SCALING UP PROVISION OF ANTI-RETROVIRALS TO INJECTING DRUG USERS AND NON-INJECTING DRUG USERS IN ASIA

World Health Organization “3 x 5” initiative

Report produced by the Asian Harm Reduction Network (AHRN)
for the International Harm Reduction Association (IHRA)
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LIST OF ABBREVIATIONS

AHRN - Asian Harm Reduction Network
ARV - Anti Retroviral Therapy
ATS - Amphetamine Type Stimulants
ADB - Asian Development Bank
CCDAC - Central Committee for Drug Abuse Control (Myanmar)
CCM - Country Co-ordinating Mechanism
CHR - Centre for Harm Reduction, Burnet Institute
DIC - Drop in Centre
DOTS - Direct Observation of Treatment Supervision
DS - Drug Substitution
DU - Drug User/Drug Use
FHI - Family Health International
GFHTM - Global Fund for HIV, Tuberculosis and Malaria
GO - Government Organisations
IDU - Injecting Dug Users/ Injecting Drug Use
IHRA - International Harm Reduction Association
HCV - Hepatitis C Virus
HIV - Human Immune Deficiency Virus
HR - Harm Reduction
MAC - Malaysian AIDS Council
MOH - Ministry of Health
MSF - Medicines sans Frontier
NEX - Needle/Syringe Exchange Programs
NEP - Needle Exchange Program
NCCD - National Committee for Control of Drug (Cambodia)
NAC -National AIDS Committee
NGO - Non-Government Organisation
OI - Opportunistic Infections
ONCB - Office of Narcotics Control Board (Thailand)
PLWA - People Living With AIDS
PLWHA - People Living With HIV/AIDS
PMTCT- Prevention of Mother to Child Transmission
TDN - Thai Drug Users Network
VCT - Voluntary Testing and Counselling
WHO - World Health Organisation

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EXECUTIVE SUMMARY

INTRODUCTION

This report was prepared to support WHO efforts to introduce and scale up anti-retroviral therapy (ARV) according to the "WHO 3x5" initiative which is designed to provide three million people with ARV by the year 2005. The International Harm Reduction Association (IHRA) together with regional harm reduction networks was asked to recommend strategies for scaling up ARV to injecting drug users (IDU) and to identify the potential role of the harm reduction networks.

This report gives a regional and country specific overview of the current situation with regards to the provision of services including ARV to IDU/DU in Asia. It provides an analysis of the political environment that impedes or facilitates the provision of ARV to IDU, and offers some recommendations for scaling up ARV and identifies possible models of care.

METHODOLOGY

To gather the information for this report a survey/questionnaire was designed (see Annex 2) and implemented in 12 countries designated by the terms of reference for this investigation: Bangladesh, Cambodia, China, India, Indonesia, Iran, Laos, Malaysia, Myanmar, Nepal, Pakistan, Thailand and Vietnam. Where possible, country coordinators were identified and chosen on the basis that they had access to the organisations working in the field of drug use and/or HIV prevention, care and support. The country coordinators were asked to distribute the survey and return the completed questionnaires to the project staff at the AHRN within two weeks. The surveys and country specific questions about political environment (see Annex 3) were analysed and findings presented below.

KEY FINDINGS

A) This report finds that just 1-5% of IDU in Asia access any drug prevention or treatment at all. (Including outreach, needle-syringe programs, drug substitution therapy or even information materials or primary health care). It is evident that ensuring access to ARV for IDU in this region will be a difficult task

B) Despite some increases in epidemiological surveillance, the population of IDU/DU is still very much hidden and the extent of the HIV epidemic among DU and their social networks is relatively unknown.

C) Most organisations working with IDU/DU need training materials in local languages concerning most aspects of outreach, primary health care, advocacy, and ARV provision guidelines.

D) Most organisations lack enough funding to adequately provide services to IDU, including ARV. The majority of organisations had not accessed or applied for funding from the GFATM.

E) Most countries in the region lack the required infrastructure to deliver ARV to IDU including laboratory equipment, trained medical providers. There is a large and willing human resource needing capacity building.

F) There are networks of PLWA but under developed networks of DU organisations. PLWA groups are often involved at National Policy Workshops but DU is not.

G) Many countries in the region are beginning to form joint action plans between law enforcement departments and public health organisations to tackle the duel epidemic of drug use and HIV. (UNODC G22 Project, AUSAID Regional Harm Reduction Project)

H) Several small pilot programmes in the region are providing ARV but DU is often excluded.

I) Many organisations have access to detoxification centres and/or those in prison and several organisations offer primary services to this group. This is significant, as providing services to IDU in closed settings is a realistic environment for monitoring ARV therapy.

RECOMMENDATIONS

1) As outreach (especially where it is linked to sterile injecting equipment and peer education) is known to be a highly effective way to reach IDU/DU, the scale-up of outreach needs to be the first step in potentially providing ARV to this group.

2) As drug substitution therapy has been highly effective in reducing incidence of injecting drug use among opiate users and also keeping them in regular contact with health services, these too must be rapidly expanded.

3) PLWA networks have been highly successful in providing services and support to other PLWA. The specific needs of IDU/DU with HIV may be different. Supporting networks of this group is likely to result in the delivery of better services to them, (e.g. SASO in Manipur, India)

4) ARV education and provision, adherence monitoring and provision of other services for HIV positive DU/IDU should then be implemented through the aforementioned processes above.

5) Training tools, information and best practice guidelines surrounding ARV provision and services to IDU/DU that often already exists (e.g. WHO advocacy document for IDU programs), needs to be adapted to local conditions and made available in local languages and disseminated through the various networks without delay.

6) Supporting local organisations through technical support in grant application writing would greatly increase the funding available for ARV and services to IDU/DU.

7) The Regional Networks including AHRN in conjunction with technical assistance organisations like CHR should have on going roles in all aspects of scaling up ARV to IDU/DU including implementation, monitoring and advocacy.

8) See Annex 1 for examples of possible models: including provision of methadone in Northern Thailand, provision of ARV to DU in Manipur, the concept of work force development, provision of services to DU in closed setting.

PROVIDING ARV TO IDU/DU – GENERAL REQUIREMENTS

- Anti-discrimination: There needs to be *universal anti-discrimination* legislation that allows access to treatment for anyone with HIV regardless of how it was contracted. In tandem with necessary changes in the law it will be necessary to conduct advocacy in the community so as to create enabling environments where ARV treatment to IDUs can successfully be implemented.

- Research: There is also a need for *further research* into complex interactions between drugs used by DUs/IDUs and ARV. The only available research on this topic was conducted in developed countries, but little in known on this issue in developing and transitional countries. This research will most likely need to be funded by pharmaceutical companies and they will have to be approached with funding requests. .

- Training / best practice: Later this year, the Open Society Institute (OSI) will be funding a *training* meeting of leading professionals who prescribe ARV in order to discuss and recommend *best practice guidelines* for ARV therapy with illicit drug users. In the South and Southeast Asia regions, a wide variety of drugs are used, and so it will be necessary for ARV providers to have extensive understanding of ARV treatment delivery options. Results of research on this topic will need to be executed and disseminated rapidly.

- Scaling up drug substitution: Providing IDU/DU with ARV presents serious difficulties. In general, there needs to be a *scale up of drug substitution* programmes, in affordable, accessible locations. Drug substitution facilities need to be broad-based and in line with best practice knowledge. Drug substitution therapy needs to take account of local conditions. For example in Myanmar, it may be difficult to provide methadone but the country has a capacity to provide opium tincture as substitution. Continued research into the best, culturally appropriate options for drug substitution must continue. Drug substitution programmes, linked in with peer outreach linked in with HIV care providers would allow greater access to DUs and IDUs and facilitate the provision and monitoring of ARV to this group. It would also increase compliance to ARV and decrease HIV resistance. It would also allow DU to have the drug use stabilized through a variety of treatment options and have their basic primary health care needs met including treatment for HCV (see Annex 5).

- Ancillary services including treatment for OI: Provision of medicines to fight opportunistic infections is essential and must be available to DUs and IDUs. The primary health needs of injectors may vary in some ways from that of other PLWHA as drug -use practices may increase susceptibility of drug users living with HIV/AIDS to opportunistic infections. It is necessary therefore to ensure that DUs and IDUs have adequate access to primary health services.

- The continued involvement of PLWA and DU networks in all levels of policy planning and programme implementation should be an essential ingredient of the resources needed to provide ARV to DU. The information gathering for this report has highlighted the role of networks (AHRN and in-country organisations working with IDU/DU) in gathering and disseminating essential information. Harm reduction networks, DU networks and PLWA groups can work in combination with service providers to help access, disseminate ARV to DU/IDU and ensure adherence.

Thus, the role of the networks is both obvious and mandatory. Networks can provide the following:

A) Support in capacity building of organisations, identifying funding options and assisting with funding applications

B) Organise training in collaboration and with advice from FHI and other technical agencies such as WHO and CHR

C) Disseminating information, best practice guidelines, continued advocacy

D) Increasing the numbers of outreach workers to assist in provision of services including ARV and direct observation of ARV compliance.

