meeting on 'Treatment and Psychosocial Support for People living with HIV/AIDS who are Substance Dependent', Odessa Ukraine, (August 2001) (including country reports from Ukraine, Viet Nam, Russia, Brazil, Argentina and city reports from Odessa, Moscow, Rio de Janeiro and Buenos Aires and background paper from the USA)

- WHO funded Rapid Assessment studies in 10 cities (Tehran, St. Petersburg, Minsk, Kharkiv, Bogotá, Penang, Hanoi, Beijing, Nairobi, Greater Rosario and Lagos).

In the preparation of this report data will be presented regionally:

A. Asia: South and Southeast Asia and East Asia and the Pacific
B. Latin America and the Caribbean
C. Europe: East and Central Europe and Western Europe
D. Africa: Sub-Saharan, North Africa and Middle East

Part 3

Many drug treatment and care facilities also provide treatment and care for those living with HIV and/or refer patients to either specialised HIV/AIDS treatment facilities or to generic health services. However, although not all such interventions are made explicit they will in certain instances be described because although not providing ARV they nevertheless provide treatment and care for IDUs living with HIV/AIDS in countries where ARV is generally unavailable. In addition we attempt to identify:

1. Whether ARV is available in a country
2. Whether IDUs are prescribed ARV and in what circumstances
3. Whether the number of IDUs receiving ARV represents true proportion of IDUs who need this medication.
4. Services that focus on IDUs living with HIV/AIDS

Findings will be provided country by country grouped by region: Asia (South Asia and East and South East Asia), Central and Eastern Europe and Central Asian Republics, Sub-Saharan Africa and North Africa and the Middle East, Latin America, Central America and the Caribbean.

Note that information presented on the tables should be treated with caution. An indication that ARV is available in a country means that access is universal (YES). The column headed NO indicates either that it is not at all available or that it is only available privately or from an NGO (special project). Country notes are designed to provide additional information to elucidate the tables. 'No Info' generally can mean that no information was found during the execution of this study.

A. Asia

UNAIDS estimates that 7.4 million people in Asia are living with HIV/AIDS comprising nearly 1/5 of the world's infections. Estimates of the total number of IDU in the region range from a low of about 2 million to 4 million, and the best 'average' estimate of the total number of HIV infected IDUs in the Region is about 750,000 with about 2/3 of the regional total in China [47]. The epidemic differs from country to country but overall injection drug use is contributing disproportionately to the spread of the epidemic in the region.

A.1 South and Southeast Asia

Injecting drug use followed the introduction of heroin in the region and expanded significantly in South and Southeast Asia since 1990s. Data on the numbers of IDUs in the region is patchy. Four countries: India, Thailand, Myanmar and Indonesia account for 99% of the total HIV in the region [47]. There are an estimated 60,000-100,000 IDUs in Pakistan, 20,000-25,000 IDUs in Bangladesh, 80,000-118,000 in India and nearly 300,000 in Iran. IDU does not seem to be prominent in Bhutan, Sri Lanka and only a minor factor in the HIV/AIDS epidemic in Bangladesh.[48]

Around half of injection drug users in Nepal, Myanmar, Thailand, Indonesia and Manipur State in India are HIV+[49]. However, despite the high incidence of HIV/AIDS infections among IDUs in the Asia region specialist treatment and care facilities are scarce and patchy. There are a number of interventions that aim to reduce the risk for IDUs of contracting the HIV virus and other blood borne diseases through education and prevention approaches, and by employing harm reduction strategies. The small scale of preventive and harm reduction strategies in the region is indicative of official neglect. (For example only about 5% of IDUs in India (and only 10% in Manipur) and 10% of IDUs in Bangladesh are reached by prevention projects). Where projects do exist they are limited in scope and coverage and most are not supported by official policy.

ARV: It is estimated that 800,000 PLWHA need ARV, but currently just 40,000 are receiving it [49]. Even where it is available, there is insufficient evidence on whether free access is in fact practised and most particularly whether IDUs receive such treatment and under what circumstances. In some countries (e.g. Malaysia) some categories of AIDS patients are provided access to ARV but IDUs are specifically excluded. Delivery and access to ARV medication in the region is patchy and data are not readily available. In some countries non-government organisations (NGOs) or private physicians are providing ARV to some of their clients. With few exceptions the patients have to bear the cost of the medication. A target of 400,000 PLWHA gaining access to ARV by the year 2005 will require a scale-up by a factor of 10 [49].

TABLE 1: ARV TREATMENT IN SOUTH AND SOUTHEAST ASIA

	ARV availability			**ARV availability for IDUs**		**IDUs in ARV treatment**	**People in ARV (% of those with advanced HIV receiving ARV)**	**Estimate Nº of people in need of ARV**
	YES		**NO/ nk**	**YES**	**NO**			
	Public Sector	**Private/ NGO**						
Afghanistan [48]		√			√	0	nk (0%)	nk
Bangladesh [48]		√			√	0	5 (0%) [49]	1,800 [49]
Bhutan [48]		√		n/a (no IDUs)			5 [49]	14 [49]
Brunei D. [50]	√			nk			nk	
Cambodia [51]		√		nk			950 (3%) [51]	nk
India [47]		√		nk			13,000 (2%) [49]	600,000 [49]
Indonesia	√			nk			600 [52] (2.7%) (5% are pregnant women) [53]	18,400 [49]

Iran [53]	√			√		50-60	130-140 (20% if AIDS cases)	nk
Lao [54]		√			√	0	nk	
Malaysia [55]	√				√	0	1,100[57] (nk) [56]	
Maldives [48]		√		n/a (no IDUs)			0 (0%) [49]	14 [49]
Myanmar		√		nk			1,000[49] (<1%)[67]	60,000 [49]
Nepal		√			√	0	250 (nk)[49]	8,000 [49]
Pakistan [58]		√			√	0	(2.2%) [67]	nk
Philippines		√			√	0	60 (3.5%)[67]	nk
Singapore [60]		√			√	nk	(0%)[67]	nk
Sri Lanka [61]		√			√	0	25 (2%) [67]	680 [49]
Thailand	√				√	0	(4%)[67] 13,000 [49]	96,000 [49]
Timor [62]		√ [49]		nk			0	nk
Viet Nam		√ [63]			√	0	50-100(1%) [67]	21,000 [64]
Total=20	5	15		1	11			

For further country information please consult Annex 1

Examples of interventions designed to provide treatment and care to IDUs living with HIV/AIDS

Projects that target IDUs particularly those that have a harm reduction orientation also provide some treatment and care for clients who are living with HIV/AIDS. Some of the projects provide little other than palliative care or referral to specialised HIV/AIDS treatment programmes while others attempt to provide a holistic service to PLWHA.

Triangular Clinic project in Kermenshah – Iran [54]

This clinic was established in March 2000 after community consultation that included the religious authorities.

- The centre's principles are based on the understanding that drug users require integrated, multifaceted and comprehensive care.
- The centre has 10 staff and a budget of $100,000 per year (excluding medication).
- The centre offers a wide range of services: By end 2002
- the centre had provided 8619 individual counselling sessions and 325 family counselling sessions, 2233 HIV tests (290 were found to be HIV+), and distributed 25,000 needles and syringes, 12,000 condoms and made 442 referrals to drug dependence treatment agencies.
- The centre provides prophylaxis for HIV infected individual as well as Tuberculosis and PCP prophylaxis. ***14 clients are receiving HAART.*** (As Antiretroviral medication is in short supply IDUs are expected to attend for at least 6 months in either methadone maintenance, needle and syringe scheme or to have achieved abstinence).

For further information contact: alaei2001@yahoo.com

The SASO Project: Imphal North East India [65]

Ex-drug users in Imphal Manipur established the Social Awareness Service Organisation (SASO) in 1991. Its mission was to advocate and provide awareness on social, gender and human rights issues. It is a participatory and cost effective project, which has successfully forged links with other community organisations in the city, and made considerable efforts at overcoming stigma and gaining community acceptance. It negotiates grants, loans, and discounts for their clients (e.g. for laboratory services from the Ministries of Social Justice and Empowerment and Family Welfare).

SASO does not provide antiretroviral medication for lack of funds (Just 21 patients of the home-care programme are using ARV and these are obtained privately) and the project is limited to Imphal area and unfortunately reaches only a small % of those who need it.

- The main objectives of the SASO project are: to provide quality home-based care for people with HIV, to prevent transmission to spouses and children and to provide care and support to them when needed and to actively engage in advocacy to remove misconceptions associated with HIV in the family, medical profession and wider community.
- The activities undertaken by the project include*:*

Outreach and detoxification followed by rehabilitation and after-care support facilities.
Harm reduction activities including Needle and Syringe programme, safe sex education and condom distribution
Home Care which consists of visits to those who are a-symptomatic as well as to those who are sick or terminally ill by care workers, doctors or social workers as appropriate. **400 drug users and their families who are living with AIDS are being supported with basic home/community based care provisions such as counselling, nursing, referral, medical and psychosocial support.** Home detoxification is provided if needed. Free medical treatment including TB medication (in a community clinic that is open 5 days a week and offers treatment for opportunistic infections and STD). Referrals to drug treatment as well as other hospital services and Voluntary Testing and Counselling (VTC). Education of family members on prevention of transmission and bio-safety nursing care.

- The project facilitates and provides financial support for a number of self-help groups including groups formed under the home-care programme, a widows group, and groups for spouses of clients.

For further information contact: Umesh Sharma sasoimph@rediffmail.com

The SHARAN (Society for service to Urban Poverty)-Delhi [66]

SHARAN began developing services for drug users in the early 1990's. By 1999 however, it set out to be a 'comprehensive HIV and STI prevention and care programme for injecting drug users and their sexual partners in India. Services were designed to facilitate access and to meet the health care needs of drug users in the city. This is a harm reduction project, which focuses on the homeless IDU. Many of the clients are HIV+. The project offers a range of services from low-threshold drop in and crisis services to

long-term residential rehabilitation. SHARAN is active in advocacy for IDUs, most particularly within the health sector where they are systematically excluded and discriminated against. SHARAN staff accompanies clients to hospital emergency department and endeavour to assist them to receive the necessary help. SHARAN provides care and crisis shelter to homeless clients in need of residential care and support due to their drug use and HIV status. The project works through advocacy to improve hospital environment for HIV positive clients in India

- Provides buprenorphine maintenance, needle and syringes, first aid to street drug users. (E.g. between March and September 2000 2708 clients were provided with oral substitution and 635 given access to detoxification and rehabilitation and an additional 1534 heroin chaser approached the project in the same period)
- Residential and day facilities
- Drop in centre - provided primary health care (GP were regularly available for consultations), HIV information and education and first aid to injecting drug users and their sexual partners
- Promote drug user organisations

For further information contact: Sharanindia@vsnl.com

A.2 East Asia and the Pacific

In *East Asia* China is the country, which has the largest number of IDUs, and a growing epidemic of HIV/AIDS. The Ministry of Health estimates 600.000 infected with HIV/AIDS 2001 (UNAIDS estimates 850 000 in July 2002 [67]) much of it among IDUs, who constitutes 70% of the total known HIV infections in the country. In some of the countries of the region little information is available on either drug use or HIV/AIDS (e.g. Mongolia or the Democratic People's Republic of Korea)

ARV Throughout the region access to ARV is extremely limited and generally as yet unavailable (particularly to IDUs). Only Hong Kong and Taiwan have universal access to ARV medication but the numbers of IDUs who need it in both countries is small.

