nam www.aidsmap.com

HATiP

HIV & AIDS Treatment in Practice

Issue 159 | 28 May 2010

In this issue:

Harm reduction and human rights; ***by Theo Smart*** ***page 2***

- Harm reduction, human rights and clinical services targeting people who use drugs

Collaborative TB and HIV services for drug users; ***by Theo Smart*** ***page 3***

- The need for collaborative services
- Policy guidelines issued for collaborative TB/HIV services for drug users
- Implementing the guidelines: case studies in India, Brazil, Zanzibar and Ukraine
- Joint planning for service delivery
- Implementation of the key TB/HIV services
- Barriers — and overcoming them
- Global lessons and remaining barriers

© Copyright NAM — All rights reserved. Please photocopy and pass on.

NAM publishes a wide range of publications on treatment for HIV. For details contact:

NAM, Lincoln House, 1 Brixton Road, London, SW9 6DE, UK

tel +44 20 7840 0050 **fax** +44 20 7735 5351 **email** info@nam.org.uk **web** www.aidsmap.com

aidsmap

Harm reduction and human rights

By Theo Smart

Harm reduction, human rights and clinical services targeting people who use drugs

"Harm reduction for people who use drugs has reached the tipping point - we have solid scientific evidence that shows combination harm reduction prevents new infections. Combining oral substitution therapy [for people who inject opioids], HIV and tuberculosis (TB) treatment stabilizes the lives of the drug user, prevents illness and lowers community viral load. Reaching zero new HIV infections amongst drug users is not a dream, it is a reality — it is happening right now in countries with the full-scale programmes," said Michel Sidibé, Executive Director of UNAIDS, at the keynote address of Harm Reduction 2010, the 21st annual conference of the International Harm Reduction Association held in Liverpool from April 25-29th. "But despite of the proof, the policy and the politics, we still have a long way to go."

Indeed, reports released at the conference described how essential services for people who use drugs have very limited coverage, are dramatically under-funded, and that a number of countries particularly in the Asia Pacific region are detaining people who use drugs, purportedly for compulsory drug treatment, although they offer little other than cold-turkey detox, forced labour and inhumane living conditions.

Background

With the World AIDS Conference being held in Vienna this year, 'next-door' to Eastern Europe (where some of the world's fastest growing HIV epidemics are being driven through the use of contaminated drug injecting equipment), the prevention, treatment and care needs of people who use drugs have moved up the international HIV agenda.

Globally, around 3 million out of the estimated 15.9 million people who inject drugs are believed to be HIV infected, and along with HIV there are increased risks of hepatitis (B & C), TB and multi-drug resistant TB (especially among people who have been incarcerated).[1] However, "in Eastern Europe, 57% of all new infections occur among injecting drug users," said Sidibé. Over the last decade in Russia, the number of HIV infected people has increased tenfold from an estimated 100,000 to one million. In Bangladesh, 90% of new HIV cases are linked with injecting drug use. Meanwhile, drug injecting is becoming more common in new parts of globe, such as East Africa, where there is a risk it could fuel new concentrated epidemics.

However, many countries have been able to curb HIV transmission among people who use drugs through harm reduction —a public health strategy that focuses on reducing the harmful health, social and economic consequences of using drugs rather than on the prevention of drug use itself. Examples include adequately resourced clean syringe/needle exchange programmes which reduce the risk of transmitting blood borne infections, and oral opioid substitution therapy (OST), which gives people a much safer alternative to injecting.

Michael Bartos, also of UNAIDS, described some of the evidence documenting the effectiveness of harm reduction on the ground. "The most recent UNAIDS Global Report showed the Netherlands with only six new HIV infections amongst drug users. If you look at Australia's national HIV surveillance, they found only three new HIV infections from a thousand drug users attending STI clinics. Portugal, with Western Europe's most severe HIV epidemic amongst drug users, has seen new HIV infections halved since it introduced comprehensive health and harm reduction including needle exchange to its drug policies a decade ago," he said.

Poor coverage

UNAIDS, WHO and the United Nationals Office on Drugs and Crime (UNODC) have endorsed a package of interventions for drug users, with nine essential elements of a comprehensive response.[2] These include: needle and syringe programmes (NSP); OST; antiretroviral therapy; HIV counselling and testing; prevention and treatment of sexually transmitted infections (STIs); condom programmes for drug users and their sexual partners; targeted information, education and communication (IEC); prevention, diagnosis and treatment of viral hepatitis and TB. Subsequently, WHO released a technical guide to help countries scale up these services at a level that might be expected to have a public health impact.[3] Preliminary data suggest that a growing number (93) of countries and territories now support harm reduction.