BRIEF REGIONAL OVERVIEW ON THE CAPACITY TO DELIVER ARV TO IDU/DU

The questionnaire that we implemented (see Annex 2) was distributed through identified country co-ordinators. Within a period of just two weeks we received some 90 completed questionnaires from organisations in South/South East Asia. An analysis of the surveys was undertaken in order to identify the gaps in the capacity of organisations working with IDU to provide ARV therapy. It must be noted immediately that overall, 100% of organisations expressed the willingness to be involved in the provision of ARV to DUs and IDUs. Below is a summary of the main responses to the questionnaires.

(NOTE: For a full list of respondent organisations from each country please consult the Annex)

Question: Does your organization provide medicines in the treatment of opportunistic infections?

Over 60% of returned surveys indicated that respondents provided medicines for the treatment of OI. Respondents from India, Nepal and Iran indicated that all provided medicines for OI. This does not mean that there are not gaps in provision but it does mean that there are systems in place in many organisations to provide medicines. Respondents from organisations in China, Malaysia and Bangladesh indicated a lack in provision for OI. There was limited response from Laos and no response from Pakistan.

Question: Do your staffs have up to date knowledge on the range of ARV available to treat HIV?

Sixty-six percent of total responses indicated that they did have up to date knowledge of the range of ARV available. This was almost uniform across organisations in China, Iran, Nepal, India, and Vietnam.

Question: Can anyone in your organization prescribe ARV?

66% of respondents indicated that they had no capacity to prescribe ARV. Organisations in Iran did have the capacity and did prescribe. No organisations in Bangladesh, Nepal could prescribe and about 50% in India, Vietnam could prescribe ARVbut the ability to do so is drastically reduced by either lack of availability of medicines, finances for medicines or an enabling environment.

Question: Does your organization have the capacity to monitor drug interactions between ARV and licit/illicit drugs?

About 40% of respondents indicated they could monitor drug interactions. This was interesting because many of the positive responses also indicated there was a lack of laboratory equipment, which means as non-medical practitioners, their sense of clinical assessment, was incredibly high or that as they have little experience they do not appreciate the difficulties. Again big gaps exist in India and Malaysia. These countries did however have more responses and more total organisations that could monitor interactions.

Question: Does your program have access to CD4 counting facilities?

Across the region about 50% of organisations had access to CD4 counting facilities. There is however an acknowledged lack of facilities in most of the countries compared to the need and a general lack of trained laboratory staff to operate equipment. Respondents from Nepal indicated that they had access to CD4 testing but then mentioned that the one machine available in the country, in Kathmandu, is currently dysfunctional.

Question: Does your program have access to viral load testing?
Similar results to the above question with just fewer than 50% of organisations indicating that they can access testing facilities.

Question: Are there organizations involved in a continuum of care?
Sixty percent of respondents across the region indicated that they were either involved with or were an organisation providing a continuum of care.

Question: Is your program linked to other service providers who can provide ARV?
Sixty-six percent or organisations were linked to ARV providers.

Question: Has anyone in your organisation been given formal training in ARV therapy/drug use and treatment/HIV voluntary testing/counselling/Family counselling?
Over 80% of organisations had received formal training in one or more of the following. The same % as required more training in the above. Whilst some organisations have received some training there is a huge need to provide ongoing and up to date trainings in all aspects of service provision.

Question: Could your program deliver ARV to IDU?
Sixty-six percent of respondents could deliver ARV to IDU but would require links to providers, training, equipment, medicines, and funds. Having said this, only about 15% of organisations had applied for funding to GFATM.

COUNTRY SPECIFIC SITUATIONS

Author's note – unless otherwise stated, background is taken from
a) "Revisiting the Hidden Epidemic 2002" Reid and Costigan, CHR, Melbourne
b) UN Reference Group on HIV/AIDS prevention and care among IDU, estimates from 1998-2003
c) A combination of both

BANGLADESH

Background

Estimated number of IDU: 25,000 – 170,000
Acknowledges cases of HIV: 363 cases
Estimated number of cases HIV: 13,000
Estimates prevalence of HIV amongst IDU: 0.2-2.5%
Estimated number of IDU reached through NEX: estimates vary from 5%-50%

Political Environment for Provision of ARV and services for IDU

Currently provision of ARV in Bangladesh is not the real priority for the Government. There is no commitment for ARV in the National AIDS Plan. There is acknowledgement that harm reduction is a best practice intervention amongst IDU for HIV/AIDS prevention and care. There is however no budget for IDU issues in the national budget and in fact HIV prevention/care interventions depend on foreign aid and donations. There is no integrated work plan between public health, law enforcement and civil society with regard the treatment of IDU or PLWA. There has been limited involvement of PLWA in National Government Workshops but no participation of DU. There is currently only one organisation (CARE- Bangladesh) running NEP and they estimate that they cover about 4,000 IDUs through a network of 25 DIC and current and ex IDU Peer Out-reach workers. There are also two self help groups involved in community based drug detoxification.

Recommendations for Scaling up ARV therapy to IDU/DU Bangladesh

As stated, currently there is no ARV provision in Bangladesh. During this assessment contact and discussion was had with different Government/Non Government officials and other organisations and stakeholders involved in service provision to IDU/DU. In summary the suggestions for scaling up ARV to IDU/DU in Bangladesh are as follows:

1) Establishing a team linked in with regional advisors, that can carry out a situation and mapping assessment.
2) Identifying key players in GO/NGO that could provide ARV.
3) Improving capacity through organised and official training.
4) Using existing infrastructure of organisations providing services to IDU (drop in centres) and linking them to people/organisations that have capacity to implement ARV provision.
5) Continued and renewed political advocacy for scaling up access to IDU/DU groups and other marginalised groups.
6) Logistical support for acquiring ARV and monitoring/evaluating the provision of ARV.

CAMBODIA

Background

Estimated Number of IDU: unknown
Acknowledges cases HIV: unknown
Estimated cases HIV: 170,000 people
Estimated prevalence of HIV among IDU: unknown
Estimated number of IDU accessing NEP: unknown

Political environment for scaling up ARV and services to IDU

In theory there is Government support for ARV access in Cambodia. It was hoped that 3,000 people would be receiving ARV by the year 2003 but this does not seem to be happening. Attaining this objective is dependent on purchasing affordable ARV, and to this end an apparent agreement that exists with China to produce local generic ARV, is being explored. Currently there is no legal right to ARV as in theory they are not available in the country. However, there are some pilot programs operating in Cambodia. (300 people are accessing ARV through the Preah Norodom Sihanouk Hospital funded by MSF and the French group ESTHER is also providing some ARV in a pilot programme. Strategy 5 of the National AIDS Plan makes several references to access to ARV, providing accessible services to PLWA and ensuring community involvement in the design and implementation of services and treatment for people living with HIV.

There is insufficient information about injecting drug use in Cambodia. January 2004 saw several meetings take place between the National AIDS Committee and the National Committee for Combating Drugs (NCCD), and they have agreed to undertake 3 pilots NEP in Phnom Penh to be run by Mith Samlanh - Friends. These pilot projects have been preceded by t rapid assessments of drug use including IDU. The feedback from this process is due now and is expected to result in support for scaling up access and services to IDU/DU, from the NCCD. It is hoped that ongoing partnerships between NCCD/NAC will result from the current collaborative efforts.

Recommendations for scaling up ARV to IDU in Cambodia

Recent commitment by the Government to ensure access to ARV for DUs / IDUs has created a good environment for scaling up ARV. It is hoped that when the research from the pilot programmes is released and the programmes are expanded that the availability and access to ARV will also be expanded. It would make sense that the current pilot providers of ARV be expanded and supported by Government and WHO collaborations. Other recommendations would include technical capacity building of local providers to monitor complex drug interactions, the establishment of monitoring and evaluation of ARV provision, and the scale up of laboratory equipment to allow the diagnosis and monitoring of DU living with HIV.

CHINA

Background

Estimated numbers of IDU: 400,000 – 3.5 million
Acknowledged cases of HIV: 27,000
Estimated cases of HIV: one million
Estimated prevalence of HIV among IDU: upwards of 70%
Estimated numbers of IDU accessing NEP: unknown, likely to be incredibly small.

Political Environment for provision of ARV and services to IDU

ARV provision is a real priority for the Government and Local Governments of China due to the high prevalence of HIV, increasing numbers of AIDS cases especially in rural areas where services are not accessible or affordable. Unfortunately most IDU/HIV positive people are excluded from medical care services due to stigma and discrimination. Whilst IDU/HIV is recognised in the National AIDS plan, there is no specific funding for service provision outside of detoxification centres. There is no integrated work plan between public health, law enforcement and civil society with regard treatment of IDU or PLWA. Only at basic grass root organisation level is there involvement of IDU/PLWA groups in development of working plans.