In the 20 *Pacific Islands and Territories (*excluding Australia, NZ and PNG) report a total of 797 HIV cases and 302 AIDS cases as of September 2001[56]. New Caledonia, French Polynesia and Guam account for 76% of reported infections. The numbers of IDUs is small and they do not contribute substantially to the HIV/AIDS epidemic. By December 2001 Just 51 cases were directly attributable to IDU. However in many cases the exposure category is not known. Treatment services for drug users in the region are limited and none have developed interventions geared to the special needs of drug users living with HIV/AIDS. The provision of ARV is extremely limited – perhaps because relatively few have reached the AIDS stage of the disease. Additional notes on the countries below can be found in Annex 2.

TABLE 2: ARV TREATMENT IN EAST ASIA AND THE PACIFIC

	ARV availability			ARV availability for IDUs		IDUs in ARV treatment	People in ARV (% of those with advanced HIV receiving ARV)	Estimate Nº of people in need of ARV
	YES		NO/ nk	YES	NO			
	Public sector	Private/ NGO						
China		√			√	0	3551 [68] (5) [67]	126,000 [69]
Yunnan [72]		√			√	0	nk	
Hong Kong [70]	√			√		10-20 [71]	(100%)	n/a
Taiwan [76]	√			√		nk	nk (100%)	nk
Fiji [73]		√			√	0	20 (nk)	nk
Guam[74]			√	nk			nk	
Korea (Dem. People's Rep. of)			nk	nk			nk	
Korea (Rep. of) [58]			√	nk			nk	
Micronesia [74]			nk	nk			nk	
Mongolia		√			√	0	0 (nk)	nk
New Caledonia [74]			nk	nk			nk	
Papua New Guinea [75]		√		nk			0 (0%)[67]	nk
Total – 12	2	5		2	4			

For further country information please consult Annex 2
No examples of interventions that specifically target IDUs with HIV have been identified for this region.

B. Latin America

Overview [77]*:* It is estimated that in Latin American there are about 1.5 million people living with HIV/AIDS (end 2002). The predominant modes of transmission in the region vary and this is reflected in the AIDS figures [78]. Thus for example in the Andean Region (Bolivia, Colombia, Ecuador, Peru and Venezuela) for the years 1983- 2001 just 0.2% are injecting drug users. By contrast in the Southern Cone region (Argentina, Chile, Paraguay, and Uruguay) for the years 1982-2001 34.3% of those living with AIDS are injecting cocaine users (Studies in Argentina and Brazil show that between 75%-83% of drug injectors use cocaine [78]). In Brazil the number of AIDS cases for the years 1980-2001 is 215,810 of whom 23.7% are IDUs. In both Central America and Mexico IDUs represent just 0.9% of total AIDS cases [78]. Injecting drug use accounts for an estimated 40% of *new infections* in Argentina and 28% in Uruguay. So too, in North Mexico, Bermuda and Puerto Rico the HIV/AIDS epidemic is largely among cocaine injectors. Crack cocaine also plays a role in the epidemic, through unsafe sexual practices while intoxicated or transactions of drugs for sex'. In most of the region HIV surveillance and behavioural data is inadequate so much of the information presented is based on estimates.

ARV treatment Data for Latin America and the Caribbean suggest that 196,000 people in the region are receiving ARV of a total of 370,000 who are estimated to need it (53%) [79] The majority of those receiving ARV are in Brazil where 113,000 were receiving ARV in 2001[80]. In the Andean area, Paraguay and Argentina 47,632 people are receiving ARV out of 69.917 who need it.[79] Argentina, Brazil, Costa Rica, Cuba and Uruguay guarantee

free antiretroviral medication and much has been done to ensure locally manufactured and cheaper drugs. In the countries of Central America ARV provision is unequal. For example in El Salvador, Guatemala, Honduras, Nicaragua and Panama an estimated 12,050 people are in immediate need of ARV and just 4,730 are receiving it [81]. By contrast Costa Rica provides ARV to all that need it. However, despite official universal access actual access remains unequal across the region partly due to varying drug prices. In some countries in Latin America antiretroviral medication is prescribed through different funding sources: Ministry of Health and the Social Security system (for those who have health insurance). At present the public health care system, which deals with the most vulnerable people, provides limited access to ARV however, efforts are being made everywhere to reduce the cost of ARV.

With the exception of Brazil, information in this region about ARV availability is not provided by transmission category. There are some countries where IDUs are generally excluded though information on this matter is not reliable.

TABLE 3: ARV TREATMENT IN LATIN AMERICA

	ARV availability			**ARV availability for IDUs**		**IDUs in ARV treatment**	**People in ARV treatment (% of those with advanced HIV receiving ARV)**	**Estimate Nº of people in need of ARV**
	YES		**NO/ nk**	**YES**	**NO**			
	Public sector	**Private/ NGO**						
Argentina	√			√		nk	24,603 (100%) [79]	nk
Belize	√			n/a (no IDUs) [82]			200[83] (7.7%) [67]	nk
Bolivia	√			nk			24 (6%) [79]	440 [79]
Brazil	√			√		15,000	113,000[80] (100%)	nk
Chile	√			√		nk	3,288 (91.2%) [79]	nk
Colombia	√			nk			8,433 (35%) [79]	nk
Costa Rica	√			√		nk	(100%) [79]	nk
Ecuador	√			nk			324 (65%)[79]	500 [79]
El Salvador	√			nk			(86% of cases in the Social Security System. 10.5% in the Health Sector)[79]	650 - 1,500 [81]
Falkland Islands			nk	nk			nk	
Guatemala	√			nk			(46%) [67]	1,400 - 4,600 [81]
Guyana	√			n/a (no IDUs)			200 [79] (0%)[67]	nk
Honduras	√			nk			(<1%) [67]	450 – 5,000 [81]
Mexico	√			nk			(92%) [67]	nk
Nicaragua		√[79]		nk			(0%) [67]	50- 450 [81]
Panama	√			nk			1,150 [81]	+200 [81]
Paraguay	√			nk			385 [79] (50%)[67]	600 [79]
Peru	√			nk			1,050 [79] (19.2%) [67]	7,000 [79]

Surinam [84]	√			n/a (no IDUs) [85]			nk	nk
Uruguay	√			nk			790 [57](100%)[86]	nk
Venezuela	√			nk			9,525 (100%) [79]	nk
Total =21	19	1		4				

For further country information please consult the annex 3.

Treatment and care for drug users living with HIV/AIDS

Overall there are few specialised facilities for drug users with HIV/AIDS in Latin America. However, harm reduction programmes are gradually being implemented. The two countries where the problems are most prominent are Argentina and Brazil, yet each deals with the situation in a different ways. Argentina follows the US model of the 'war on drugs', and employs a predominantly prohibitionist model to drug use. Thus possession of even of small amounts of drugs is punished and treatment focuses on the goal of total abstinence. Harm reduction services are just beginning. In early 2000 the first programme of the Harm Reduction Association of Argentina begun to deliver injection equipment with the government. ARV is available to IDUs only after they have become abstinent. Brazil has adopted different policies directed primarily at preventing the spread of HIV/AIDS among drug users and from them to their partners and the rest of the community and is now providing universal access to ARV for all those who require it.

'Brazil is a good example of how the issue of HIV/AIDS among injecting drug users could be addressed… The impact of all these interventions, it seems, resulted in a stabilisation of the prevalence rate among injecting drug users in Brazil…. The Brazil projects are not overall an example of good practice, but some of the elements are outstanding…The interventions in Brazil come very close to what is envisioned in the system-wide position paper as the comprehensive approach.' [87]

Example of 'Managed care' for IDUs living with HIV/AIDS in Rio de Janeiro: Prevention and care [1] [88]

A mobile unit was set up to regularly visit the 2 major drug treatment centres in Rio de Janeiro. Visits stimulated individual counselling sessions, group discussions and on site clinical consultations. The Unit's activities represented the first attempt to fully integrate outreach activities, referral services, prevention, and treatment and served to foster contact between health care professionals with very different backgrounds. The mobile team fostered a partnership that aimed at comprehensive prevention and care of people enrolled in different research projects.

3 main initiatives: designed to integrate prevention and care.

- Waiting room debates - on different topics co-ordinated by health professionals and covering a wide range of issues including aspects of substance abuse and its related harms and how to prevent and manage them. Debates are conducted in the waiting rooms of the clinic.
- AA and NA meetings in a room at the clinic
- Anti-retroviral therapy adherence group

Contact info: Monica Malta Oswaldo Cruz Foundation, Rio de Janeiro, Brazil

B.1 Caribbean region

The Caribbean is one of the region hardest hit by HIV/AIDS outside sub-Saharan Africa. Official estimates show more than 360.000 people living with HIV/AIDS, but estimates place the number at over 500,000 due to underreporting [89] Heterosexual transmission is the major vector for the infection.

At present injecting drug use is still relatively rare though there is growing evidence that it does exist in some of the Caribbean (e.g. Bermuda and Puerto Rica where most injectors are returnees or deportees from the 'drug scene' in the USA). However, non-injecting drug use although not a direct risk factor it is still an important indicator of risk for HIV infection through its association with unsafe sexual behaviour. This link is increasingly being acknowledged and studied in the region, though data is still lacking with the exception of some qualitative studies (e.g. In Trinidad and Tobago [90] and a large quantitative study in young people in Grenada [91]). Altogether it has been estimated that in the In the English, Dutch and French Overseas Departments 0.7% of HIV cases are known to be IDUs and in Latin Caribbean (Cuba, Dominican Republic, Haiti, Puerto Rico) 3.2% are IDUs[89] However, cases of HIV/AIDS where the link with non-injection drug use has been established are low.

Examination of the existing sources of drug use data yields an incomplete picture of the drug use and related HIV/AIDS problem in the region. Epidemiological data derived mostly from student population suggests that the most commonly used drug is cannabis but there is growing evidence in a number of islands that cocaine from S. America, destined for the North American and European markets are being used locally. Trinidad and Jamaica have the greatest documented drug use problem among their school age and national populations with lifetime use for cannabis and cocaine of approximately 25% and 2% respectively, thus signalling the increasing popularity of recreational drug use[92]. Most drug treatment and rehabilitation programmes are residential, high threshold, lengthy and abstinent-based there are few outreach or counselling services. Harm reduction interventions are only just beginning. On the whole antiretroviral treatment is unavailable for all HIV/AIDS patients except for the few who are able to pay.

ARV - In May 2003 CARICOM has succeeded in reaching an agreement with the pharmaceutical industry for the purchase of antiretroviral drugs and there are plans to scale up ARV availability. The price will be $800 per year. It is expected that similar agreements will be made in the Eastern Caribbean and Haiti.