"But still only a minority of countries are actually delivering these services to the scale that is required to reduce HIV transmission," according to Dr Bradley Mathers of the Reference Group to the UN on HIV and Injecting Drug Use, and the University of New South Wales, who presented the findings of a global systematic review into how well countries are meeting the targets relating to the first three elements of the comprehensive package.[4, 5]

Overall, only 22 sterile needles are being distributed per drug user per year; for every 100 people who inject drugs around the world, only eight are receiving OST and for every 100 people who inject drugs living with HIV, only four are receiving ART.

"It is unacceptable that on average, each injecting drug user gets less than two clean needles per month or that so few drug users are on substitution treatment. It is unacceptable that only 4 percent of injecting drug users living with HIV are on HIV treatment, and that curable and preventable TB, remain a common killer of drug users," said Sidibé.

Underfunding

"It is a pretty dismal result," said the following speaker, Professor Gerry Stimson, outgoing executive Director of the International Harm Reduction Association. "We know there are many obstacles to implementing harm reduction, including ignorance by governments, antipathy to drug users, massive over-investment in criminal justice approaches to drugs, legal barriers to harm reduction interventions, for example in some countries where it is illegal to prescribe methadone; and the undervalued place people who use drugs hold in society, and by association, those who work with them. These obstacles go hand in hand with a lack of investment."

In fact, the world's investment in harm reduction and HIV prevention for people who inject drugs is less than 3 cents per day per injector, or US $13 per year, according to a new report from the International Harm Reduction Association (IHRA).[6] This represents only one twentieth of the recommended $3.2 billion needed to implement comprehensive package of interventions.

In 2007 approximately $160 million was invested in HIV-related harm reduction in low and middle-income countries, about 90% of which came from international donors (most notably the Global Fund). "This figure is similar to the amount spent on President Obama's inauguration," said Professor Stimson, who also pointed out that private funders, such as the Gates Foundation, are contributing next to nothing to harm reduction.

"Not enough money is being spent on harm reduction. The goal of universal access to HIV prevention, treatment, care by 2010 is

© Copyright NAM — All rights reserved. Please photocopy and pass on.

NAM publishes a wide range of publications on treatment for HIV. For details contact:

NAM, Lincoln House, 1 Brixton Road, London, SW9 6DE, UK

tel +44 20 7840 0050 **fax** +44 20 7735 5351 **email** info@nam.org.uk **web** www.aidsmap.com

aidsmap

nowhere being met for people who use drugs and at the current rate of progress it will never be met," he said.

Not only is it inequitable to neglect the prevention needs of drug users, it is also wasteful at a time when funding for treatment and care shows few signs of expanding. The IHRA report points out that prevention of HIV is much cheaper than treatment of HIV/AIDS. For example, in Asia it is estimated that the comprehensive package of HIV-related harm reduction interventions costs $39 per disability-adjusted life-year saved, whereas antiretroviral treatment costs approximately $2,000 per life-year saved.

The report makes seven key recommendations:

1. More global resources are needed for harm reduction;
2. Resources for harm reduction and HIV services for people who use drugs should be proportionate to need within countries;
3. Donors should set targets for the proportion of global spending going to HIV related harm reduction, with 20% of global prevention funds going to harm reduction;
4. Global expenditure on harm reduction must be properly monitored by UNAIDS and NGOs;
5. Better estimates are required of the resources needed for HIV-related harm reduction;
6. New ways of delivering harm reduction services may be needed;
7. A global Community Fund for Harm Reduction should be established to advocate for increased resources for harm reduction.

Criminalisation and detention

Finally, there was a call to put an end to the ongoing arrest and detention of people who use drugs.

"The UN Reference Group on HIV and drug use has drawn attention to the scale of drug detention - in some countries there are more than ten times as many drug users detained in drug centers than receiving any form of treatment or prevention service. Yet many of these centres operate with no due legal process and no effective drug treatment, with the result that when users are released, they almost invariably return to drug use. Inhumane conditions, and the failure to respect the most basic of legal rights, cannot be excused," said Bartos.