Recommendations for scaling up ARV for IDU/DU in China

Whilst ARV are available in China, all of the organisations surveyed agreed that the high cost makes provision unaffordable for the majority of the target group. The responses suggest that the professional training is very inadequate at both national and provincial level and there is clearly a need to build the capacity of programmes to be involved in the provision of ARV. Whilst some organisations could provide ARV, only one surveyed actually does, whilst two are involved in planning to provide ARV to IDU. The major limitations with providing ARV to IDU is the fact that the links between IDUs, communities, peer support and harm reduction projects is at best extremely minimal. The priority needs for China to enable it to provide ARV to IDU are:

1) Providing low cost ARV and professional training to practitioners.
2) Continued advocacy at national and provincial Government levels.
3) Establishing links between ARV providers and organisations working with IDU.
4) Training staff at all levels is the major need for the organisations surveyed.

Moreover there needs to be a comprehensive scale up and improved access to HR/Methadone programmes and to social/peer support – without this the small ARV programmes set up in China will not have the capacity to deliver ARV to specific groups. Medical staffs are often inadequately trained and not willing to treat IDU. IDUs state that their main need is drug substitution treatment. Their knowledge and understanding of ARV treatment is almost non existent.

INDIA

Background

Estimated Number of IDU: 100,000 in five cities alone, Kolkota, Imphal, Delhi, Mumbai and Chennai (Revisiting Hidden Epidemic, 2002)
Acknowledged cases of HIV: unknown
Estimated cases HIV: 4.55-4.58 million
Estimated prevalence of HIV among IDU: 44% Delhi, 88% Manipur
Estimated number of IDU accessing NEP: 21 responding organisations believe they contact about 60,000 IDU. Limited data makes true estimates hard to obtain.

Political Environment for provision of ART and services to IDU

Currently there is extremely low access to ARV throughout the country. The Government of India announced that ARV would be provided to certain groups from Government hospitals targeting women and children, with particular attention to PMTCT. The National AIDS plan (1999-2004) is focussed on providing low cost care with no provision of ARV. There is some government support to IDU service provision, approximately 1.5% of the total health budget; but it is unclear to what this support extends to. It is also unclear whether there is an integrated work

plan between law enforcement, public health and civil society with regards IDU issues although several harm reduction projects operate with the tacit knowledge of law enforcement organisations. PLWA groups are currently involved with at National Government AIDS policy workshops but IDU are not. There are well-developed links between organisations working with IDU as highlighted by this survey which managed to get responses from 21 organisations through one technical co-ordinator in two weeks.

Recommendations for ARV scale up to IDU in India

It is known that seven sites/cities have access to ARV – at cost, the patient still has to pay for the service. Several NGOs are directly involved in provision of ARV but it is unclear whether IDUs have access to ARV except in Manipur State and Delhi where PLWA individuals and/or DU networks are directly responsible for accessing ARV through consultation with local, private medical practitioners.

Currently there are 400 targeted intervention projects for IDUs providing NSEP/outreach in the country, funded by the National AIDS Control Organisation, but coverage is unknown. There are 72 Government funded de-addiction centres, 139 counselling centres, and 342 de-addiction/rehabilitation centres. Drug substitution by buprenorphine is available only in Delhi (SHARAN) covering about 50 IDU. The total number of DU accessed in India according to this survey was 113,000.

As can be seen there is an extensive network of centres through which NGO and GO reach DU, these have the potential to provide ARV to DU if other barriers are removed. The barriers include -

1) Very high prevalence of Hepatitis C among IDU, upward of 95%, unless IDU are treated for Hepatitis. C they are likely to be sidelined from ARV treatment.
2) There is a lack of trained professional providers of ARV countrywide.
3) Lack of universal precautionary measures in health care settings is the main reason for doctors to deny treatment to patients with HIV/AIDS.
4) A serious lack of diagnostic equipment including CD4 counts, viral load count facilities and also facilities for drug adherence testing.
5) There are almost no drug substitution/services to IDU that would facilitate better access to IDU.

The capacity building needs to scale up ARV to IDU in India include –

A) a workforce development, particularly private and government ART medical providers and laboratory technicians
B) There is an immediate need to introduce more teaching and information on HIV/AIDS and ARV provision into academic curriculum for health and social care professionals
C) The current model in Manipur whereby grassroots NGOs/PLWA groups facilitate the links between service providers and IDUs may be a good model to expand given the shortage of drug substitution, access and money for a true scale up of services to drug users.
D) The expansion of support groups, networks services and treatment facilities. The defining of roles of health authorities, NGOs, medical practitioners and PLWHA.

INDONESIA

Background

Estimated numbers of IDU: 200,000 – 1,000,000
Acknowledged cases of HIV: 2000 (September 2002, Government Surveillance)
Estimated cases of HIV: 90,000-130,000
Estimated prevalence of HIV among IDU: 15%-56%
Estimated number of IDU accessed by NEX: From the two providers in 2001 it was estimated that potentially just greater than 900 people accessed NEP.

Political Environment for Provision of ARV and services to IDU in Indonesia

The Ministry of Health in Indonesia states that ARV provision to PLWA is an absolute priority. The Indonesian parliament however says that the priority is not that high considering other problems in the country including famine, unemployment, ethnic wars, local terrorism and religious radicalism. There is a commitment in the National AIDS plan for ARV provision but it does not follow that funding is available. . There is limited support for projects working with IDU but more support for general DU projects. There is no integrated work plan between public health, law enforcement and civil society with regards treatment of IDU/PLWA although recently a highly ranked Indonesian police official expressed interest with regard to methadone provision in prisons. Strong advocacy work continues with government and law enforcement, particularly in Bali with regards harm reduction.

Recommendations for scaling up ARV and IDU services in Indonesia

Indonesia's National AIDS plan 2003-2007 claims that it will scale up harm reduction in the country through support (although not funds) of NGOs working in NEX and drug substitution. The recent "Country Preparedness Study" suggests that currently about 500 people receive ARV. In order for this to be scaled up it will be necessary to lower the cost of ARV though local generic manufacturee The capacity of organisations to undertake CD4/viral load testing is weak, even in good hospitals. This would need addressing as many people do not know of or access VCT. These general recommendations for ARV scale up also apply to ARV treatment for IDUs. These include encouraging the NGO sector into providing care and support, developing country specific ARV guidelines and urgently enhancing the capacity of physicians to prescribe ARV, paying particular attention to the special problems of dealing with IDUs. .

IRAN

Background

Estimated numbers of IDU: 200,000-300,000
Acknowledged cases of HIV: 7,000
Estimated cases of HIV: 40,000
Estimated prevalence of HIV among IDU: 0.5%-13%
Estimated numbers of IDU accessing NEP: In Kermanshah alone 25,000 are estimated to access NEP

Political environment for provision of ARV and IDU services in Iran

Currently in Iran, 100% of all people who need ARV are able to receive ARV free of charge. There is a national commitment to tackle HIV/AIDS however much still needs to be done in terms of advocacy, education and sensitisation to establish harm reduction for IDUs. At present there are a number of organisations working with IDU both inside and outside of prison settings that operate with the support of the government. Some of these projects have been judged to be very successful and are being scaled up after initial pilot periods. Drug use in Iran is still a

criminal act and as such many projects remain tacitly supported in a pilot stage. The national Government budget for IDU is basically zero. Most organisations operate with the support of donors. There is limited integration of law enforcement, public health and civil society in IDU issues and limited involvement of PLWA in national policy initiatives. There is however significant programmes working with IDUs in prison and Iran ranks high in 'best practice' with regards this.

Recommendations for scaling up ARV to IDU in Iran

It is currently estimated that up to 90% of the 7,000 HIV positive people in prison are being provided HIV care, but of those not in prison, it is estimated that just 5% of the 40,000 HIV+ are being provided treatment. As the majority of those infected are IDUs this shortfall in treatment provision (even thought it is theoretically available to all) is mainly due to the illicit nature of drug use and the discrimination/stigmatisation of HIV positive people. ARV is provided through GO and NGO outlets – it is thought however that IDUs are likely to feel more comfortable accessing treatment through NGOs. In an ideal scenario -

A) a complete and total assessment of the extent of IDU/HIV would be carried out
B) Followed by training of ARV providers.
C) Access to IDU would probably need to follow a peer driven/snowballing model.
D) Concurrently the need for continued advocacy at government/community level remains high.
E) Increasing the involvement and capacity of PLWA and DU networks to be involved in monitoring of ARV provision.
F) Technical capacity building across all groups would be highly desirable.