TABLE 4: ARV TREATMENT IN THE CARIBBEAN REGION

	ARV availability			ARV availability for IDUs		IDUs in ARV treatment	People in ARV treatment (% of those with advanced HIV receiving ARV)	Estimate Nº of people in need of ARV
	YES		NO/ nk	YES	NO			
	Public sector	Private/ NGO						
Bahamas		√		n/a (no IDUs)			1200[97] (<1)[67]	nk
Barbados [93]		√		n/a (no IDUs)			400 [79]	1,200 [79]
Bermuda & Cayman [79]	√			√	nk	nk	(100%)	nk
Cuba	√ [94]			n/a (no IDUs)			556 (100%) [67]	nk
Dominica		√		nk			0	nk
Dominican Rep.		√		nk			320 (2%) [57]	nk
Grenada			nk	nk				nk
Haiti		√		n/a (no IDUs)			400 [95]	
Jamaica	√			n/a (no IDUs)			(<5%)[79]	4,000[79]
Puerto Rica [96]	√					nk	nk	nk
Trinidad & Tobago [79]	√			n/a (no IDUs)			600 [79]	nk
Total=11	5	5	1					

For further country information please consult Annex 4

C. Europe

C.1 Eastern Europe and Central Asia and South East Europe

Introduction

Eastern Europe and the countries of the former Soviet Union are experiencing the world's fastest growing HIV/AIDS epidemic (UNAIDS/WHO 2002). Several factors including economic crisis, rapid social change, increased poverty and unemployment have all contributed to the spread of HIV in the region. In 2002 there were an estimated 250 000 new infections in the region bringing to 1.2 million the number of people living with HIV/AIDS. In some countries of Eastern Europe the majority of HIV/AIDS infections are attributable to IDU.

In the *Central Asian Republics* the epidemic in the general population is at a low-level (under 5%). However the leading mode of transmission is injecting drug use that is spreading with heroin injecting displacing the traditional opium smoking and the estimated numbers of IDUs in the region range from a relative low of 9,000-13,000 in Turkmenistan to a high of 97,000-250,000 in Kazakhstan [98]

South Eastern Europe has so far been spared the explosive increases in HIV/AIDS seen in many parts of the former Soviet Union. However, there are many signs that this could change in the near future. The prevalence and incidence of IDU is increasing throughout the region and there is evidence of high-risk drug use and sexual behaviours. A rapid assessment in SE Europe showed that 90% of injectors had sex while under the influence of drugs but only 14% used condoms regularly. Almost 2/3 of IDUs shared needles and syringes. [99]

Access to ARV [100] is very inadequate throughout Eastern Europe and Central Asia. In the Newly Independent States only 733 people - 0.3% of HIV/AIDS registered cases receive triple combination ARV No ARV of any kind is available in Armenia, Azerbaijan, Kyrgyzstan, Tajikistan or Turkmenistan. Furthermore although IDUs constitute 82% of total infections they are just 23% of those who receive ARV. Countries with the highest number of IDUs living with HIV/AIDS are least likely to provide them with ARV (e.g. in Estonia and Lithuania where IDUs are 85% and 72% of total HIV cases but no IDUs receives ARV) [100]. Access to ARV is greatest where the % of IDUs is the smallest among registered HIV/AIDS cases often at no cost (e.g. Hungary, Croatia, and Bulgaria). Harm reduction programmes in the region report that 73% of IDUs have no access to primary care from any source.

TABLE 5: ARV TREATMENT IN EASTERN EUROPE AND CENTRAL ASIA

	ARV availability			**ARV availability for IDUs**		**IDUs in ARV treatment**	**People in ARV treatment (% of those with advanced HIV receiving ARV)**	**Estimate Nº of people in need of ARV**
	YES		**NO /*nk***	**YES**	**NO**			
	Public sector	**Private/ NGO**						
Armenia [101]		√			√	0	(0%) [102]	50[102]
Azerbaijan [100]			√		√	0	(0%)[103]	50[103]
Belarus		√			√	2 [104]	136 (<1%)[67] or (6.8%)[102]	2000 [102]
Bosnia & Herzegovina [105]		√			√	0	(10%)[102]	nk
Bulgaria [105]	√			nk		0 [102]	89 (44.5%)[102]	200[102]
Croatia	√			√		12 [102]	148 (98.7%)[102]	150 [102]
Czech Rep.	√			√		10 [101]	400[103] (93.9%)[102]	330 [102]
Estonia	√			√		nk[100]	48[106] (48%)[102]	100 [102]
Georgia		√		√		nk[103]	(8%)[67]	100 [102]
Hungary	√			√		1	320 (97%) [102]	330 [102]
Kazakhstan		√		√		40 [104]	(55%) [102]	100[102]
Kyrgyzstan [100]			√		√	0	0 (0%) [102]	10[102]
Latvia	√			√		46[101]	102 (51%) [101]	200[102]
Lithuania	√				√	0 [100]	22 (62.9%) [104]	35 [102]
Poland	√			√		650 [101]	1,720 [107] (92.9%) [102]	nk
Moldova Republic			√		√	0 [100]	(8.3%) [67] or (1%)[102]	100 [102]
Romania	√			√		nk	4,410 (64.4%)[102]	7,000[102]
Russian F.	√	√		√		1,400 [101]	2,800 (5.6%)[102]	50,000[102]
Slovakia	√			√		n/k	37 [104] (100%)[102]	37 [102]
Tajikistan[100]			√		√	0	0 [102]	5[102]
Turkmenistan[100]			√		√	0	(0%)	100 [102]
Ukraine		√		√		29 [104]	50 [102] (5.7%) [102]	15,000[102]-45,000[103]
Uzbekistan			√		√	0	4 [103]	100 [102]
Total =23	11	7	6	12	6			

For further information country information please consult Annex 5

There are numerous services in the region targeting IDUs. Many are designed to provide harm reduction intervention to help prevent IDUs from becoming infected. For example 211 Needle and Syringe Exchange schemes, 68 drug maintenance facilities and 112 withdrawal treatment services have been identified in the region by the UN reference group and the Central and Eastern European Harm Reduction Network (CEEHRN). ARV is provided to a limited number of patients in the region but the context within which this is provided is unclear.

C.2 Western Europe

TABLE 6: ARV TREATMENT IN WESTERN EUROPE

Western Europe	ARV availability			ARV availability for IDUs		IDUs in ARV treatment	People in ARV treatment (% of those with advanced HIV receiving ARV)	Estimate Nº of people in need of ARV
	YES		NO/*nk*	YES	NO			
	Public sector	Private/ NGO						
Albania [105]		√			√	0	(0%)[102]	30[102]
Macedonia [100]		√		nk			2 (20%)[102]	10[102]
Slovenia [102]	√			√		4 [104]	77 (100%) [104]	77 [102]
Serbia & Montenegro (F. Yugoslavia)	√				√	105[104]	317 [104] (26.4%) [102]	1200 [102]
Total - 4	2	2	0					

For further country information please consult Annex 6

No interventions specifically targeting IDUs living with HIV/AIDS have been identified in this region. IOM/UNICEF (2002) [105] reports a low level of drug and HIV treatment and prevention activities in the region reflecting the perceived low level of the drug problem. In Albania the Soros Foundation supports a harm reduction project for Albanian NGOs and one drug rehabilitation centre was established by an Italian religious organisation. Macedonia has one methadone treatment centre and 2 NGO run needle exchange programmes. Slovenia has methadone maintenance programmes run by the Ministry of Health and in the Serbia the Institute for Drug Dependence is the only treatment facility in the Former Yugoslavia. It does not offer methadone substitution. It is unclear how and where ARV is provided to IDUs in Serbia.

D. Africa

D.1 Sub-Saharan Africa

Africa has the largest number of HIV/AIDS cases worldwide. In 2003 an estimated 26,6 million people in the region were living with HIV, including the 3.2 million who became infected in 2003. AIDS killed approximately 2.3 million people in the same year [108]. The link between drug use and HIV/AIDS has now been established in Africa and 15 countries have reported injecting drug use. According to studies conducted in Kenya, Nigeria and South Africa, intravenous drug use appears to be higher than commonly believed. (A World Health Organization study in Nairobi City revealed an unexpected high number of heroin abusers injecting intravenously. In Nigeria, a study carried out in 2000 in Lagos revealed that the HIV prevalence rate among heroin and cocaine street users was almost twice as high as among non-drug users)[109]. However, there is little specific data anywhere in Sub-Saharan Africa on the extent of HIV among drug users. There are few treatment facilities for drug users, the majority of them in South Africa, and none that focus on treatment and care for drug users with the HIV disease.

ARV Antiretroviral medication is not available from the public sector in most countries in Sub-Saharan Africa (except Mauritius). However in some countries ARV is available to certain categories of HIV infected people particularly pregnant women and infants though it is in fact available everywhere to those who can afford to pay. WHO estimates that ARV coverage is approximately 1%, and the greatest success in reaching patients in high-prevalence countries has occurred in Botswana and Uganda, which reportedly cover 7.9% and 6.3% respectively of those in need as of December 2002. Other countries such as Cameroon, Cote D'Ivoire and Nigeria have made recent efforts to increase ARV coverage. In South Africa, Zambia and Zimbabwe all of which have infection rates among the world's highest, WHO reports that coverage in the public sector was effectively nil in 2002 [67]. In none of the countries of the region are there special programmes targeting IDUs living with HIV/AIDS but their numbers are believed to be low. Such drug users with HIV as are treated are seen in the generic HIV/AIDS treatment services and it is unclear to what extent IDUs are able to avail themselves of ARV drugs. The critical shortage of treatment facilities is increasingly being acknowledged, as is the role, which IDUs play in the epidemic in the region:

'the **escalation of the combined effects of drug abuse including Injecting Drug Use and HIV/AIDS…** The inadequacy or lack of facilities for the treatment, rehabilitation and reintegration of victims of drugs is also becoming increasingly evident. Consequently we support the formulation and implementation of joint Drug and AIDS control projects in our countries'.[110]

TABLE 7: ARV TREATMENT IN SUB-SAHARAN AFRICA

	ARV availability			ARV availability for IDUs		IDUs in ARV treatment	People in ARV treatment (% of those with advanced HIV receiving ARV)	Estimate Nº of people in need of ARV
	YES		NO/ nk	YES	NO			
	Public sector	Private/ NGO						
Angola			nk	n/a (no IDUs)			(<1%)	nk
Benin		√		n/a (no IDUs)			430 (2.5%) [67]	nk
Botswana		√		n/a (no IDUs)			2,780 (7.9%) [67]	110,000 [112]
Burkina Faso		√		n/a (no IDUs)			675 [67](1.4%)[67]	nk
Burundi		√		n/a (no IDUs)			844 [57] (1.9%) [67]	nk
Cameroon	√[113]			n/a (no IDUs)			7000 (2,5%)[113], or 12,780 [57]	nk
Central African Rep.			nk	n/a (no IDUs)			(<1%)[67]	nk
Chad		√		n/a (no IDUs)			60 [57]	nk
Comoros			nk	n/a (no IDUs)			nk	
Congo		nk		n/a (no IDUs)			75 [57]	nk
Congo (Dem. Rep. of)			nk	n/a (no IDUs)			(0%)	nk
Cote D'Ivoire		√		nk			1,800[57] (2.7%) [67]	nk
Djibouti		√		n/a (no IDUs)			100 (1.8%) [67]	nk
Equatorial Guinea		√		n/a (no IDUs)			(6.8%) [67]	nk
Eritrea		√		n/a (no IDUs)			(<1%)	nk
Ethiopia			nk	n/a (no IDUs)			(<1%)	nk
Gabon			nk	n/a (no IDUs)			nk	
Gambia		√		n/a (no IDUs)			(6.3%) [67]	nk
67Ghana		√		Nk			(1.8%) [67]	nk
Guinea		√		Nk			153 [57]	nk
Guinea-Bissau			nk	n/a (no IDUs)			nk	
Kenya		√		nk			270 [111](3%-4%) [112]	nk
Lesotho			nk	n/a (no IDUs)			100 [57](<1%)	nk
Liberia			nk	n/a (no IDUs)			nk	
Madagascar			nk	n/a (no IDUs)			nk	
Malawi		√		n/a (no IDUs)			607 [111] (1.8%)[67]	nk
Mali		√		n/a (no IDUs)			412 [57] (2.5%)[67]	nk
Mauritania			nk	n/a (no IDUs)			nk	
Mauritius	√			nk			(100%) [67]	nk
Mozambique		√		n/a (no IDUs)			85 [111](0.2%)[114]	120,000 [216]
Namibia			nk	n/a (no IDUs)			(0%) [67]	nk
Niger			nk	nk			nk	
Nigeria	√[113]			nk			8,100 (1.5%)[67]	nk
Reunion			nk	n/a (no IDUs)			nk	
Rwanda		√		n/a (no IDUs)			1,500 (<1%)[67]	nk
Senegal	√ [113]			n/a (no IDUs)			500 [57] (<1%)	nk
Sierra Leone			nk	n/a (no IDUs)			(0%)	nk
Somalia			nk	nk			nk	