"The 'war on drugs' is a war on drug users and its fuelling the HIV epidemic, making public health responses much more difficult," said Alvaro Bermejo, Executive Director of the International HIV/AIDS Alliance.

"Criminalising drugs and criminalising drug users causes considerable harms, serves as a barrier to public health objectives and has no discernible purpose other than to punish. A reassessment of the international drug control system is way, way overdue," said Prof Stimson.

"Protective laws and policies for people living with HIV and people most at risk of infection are essential in promoting effective HIV prevention, treatment, care and support for people who inject drugs," according to a Joint Position Statement on Detention Centres for "Drug Treatment" put out during the conference by the Global Network of People living with HIV (GNP+) and The International Network of People who Use Drugs (INPUD). "The human rights to due process, freedom from arbitrary detention, and medically and ethically acceptable health services on a voluntary basis are the most effective means of preventing HIV and other diseases."

"Harm reduction is a much more effective approach to addressing HIV and drug use. It means drug users can prevent HIV transmission and live positively. It's time to move away from the detention centre system and to provide services for users in their communities and in government health clinics so they can see them as places where they can get help and not be badly treated," said Bermejo.

"We must be prepared to speak out about human rights abuses wherever they occur. The crimes which are being committed today in the name of 'Drug Detention' must be renounced," said Sidibé. "So I have made the call to decriminalise drug users as one of my main efforts as UNAIDS Executive Director."

References

[1] Mathers B.M. et al. *Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review*. The Lancet (online edition).
[2] WHO. Improving quality assurance in HIV prevention, WHO report to the UNAIDS Reference Group on Developing Minimum Quality Standards for HIV Prevention Interventions, Geneva, 2008..
[3] World Health Organization, WHO, UNODC, UNAIDS Technical Guide for Countries to set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users. Geneva: World Health Organization, 2009.
[4] Mathers B et al. How successful have global efforts to expand HIV prevention for IDUs been. Results of a global systematic review. Harm Reduction 2010, Liverpool.
[5] Mathers BM et al. HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. Lancet 375(9719):1014-28, 2010.
[6] Stimson G et al. Three Cents a day is not enough: Resourcing HIV-related Harm Reduction on a Global Basis. International Harm Reduction Association, 2010.
http://www.idpc.net/sites/default/files/library/IHRA_3CentsReport.pdf

Collaborative TB and HIV services for drug users

By Theo Smart

This edition of HATIP is kindly supported by the Stop TB Department of the World Health Organization.

This article is based on interviews and research carried out during site visits sponsored by the World Health Organization. Any views expressed in the article are the author's own, and do not reflect the policy of the World Health Organization.

The need for collaborative services

Trying to get access to essential healthcare services can be tremendously difficult for a person who uses drugs. Stigma and discrimination can make this marginalized population feel shunned and unwelcome in healthcare facilities. At other times, healthcare staff or systems may unintentionally place barriers in the way of access, such as requiring advance scheduling of visits (it can be hard to keep appointments when living on the street, or trying to get one's next 'fix').

The problem is compounded when people have several illnesses at the same time. In many settings, drug users must visit separate clinics run by separate health services. Often people using drugs who have both TB and HIV are shunted from one clinic to the next with each clinic saying that they should first be getting treatment somewhere else.

Another common problem is when national TB programmes require that a drug user with TB be an inpatient in order to get TB medication. Again, when facing withdrawal symptoms, staying confined in the hospital can seem next to impossible. TB programmes generally have not offered treatment for drug dependency in the TB facility, so the client must make an

© Copyright NAM — All rights reserved. Please photocopy and pass on.
NAM publishes a wide range of publications on treatment for HIV. For details contact:
NAM, Lincoln House, 1 Brixton Road, London, SW9 6DE, UK
tel +44 20 7840 0050 **fax** +44 20 7735 5351 **email** info@nam.org.uk **web** www.aidsmap.com
aidsmap

impossible choice between having their TB treated and relapsing — in which case they are likely to discontinue their TB medication anyway.

Some countries require healthcare workers to report people who use drugs to the authorities, leading to their arrest, forced detoxification and possible sentencing to a prison or labour camp. Making matters worse, these camps or prisons may be unsafe living environments where infections such as TB are frequently spread.

These barriers to care don't just threaten the health and lives of the drug user and his or her family, they can have important consequences for the wider community and the public system because delays receiving appropriate care means more onward transmission of HIV, TB and other infections, as well as higher healthcare costs when a person presents with more advanced illness.