LAOS

Background

Estimated Number of IDU: 5000-11,000 injecting drug users
Acknowledged cases of HIV: 603 cumulative HIV cases to 2000
Estimated cases of HIV: UNAIDS estimates however, that there are at least 1,400 cases (2001)
Estimated prevalence of HIV among IDU: 2.5%
Estimated numbers of IDU accessing NEP: 0

Political environment for providing ARV and services to IDU in Laos

Currently ARV provision is not a priority for the Government of Laos. There is just one hospital in Savannakhet that provides ARV under a pilot care and support project sponsored by MSF. It is the only such place in the country and it is not known whether this project will continue after the pilot finishes. There is a plan to expand ARV treatment to one hospital in Vientiane (whose plan?). There is a statement in the National AIDS strategic plan about care and support and a commitment to examine affordable treatment options including issues of procurement of anti-retroviral medicines through potential partnerships with other countries. There has been some progress in creating partnerships between the Lao Committee for Drug Control and the National Committee for AIDS. It is hoped that Government departments will come together over the issue of drug use and HIV. The Lao Government is concerned about the high rates of ATS use but the links between ATS (which is mainly smoked) and HIV are not fully proven in Laos or the rest of the Mekong countries. Research under way in Northern Thailand is looking at risk behaviour associated with ATS use and it is suspected that increased HIV transmission through unprotected sex is related to ATS use.

Recommendations for scaling up ARV in Laos

Currently little is known about IDU in Laos, for that matter, little is known about the extent of HIV prevalence. Laos is undergoing major infrastructure development through the ADB funded, East-West and North-South Highway construction. There is a great deal of mobility associated with this construction with migrant workers from Yunnan and Vietnam joining workers from Laos and Thailand. It is believed that HIV risk behaviours, either through drug use or sex is highly prevalent amongst the migrant workers. The potential for a rapidly expanding HIV epidemic is real. The opportunity to intervene remains open for a very limited time. As Laos prepares to increasingly open its borders and be more accessible to the region, so too one can expect that drug using pattern, including an increase in injection behaviours will spread across the Mekong.

Assuming the best case scenario that funding, either Government or International, exists for providing ARV in Laos, then –

A) The health system would need to be prepared to deliver ARV.
B) Health professionals would need to be trained and supplied with all necessary facilities including laboratories.
C) There would need to be clinical guidelines for provision of ARV and strict monitoring to access those most in need.

MALAYSIA

Background

Estimated numbers of IDU: 200,000 – 400,000
Acknowledged Cases of HIV: 56,000 (Consensus on HIV Epidemiology in Malaysia, 2003)
Estimated Prevalence of HIV among IDU: upwards of 76%
Estimated number of IDU accessing NEP: 1 NEP in 2001 but no figures on numbers accessed, likely to be extremely small if any

Political Environment for provision of ARV and services to IDU in Malaysia

The government is currently assisting in reducing the cost of ARV by providing one drug from HAART free of charge. The price of ARV has also decreased as Malaysia is purchasing generic drugs that are less expensive. ARV is provided free to government employees and the Malaysian AIDS Foundation (MAC) is currently providing ARV to 100 PLWA and to some children affected by HIV/AIDS. Apart from importing generic ARV, there is no commitment to ARV in the National AIDS Plan. Currently the Ministry of Health and MAC are co-operating in designing a new working proposal to be presented to the national government. A working group on HR has been established to examine the high relapse rate following detoxification, which are approximately at 90%. The cost of treatment in Malaysia's 29 rehabilitation centres is 44 million Rupees a year (11.5 million US dollars).
There is an integrated work plan between public health and civil society with regards PLWA but not IDU. There is involvement of PLWA at National Policy workshops.

Recommendations for scaling up ARV to IDU in Malaysia

Currently no ARV is provided to IDU/DU unless they are registered with HIV clinics. The development of IDU friendly drop in centres would be good models for provision of DOTS ARV for street IDU. More stable IDU may be able to access ARV through registered HIV clinics. Those IDU currently in rehabilitation clinics would be the ideal group to begin ARV provision as they can be monitored and their drug use stabilised. Currently, an enormous advocacy effort at Government level is required to improve the political will and improve access to ARV for DU.

Last year, the new Prime Minister Datuk Seri Abdullah Badawai directed law enforcement authorities and the Attorney General to explore successful models of law enforcement approaches to issues of drug use in other countries and to develop a new strategy for Malaysia.

The role of HR networks is to –
A) continue to advocate for reform,
B) unify treatment protocols,
C) Provide education and training by facilitating and making connections with technical expertise in and outside of Malaysia.

MYANMAR

Background

Estimated number of IDU: estimates vary between 140,000 – 300,000
Acknowledged cases HIV: 45,968 detected
Estimated number of HIV cases: 180,000 – 420,000 (UNAIDS)
Estimated prevalence of HIV among IDU: varies from 40% - 90%
Estimated number of IDU accessing NEP: no data available

Political Environment for Provision of ARV and services to IDU

It is not clear in the existing policy document whether ARV is a priority for the Government of Myanmar, yet the Global Fund has agreed to provide financial assistance for the implementation of ARV treatment in Myanmar. The National AIDS Plan aims to reach 1% of the infected people per township, with a target of 40 townships, for ARV. It is stated that in five years time, 200 institutions will be providing ARV. There is currently a three-year joint program (2003-05) to fight HIV/AIDS, which is recognised, as one of the three priority health problems in the country. The joint programme has five components and components 2 and 5 focus on IDU and their sexual partners. (UNAIDS Joint Programme documents) The approximate national budget for HIV/STD programs is Kyats 22.5 million (3.4 million US dollars), a further 5 million kyats (80,000 US dollars) is set up for purchasing HIV test kits and laboratory equipment. Foreign aid budgets, mainly from UN agencies, totalled 1.3 million US in the 2000-2001 year for HIV/AIDS. The next four years sees a potential allocation of 295.75 million kyats (45 million US dollars from the Government and international donors. This will be targeted into-

1) Health education and awareness raising
2) Target group interventions with high risk groups including IDU, youth, migrant workers and women at risk
3) Training programmes for health personnel and community volunteers
4) Increasing manpower development for AIDS/STD control activities.

In terms of an integrated work plan between public health, law enforcement and civil society; a mechanism has been established whereby INGOs, National NGOs together with the Central Committee for Drug Abuse Control (CCDAC) under GFHTM, will set up primary health care services for IDUs, linked in with existing drug treatment services. Involvement of PLWHA and civil society in policy, planning and implementation has been encouraged through the Country Co-ordination Mechanism (CCM) established for GFATM. PLWHA have also been included in consultations with MOH and other ministries, UN agencies, INGO, NNGO, Faith based organisations, and the private sector). IDUs are not however involved in the aforementioned mainly due to legal barriers, stigma and because they are a hidden population. Targeting IDU through joint programme activities may help include IDUs in programme specific planning and implementation.

Recommendations for scaling up ARV to IDU in Myanmar

Currently ARV is being provided through only one outlet in the public sector, Waibaigi Hospital. This is a pilot programme run by MSF. About 100 people are receiving ARV from this programme. It is not documented whether these patients have a history of IDU. Mandalay has two doctors trained to provide ARV but the service has not begun yet. There are no other doctors in the public sector that have the capacity to provide ARV – this would seem a logical place to improve capacity by providing training to physicians. Access to ARV is available from the private sector but is unregulated. Very rough estimates indicate that about 5000 people are prescribed ARV through this mechanism. ARV is only available to those that can afford it.

Substitution treatment and maintenance, not just detoxification would have to be included as an integral part of ARV scale up. Currently only short - term detoxification programmes are available, mostly consisting of detoxification with opium tincture in drug treatment centres. There are no developed outpatient treatment centres. The legal framework of mandatory registration as a drug addict would need to be reformed as at present IDUs generally prefer to stay hidden rather than be registered. The MOH needs to take a more active role in IDU issues of treatment. Current international economic sanctions are creating more poverty and hardship in Myanmar. Until the country reforms this will remains the most important impediment to Myanmar's economic development without which the future of IDU/HIV treatment looks very bleak indeed.

The CCDAC has accepted the HR principles and there exists funding and programmes to develop outreach, DIC, NSEP. There is a need to monitor the implementation of these programmes and to ensure they are ongoing. Continued advocacy and training is needed at a Government and local government level, as technical capacity remains low. Reaching out to the IDU community through a humane approach to treatment/maintenance would provide access and increase the chance of providing ARV.

NEPAL

Background

Estimated numbers of IDU: 60,000 people (FHI, 2002)
Acknowledged cases of HIV: 2494 (February, 2004)
Estimated prevalence of HIV among IDU: 5% - 80% in some areas.
Estimated number of IDU accessing NEP: Currently not known, 2001 around 800 people, this would have reached upwards of 6,000 people through the inception of the country wide harm reduction project, it would now have dropped back to 400-800 as the country-wide HR project collapsed.

Political environment for provision of ARV and services to IDU in Nepal

Although the problem of HIV is increasing and the PLWA becoming more visible each day the Government has not put any real priority on securing ARV for PLWA. The stated reason is that there are many other priorities. The commitment of the Government to IDU issues in the National AIDS plan is questionable considering the need for enormous funding, efforts and advocacy. Several HR scale projects have come and gone in recent years. There is no budget for IDU issues in National AIDS plan. There is no integrated work plan between law enforcement, public health and civil society with regards IDU/PLWA. There is a small involvement of IDU/PLWA in non-government organisations.