South Africa		√		nk			540[111](0%) [67]	nk
Swaziland		√		n/a (no IDUs)			450 (1.7%) [67]	nk
Tanzania			nk	n/a (no IDUs)			(<1%)	nk
Togo		√		n/a (no IDUs)			300-400 [57]	nk
Uganda		√		n/a (no IDUs)			10,000 (6.3%)[67]	nk
Zambia			nk	nk			(0%)	nk
Zimbabwe			nk	n/a (no IDUs)			(0%)	nk
Total = 45	4	21	20					

For further country information please consult Annex 7

D.2 Middle East and North Africa

Detailed information on both the drug and the HIV situation in this region is lacking. However new patterns of drug use are emerging and injecting drug use has been officially reported in a number of countries. There is also evidence of an increase in non-injecting drug use among street children in some urban conurbation.

HIV/AIDS in the region At the end of 2003 it is estimated that approximately 600 000 PLWHA in the region of whom 55,000 have become infected the previous year AIDS killed a further 45,000 people in 2003 [115]

HIV among IDUs Injecting drug use is increasingly a significant mode of HIV/AIDS transmission in some countries in North Africa and the Middle East. 15 countries in Africa have made the link between drug use and HIV and 8 countries in Africa have identified HIV infection associated with drug use [109]. Information suggests that 4% of registered HIV/AIDS cases in North Africa are reportedly caused by IDU and individual countries report even higher rates[116] or example in Bahrain IDUs represent 7.3% of cases in Libya 91.7% of cases in Algeria 18.4% of cases and in Tunisia 3.4% of cases while HIV infections linked to IDU have also been reported in Egypt, Kuwait, Morocco, and Oman.

TABLE 8: ARV TREATMENT IN THE MIDDLE EAST AND NORTH AFRICA

	ARV availability			**ARV availability for IDUs**		**IDUs in ARV treatment**	**People in ARV treatment (% of those with advanced HIV receiving ARV)**	**Estimate Nº of people in need of ARV**
	YES		**NO/ *nk***	**YES**	**NO**			
	Public sector	**Private/ NGO**						
Algeria		√		nk			nk	
Bahrain			nk	nk			nk	
Cyprus [117]	√			√		nk	(100%)	nk
Egypt[2]		√			√	0	25	nk
Iraq		nk		nk			nk	
Jordan	√			nk			(21.3%)[67]	nk
Kuwait	nk			n/a (0% of HIV prevalence among IDUs)			nk	
Lebanon	√			nk			100%[67]	nk
Libya								
Morocco	√			nk			(20.7%)[67]	nk

Oman	nk			nk			nk	
Qatar	√			nk			(100%) [118] (64.9%)[67]	nk
Saudi Arabia	√			nk			Available for pregnant women	nk
Sudan			√		√	0	<1% [67]	nk
Syria			√		√	0	0	nk
Tunisia	√				√	0	(100%)	nk
Turkey	√			nk			(100%)	nk
United Arab Emirates	√			√			√	
Yemen	√			√			√	
OPT(Occupied territories of Palestine) [119]		√		nk[120]			nk	
Total=21	8	5	2					

For further country information please consult Annex 8

Treatment and care for IDUs living with HIV/AIDS Overall in the region there are very limited services for drug users with /without HIV/AIDS. The majority of drug treatment approaches are abstinent based and harm reduction strategies are only minimal. Special services for drug users living with HIV/AIDS do not exist. Where ARV is available IDUs are not specifically excluded. But ARV is generally unavailable except on a private prescription.

Part 4: Summary

***Methods and objectives*:** This is a desk study of antiretroviral medication in developing and transitional countries. Data was obtained from a large number of sources including personal communications with key informants. Data was collected on the level of provision of ARV in countries in Asia, Africa and Latin, Central America and the Caribbean to those who need it and to IDUs in particular. Additional information on the prevalence of HIV/AIDS and of IDU was also collected and is provided in the country notes.

Research on ARV in developing and transitional countries is generally limited to the countries of Latin America. Most of the texts reviewed in this report are from work conducted in developed countries. However, it is considered that their findings are relevant to the situation in developing and transitional countries. Research evidence suggests that barriers to HIV/AIDS treatment for IDUs are considerable. There is a lack of resources financial and human and even in countries where IDUs are the majority of those infected they are not a priority. Drug users experience prejudice and stigma, and generate concerns about their capacity to adhere to ARV treatment. Providing HAART therapy for IDUs is seen as a considerable challenge although there is ample evidence that given the appropriate support IDUs are able to satisfactorily adhere to ARV treatment.

Key Findings: This study yielded an incomplete picture of the situation world wide because the availability of data differed from region to region. As is apparent from the tables and country notes, information is often based on estimates. From the data obtained

in this study it is not possible to estimate the overall number of drug users who are being prescribed antiretroviral medication nor the number of IDUs who need it. This study identified 14 countries where IDUs are known to be prescribed ARV and mostly they represent a small proportion of those who need it (with the exception of Brazil). In most countries IDUs are not explicitly excluded but it is not clear whether they are included in the overall figures of people receiving ARV, and whether they are excluded from treatment or whether they are simply discouraged from applying.

Treatment and care for IDUs living with HIV/AIDS Few examples of treatment and care services that focus directly on drug users living with HIV/AIDS have been identified although there are numerous harm reduction services that provide services to drug users, some of which also provide ARV. Data from individual countries should assist in identifying such interventions.

Summing up the studies and reports reviewed in this report a number of strategies to ensure that IDUs receive ARV treatment have been noted. These include the following elements:

- Advocacy to overcome stigma and discrimination.
- Ensuring that data on the suitability of IDUs for ARV treatment is accessible and publicised.
- Establishing 'User friendly' services that are well co-ordinated and which provide adequate access to both specialist and primary health care services and which includes drug treatment as well as HIV/AIDS treatment.
- Ensuring client participation in determining treatment strategies, goals and drug regimen
- Noting and dealing with drug interactions for those IDUs still using drugs or attending maintenance treatment.
- Using appropriate measures to ensure adherence to ARV. Providing ancillary services including counselling, psychosocial treatment and care, peer support, supportive environment, and outreach to include practical help when needed.

Part 5

Annex 1: South and Southeast Asia - Country notes:

Afghanistan It is estimated that there are between 23,000 and 45,000 IDUs in the country [98] Information on the extent of HIV infection is not available (UNAIDS - no date given).

Bangladesh there are estimated 50,000-100,000 drug users in the country[122] of whom 20,000 to 25,000 injecting drug users of whom 1.7% are living with HIV/AIDS [48]. (UNODC estimates just 8000-10 000 IDUs[122]) There are limited treatment services for drug users and overall access to ARV is limited to private patients. In addition some NGOs provide ARV to very few people (though these are unlikely to be IDUs) [121.]

Bhutan No data about drug use is available [122]. UNAIDS (2002) estimates that there are 100 people in the country who are infected. By November 2003 just 38 cases of HIV have been reported (extensive testing). Health care is provided free to all who need it but ARV is not available.

Brunei Darussalam UNODC (no date) reports uncertainty the level of injecting drug use in the country, which is thought to be low with some government sources reporting no IDU. However estimates of between 3000 - 4000 IDUs have been indicated.[98] By August 2000 the country had 22 cases of AIDS and 575 notified cases of HIV [123]. However, HIV statistics indicate that 3.8% of all HIV infections are due to IDUs. Officially ARV is available freely to all those who need it but no data were found on the numbers of patients receiving this medication.

Cambodia Has a cumulative total of 41.423 cases of registered HIV by June 2000 [120] and an estimated 169,000 people living with HIV/AIDS. There is growing evidence of an emerging drug problem in the country and it is estimated that there are between 300-1000 IDUs in the country [98] In a study of vulnerable youth in Phnom Penh 18% said that they had or were injecting heroin[124.]

India has an estimated 563,000- 2,025,000 IDUs [98] and 3.97 million people living with HIV/AIDS. It is estimated that there are 35,300 IDUs living with HIV in the country[122]. Six states in India (Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland, Tamil Nadu) have the highest number of infections [49] In India the epidemic among IDUs indicates a differential epidemic characteristics. For example in Manipur reports an 80.7% HIV infection among IDUs whereas in Calcutta HIV prevalence among IDUs is less than 2%. Cities like Chennai show an increasing trend for HIV infections among IDUs (31.2%)[122]. The Indian Government announced on International AIDS Day that by April 2004 they intend to provide free antiretroviral medication for 100,000 people in 6 states with high prevalence of HIV/AIDS[126] Current situation unclear.

Indonesia there are an estimated 160 000 IDUs[i] of whom 42,749 are living with HIV/AIDS [127] of a total estimated 90,000-130,000 PLWHA (UNAIDS 2002) accounting for 23.8% of HIV infections in the country. UNAIDS estimates that just 1.5% of IDUs are reached by prevention services [67]. Government estimates that there are some 10,000 people with AIDS in 2002. In some locations the % of IDUs living with HIV/AIDS is much higher (In Jakarta 47% at the end of 2001) Interventions are scarce and some drug treatment centres refuse to treat IDUs who are HIV+[128.] There is a pilot substitution project in 2 government hospitals [55] - about 200 treated with methadone and just 1.5% are reached with HIV/AIDS prevention programmes and harm reduction has been initiated as pilot projects [52] Information on ARV is unclear. In one hospital (Cipto Mangunkusumo there are 300 people out of a total of 668 patients in need who are receiving ARV. The Ministry of Health and the FDA are working on a national strategy to produce affordable medicines. MSF has begun a project in Jakarta and has been providing ARV since March 2003. In general ARV is limited to those who can pay.

Iran[53] Has an estimated 2 million drug users[48] of whom 112,000-300,000 IDUs [67] and 20,000 [67] cases of HIV/AIDS of whom 4,846 are registered (2003). UNAIDS estimates that just 0.5 of IDUs are reached by prevention services [67]. To date 1% of all injectors are believed to be HIV+ and constitute 65% of all AIDS cases. By 2000 there was no treatment and support for drug users living with HIV and in fact suicide was the major cause of death for people living with HIV/AIDS. However, in August 2003 the

government announced that the Health Ministry will begin to distribute free syringes to drug users in certain places in Tehran in exchange for used syringes. Officially ARV/*HAART* triple therapy is available free of charge to each patient who needs it. To-date, there are 130-140 AIDS cases in Iran who are receiving antiretroviral medication (2002). About 40% of these are injecting drug users and 50% of them continue with their addiction. Because of limited availability of ARV it is restricted to those who participate in a harm reduction programme for at least 6 months, Most of the infections in Iran appear to be associated with IDUs with very high levels of infections in Iranian prisons. HIV prevalence among IDUs in prisons reached 63%.