The high risk of HIV among people who share contaminated equipment to inject drugs is well established — and the scale of the problem is substantial. Most recent estimates are that there are 11-22 million people globally who currently inject drugs, while around 3 million (range 0.8 to 6.6 million) people who currently inject or previously injected drugs are estimated to be infected with HIV accounting for roughly 10% of the 33 million people living with HIV worldwide. However, in many countries in Eastern Europe and Central Asia, injecting drug use drives the epidemic, with people who inject drugs (PWID) making up more than 60% of the people living with HIV — and recent data suggest that the problem is growing in East Africa as well. Moreover, there are millions of other people who don't inject drugs but whose drug use (smoking heroin, crack, sniffing or smoking methamphetamines) is nonetheless associated with behaviours that put them at a much higher risk of HIV and other illnesses than people in the general population.

HIV activism and the international response to AIDS have encouraged programmes in some countries to at least begin to tackle the HIV-related risks of drug use. But other conditions that commonly affect drug users, such as hepatitis and TB have received much less attention.

But people using drugs are estimated to have at least a 10-30 fold increased risk of TB. Being incarcerated increases the risk by 10 to 50 times, because overcrowded prisons with inadequate air circulation and poor health services serve as reservoirs for the disease. Coinfection with HIV increases a person's lifetime risk of developing TB to around 5-10%. There is also increasing evidence that drug use is closely associated with the growing epidemic of multidrug resistant (MDR) TB.

TB is the leading cause of death among people with HIV in most of the world — and there is good reason to believe this may also be especially true for drug users with HIV.

Policy guidelines issued for collaborative TB/HIV services for drug users

But TB is treatable and preventable so the poor outcomes both for the person using drugs and for the health system are unnecessary and avoidable. To help make certain that people using drugs, including those in prison, receive appropriate TB/HIV care, in 2008, the WHO, UNAIDS and the UN Office on Drugs and Crime (UNODC) released the new *Policy Guidelines for Collaborative TB and HIV Services for Injecting and Other Drug Users — An Integrated Approach.* The policy contains thirteen primary recommendations under three categories: 1) joint planning of services 2) key collaborative services to be delivered and 3) overcoming barriers to care (see box for summary).

Summary of Guidelines for Collaborative TB and HIV Services for Injecting and Other Drug Users

Joint planning	Key interventions	Overcoming barriers
Service delivery will have to be planned to make certain that drug users can access the services they need when and where they need them: • Multisectoral coordination of TB and HIV services for drug users at the local and national level, including health and criminal justice authorities • National plans with roles and responsibilities of service providers, monitoring and evaluation • Staff training to build effective teams with adequate numbers of personnel trained to work with drug users • Operational research on how collaborative TB/HIV services can be best provided for drug users	Services to reduce the burden of TB and HIV among drug users • TB infection control in congregate settings including healthcare facilities and prisons. • Case-finding protocol for TB and HIV for any facility or organisation working with drug users. • Ensure access to all appropriate treatments for drug users (TB therapy, antiretroviral therapy, treatment for STDs, hepatitis B or C & drug dependency) in accordance with guidelines • Isoniazid preventive therapy (IPT) to prevent active TB in drug users living with HIV once active TB is reasonably excluded • Comprehensive HIV prevention services for drug users and health care staff	HIV, TB treatment programmes and services for drug users can organise themselves to overcome the many barriers, such as stigma from health workers, law enforcement personnel and social service workers, which contribute to much poorer health outcomes among drug users. • Ensure universal access to TB and HIV prevention, treatment and care as well as drug treatment services* for drug users: One stop, if possible • Provide equivalence of care to prisoners and continuity of care on discharge • Treatment adherence support tailored to the specific needs of drug users* • Make certain co-morbidities are not used as reasons to deny TB or HIV treatment

*For people who inject heroin or other opioids, opioid substitution therapy (OST) plays a role both as HIV prevention, and as an aid to adherence in people on HIV or TB treatment.

Implementing the guidelines: case studies in India, Brazil, Zanzibar and Ukraine

But it is up to people working at the country level to take these guidelines and move them from paper to practice. Naturally, the approach to implementation may vary somewhat from region to region depending upon how health systems are structured, local resources and other factors.

In order to see how the guidance for collaborative TB and HIV services for people who use drugs can be put into action on the ground, a series of case studies was conducted, supported by WHO. Four very different locations were selected that were known to be trying to improve access to health services for people using drugs, and that had very different epidemics, characteristics, and cultures: Zanzibar, India, Ukraine and Brazil.