It is not be currently possible to provide universal access to ARV in Nepal as the infrastructure; surveillance mechanisms and professional capacity are not there. There exists only one CD4 count machine in the country and at the moment it is out of order. To begin scale up of ARV Nepal would certainly require at least functional pathology equipment.

Recommendations for Scaling up ARV and IDU services in Nepal

Currently there are only three trained doctors in the country who can prescribe ARV to IDUs and people have to purchase their own drugs. This service is only available in Kathmandu. The government has applied to the GFHTM to start provision of ARV to HIV positive people. It is not clear how this will be done. National guidelines for the provision of ARV need to be established. In addition access to VCT in Nepal is very limited and this would also need increasing. IDUs in Nepal say that they are much more comfortable dealing with the NGO sector. A suggested model for ARV scale up would be a GO/NGO partnership whereby the Government/International Community provides resources/pathology equipment and capacity training whilst NGO sector provide VCT, monitoring and dispensing of ARV. Cost and access to ARV remains a major problem.

The involvement of HR providers, DU/PLWA networks, is needed in order to increase advocacy and awareness at Government level to respond to HIV/AIDS epidemic. There need to be recommendation to the Government to place emphasis on care and support of PLWA, reducing stigma and misconceptions. The specific needs of vulnerable groups have not been addressed in part due to the absence of these groups at the policy table. Services for IDU are inadequate in terms of coverage and quality. The networks and the various world bodies likeWHO/UNAIDS must continue to engage the government highlighting its enormous responsibilities to its people as well as providing as much technical support as possible, as the HIV epidemic continues to spiral out of control in Nepal.

PAKISTAN

Background

Estimated numbers of IDU: 180,000 (conservative)
Acknowledged cases of HIV: 1700 reported to National AIDS Committee, 2002
Estimated cases HIV: 80,000 (conservative)
Estimated prevalence of HIV among IDU: 4% HIV cases attributed to drug use, prevalence unknown
Estimated number of people accessing NEX:

Political environment and recommendations

There was no information received for this report although attempts to gather information were made. It is known that IDU is increasing in Pakistan, especially in borderous areas close to Afghanistan. Surveillance and monitoring is very low to non-existent and ARV is not part of government policy at the moment. It would seem logical to be recommending an increase in capacity to monitor IDU/HIV and increase provision of services to this group.

THAILAND

Background Numbers

Estimated Number of IDU: 20,000-100,000
Acknowledged cases of HIV: 695,000 (UNAIDS Joint Plan of Action on HIV/AIDS in Thailand, 2002-2006)
Estimated cases of HIV: 750,000 (USAID Congressional Budget Justification for Thailand, 2004)
Estimated prevalence of HIV among IDU: 50%
Estimated number of IDU accessing NEX: 0

Political Environment for providing ARV and services for IDU

In Thailand providing ARV for all those who need it by 2005 is a government priority. This is indicated by the access to funds from the GFHTM for this expressed purpose. It is also indicated in the National AIDS Plan. There is not however any commitment to harm reduction projects IDU except for the recent formation of the harm reduction taskforce. This is a working group between the Thai Drug Users Network (TDN), Ministry of Public Health (MOPH) and the Narcotics Control Board (ONCB). Recently the TDN accessed funds from the GFHTM to set up five-harm reduction sites in the country. The funding is not conditional on the signing off of an agreement between ONCB, MOPH and TDN that demonstrates a workable relationship between the organisations, but it would certainly aid in the formalising of the project. It is not clear at this stage how far this has been achieved. It is hoped that continued advocacy and support for TDN and HR approaches would facilitate the scale up of services for drug substitution and HR. The majority of IDUs in Thailand are hard to access and those not in forced treatment or prison are believed to still engage in unsafe injecting practices.

Recommendations for ARV scale up to IDU in Thailand

There is an urgent need for the HR working group to sign off on an agreement that will allow the fully funded establishment of the five pilot harm reduction sites. This will provide treatment and care interventions to IDU and potentially create an opportunity to link to ARV therapy. Continued tacit support exists for out reach methadone in the North of the country. This project could be expanded and could potentially be used as a regional model for delivery of methadone and ARV where needed to marginalised groups. This out reach project has been shown to dramatically reduce the rate of injecting drug use (Personal communication with Mae Chan Methadone distribution, July 2003) and to provide the access necessary for HIV awareness/VCT. It is essential that in order to scale up ARV there be involvement of the well established networks of PLWA and the newly established TDN. It is also hoped that local generic manufacture of ARV and the Government/International Donor money will allow Thailand to reach its goal of providing ARV to over 50,000 people. This can only be achieved if there is no social exclusion criteria such as currently exist, particularly in respect of marginalised groups like IDUs. Thailand has been deservedly praised for its containment of the HIV epidemic through the 100% Condom campaign but risks undoing this excellent work by ignoring a rising epidemic among drug users.

VIETNAM

Background

Estimated numbers of IDU: 70,000-100,000
Acknowledged cases of HIV: 78,000 (Peoples' Daily, March 2004)
Estimated cases of HIV: 160,000 (Vietnam Ministry of Health, end of 2002)
Estimated prevalence of HIV among IDU: 60-90%

Estimated numbers of people accessing NEX: unknown but considered small. People can access needles from pharmacies country wide at very low cost

Political Environment for providing services and ARV to IDU/DU

ARV is a real priority for the Government of Vietnam as indicated by the National AIDS Strategy 2001-2005 (term 3.4) and in the provisional strategy for 2005-2010. There is currently small scale NEP operating in Vietnam. The AusAID regional project and UNODC G22 project is helping to make links between law enforcement and public health. It is hoped that as the prevalence of HIV is extremely high among IDU that current pilot projects will be scaled up nationally. The Far Eastern Economic Review, January 2004, stated that currently the Government provides ARV therapy to 50 people at a cost of 2,400 US dollars per person. It also states that no more than several hundred people countrywide access ARV. The Prime Minister of Viet Nam has just signed off on the National AIDS policy which states that HR is an official government policy. The MOH has just applied to the GFHTM for assistance in implementing ARV scale up and an expansion to all provinces by 2009 of HR activities.

Recommendations

The ongoing legislation (05/06) from the Ministry of Social Evils, which has expanded nationally to place drug users in camps, is likely to remain. The WHO ARV scale up recommendations has stated that IDU in these camps that need ARV should have access to it. It will be necessary to ensure that anyone who accesses ARV in the camps also has access once they leave the camps. For example, 28,000 DU are set to leave the camps in HCM city alone in the next five years. An enormous amount of community capacity building will need to occur to ensure access to ARV outside of a camp setting, from procurement to access to the involvement of social networks in administration and awareness of ARV and implications for its use.

ANNEX 1: POSSIBLE MODELS FOR DELIVERY OF ARV TO IDU/DU IN ASIA

Mae Chan Methadone Outreach Program, Northern Thailand

The FHI funded methadone-dispensing programme has been running for several years. It provides methadone to mainly ethnic minority groups in villages around Mae Chan, Northern Thailand. The project operates with a four-wheel drive and accesses about 12 villages. The villagers' intake of methadone is directly observed and scaled up or down according to the needs. In a personal communication with the program manager, she stated that the reduction in heroin injection is almost total among the villages accessed by the programme. Average per yearly income of families accessed by the programme has jumped from 5000 Baht (125 US dollars) to 35,000 Baht (875 US dollars a year) due to increased productivity of those on methadone as opposed to heroin. This programme is set to be expanded to other villages in the area and potentially could be used as a model for drug substitution and outreach in the region, ultimately it creates the infrastructure to deliver ARV as well.

SASO, Manipur, Northeast India

Manipur is home to a very large IDU community and is often cited as an example where IDU caused a rapidly expanding epidemic of HIV among IDU and subsequently their sexual partners. It is also the location of well-established programmes providing services to IDU/DU. The majority of services are built around the outreach model. Peer educators accessing DU social networks and providing primary health care, information about HIV and sterile needles. The programmes are often linked in with DIC and medical providers, including those providing ARV. Responsibility of accessing and observing DU/IDU has been given to the programmes' outreach workers and PLWA networks. There is an enabling political environment in Manipur, a multi-sectorial understanding between law enforcement, public health and civil society networks. All of this operates effectively despite the political instability among multiple factional groups in state of Manipur, particularly the capital of Imphal.