Lao has an estimated 5000-11,000 injecting drug users [98] and 603 cumulative HIV cases to 2000, but UNAIDS estimates that there are at least 1,400 cases (2001). No data was found about drug users with HIV/AIDS in the country. The surveillance does not include drug users among the groups tested.[54] No information found about availability of ARV.

Malaysia [55] the total number of IDUs (cumulative fig. 1998 – to 2002) is 234,495 and in 2002 17 080 new drug users were notified of whom 13.8% were IDUs. Over 40% use heroin. UNAIDS (2002) estimated 42,000 PLWHA and IDUs account for about 75% of infections (approximately 24,000[47)] However ARV is only provided free to just 5 categories of patients from which IDUs are excluded. Everyone with HIV who requires it can receive free AZT (this was available since 1998) but the other two drugs required for triple therapy have to be bought.

Maldives Brown sugar Heroin is the most widely abused drug in the Maldives, followed by Hashish oil. IDU is rare[129] . By the end of 2003 UNAIDS estimated that there were less than 100 cases of HIV/AIDS in the country. The major mode of transmission is heterosexual. No ARV was available at present.

Myanmar It is estimated that there are between 90,000- 300,000 injecting drug users in the country[98]and an estimated 38,300 IDUs living with HIV/AIDS [47]. There are no special facilities for the treatment of IDUs living with HIV/AIDS. Once they develop symptoms of AIDS they are treated in the Contagious Diseases hospital in Waybargi outside of Yangon City. If an IDU develops symptom while in drug treatment an AIDS physicians would be consulted. The Ministry of Health does not provide ARV however, there may be some available in the outside market. IDUs are not discriminated against as far as HIV/AIDS treatment is concerned [130].

Nepal has an estimated 30,000 - 50,000-drug users of whom approximately 74.8% are injectors. [122] Approximately 8500 IDUs are infected [47]. Currently there are 10 harm reduction programmes in Nepal covering 5000 IDUs with comprehensive interventions. UNAIDS estimates that 22% of IDUs are reached by prevention services[67]. UNAIDS estimated that 60 000- 100 000 people are living with HIV/AIDS [131] By June 2002 there were 2392 reported cases of HIV and 606 cases of AIDS. Currently ARV is not available but national guidelines for oral drug substitution and ARV have been developed and the plan is to start in 2004 with both oral substitution and ARV[132]

Pakistan The country has an estimated 500 000 regular heroin users [133]. Of whom about 60 000 are IDUs and 11% of them are infected with HIV[48] (5400 [125]) Pakistan has an estimated 70,000-80,000 people infected with HIV/AIDS and IDUs represent about 1% of those living with HIV/AIDS. Thus far none of the interventions directed at drug users focus on HIV and no ARV is available from national health sources.

Philippines the country has and estimated 10,000-24,000 IDUs [98] Other estimates put the figure at 400,000[134] IDUs have been identified in Cebu, Davao, and Santos City (numbers unknown). Most drug takers use Shabu, syrups, marijuana and solvents rather than inject drugs. By 2002 1 776 cases of HIV/AIDS were notified to the Ministry of Health of whom just 6 were IDUs.[135] UNAIDS (2002) estimates that 9400 people living with HIV/AIDS. ARV is included in the list of essential drugs but availability is still a problem.

Sri Lanka - There are an estimated 40 000 heroin users in the country of whom about 3000 inject drugs[122]. The estimated number of people living with HIV/AIDS in Sri Lanka is 4800 by mid 2002[131].There have been no reported IDUs living with HIV. To date no special attention has been given to the treatment and care for IDUs LWHA[136]

Singapore Injecting drug use is very rare in Singapore [136] and HIV among them is believed to be very low. UNAIDS estimates about 3,400 PLWHA (2001) Some ARV available (In a small study Chan found that 57% of those who need it receive this medication [137]). .

Thailand has an estimated 20,000-76,000 IDUs [98] AIDS figures from 1984 –2003 indicate the IDUs account for 47% if AIDS cases[138].Thailand has an estimated 50 000 IDUs LWHA [125] In theory Thailand has agreed to provide ARV to all who need it but so far IDUs have been excluded from ARV treatment [139]. A proposal to make ARV access reaching an estimated 50.000-60.000 in the fiscal year beginning October 2003 are being reviewed and considered.[67] [Aim was to provide 28,000 patients with ARV in 2003 in 630 hospitals [138]]

Viet Nam there are 113,903 registered drug users in Viet Nam of whom 70% use and inject heroin [140]. (Vietnam News 8 June 2001 estimates 140,000 drug users). UNAIDS estimates that in Viet Nam 62.7% of IDUs are reached by prevention services [67]. UNAIDS estimates that there are 130,000 PLWHA in the country [141]and an estimated 45,000 IDUs living with HIV/AIDS[125] and IDUs represent 60-65% of reported HIV/AIDS cases in the country. The country plans to provide 70% of all AIDS cases with ARV by the year 2010.

Annex 2: East Asia and Pacific country notes

China has and estimated 3.5 million drug users [98] and official figures of 680,000 IDUs of whom 300,000-500,000 are infected with HIV/AIDS[125.] However estimates quoted by UNODC (2000) reports that there is an estimate of 7 million drug users. Just 5% of drug users are reached by prevention services [67]. By the end of 2002 the Ministry of Health estimated that China has approximately 1 million PLWHA. High rates of HIV prevalence have been found in several Chinese provinces. Including 35-80% in Xingjian and 20% in Guangdong.[142] China has launched a national programme of care called China CARES (China Comprehensive AIDS Response), which in 2003 began to provide care including in some places locally produced ARV. However, policy/access to ARV is unclear and currently ARV is provided mostly to those who were infected through blood donation. The government announced plans to distribute antiretroviral drugs free-of charge to all those who need it. (New York Times report) China's programme is already failing because of low adherence as no support services. There are no IDUs receiving ARV with the possible exception of few who managed to get onto clinical trials in Yunnan [143]

Yunnan [72] It is estimated that there are between 60-70,000 HIV + in the Province the majority of them IDUs. But no treatment for HIV/AIDS is available except for a few scattered cases.

Hong Kong the number of IDUs infected with HIV in Hong Kong is low. IDUs account for 69 HIV cases of a total 2311 and 11 of 676 cases of AIDS[70]. Although most IDUs inject drugs sharing of needles is rare. ARV treatment is available free of charge to all that need it. IDUs are not treated with ARV in methadone treatment clinics but in the Integrated Treatment Centre which is operated b the AIDS unit of the Department of Health[71].

Taiwan Injecting drug users account for just 2.15% of all reported HIV infections (112 of a total 5,221 cases) and 1.94% of AIDS cases (31 of 911) [148]. Free medical care for PLWHA has been available since 1990 and HAART since 1997. No information was found about IDUs access to this treatment but there are no indications that they are discriminated against.

Democratic People's Republic of Korea No information is available on injecting drug use in the country. UNAIDS/UNDP estimates that by 2000 there were < 100 people with HIV infection in the country. No information was found on whether ARV is available.

Fiji No information was found on injecting drug use in Fiji. By June 2003 there were 104 cases of HIV [145] of whom 25 cases have AIDS. However, UNAIDS estimates (2001) that there are at least 300 PLWHA. There is no information on access to HAART but the Fiji government online website indicates that Fiji will benefit from the Global Fund and will provide ARV when cost has been cut.

Guam Drugs used in Guam are methamphetamines and marihuana. Heroin use is confined to a small local population and tourists and cocaine use is limited. There is no specific information about injecting drug use.[5] The number of HIV cases reported as of October 2002 was 173 of whom 76 have AIDS. Just 8 cases are attributable to IDU. [147] Access to ARV is said to be 'limited' but no specific data was found.

Micronesia [145]has 14 reported cases of HIV/AIDS and of these half (7 cases) have AIDS by October 2002. No known cases of HIV among IDUs. No information on ARV.

Mongolia There is no documented IDU in the country though there are reports of injection of pharmaceutical drugs outside of the clinical environment and of sniffing of glue petrol and shoe polish. In 1997 a government study reported 2% of young people aged between 10-20 were sniffing glue, petrol, shoe polish and other unspecified medicine, of which 58% did it often. Of about 4000 street children 1/3 were reported to be using some of the above[146]. By July 2001 only 3 cases of HIV have been reported in Mongolia. UNAIDS estimates (2002) that there are fewer than 100 people infected.

New Caledonia No specific information about the prevalence of IDU was found but 19 of the reported infections were among IDUs (Dec 2001) [147]. There are 246 HIV/AIDS cases in the country (July 2002) and 93 AIDS cases of which 49 have died [145]. No information on availability of ARV was found.

Papua New Guinea UNODC reported no IDU (in 2000). Drugs used include cannabis and inhalants. HIV/AIDS is increasing in PNG. By December 2001 [145] there were 4792 cumulative reported cases of HIV/AIDS of whom 1577 are AIDS cases and 270 people have died. However, UNAIDS estimates that there are about 17 000 people infected and at least 880 deaths. The mode of transmission is unknown for the majority of cases but for those for whom transmission mode is known the majority are heterosexual. The health system is under – resourced and no ARV is available.

Republic of Korea it is estimated that there are between 1000-5000 IDUs in the country [98].UNAIDS estimates that there are about 4000 people in the Republic that are infected with HIV (July 2002). National sero-prevalence surveys have identified sporadic HIV infections most through sexual transmission. 1999 data (WHO/WPRO) found no IDUs among the 964 confirmed infections. No more recent information found on ARV.

Annex 3: Latin America country notes

Argentina the total estimated number of people living with HIV/AIDS in Argentina is 130,000[149] and 19,959 are known to have AIDS (to 2001) [75].The country has an estimated 650,000 drug users of whom about 10% are IDUs. A study by PAHO found that 54% of IDUs in Buenos Aires are HIV infected[97]. The majority of IDUs use cocaine intravenously and between 12,137-34,538 of them are living with HIV/AIDS [151]. The capital Buenos Aires IDUs represents almost 40% of all HIV infections. Treatment facilities for IDUs living with HIV are limited; IDUs are only treated with antiretroviral medication after they have become drug free and is often denied because of concerns about adherence. ARV is provided by the Ministry of Health (to 70% of total patients) and the Social Security System provides the rest[79]. There is no official policy of coordination or co-operative work between drug treatment and HIV/AIDS treatment services.

Belize there is no data on the number of drug users in the country. However heroin and ecstasy use has been observed but no IDU has been identified. There are no government run drug treatment facilities, and just one private residential centre. Belize has an estimated 2500 PLWHA and probably 300 died from AIDS [154]**.** The government announced free access to ARV to all that are eligible.