The case studies are not exhaustive, but were rather meant to draw attention to the challenges and potential solutions to improving access to TB/HIV care for people using drugs that are being explored in each setting in the hope that these may provide some best practice insights for advocates and policy makers in similar situations. The project involved site visits and unstructured in depth interviews with policy makers, healthcare providers and people who use drugs.

© Copyright NAM — All rights reserved. Please photocopy and pass on.

NAM publishes a wide range of publications on treatment for HIV. For details contact:

NAM, Lincoln House, 1 Brixton Road, London, SW9 6DE, UK

tel +44 20 7840 0050 **fax** +44 20 7735 5351 **email** info@nam.org.uk **web** www.aidsmap.com

aidsmap

Zanzibar

Zanzibar, a semi-autonomous archipelago that is part of the United Republic of Tanzania, sits along the old Indian Ocean trade routes that are now being used to smuggle heroin from Afghanistan to the West. Like in many countries in this region, Zanzibar has a growing number of people that have recently begun to use heroin. Currently, there are estimated to be between 4000 to 6000 people who inject drugs, but as there are only 1.4 million people living on the islands, this represents a substantial burden affecting many families. Around 60% of the population are unable to find employment and poverty increases vulnerability to the drug trade in Zanzibar.

At the same time, Zanzibar is a very conservative Islamic society with a much lower prevalence of HIV than on the mainland. However, there are concentrated HIV epidemics in the most-at-risk populations (MARPs): people who use drugs, men who have sex with men (MSM) and sex workers. Estimating the actual size of the burden of HIV in these groups is difficult — MARPs are particularly hard to reach in Zanzibar — many members of these groups fear arrest and sentences can be harsh. However, one recent respondent driven sampling (RDS) survey found that 16% or more of people injecting drugs in the islands are HIV-infected.

Zanzibar was selected for the case study because international and local NGOs and the local government have partnered to launch the 'United for Risk Reduction and AIDS Prevention (URRAP) programme that is trying to identify drug users and link them to clinical facilities where TB/HIV services are being integrated. After a small grant was secured to fund activities and partners identified, the project began with the development of M&E tools, extensive training of community workers, community sensitization and community mapping.

Presently, with the exception of HIV screening, clients are linked to clinical services by accompanied referral. As of yet, there is no opioid substitution therapy (OST) available for people who use drugs in Zanzibar although there are plans to pilot it at a later date. Notably, the TB programme is not yet formally involved in activities targeting people using drugs.

India

With the many voices calling for better health services in India, it can be difficult for people who use drugs to get their issues heard. For instance, India is the country with the greatest TB burden in the world: 1.9 million new cases per year, and about 400 million people with latent TB infections. It also has one of the largest absolute numbers of people living with HIV — although only 0.36% of the general population are infected, that adds up to 2.3 million people. However, India is making great strides in combating these illnesses, though there are major differences between the structures of the national TB programmes (RNTCP) and the national AIDS programme (NACO) which affect how accessible their services are.

RNTCP is widely decentralised — one does not need to go to a TB hospital for TB treatment. However, there are far fewer sites providing HIV services. NACO has set up more specialised sites for HIV testing (thousands of them, usually within other larger health facilities), and a few hundred sites to provide HIV care. In the last couple of years, the national AIDS programme (NACO) and the national TB programme (RNTCP) have begun introducing most collaborative TB/HIV activities. Nevertheless, there is a strong bias against drug users, and without special assistance, it would be difficult for drug users to access any of these health services.

Close to opium-producing regions of the world, there is a long history of drug use in India, although there are distinct regional differences. Several years ago, a study suggested that there were about 2 million people using heroin or synthetic opioids — most were chasing (smoking) or snorting heroin. At present, it is estimated that there are currently close to 200,000 people who are injecting drugs, either heroin or a mix of pharmaceuticals, although people often switch from smoking to injecting depending upon drug availability.

People using drugs in India face a number of health risks: in addition to the risks of acquiring HIV or hepatitis C from sharing contaminated drug injecting equipment, studies suggest that men using drugs are much more likely to frequent sex workers and to not use condoms when having sex. In addition, people using drugs are at high risk of being imprisoned in India, and this compounds their risk of being exposed to TB, or blood-borne diseases — some studies from India report as many as 30 inmates sharing one needle to inject drugs in prison. Recent data suggest that the HIV prevalence among people who inject drugs is 9.19% in India. The burden of tuberculosis and MDR-TB among drug users is unknown.