SASO started providing basic health services to IDUs, PLHAs and spouses/children of IDUs in 1995. It operates an OPD clinic that also provides referrals, and a home-based care unit. Currently, 153 clients receive ARV, where 118 is via home-based care. Of the total number, 25 are females and three are children. Majority of the PLWHAs are former IDUs (125) and treatment induction is recommended when they develop OIs and when their CD4 count drops below 200 (or below 300 for some cases). However, prior to therapy, doctors consider cost implications and others impacts on the person. The common regimens are Stavudine, Lamivudine and Nevirapine that cost from US$ 26 to US$ 29. Other drugs like Efavirez, Nelfinavir, Zidovudine and Didanosine are also available and prescribed. Ideally, at 3 and 6 months after treatment induction, a haemoglobin and CD4 or lymphocyte count is conducted, respectively; a liver function test (LFT) is done only on doctor's advise. Meanwhile, regular follow-ups continue at the OPD. Serious conditions are referred to hospitals.

The two doctors at SASO who prescribe ARV were trained at the YRG Centre for AIDS Research and Education (a division of Y.R. Gaitonde Medical and Research Foundation) Voluntary Health Services in Chennai. Outside of SASO, government doctors also prescribe ARV. Some of the issues that arise for drug users under ARV therapy include combination with TB medications, with buprenorphine (however, the buprenorphine project is now closed), or with Hep C medication.

Contacting SASO: L. Birendrajit Sigh (sasoimph@sancharnet.in), RIMS Road South, Imphal 795001, India. Phone +91 385 411408

Work Force Development

The Centre for Harm Reduction in collaboration with FHI has produced a concept paper for the scale up of a work force to provide services for DU in Asia. The main point of the paper is to start regional training centres in Asia and provide technical training in all aspects of working with DU in Asia. It also calls for the introduction of DU/HIV issues into all medical students' curriculum across Asia. Recently, collaboration between Johns Hopkins University, Chiang Mai University and Centre for Harm Reduction has been funded for the next five years by the Fogarty Grant, to begin training in issues relating to DU/HIV in Asia. A copy of the concept paper can be attained by contacting the Centre for Harm Reduction, Melbourne.

Closed Settings (refers to the range of custodial institutions including compulsory drug treatment and rehabilitation centres, prisons, lock-us and remand centres)

The large numbers of people in prisons in Asia is already causing concern considering the large number of acknowledged IDU and the high prevalence of HIV/HCV. Several countries in Europe have been examining this problem for a number of years now and several pilot programmes are operating drug substitution therapy and needle exchange. The basic premise is that closed settings are exact mirrors of settings outside of it. This means that access to health services inside a prison, for example, is as much a priority (as outside of it). In terms of scaling-up ARV provision to HIV positive drug users, the 'closed' environment provides Asia with an opportunity to begin large-scale pilots, and this is already being done on a large-scale in Iran. Further to this:

a) drug users within closed settings are monitored and are in a set routine which allows DOTS of ARV;

b) their drug use could be stabilised with the provision of DS;

c) training of medical providers and provision of ARV would allow direct observation and adherence to ARV medicine; and

d) it would be essential to link these people with networks when they leave prison so they can access the same level of treatment outside closed settings.

ANNEX 2– SURVEY DISTRIBUTED TO COUNTRY COORDINATORS FROM AHRN AND DISEMINTATED TO ORGANISATIONS

The Asian Harm Reduction Network (AHRN)
P.O. Box 18, Chiangmai University Post Office
Muang, Chiang Mai, Thailand 50202
Phone: 66-53-893175 Fax: 66-53-893176
Email: ahrn@loxinfo.co.th Website: http://www.ahrn.net

Scaling-up Anti-Retroviral Treatment for Injecting Drug Users (as part of the WHO 3x5 initiative)

Dear Colleagues,

Globally it is estimated that there are 12.6 million IDUs with major epidemics of HIV infection. In many settings and particularly in developing and transitional countries (where HIV prevalence among IDUs may reach 50-60%) current evidence indicates obstacles to provide HIV treatment and care to IDUs.

We would like to request you to complete this survey questionnaire in line with the mapping and assessment by the Asian Harm Reduction Network (AHRN), together with the International Harm Reduction Association (IHRA). Our intention is to facilitate the development of effective regional, national and local strategies, and mobilize in-country organizations to bring ART to injecting drug users under the WHO initiative to provide ART to three million people living with HIV/AIDS by 2005, with special emphasis on capacity building.

Please return completed forms to: FAX _____ / EMAIL _____

If you have questions, please contact your local Country Coordinator: (NAME) _____ at EMAIL: / TEL

Thank you in advance for your cooperation and we hope to support you better with this assessment.

AHRN Secretariat

NOTE: Please tick (√) the boxes corresponding to your answer.

SECTION # 1: CONTACT INFORMATION

Country: _____State/Province/City/Town/Region:_____

Name of Organization (if applicable): _____

Name of Organization in English: _____

Postal address: _____
(A copy of the cumulated data and analysis will be sent to you)
Phone number: _____ Fax Number: _____

E-mail address: _____ Website Address: _____

Main contact person's name: _____

Title: _____

When was the organization registered? _____

Type of organization:

N.G.O:
☐Trust
☐Society

Govt:
☐Central
☐State

☐Corporation

Other (please specify): _____

Level of work:

☐Village ☐District ☐State ☐National ☐International

Level of paid staff/volunteers:

☐Professional ☐Semi-skilled ☐Socially supported staff

☐Unpaid volunteers ☐ Others _____

Are you a part of any NGO network or e-mail network, please list them

_____

_____

Name of Person Completing Survey: _____

Position of Person Completing Survey: _____

SECTION # 2: YOUR ORGANIZATION'S CLIENTS (Target population)

2.1 Please tell us which of the following describe the people who use your organization's services (tick one or many):

Target group	Age range	% of clients	Remarks
☐ Women			
☐ Men			
☐ People of particular ethnicity/language group			
☐ Sex workers			
☐ Prisoners			
☐ MSM			
☐ Migrant workers			
☐ Eunuchs/transgender			
☐ Street children			
☐ Drug user			

☐ Other (please specify) _____

2.2 What is your clients' first drug of choice?

Types of drugs	Local names	Why popular	Estimated number of users
Amphetamine	Yaba, shabu, speed etc.		
Heroin	Brown/white		
Opium			
Cannabis	Ganja, marijuana, hashish		
Cocaine			
Pharmaceuticals o Benzodiazepines			
o Codeine based cough syrups			
o Morphine			
o Buprenorphine			
Others			

SECTION # 3: YOUR ORGANISATION'S ACTIVITIES

3.1 What is the geographical/demographical area covered by your organization (the name and short description of area and population)?

_____

_____

3.2 What is the estimated size of your organization's potential target population?

☐ 0 – 50	☐ 500 – 1,000	☐ 3,000 – 4,000
☐ 50 – 100	☐ 1,000 – 2,000	☐ 4,000 – 5,000
☐ 100 – 500	☐ 2,000 – 3,000	☐ above 5,000

3.3 What is the estimated number of the target population who receive your service?

☐ 0 – 50	☐ 500 – 1,000	☐ 3,000 – 4,000
☐ 50 – 100	☐ 1,000 – 2,000	☐ 4,000 – 5,000
☐ 100 – 500	☐ 2,000 – 3,000	☐ above 5,000

3.4 What are these estimates based on?

☐Polls ☐Surveys/questionnaires/intake ☐Official records/estimation ☐Empirical estimates
☐Others

3.5 Does your program provide advocacy/support services?

If ☐Yes, then	If ☐No, then
Which level ☐Individual level ☐Micro level ☐Systematic level	Does another organization/individual provide advocacy and support services for your client population? ☐Yes ☐No
For whom ☐Law enforcement agencies ☐Medical & health agencies ☐Community at large Risk population (tick applicable) ☐sex workers ☐prisoners ☐street children ☐Others	

3.6 What services does your organization provide?

☐Primary health care including wound dressing, general health, sexual health
☐Support service (i.e. daycare, night shelter, vocational training, etc.)
☐Counseling awareness & education
☐Drug treatment facility
☐Substitution therapy
☐Needle syringe exchange
☐Treatment of opportunistic infection
☐ARV provision
☐Other, list them _____

3.7 What is the estimated numbers of IDU?

1) Serviced by your program

☐ 0 – 50	☐ 500 – 1,000	☐ 3,000 – 4,000
☐ 50 – 100	☐ 1,000 – 2,000	☐ 4,000 – 5,000
☐ 100 – 500	☐ 2,000 – 3,000	☐ above 5,000

2) Serviced by other programs

☐ 0 – 50	☐ 500 – 1,000	☐ 3,000 – 4,000
☐ 50 – 100	☐ 1,000 – 2,000	☐ 4,000 – 5,000
☐ 100 – 500	☐ 2,000 – 3,000	☐ above 5,000

3.8 What is the estimated numbers of DU?

1) Serviced by your program

☐ 0 – 50	☐ 500 – 1,000	☐ 3,000 – 4,000
☐ 50 – 100	☐ 1,000 – 2,000	☐ 4,000 – 5,000
☐ 100 – 500	☐ 2,000 – 3,000	☐ above 5,000