Bolivia 1 million people in Bolivia consume coca leaf and there is an increase in use of other illegal drugs[152], however to date there are only an estimated 100-300 injecting drug users in the country [98]. There are an estimated 4600 cases of HIV infection [149] and 804 who were officially notified by end 2001 [152]. In emergency rooms 1.5% of cases seen is related to illicit drug use [152]. Drug users represent 1% of HIV cases[152] and there are 3 cases of IDUs who have AIDS [153]

Brazil there are an estimated 600,000-1,000,000 injecting drug users in Brazil[98]. 2.3% of population reported cocaine use (at least once) and there are an estimated 5,000-10,000 drug users in Rio de Janeiro alone[155] altogether the country has an estimated 610,000 cases of HIV infection and 215,810 [78] cumulative AIDS cases to 2001. IDUs have played a central role in the HIV/AIDS sub-epidemic in the industrialised Southeast especially in Sao Paulo State and in the south coastal line extending from Sao Paulo to the southern border of Brazil. In some municipalities located in the coastal stripe over 50% of all AIDS cases have been reported among IDUs. Overall, one quarter of registered AIDS cases are drug related (2000)[155]. Studies in Brazil indicate HIV among injectors range from 25%in one study in Rio de Janeiro to 75% Sao Paulo. The National AIDS programme estimates that half of all drug injectors in Brazil are infected with HIV. The country has successfully reduced the incidence of AIDS resulting from IDU from 21.4% to 12% in the years 1994-2000. Brazil has a range of harm reduction programmes for IDUs including 365 IP units for HIV/AIDS patients and 52 home care units and 155 OP units. ARV is provided to all that need it. It is provided to 15,000 IDUs. Existing linkage between HIV and substance dependence services are as yet not well developed in Brazil. There is a lack of structured network of referral to and from community programmes and the facilities belonging to the National Health system especially in the realm of substance dependence management.

Chile has an estimated 29,000 IDUs in the country [98]. Most drug users are found in the northern border areas. The country has 20,000 cases of HIV infection[149] and 4,646[78] cumulative AIDS cases to 2001. Drug users represent 42% % of HIV/AIDS cases [156]. ARV is universally available from the Ministry of Health

Colombia there is no precise data on the extent of drug use in Colombia though UNODC report (2003) and a Rapid Assessment study (July 2001) both report an increase in drug use and some scattered injecting especially in Bogotá. It is estimated that there are between 2000-8000 IDUs in the country [98] Colombia has the 4th largest number of HIV/AIDS cases in Latin America estimated at 140,000. ARV is available to just one third of those who need treatment (12% from the Ministry of Health and 72% from the Social Security System and 14% from the military authorities).

Costa Rica has an estimated that there are approximately 1000 IDUs in the country[98]and an estimated 11,000. HIV/AIDS cases. Just 1.0% of cases are IDUs (22cases) in 2003 [157].

Ecuador has an estimated 8000-11,000 IDUs in the country[98] ·ARV is available to about 65% of those who need it. Most of it through the Social Security System (52%) Ministry of Health provides 22% and the rest is provided by the military and the police authorities [79].

El Salvador has an estimated 4000-5000 IDUs [98].Currently 86% of those who require ARV treatment from the social security system receive it, and just 10.5% who come to the Ministry of Health facilities. Just over half the pregnant women who require ARV treatment from the Ministry of Health receive it[79].

Guatemala has an estimated 6000-9000 IDUs [98]. UNAIDS estimates that there are 67,000 PLWHA in the country [149]. MSF provides ARV to some 421 people in Guatemala City[158] Some 64% of those who have social security (those who have insurance) and need treatment receive it but just 3% who require it from the national health care Ministry of Health facilities.

Guyana No recorded IDUs. However, the country has 18.000 PLWHA.

Honduras has an estimated 4000-5000 IDUs [98]and an estimated 57,000 PLWHA. ARV is provided by MSF to 118 people in Tela[158]. Just 5.2% of those who come to Ministry of Health facilities for treatment of AIDS receive ARV.

Mexico[159]The use of cocaine/crack, heroin and methamphetamines is rising. However there are major regional differences. Estimates on the number of IDUs in the country range from 10,000-96,000 [98]. UNAIDS estimates 150,000 PLWHA[149]. Of a total of 150 000 cases of HIV/AIDS in the country just 449 were linked to IDU[159] Mexico has few harm reduction facilities and on the whole takes a prohibitionist attitude to drug use. There are no facilities that target IDUs living with HIV/AIDS. Overall, ARV is available only to those with social security or with private health insurance but this is generally out of reach for those who rely on the public health care system. Mexico's National AIDS programme estimates that 50% of those who need it do not have social security or private insurance. An initiative 'FONSIDA' which is collaboration between NGOs, the pharmaceutical industry and academic institutions now provides free treatment to all infected children under 18 and to pregnant women who are not covered by private insurance or social security. There is no information whether any drug users have been allowed to benefit from this scheme.

Nicaragua has an estimated 3000-4000 IDUs[98] and an estimated 5,800 PLWHA. ARV is not generally available. Only 30% of pregnant women with HIV are provided with ARV[79].

Panama has an estimated 2000 IDUs[98] and 25,000 PLWHA. 2.9% of the total HIV/AIDS infections are IDUs (101 cases)[160]. The Panama National Health Service began to provide ARV in 1999. 85% of those coming to the social security system and need ARV receive this medication and 17% of those coming to the Ministry of Health facilities[79]. No information was found about ARV to IDUs.

Paraguay has an estimated 3000-4000 IDUs[98] and 662[78] cumulative AIDS cases recorded up to 2001. IDUs account for 10% of HIV/AIDS [156] cases and 29% of new HIV infections. The Ministry of Health provides ARV to just over half of those who need it.

Peru has an estimated 1000 IDUs [98] UNAIDS estimates that there are 53,000 PLWHA in the country. ARV availability is limited to just 15% of those who need it the majority are prescribed under the social security system. [79]

Suriname The country has no IDUs known IDUs but a growing problem with cocaine. (In 2001 359 people were arrested for possession of drugs and 1061 for trafficking) [85]. HIV transmission is mostly heterosexual. Surinam has the 2nd highest HIV prevalence in South America with 1.2% of the population infected. UNAIDS estimates that there are some 5000 PLWHA. ARV is not included in any public or private health insurance and is

not subsidized by the government although Suriname can get cheap antiretroviral medication from Brazil it is still too expensive for most. An Emergency Treatment fund for HIV/AIDS was set up to help provide care and prevent more death with the collaboration of PAHO. So far the fund has been successful in obtaining sufficient funds for the next 1-2 years[84].

Uruguay has and estimated 2000-3000 IDUs [98]and an estimated 6300 cases of HIV/AIDS[149] There has been a significant increase in % of people with HIV who are IDUs (and their partners). 28% of all new HIV infections are IDUs and they represent 26% of HIV/AIDS cases [162]. The country has limited harm reduction programmes and some 30 IDUs have regular contact [163].The country provides universal access to ARV. Though it is uncertain what that means in practice especially for IDUs.

Venezuela has an estimated 2000-3000 IDUs[98] ARV is provided to all those who need it by the Ministry of Health and through the social security system and the Military authorities It is unclear how many IDUs are living with HIV/AIDS nor whether any are receiving ARV.

Annex 4: Caribbean region country notes

Bahamas - the adult HIV/AIDS prevalence is 4%. No IDUs have been officially identified. ARV is available in selected institutions [164]

Barbados the Barbados Drug Information system: national Drug Report (June 2003) from the National Drugs Council in Barbados makes no mention of IDUs. Marijuana and crack cocaine are smoked. It is estimated that the 2,415 documented cases of HIV is only one fifth of the infected population. Barbados has received support from the World Bank to help provide antiretroviral medication[164]

Bermuda and Caiman Islands it is estimated that these islands have between 2000-8000 IDUs [98] Bermuda had 475 cumulative notified AIDS cases of which 184 are IDUs[165].

Cuba it is estimated that there are between 7000-10,000 IDUs in Cuba [98]. Cuba provides universal access to ARV but there is no information on how many IDUs are living with HIV/AIDS

Dominica No information was found on the HIV/AIDS situation ARV is not available.

Dominican Republic At present drug abuse is not regarded as a problem as most drugs are transiting the DR. Numerous studies have found only small, isolated, clandestine, invisible and relatively unstable network of IDUs (many are returnees or repatriated from the USA, foreign nationals). There is no reliable data on numbers of IDUs. It is estimated that there are 130,000 PLWHA [149]There is no information about number of IDUs living with HIV/AIDS nor about the % of total HIV infections attributable to IDU. However, about 1% of AIDS cases who died in DR were IDUs but all came home to DR to die. ARV provided to private patients at high cost.

Grenada Marijuana is main drug of choice in the island but some use of crack cocaine was noted. AIDS surveillance reported a total of 223 cases since the beginning of the epidemic. There is no information to suggest whether any of these were drug related. However, there are concerns in the country about possible links. No information on ARV was found.

Haiti is the worst affected nation in the Caribbean with an estimated 250,000 (with a range of uncertainty from 190,000-390,000) living with HIV/AIDS [149] Overall 8% of adults in urban areas and 4% in rural areas are infected. No information was found on drug users. ARV is available from special projects implemented by Partners in Health.

Jamaica It is estimated that there are 20,000 PLWHA in the country[149]ARV is available in selected institutions[95]

Puerto Rica The extent of IDU in PR is estimated at 12,000-17,000[98] HIV prevalence among drug injectors has been recorded at levels between 30-45% and altogether about 74% of all cases are drug related[161]. The results of a study of 800 drug using PR living in NY and 399 who are living in Puerto Rica [168]found that the latter are less likely to be infected with HIV than those in NY. On the other hand they are more likely to inject more frequently, use shooting galleries, share syringes have multiple partners and not use condoms. Puerto Ricans residing in Puerto Rico were less likely to use health services and drug treatment including methadone. Intervention studies suggest that among IDUs high-risk sexual behaviours are more resistant to change than drug injection behaviour.) ARV is available free to those who cannot pay – (as USA).

Trinidad and Tobago: Has an estimated 17,000 cases of HIV/AIDS [149] (2% of the adult population aged 15-44). A study conducted by clients attending an STD clinic in 1990 found that crack cocaine use was the strongest indicator for HIV/AIDS. Researchers have noted the practice of exchanging sex for drugs but drug use is not restricted to the lower socio-economic stratum of society[90].

OECS (organisation of Eastern Bermuda and Caribbean States Have an estimated 320-460 IDUs[98]

Annex 5: East & SE Europe and Central Asia Country notes

Armenia It is estimated that Armenia has between 7,000-11,000 IDUs[98] and an estimated 2,400 cases of HIV/AIDS [170]. The largest number of AIDS cases is attributed to injecting drug use (55.2%)[170].No information was found about interventions for IDUs living with HIV/AIDS[170] or about the overall availability of ARV.

Azerbaijan it is estimated that there are between 15,000 and 23,000 IDUs in the country[98] and an estimated 1400 people are living with HIV/AIDS and 58.9% of AIDS cases are attributable to drug injection [171]. No ARV is prescribed.

Belarus [171] has an estimated 41,000-51,000 IDUs[98]. The country has an estimated 15,000 PLWHA[149]. Information from UNAIDS (2002) suggest that 75.5% of all reported cases of HIV are IDUs. Despite the fact that the government guarantees medical care for every citizen there is no access to adequate antiretroviral care [103] Drug treatment for IDUs is available in Minsk and in Gomelskaya Oblast where the number of IDUs is high.

Bosnia and Herzegovina [105] Little known about the extent of IDU but estimates suggest that there may be 11,000 IDUs in the country[98]. Of the 35 cases of recorded HIV 17% were IDUs [103]. There are limited Harm Reduction services provided by an NGO - but no government funded programmes. ARV is available for those who can pay.