However, India is also rolling out "targeted interventions" for people who inject drugs. These are community-based services (often staffed by people who use or formerly used drugs) with government providing financial and technical support. The 'targeted interventions' (TIs) take a harm reduction approach to HIV prevention (including free syringes and needle exchange), offer limited clinical services at drop-in centres (STD screening and treatment, treatment of abscesses), and sometimes OST. Clients are linked to other services via accompanied referrals. Some of the TIs are now also offering some limited TB/HIV services. However, human and financial resource constraint limits the number and coverage of services.

Ukraine

People using drugs make up the majority of the estimated 440,000 people living with HIV in Ukraine. Currently, there are between 325,000 and 425,000 people who inject drugs in the country, about 42% of whom are believed to be HIV-infected. In addition, Ukraine has major TB and MDR-TB epidemics — and there are data suggesting that MDR-TB is especially common in people who use drugs in Ukraine.

Like many countries in the region, Ukraine inherited a vertical health care system from the former Soviet Union that keeps certain medical disciplines separate during education and planning through to service delivery. Clients seeking care for tuberculosis and for HIV have to go to separate facilities that may be far from each other. In addition, policies and practices of the individual health services act as barriers for care to people using drugs.

For instance, antiretroviral therapy (ART) had only been available at AIDS Centres that are usually located far from the centre of town — and people using drugs make up a small minority of the people on ART in the country, despite being the majority of people with HIV. The tuberculosis programme in Ukraine does not adhere to international practice — to receive the intensive phase of tuberculosis treatment, one must be hospitalised in a TB facility, which is difficult for a person with a drug dependency (leading to treatment adherence problems — the main reason why drug users often have MDR-TB). Narcological dispensaries, which should offer treatment and care for drug users, have traditionally been more concerned with drug control — acting as a bureaucracy to 'keep track' of drug users. Finally, although the National AIDS Law in Ukraine endorses universal access to treatment and harm reduction, frequent changes in government have made it difficult to manage the health system and address its inefficiencies, forcing civil society to take on more of a leadership role in securing donor funding and delivering care.

© Copyright NAM — All rights reserved. Please photocopy and pass on.

NAM publishes a wide range of publications on treatment for HIV. For details contact:

NAM, Lincoln House, 1 Brixton Road, London, SW9 6DE, UK

tel +44 20 7840 0050 **fax** +44 20 7735 5351 **email** info@nam.org.uk **web** www.aidsmap.com

aidsmap

However, Ukraine was selected as a case study because civil society has been working with care providers and technical assistance agencies to run a number of projects demonstrating that care can be made more accessible to people who inject drugs. After a number of narcological dispensaries and the Kiev AIDS Centre began piloting small programmes offering OST to drug users, they began to investigate whether services including OST and sometimes integrated TB/HIV care could be provided at TB clinics, AIDS centres and general hospitals by establishing onsite multidisciplinary teams. At the same time, civil society has been trying to reform restrictive government policies that reinforce the vertical health system and that limit the scale-up of OST.

Brazil

In Brazil, universal access to treatment and care is federal law — and the country has been a model to other low and middle-income countries in providing TB and HIV care for its population (70% of the population utilise the public health system). TB/HIV integration is ongoing in the HIV and TB programmes, although it should be noted that antiretroviral therapy is only available through HIV programme sites.

The country also has pioneered programmes working with marginalised most at risk populations (MARPs) including people using drugs. The ministry of health promotes a harm reduction approach (although local municipalities make their own decisions about how to implement prevention activities).

However, drug use in Brazil differs dramatically from the other countries mentioned here because heroin is not widely available — cocaine is by far the most commonly used drug. At one time, drug users injected cocaine, but this has become uncommon as cheap crack cocaine has flooded the market — so much that some neighbourhoods are notorious for being 'Cracklands.' There may be as many as 500,000 people using crack in the country.

But even though injecting has fallen off, people using drugs still appear to be at an elevated risk of HIV and TB — partly because sexual risk taking behaviours are more common in this population (including sex work to support their drug use), and there is an increased risk of TB transmission in places where drug users congregate. A series of recent studies suggest that 'specially vulnerable' drug users (people who have used drugs 21 days out of the last two months) have an HIV prevalence of around 6%. Meanwhile, the burden of TB among crack users is unknown — however, the national TB programme believes it is probably high because other studies show that the rates of TB in the Brazilian prisons (where many drug users wind up) is 30 times higher than the general population, and another study suggests that among the homeless (often crack users), it is 60 times higher than the general population.