2) Serviced by other programs

☐ 0 – 50	☐ 500 – 1,000	☐ 3,000 – 4,000
☐ 50 – 100	☐ 1,000 – 2,000	☐ 4,000 – 5,000
☐ 100 – 500	☐ 2,000 – 3,000	☐ above 5,000

SECTION # 4: ARV THERAPY PROVISION

4.1 Are ARVs available in your country?

☐ Yes, ☐ No

- ☐ at minimal cost
- ☐ at cost
- ☐ thru trials
- ☐ thru illegal/unregulated transport

4.2 Do you know of programs through which ARV are made available?

1) In your target area ☐ Yes ☐ No
2) In your country ☐ Yes ☐ No

4.3 What is the estimated number of people receiving ARV with a history of drug use?

1) Through your program

☐ 0 – 50	☐ 500 – 1,000	☐ 3,000 – 4,000
☐ 50 – 100	☐ 1,000 – 2,000	☐ 4,000 – 5,000
☐ 100 – 500	☐ 2,000 – 3,000	☐ above 5,000

2) Through other programs in your target area

☐ 0 – 50	☐ 500 – 1,000	☐ 3,000 – 4,000
☐ 50 – 100	☐ 1,000 – 2,000	☐ 4,000 – 5,000
☐ 100 – 500	☐ 2,000 – 3,000	☐ above 5,000

4.4 What is the estimated number of people receiving ARV with a history of injecting drug use?

1) Through your program

☐ 0 – 50	☐ 500 – 1,000	☐ 3,000 – 4,000
☐ 50 – 100	☐ 1,000 – 2,000	☐ 4,000 – 5,000
☐ 100 – 500	☐ 2,000 – 3,000	☐ above 5,000

2) Through other programs in your target area

☐ 0 – 50	☐ 500 – 1,000	☐ 3,000 – 4,000
☐ 50 – 100	☐ 1,000 – 2,000	☐ 4,000 – 5,000
☐ 100 – 500	☐ 2,000 – 3,000	☐ above 5,000

SECTION # 5: CAPACITY BUILDING OF PROGRAM TO BE INVOLVED IN THE PROVISION OF ARV

5.1 Do your staffs provide any medicines in the treatment of opportunistic infections? ☐ Yes ☐ No

5.2 Do your staffs have up to date knowledge of the range of ARV available to treat HIV? ☐ Yes ☐ No

5.3 Can anyone in your staff prescribe ARV? ☐ Yes ☐ No

5.4 Does your program have the capacity to monitor drug interactions between ARV and other licit/illicit drugs? ☐ Yes ☐ No

5.5 Does your program have access to a CD4 counting facility?

☐ Yes
☐ No, Why?
1) cost/funding 2) lack of trained staff 3) other _____

5.6 Does your program have access to viral load testing Facility? ☐ Yes ☐ No

5.7 Are there organizations involved in a continuum of care?

☐ Yes, list them down _____
☐ No

5.8 Is your program linked to other service providers who can prescribe and monitor ARV therapy?

☐ Yes ☐ No

5.9 Has anyone in your organization received formal training in?

☐ Yes (tick one or many) ☐ No
- ☐ ARV therapy (counseling, testing, provision)
- ☐ Drug use and treatment
- ☐ HIV voluntary counseling/testing
- ☐ Family counseling

5.10 Do you require training in the above skills?
☐ Yes, list areas _____
☐ No

SECTION # 6: PROJECT OPERATIONS

6.1 Does your project operate with support from any of the following structures?
☐Government departments ☐Law enforcement
☐Local health care providers ☐Community
☐Other

6.2 Main objectives of organization
☐Drug treatment
☐Methodone / Buprenorphine / Substitution LAAM
☐Detoxification
☐Needle syringe program
☐Primary health care
☐Advocacy
☐All of the above
☐Others, list them _____

6.3 Could program deliver ARV to IDUs?
☐ Yes ☐ No

6.4 Could program deliver ARV to DUs?
☐ Yes ☐ No

6.5 Is your program currently involved in planning for an ARV program?
☐ Yes ☐ No

6.6 Describe the best way to provide ARV in your setting. This may include in collaborations with other service providers and government agencies.
_____
_____

6.7 Has the project applied for funding for HIV prevention/care through the Global Fund? ☐ Yes ☐ No

6.8 What would your project require to deliver ARV to IDU?
☐Links to ARV providers
☐ARV
☐ARV dispensing training and local language training materials
☐Funding
☐Changes to political/social environment
☐Local language IEC materials to attract DU for treatment
☐Other: please specify
_____
_____
_____

6.9 What are obstacles to providing IDU with ARV?
☐Government policy
☐Program policy
☐Cost
☐Access to ARV

☐Lack of storage/transport facilities (infrastructure)
☐Lack of trained staff
☐Access to IDU
☐Monitoring treatment regimes
☐Other illness of target group, i.e. Hep C/TB/
☐ 'Attitude of doctor on current user
☐Ignorance of prescribing doctor
☐Lack of information on drug interaction with TB, Hep C, methadone, buprenorphine, heroin, amphetarnius etc
☐Others, list them _____

6.10 What sort of staff support exists in your organization?
☐Salary
☐Training
☐Adequate staffing
☐Stress/burnout management
☐Others, list them _____

6.11 Do any programs in your area work within a prison or detoxification centre? ☐ Yes ☐ No

6.12 Is there any involvement of IDU or PLWA groups with :

1) Local government in your target area	☐ Yes	☐ No
2) Your organization	☐ Yes	☐ No

SECTION # 7: ROLE OF NETWORKS

7.1 Are there active network groups in your area representing:

1)	PLWA	☐ Yes	☐ No
2)	Sex workers	☐ Yes	☐ No
3)	Migrant workers	☐ Yes	☐ No
4)	DU groups	☐ Yes	☐ No
5)	Youth	☐ Yes	☐ No

7.2 Are you involved with any of the above networks? Specify
_____

7.3 Are any of the above networks involved in the provision of ARV? ☐ Yes ☐ No

7.4 If yes, specify the service they provide?
_____

ANNEX 3: QUESTIONS ON POLITICAL ENVIRONMENT FOR PROVISION OF ARV

Is ARV provision a real priority for the Government or Local Government?

Is there a commitment in the National AIDS plan?

Is there a commitment to IDU project?

What is the approximate national budget allocation to IDU issues?

Is there an integrated work-plan between public- health, law enforcement and civil society with regards the treatment of IDU/DU, treatment of PLWA?

Is there involvement of PLWA/DU networks at National policy initiatives?

ANNEX 4: SUMMARY OF SURVEY ANSWERS TO QUESTIONS 4

Country	Answer	Section 4			Total Questionnaires
		4.1	4.2.1	4.2.2	
Bangladesh	Yes	5		2	8
	No	1	5	4	
China	Yes	7	6	5	7
	No		1	1	
India	Yes	22	9	10	22
	No		10	10	
Indonesia	Yes	13	7	11	14
	No		4	1	
Iran	Yes	10	6	8	10
	No		1	1	
Malaysia	Yes	18	15	16	23
	No	1	3	2	
Nepal	Yes	9			10
	No		9	8	
Pakistan	Yes		1		2
	No	1			
Thailand	Yes	3	2	5	4
	No				
Vietnam	Yes	15	5	11	16
	No	1	4	1	
Total	**Yes**	102	51	66	116
	No	4	37	28	
No answer		10	28	22	

ANNEX 5: SUMMARY OF SURVEY ANSWERS TO QUESTIONS 5 AND 6 SURROUNDING ARV PROVISION

Country	Answer	Section 5										Section 6							Total Q
		5.1	5.2	5.3	5.4	5.5	5.6	5.7	5.8	5.9	5.1	6.3	6.4	6.5	6.7	6.11	6.12.1	6.12.2	
Bangladesh	Yes	1	1		2	1		1	1	2	4				1	3	1	4	4
	No	3	3	4	2	3	4	3	3	2		4	4	4	3	1	1		
China	Yes	4	5	4	3	4	4	2	5	5	5	4	4	5	2	2	2	4	7
	No	3	2	3	4	3	3	4	2	2	1	3	3	2	5	5	3	2	
India	Yes	17	14	8	7	9	6	13	16	20	20	17	16	11	2	17	13	22	22
	No	3	7	13	13	13	15	5	6	2	2	5	6	11	17	3	2		
Indonesia	Yes	1	1		1	1	1	1	2	1	1	1	1	1		2	1	2	2
	No	1	1	2	1	1	1	1		1	1	1	1	1	2				
Iran	Yes	6	8	7	4	5	5	9	7	10	10	8	8	4	5	10	1	4	10
	No	4	2	3	3	2	5	1	1			2	2	3	5		4	1	
Malaysia	Yes	6	11	4	7	10	10	11	11	15	14	12	11	7	4	13	10	15	23
	No	14	8	16	13	10	7	6	10	5	5	7	7	11	14	7	6	1	
Nepal	Yes	9	9		9	10	8	2	10	8	10	10	10	1	1	1		10	10
	No	1	1	10	1		1	4		2				8	8	6	8		
Pakistan	Yes	1	1		1			1	1	2	2	1	1	1		1		2	2
	No	1	1	2	1	2	2	1	1			1	1	1	2	1	2		
Thailand	Yes	3	2	1	3	1	4	2	3	4	2	3	3	3	1	2	3	3	4
	No		1	3	1	2		2	1		2	1	1	1	3	1			
Vietnam	Yes	9	9	4			1	3	2	12	11	8	8	1	1	5	9	11	16
	No	5	5	4	9	7	4	1	6		1	7	7	14	9	9	1	1	
Total	**Yes**	57	61	28	37	41	39	45	58	79	79	64	62	34	17	56	40	77	100
	No	35	31	60	48	43	42	28	30	14	12	31	32	56	68	33	27	5	