Bulgaria[105] There are an estimated 15 000-20 000 IDUs in the country[105]. The HIV/AIDS epidemic is at low level and IDUs represent about 5% of HIV cases[103]. HAART was introduced in 1999 and ARV available to everyone who needs it but just under half of those who are believed to need it are receiving ARV treatment. There is no specific programme for IDUs +HIV. IDUs can receive treatment in Infectious Diseases Hospital in Sofia, as do others with HIV/AIDS. The National centre on Drug addiction provides methadone and needles and syringes, as do some NGOs. Outreach harm-reduction project targeting Roma population began in 1998

Croatia[105] There are an estimated 19,000-23,000 IDUs in the country[98]. Many IDUs (28-67%) are known to share equipment but few have been tested for HIV so it is unclear how many of them are infected. However, IDUs represent 8.8% of known AIDS cases (end 2000) and 12.9 % of HIV/AIDS cases. HAART treatment is covered by Health insurance. ARV is provided in just one centre in the country (University Hospital for Infectious Diseases in Zagreb***).***

Czech Republic[169] There are an estimated 25,000 -26,000 IDUs in the country [98]. At the end of 2001 UNAIDS estimated that there were about 500 people in the Czech Republic living with HIV/AIDS. IDUs represent just 1% of infected people. ARV is available to all that need it. Harm Reduction services have been available since 1998

Estonia[173] There are an estimated 10,000-14,000 IDUs in the country[98]. IDUs represent 85% of the total HIV/AIDS cases but receive no ARV. The infections are mostly among Russian-speaking drug injectors in specific geographical areas. There are some prevention, treatment and rehabilitation services and targeted harm reduction focusing on IDUs.

Georgia There are an estimated 10,000-15,000 IDUs in Georgia [98]. UNAIDS estimates that there were 900 PLWHA by the end of 2001[149]about 60% had become infected through injecting drug use. About 32% have access to generic ARV mainly funded by the Global Fund[103]

Hungary it is estimated that there are about 25,000 IDUs in Hungary[98]. HIV infection rates are low. Only one IDU was identified with HIV. ARV is available to all that need it. The 2000 National Drug Strategy provides for harm reduction services (outreach, needle exchanges and methadone treatment).

Kazakhstan it is estimated that the country has between 97,000- 250,000 IDUs [98] and an estimated 23,000 cases of HIV/AIDS [174] (but elsewhere – in the same year UNAIDS estimates just 6000 cases of HIV/AIDS)[175]. There are 3511 reported cases of HIV/AIDS in May 2003 and about 80% of reported cases are IDUs[174]. Kazakhstan has more HIV/AIDS cases than its 4 neighbouring Central Asian countries together. The majority of those infected are IDUs**.** Limited ARV is available from the Global Fund grant (but IATEC -2003 say there is no availability of ARV [103]. The virus is concentrated among unemployed youth and prisoners. National programme for 2001-2005 aims to ensure that

at least 80% of HIV infected persons will be covered with medical and social programmes. Established six 'trust points' that provide harm reduction services and are visited between 350-400 IDUs daily[176].

Kyrgyzstan[149] In 1999 there were 7,270 registered drug users in the country of whom 60% were opiate users [177]. But it is estimated that there are between 19,000 and 23,000 IDUs in the country [98] and 500 reported cases of HIV/AIDS. It is estimated that 85%% of all HIV infections is due to IDU[103]. No ARV is available.

Latvia it is estimated that Latvia has between 9,000 and 12,000 IDUs [98]. The country has an estimated 5000 cases of HIV/AIDS. Since 1998, the main mode of transmission is IDU and altogether 50% of AIDS cases are IDUs[178]

Lithuania [100]There is an estimated 5000-11,000 IDUs in the county[98] HIV prevalence is relatively low[179] and IDUs represent 72% of HIV cases and 2.4% of AIDS cases. Klaipeda leads in the number of HIV infected people, but rates of increase are highest among the IDU population in the capital Vilnius. Limited services are available to IDUs these include: Substitution treatment is available since 1995 in Vilnius and since 1998 in Druskininkai. In Klaipeda there is a Drop in Centre for out-of treatment drug users, which provides preventive information, harm reduction services and referral when needed. ARV is not available to drug users. (The Network of Baltic support group for PLWHA say that Lithuania has stopped providing ARV because of shortages of funds (quoted in the IATEC 2003 [103]).

Poland has an estimated 77,000-116,000 IDUs [98] and an estimated 15,000 PLWHA. 70% of HIV/AIDS infections in the country are IDUs[103]. Poland has offered ARV treatment to all that need it since 1996. ARV is provided in 14 State Reference Centres for AIDS Treatment. There are methadone programmes in the country and IDUs can receive ARV while attending these clinics. Altogether IDUs represent half of those receiving medication[180].

Moldova It is estimated that there are between 34,000-52,000 IDUs in the country [98]. IDUs represent some 80% of HIV/AIDS cases. These are estimated at 7400 (officially registered people with HIV is 1743)[105]. No ARV is available.

Romania there is limited data on drug use in Romania but it is estimated that there are between 90,000-112,000 IDUs in the country [98]. There were 10,012 PLWHA as of end 2000 and of these just 2 were IDUs [181]. ARV is provided to 4410 people and is available to those who pay their health insurance taxes, to employees, retired people and children. It is provided in 9 Reference centres for medical evaluation and Treatment. In general the rural population, the unemployed, homeless and Roma people do not pay their health insurance and are therefore excluded from ARV treatment.

Russian Federation there are an estimated 1,455,000 - 2,500,000 IDUs in Russia [98]. The country had 214, 000 registered HIV/AIDS cases till 2002[182] but UNAIDS estimated at least 700,000 to the end of 2001. According to official statistics as of 31 December 2001 there were 79,277 IDUs living with HIV/AIDS[183]. In just 6 months between January 2002 and end of June 2002 11,099 IDUs became infected (81.5% of the total new cases). Although 90% of HIV+ are IDU only 13% have access to HAART[103.]

Slovakia there are an estimated 11,000-16,000 IDUs in the country[98].At the end of 2001 just 32 HIV/AIDS diagnosis have been confirmed and UNAIDS[149] estimates that there were about 100 PLWHA in the country. Just 3% are IDUs. Although ARV is available treatment is sub-optimal because patients are required to contribute 10-20% of their salary to meet the cost of the drugs.

Tajikistan Has an estimated 43,000-62,000 IDUs in the country [98]. UNAIDS[149] estimates that there are about 200 PLWHA in the country. No ARV is available and there are no facilities to do a CD4 count or viral load test [103].

Turkmenistan has an estimated 9000-13,000 IDUs[98] UNAIDS [149] estimates that there are approximately 100 PLWHA in the country. There is no information on ARV availability.

Ukraine there are an estimated 200,000-595,000 IDUs[98]. IDUs represent 78.9% of all HIV/AIDS cases. In 1997-9 there were a total of 23,315 IDUs infected (UNAIDS 2002) – these are officially notified people so real number much higher, UNAIDS estimated that there are 250 000 PLWHA in country. Local official data is about 56 000 are registered but real rates may be x10. ARV is not available. The Ukrainian Network of People living with HIV/AIDS estimated that 45,000 people need ARV and just 50 receive it [103]

Uzbekistan there are around 25,000-registered drug users but estimates suggests that there are between 52,000-122,000 IDUs in the country[98]. IDUs predominate HIV/AIDS figures. 90% of infections are due to drug use [184]. UNAIDS estimates that there are 740 PLWHA in the country[185]. The capital Tashkent has the highest number of cases of HIV/AIDS and IDU is the cause of the majority of infections. The government established 'Trust Points' to which people can apply for counselling and advice and information, be tested for HIV/AIDS and receive free syringes, condoms. The Uzbek government is planning to establish such 'Trust Point' in each oblast. No ARV is available

Annex 6: Country notes Western Europe

Albania The number of people injecting drugs is estimated at between 9,000 - 30,000[98]. Injecting drug of choice is heroin (many IDUs share equipment but no figures). Some harm reduction services: e.g. drug treatment in Tirana (including needle exchange). None of those infected, as of 2002 are IDUs. In 2000 a law on HIV/AIDS provided opportunity for provision of ARV, but as of 2002 not yet implemented. Some private treatment facilities provide ARV.

Macedonia[105] There is little reliable data on the scale of the drug problem in Macedonia but reportedly there is an increase in injecting and in heroin use. It is estimated that there are between 4000-6000 IDUs in the country[98]. Data from 1987-2001 collected by Institute of Public Health suggests that of a total of 59 people living with HIV/AIDS, 13.5% are IDUs (8 people) and UNAIDS estimates (20020 that there are <100 PLWHA in the country Treatment for opportunistic infections is available in the Infectious Diseases hospital in Skopje. Treatment for IDUs consists of one methadone treatment centre and 2 NGO run needle exchanges and outreach work by NGOs.

Slovenia it is estimated that there are 5000-10 000 heroin users[185]. Sharing of needles and syringes high (58%). By January 2002[105] 7.18% of all HIV/AIDS cases were infected through injecting and 93.6% of these IDUs use heroin. Network of Centres for the Prevention and Treatment of Drug addiction was established in 1995. Provide harm reduction (including methadone). UNAIDS (Epidemiological fact sheets 2002) estimates that there are 280 PLWHA in the country. ARV is prescribed but few IDUs are among the recipients

Serbia and Montenegro[105] In Serbia the majority of IDUs are in Belgrade. GOD a national NGO estimates at least 100,000 in Serbia. No substitution treatment. No government sponsored harm reduction. IDUs represent 46.5% of cumulative AIDS cases, and 61.5% of HIV cases reported in Belgrade from 1987 to end 2001. ARV is available to all and theoretically should be paid by health insurance but patients have to pay up front and reimbursement is erratic. Incidence of IDU in Montenegro is low and just 7% of HIV cases are transmitted by IDU. Preventive programmes target IDUs. At present only STI and opportunistic infections are treated in Montenegro while patients with HIV must go to Belgrade. Plan to establish a special ward within the Infectious Diseases Hospital

Annex 7: Sub-Saharan Africa country notes

Angola UNAIDS [187] estimates 350 000 PLWHA by July 2002. The estimates of IDU = <0. No additional data is available from UNODC. No information was found on ARV availability. No plans to provide ARV found in current National AIDS Prevention Strategy.

Benin [188] has an estimated 120,000 PLWHA. No information was found about IDUs. Just 2.5% of those who need it receive ARV [67]

Botswana There are an estimated 330,000 PLWHA in the country [189] HIV prevalence is one of the highest in the world. There is no information on the extent of drug use in the country. The government began to offer ARV through the Public Health system and through a partnership with the pharmaceutical industry. At the moment just 2780 are receiving ARV (7.8% of those who need it) [67]

Burkina Faso Has an estimated 440,000 PLWHA [190] 675 people receive ARV (1.4% of those who need it [67]

Burundi Has an estimated 390,000 PLWHA[191] No information was found on drug use in the country. ARV availability is low and is provided to just 1.9% of those who need it [149]

Cameroon has an estimated 920,000 PLWHA[19 2]ARV is limited to just 2.5% of those who need it [67].

Central African Republic has an estimated 250,000 PLWHA [193]. No information was found on IDU. Less than 1% of those who need it receive ARV [67].

Chad - UNAIDS estimates that there are 150,000 PLWHA [194]. No information found about drug use.

Comoros No data was found about the situation in this country (UNAIDS).

Congo has an estimated 110,000 PLWHA[195]No data was found on drug use.

Dem. Rep. of Congo Has an estimated 1.3 million PLWHA [196] No information was found about drug use in the country, nor about ARV availability.

Cote d'Ivoire Has an estimated 770,000 PLWHA[197] Just 2.7% of those who need it receive ARV[67]. No information was found on drug use in the country.