The evidence base for how to provide treatment and access to services to people using crack is limited but Brazil has developed a number of projects offering harm reduction services for people using stimulants, whether injected, smoked or sniffed. Many of the HIV sites also offer outreach and services targeting drug users. In addition, the country has established a new programme, the Centro de Atenção Psicossocial/Álcool e Drogas (CAPS AD) for people who use drugs and alcohol that provides general and psychological health services and screens for HIV and — at some sites, TB, providing referrals for care.

Joint planning for service delivery

Multisectoral coordination

In each country, there is some sort of policy guiding body with government and community representation concerned with improving access to care for drug users, though the composition and structure varies from place to place.

For instance, in Zanzibar, "after situational research showed the magnitude of the problem, the US Centers for Disease Control, ICAP [the international NGO] and the government of Zanzibar (namely, the Zanzibar AIDS Control Programme and the Department of Substance Abuse) sat together and began to plan the URRAP programme," said Frida Radedunga Godfrey, who is the Zanzibar programme manager for ICAP who is helping coordinate URRAP.

Since one of the overall goals for URRAP was to increase the capacity of indigenous organisations to implement effective prevention and programmes for people injecting drugs, three community-based organisations already working with drug users, Zanzibar Association of Information Against Drug Abuse and Alcohol (ZAIDAA), Zanzibar Youth Forum (ZYF), and ZAYEDESA (Zanzibar Youth Education Development Environment Support Association) were invited to be the local implementers of the programme. Together, the strategic government partners, local NGOs and ICAP work as URRAP's management team, planning the project's key strategies and objectives.

In Ukraine, civil society (the International HIV/AIDS Alliance, the All-Ukrainian Network of People Living with HIV) catalysed the process and pulled together a consortium of stakeholders to scale up OST and integrated care for people who inject drugs including the Ukrainian Institute of Public Health Policy, the Clinton HIV/AIDS Initiative (CHAI), the Ukrainian Medical and Monitoring Centre for Alcohol and Drug Abuse, WHO, UNODC, UNAIDS and the Ukrainian AIDS Centre (which represents the government).

In Brazil, there is a special secretary directly linked to the president's office, 'the Secretaria Nacional de Politicas sobre Drogas – SENAD (the National Secretariat for Policies on Drugs), who convenes high-level multisectoral forums to decide policy.

"We all work together — the ministry of justice; the ministry of health, the ministry of social development, and there is a human rights secretariat which is very strong as well, politically speaking, and we have some very strong political partners in our parliament/congress in Brazil," said Dr Mariângela Simão, Director of Brazil's National Programme on STDs, AIDS and Hepatitis. "We have regular meetings, issue reports and hold seminars together on HIV/AIDS and drug use, and drug use in prisons, etc... But when we are talking of the ministry of health we are talking mainly the HIV and mental health departments — not so much TB."

Indeed, one thing that stood out in all the settings was that **the national TB programmes are not yet formally included in the joint planning bodies** (nor were the prison or justice departments, with the exception of Brazil). This does not mean that TB programmes are completely uninvolved — for instance, in most settings the AIDS programmes and TB programmes are collaborating; the national TB programme in Brazil is engaged in what is happening in the prison system; while some better funded community-based organisations in the Northeast of India have worked with the TB programme to pilot TB screening at targeted intervention sites. Overall, however, the TB programme are poorly engaged in issues related to drug users — and this was reflected in a weakness in implementing the remaining guidelines.

Strategic plans setting roles and responsibilities and monitoring and evaluation

Each setting either had worked or is working on strategic plans or a guideline development process with clearly delineated roles and responsibilities for delivering services to drug users — although again, TB-related activities are not being adequately addressed. For instance, India has good downloadable guidelines (http://www.nacoonline.org/upload/Policies%20&%20Guidelines/2

© Copyright NAM — All rights reserved. Please photocopy and pass on.
NAM publishes a wide range of publications on treatment for HIV. For details contact:
NAM, Lincoln House, 1 Brixton Road, London, SW9 6DE, UK
tel +44 20 7840 0050 **fax** +44 20 7735 5351 **email** info@nam.org.uk **web** www.aidsmap.com
aidsmap

7,%20NACP-III.pdf) describing how to set up drop-in centres, set up an OST site, staffing for each site, etc — but these do not yet include enough information for staff to appropriately manage TB in patients.