ANNEX 6– LIST OF COUNTRY COORDINATORS, INDICATION ON INFORMATION SUBMITTED and LIST OF ORGANISATIONS THAT COMPLETED SURVEY

Country	Name/Detail	No.	Organization
Bangladesh	Mr.Shamim Rabbani	1	CARE Bangladesh
	Submitted :	2	Concern Worldwide
	- Pre-Questionnaire	3	APON
	- Questionnaires	4	Organisation of Development Program for the Under Privileged (ODPUP)
	- Final Assessment	5	not complete
	- Updated Database		
Cambodia	No CC (c/o Dave Burrows)		
China	Wang Jing	1	Yunnan Centre for Disease Control
	Submitted :	2	Yunnan Institute for Drug Abuse
	- Pre-Questionnaire	3	Cuxiong Public Security Bureau Detox Centre
	- Questionnaires	4	Medicines Sans Frontieres
	- Updated Database	5	Kunming Infections Disease Hospital
	- Summary of Questionnaire	6	Yunnan No.2 Women's Prison Hospital
	Pending :	7	Beijing Youan Hospital
	- Final Assessment		
India	Rajkumar Raju Singh	1	Kripa Foundation, Nagaland branch
	Submitted :	2	Kripa Foundation, Imphal
	- Pre-Questionnaire	3	Society for Aid and Help for Addictive Illness (SAHAI Trust)
	- Questionnaires	4	Sahara Drugs and AIDS Programme
	- Final Assessment	5	Community Health Action Network(Chan)
	Pending :	6	Voluntary Health Association of Meghalaya
	- Updated Database	7	Freedom Foundation
		8	Sharan-Society for Service to urban poverty
		9	Social Awareness Service Organisation
		10	Lifeline Foundation
		11	Society for HIV/AIDS and Lifeline Operation in Mizoram(SHALOM)
		12	Sahara Centre for Residential Care &Rehabilitation
		13	Society for HIV/AIDS and Lifeline Operation in Manipur(SHALOM)
		14	Prodigals' Home
		15	The Calcutta Samaritans
		16	CARE Foundation
		17	Society for Positive Atmosphere and Related Support to HIV/AIDS(SPARSHA)
		18	Sankalp Rehabilitation Trust
		19	T T Ranganathan Clinical Research Foundation
		20	Bethesda Youth Welfare Center
		21	YR GAITONDE CENTRE FOR AIDS RESEARCH AND EDUCATION (YRG CARE)
		22	North-Eastern Drug, HIV/AIDS Training Centre.
Indonesia	Sahrul Syah	1	Kelompok Independen Stigma
	Submitted :	2	Rumah Cemara
	- Pre-Questionnaire	3	Yayasan Talenta
	- Questionnaires	4	Sptritia Foundation
	- Final Assessment	5	Metamorfosa Makassar (MEKAR)
	- Updated Database	6	Rumah Sakit Ketergantungan Boat Government Hospital
		7	Yayasan Harapan Permata Hati Kita (Yayasan Kita)
		8	Matihati Foundation
		9	Youth Care HIV/AIDS
		10	Mura Malaysia Foundation
		11	Kios Infomasi Kesehatan Atma Jaya
		12	Health Drop in Center Atmajaya
		13	The Bali Health Foundation

Country	Name/Detail	No.	Organization
		14	Galatea Foundation
Iran	Ms. Nafiseh Solook Submitted : - Pre-Questionnaire - Questionnaires - Final Assessment - Updated Database	1 2 3 4 5 6 7 8 9 10	Prison Organisation. Wayfarer Health Organisation Ministry of Health Iranian Prison Organisation Substance Abuse Prevention & Treatment Office West Health Centre of Tehran, HIV/AIDS clinic, Medical University of Iran Behavioural Disorders Controlling Association Persepolis H/R NGO Disease Control Organisation Disease Control Organisation
Laos	No CC		
Malaysia	Ajit Kumar Narayanan Ms. Sangeeta Submitted : - Pre-Questionnaire - Questionnaires - Final Assessment - Updated Database **not complete**	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26	Pelang : community Foundation General Hospital Kuala Lumpur Malaysian Aids Council International Planed Parent Hood Federation(IPPF) University Malaya Rumah Victory UNAIDS Community Aids Service Penang Department of Health, Keiantan Sarawak General Hospital Persatuan PENGASIH Malaysia Kawan Drop-In Centre Centaur for drug Research PT Foundation World Youth Foundation Asia Pause Council of Aids Service Organisations(APCASO) Malaysian Care Federation of Family Planning Associations, Malasia(FFPAM) Pertubuhan Wanita Dan Kesihatan Ikhlas Drug User Program, PT Foundation Pemadam-Kinta Clinical Research Centre Persatuan Perancangan Keluarga Kelantan The Liaison Combination Sdn Bhd-TLC Aids/Std Section Disease Control Division, Department of Public Health Sarawak Aids Concern Society
Myanmar	No CC (c/o Willy De Maere)		
Nepal	Mr. Jagdish Lohani Submitted : - Pre-Questionnaire - Questionnaires - Updated Database - Final Assessment	1 2 3 4 5 6 7 8 9 10	Clean Society Counselling & Rehabilitation Centre Nepal youth Rehabilitation Centre Prerana Youth Vision Treatment & Rehabilitation Centre Freedom Centre Nepal Plus The Richmond Fellowship Nepal Life Saving and Life Giving Society (LALS) New Hope Rehabilitation Centre Vision Plus
Pakistan	Ahmad Bakhsh Awan Submitted : - Questionnaires Pending : - Pre-Questionnaire - Final Assessment	1 2	Sukkur Blood & Drugs Donating Society (SBDDS) AIDS Prevention Association of Pakistan (APAP)NGO

	- Updated Database		
Thailand	K.Wassawut Yimcheam	1	Maechan Hospital
		2	Alden House
		3	Drug Treatment Centre
		4	Thanyalak Institute
Vietnam	Dr.Do Thanh Nam, MD	1	Centre for Public Health and Development(CEPHAD)
	Nguyen Khanh Hang	2	Centaur for Community health and Development(COHED)
	Submitted :	3	Hanoi AIDS Standing Bureau
	- Questionnaires	4	Hanoi Centre for Harm Reduction - Macfarlane Burnet Institute
	- Pre-Questionnaire	5	Provincial AIDS Committee of Quang Ninh
	Pending :	6	AIDS Program
	- Final Assessment	7	Supporting Centre for HIV/AIDS/STIs Control
	- Updated Database	8	Preventive Medicine Centre
		9	STDs/HIV/AIDS Prevention Centre(SHAPC)
		10	Provincial AIDS Committee of Hai Phong City
		11	Centre for Preventive Medicine
		12	Provincial AIDS Committee of Lang Son
		13	Vietnam National Red Cross
		14	Vietnam Women's Union
		15	World Population Foundation
		16	UNODC Project in Vietnam

ANNEX 6: HEPITITIS C, DRUG USE, HIV AND ARV – COMPLEX INTERACTIONS

At this point, it is important to highlight that the ideal of providing ARV to IDU is made complex by co-infection of HCV. It is therefore necessary as part of scale up to include treatment of HCV for those co-infected with HIV. Research suggests that it may be beneficial to treat HCV before initiating ARV therapy (New York State Department, 2003). To adequately provide treatment to those co-infected it is necessary to have access to liver function laboratory equipment, the current drugs of choice for treatment (interferon and ribavirin) and the ability to monitor and follow up people regularly. All of this is made difficult by the lack of access to IDU/DU, the lack of testing facilities, the lack of essential first line drugs. Some organisations surveyed in this report suggest that up to 98% of their IDU clients be infected with HCV. Whilst this should not reduce anyone's ability to access treatment, it certainly has implications for the training needs of ARV providers and the procurement of appropriate drugs.

In an ideal scenario, people who are co-infected with HCV/HIV and are also IDU, would need to be critically assessed. Have access to drug substitution so they potentially stop injecting, stabilise the drug use, treat the HCV, then provide the appropriate ARV in a setting where their complex needs can be met. Plainly this requires significant investment in health infrastructure, shifts in drug policy, laboratory equipment and a very well trained committed health team.