Djibouti Just 1.8% of those who need it receive ARV[67]

Equatorial Guinea has an estimated 5900 PLWHA[198]. 6.8% of those who need it receive ARV[67]

Eritrea has an estimated 55,000 PLWHA [199] No data was found on IDU. Less than 1% of those who need it receive ARV[67].

Ethiopia has an estimated 2.1 million PLWHA[200] no information was found on IDU. Less than 1% of those who need it receive ARV[67]

Gabon No information was found on the situation in this country

Gambia it is estimated that there are 8,400 PLWHA in the country [201]and just 6.3% of those who need it receive ARV [67]

Ghana it is estimated that there are about 1000 IDUs in the country [98]. 0.7 of the population are believed to use opiate drugs (1998), and 1.1% use cocaine (1998) [202]Ghana has 360,000 (adults and children)[6] living with HIV/AIDS. Just 1.8% of those who need it receive ARV [67]

Guinea There is scant information about injecting drug use in the country, however 2 were identified in a prison population [98] No information was found about the HIV/AIDS situation in Guinea.

Guinea Bissau has an estimated 17,000 PLWHA [204]

Kenya has an estimated 2.5 million people living with HIV/AIDS[205] There are an estimated 5000 injectors in Nairobi, 3000 in Mombassa and 300 in Malindi[206]. However, the relationship between IDU and HIV is not yet recognised. There are scarce facilities for the treatment of addiction (either in psychiatric facilities or by NGOs). ARV treatment is available in theory, but is in fact restricted to major hospitals and big urban health institutions. Just 3% of those who need it receive ARV [67].The main barrier to ARV therapy in Kenya is the cost of drugs. There is no official policy statement that addresses this issue[207]

Lesotho has an estimated 360,000 PLWHA out of a population of less than 1 million [208] Less than 1% of those who need it receive ARV[67]

Liberia No information was found about the situation in this country.

Madagascar has an estimated 22,000 PLWHA [209] No information was found on drug use or on ARV.

Malawi has an estimated 850,000 PLWHA[210] There are no national programmes that provide ARV and just 1.8% of those who need it are estimated to be provided with ARV treatment[67].

Mali has an estimated 110,000 PLWHA [211]No information was found about IDUs. Just 2.5% of those who need it receive ARV[67].

Mauritania Prevalence of HIV in the country is less than 1%[212].

Mauritius is estimated to have about 1000 IDUs [98] Mauritius is a low prevalence country and has just 205 recorded HIV/AIDS cases (Between 2001-June 2003) and an estimated 700 [213] people living with the disease. The number of known IDUs +HIV to end June 2003 was just 32[214]. Everyone can receive free ARV when their CD4 count is below 300. However, it is unclear whether any IDUs actually receive ARV

Mozambique UNAIDS estimates 1,129,238 PLWHA[215]. It is estimated that 120,000 need ARV. The Minister of health announced in May 2004 that a pilot project has been launched to provide ARV to 8000 people[216]. MSF project supplies some ARV.

Namibia Has an estimated 230,000 PLWHA[217] No other information about Namibia was found.

Niger has an estimated 1000 IDUs[98]. No UNAIDS estimated of PLWHA

Nigeria The total number of IDUs is estimated at 5000 [98]. Nigeria has a high prevalence HIV/AIDS with an estimated 3.5 million [218] people living with HIV/AIDS. The number of IDUs living with HIV/AIDS is unknown, though there is corroborative evidence on the relationship between IDU and HIV in Nigeria. In a RAR study carried out in 2000 in Lagos HIV prevalence rate among heroin and cocaine street users was almost twice as high as among non-drug users but the number of injectors in the study was small (N-82) [42].

Reunion No information was found about Reunion

Rwanda has an estimated 500.000 PLWHA[219] 1,500 receive ARV (less than 1% of those who require it)[67]

Senegal Has 27,000 PLWHA[220] Less than 1% of those who need it receive ARV [67]

Sierra Leone has an estimated 170,000 PLWHA[221] No information was found about drug use,

Somalia It is estimated that there are about 1000 IDUs in the country [98]. There are an estimated 43,000 PLWHA in the country[222]. No data on ARV was found.

South Africa has an estimated 5 million[223] people living with HIV /AIDS. Although the numbers of IDUs is increasing there is no epidemiological information about their numbers nor about the numbers who are infected with HIV. South Africa's plan for comprehensive treatment and care for PLWHA was approved by the cabinet on 19/11/2003

Swaziland Has an estimated 170,000 PLWHA[224] just 450 PLWHA or 1.7% of those requiring ARV are receiving it[67].

Tanzania[225] has an estimated 1.3 million people living with HIV/AIDS. The country has increasing Heroin use (esp. Dar-es-Salaam)[226] and some cocaine is available(expensive), However there is no information about IDUs living with HIV/AIDS. No treatment services in the country and no information about treatment for HIV to IDUs.

Togo has an estimated 150,000 PLWHA [227].

Uganda has an estimated 600 000 people living with HIV/AIDS[228] and a serious increase in the use of heroin, cocaine and methaqualone, Khat[229] There is no information about the extent of injecting drug use nor about IDUs who are HIV+ Uganda has no government or even private treatment for drug users. Most seek treatment in the government psychiatric facilities.

Zambia has an estimated 1.2 million PLWHA [230]ARV is not available[67]

Zimbabwe has an estimated 2.3 million people living with HIV/AIDS[231]. There is limited information about the extent of drug use in the country though a study in Harare of 200 subjects found that 14% were current injectors, 51% had 'ever' used drugs[232] ARV is not available.[67]

Annex 8: North Africa and the Middle East country notes

Algeria Estimates of the number of IDUs range between 26,000 and 56,000 [98]The country has an estimated 13,000 cases of HIV and 501 cases of AIDS[233] 18.4% of cumulative AIDS cases to 2001 are attributable to IDU.

Bahrain has estimated <1000 cases of HIV/AIDS[234] and approximately 1000 IDUs [98]. Information on IDU is scant but IDUs represent 73% of all cumulative AIDS cases by 2001[234]. There are no special facilities for IDUs living with HIV. So far only first line drugs are provided (AZT, Indinavir, 3TC are provided free by Ministry of Health to all AIDS patients). One doctor only is authorised to prescribe these.

Cyprus has an estimated 1000 IDUs [98]. UNAIDS estimates <1000 cases of HIV (2002) [235]. 377 HIV cases were reported since 1986. All cases were transmitted sexually and there were no IDUs with HIV.

Egypt There are an estimated 20,000-30,000 heroin addicts[236] though much higher estimates have been suggested (between 57,000-120,000 [98]). Only a minority inject but of those that do 1/3 share N&S. Scarce authoritative data on HIV among IDUs (e.g. A study among IV drug users in 1994 in Cairo found 8% HIV+. But a study 1995-9 showed no evidence of HIV[237]) Only a minority of drug abusers seek professional help from formal sources and existing treatment and rehabilitation services are inadequate for the increasing number of drug addicts[238]. Egypt has an estimated 8000 HIV/AIDS infections [149] All HIV positive individuals in Egypt can receive treatment for opportunistic infections but anti-retroviral medication is available only to pregnant women (UNICEF funded) and for others only privately.

Iraq An estimate made before the war suggests that there were between 23,000-46,000 IDUs in the country[98]. In 2002 Iraq had an estimated <1000 cases of HIV/AIDS [238]
Jordan [239] has an estimated 3000-7000 IDUs[98] and up to June 2001 the cumulative cases of HIV/AIDS in Jordan was 258 but estimates suggest that there may be 1000 PLWHA[240]. Drugs of choice are sedatives, opiates and heroin. Heroin is mostly smoked. No HIV has been reported in IDUs.

Kuwait There is limited data on drug use in Kuwait but it is estimated that there are 23,000 IDUs in the country [98]**.** There is no data about the prevalence of HIV /AIDS in the country[241]. Testing for HIV revealed that in 1993 and 1996 1% of IDUs were HIV+. However, testing in 2000 found none infected.

Lebanon There is no exact data on drug abuse but it is estimated that there are about between 2000- 4000 IDUs in the country[98]. Drug treatment and rehabilitation run by church affiliated NGOs. There are 697 known AIDS cases in Lebanon and about 180 who would be eligible for ARV - Lebanon is expanding access to ARV.

Libya Arab Jamahiriya has an estimated 5000-10,000 IDUs[98] and an estimated 7000 [242] cases of HIV/AIDS. It is estimated that 4439 (91.7% of registered drug cases)[7] are living with HIV.

Morocco Very limited information is available on the population size and characteristics of drug users in the country**.** However, it is estimated that there may be about 19,000 IDUs in the country [98] Cannabis is main drug of abuse but there are increasing numbers of heroin and cocaine users. Poly-substance abuse is common[243]. There are an estimated 13,000 PLWHA, and the country has 693 recorded cases of AIDS of whom 5.7% were IDUs[244]. The government adapted an initiative for Accelerated Access to treatment including ARV.

Oman In 1994 the estimated number of abusers was as follows: Sedative drugs 200, Cannabis type drugs 150 and Heroin 60. No information was provided as to whether they are injectors[245]. Other estimates suggest that there are between 3000-6000 IDUs in the country[98]. Oman has an estimated 1,300 PLWHA [246]

Qatar There are an estimated 1000-2000 IDUs in Qatar[98] but there is no information on the prevalence of HIV/AIDS or on whether any IDU are infected. ARV is available to all that need it[247].

Saudi Arabia - There is scant information about drug use is which is considered a small problem[248]. However, it has been estimated that there are between 15,000- 32,000 IDUs in the country[98] HIV too is not considered to be an important problem in the country. ARV available only to infected pregnant women. [249].

Sudan has an estimated 24,000- 51,000 IDUs[98] though little data was found on IDU in the country**.** UNAIDS[250] estimates 450,000 PLWHA. ARV is not available and neither are services for those infected.

Syria has scant information on both IDU and HIV/AIDS however it is estimated that there are between 4000-8000 IDUs in the country[98]. In 1992 Syria reported 350 heroin addicts, 20 cocaine addicts and 3100-registered cannabis addicts. There is no information on whether there are injecting drug users in the country[251]. Extensive HIV testing (2+ million) yielded figures of 151 Syrian and 90 non-Syrian cases of which just 4% were IDUs. ARV was not available in Nov.2002[252]

Tunisia has an estimated 8000- 18,000 IDUs [98]. There were 797 PLWHA reported in 2003[254]. It was estimated 1999 that 34% of HIV/AIDS cases were IDUs[253] It is predicted that in the next 3 years 500 patients will require ARV treatment. Tunisia has been providing free ARV since April 2001[254].

Turkey has an estimated 67,000- 133,000 IDUs[98] UNAIDS estimates that at the end of 2002 there were 1515 (cumulative) cases of HIV/AIDS of whom 6.9% are IDUs [255]. ARV is available to all that need it[255]. However WHO/Europe estimates that just 60% of those who need it actually receive the medication.

United Arab Emirate No data was available on HIV/AIDS and ARV It is estimated that there are between 3000-6000 IDUs in the country [98].

Yemen has an estimated 13,000- 27,000 IDUs[98]. Among an estimated 9900 cases of HIV/AIDS there have been no recorded cases of HIV attributable to IDU.

OTP Occupied Territories of Palestine No reliable data on drug use is available. The only treatment is in the psychiatric hospital in Gaza and an OP centre in Khan Younis run by an NGO. Information on HIV/AIDS is not available

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