In Zanzibar, URRAP has developed a strategic plan that promotes a harm reduction approach to prevention and has been lobbying the government to adopt it. In the meantime, however, URRAP has developed and employed community mapping tools, monitoring and evaluation (M&E) tools and web-based database to make certain that clients received proper referrals and to track the programme's progress. This includes a two-way referral form that records a referral from an outreach worker and requests that healthcare workers at the treatment sites provide feedback on outcomes after referral. Thus far, however, it has proven difficult to get the healthcare workers at the referral sites to fill these forms out and return them to the outreach workers.

Indeed, perhaps because all of these programmes are in early development, the emphasis of monitoring and evaluation is on how much outreach has been performed to people using drugs and the referral linkages made rather than on following-up on the clients to learn their treatment outcomes. This failure to assess outcomes must be addressed because it is difficult to know whether the programmes are indeed improving the health and reducing the burden of TB/HIV in drug users.

Adequate human resources, training and supervision

Each setting has taken a somewhat different approach to providing adequately trained staff to meet the local demand for services for drug users.

Zanzibar is small in terms of both population and area, which to some extent made it easier to map its communities, looking for areas where drug users gather, and then to apportion the territory to the CBOs for nationwide coverage. The international NGO ICAP has a fair amount of expertise in launching new programmes, so it developed the tools and M&E forms the programme would use (many of these are available online at www.icap.org). ICAP also spent a considerable amount of time training the local CBOs on project and financial management to make their organisations stronger (and able to expand their services and continue the work one day on their own). Outreach workers, former drug users and other community members, are trained to serve as peer educators regarding HIV prevention and risk reduction, and to connect drug users and other MARPs to the health and support services. At the same time, health care workers at the referral sites are supposed to be 'sensitised' to the needs of drug users, and offered training (both formal, in a classroom, and on the job mentoring) to improve the quality of care provided to HIV-infected people who inject drugs. However, more supervision or mentoring is clearly needed to encourage the clinical staff to provide feedback to URRAP.

However, at the time of the site visit, training on TB/HIV was not being offered to outreach workers and CBO staff.

"We need more training on TB. Our outreach workers have little knowledge about TB, how to counsel people with TB, how to refer them and how to prevent getting TB, themselves," said Ms Fatima Sukwa, a nurse from the Department of Substance Abuse Prevention.

In India, Ukraine and Brazil, the size of the drug-using populations and territories being covered are much larger and so far, the efforts to reach them have been under-capacitated. For instance, Ukraine and Brazil do not have enough of their specialised services (integrated care sites and CAPS AD) to meet the demand in their countries. Some of these facilities are beginning to address TB/HIV but they only reach a small proportion of the drug users in the country.

Meanwhile, in India, NACO provides training and support for TI staff and plans to scale up enough TIs to cover the active drug injectors within the next few years — but there is clearly room for improvement in the programme. During site visits, CBO staff in India complained that TI and OST sites are being allotted too few workers to guarantee quality care, and that the remuneration being offered was not sufficient to hire qualified personnel (doctors and nurses). In addition although CBO staff do receive some training in TB/HIV, it is limited.

Also, in most of the countries training is primarily targeted to the workers in special services – not healthcare workers in the public health system who may be the first point of contact or the referral contact — which is crucial in those settings such as India that is relying upon effective referrals to get people into care.

There are efforts underway to address this problem in Brazil. For instance, one institution, the Unidade de Dependencia de Drogas at the Universidade Federal de Sao Paulo, offers e-training courses for healthcare professionals in Brazil who are interested in working with drug users (how to identify problems, provide brief interventions to encourage harm reduction based on the Frames Model (LINK), and how to address the health related concerns of drug users). The CAPS AD are also tasked with providing better training of primary care providers at the family health centre clinics, which may be the first point of contact to the health services.

But experts such as Professor Francisco Bastos of Fiocruz in Rio de Janeiro complain that it is not enough, and that in many facilities in Brazil healthcare staff are still very biased against drug users.

"They stigmatise the people. I heard so many times at Fiocruz, "Don't put the drug users here, put them outside, I don't want them here!" And this is in our referral lab, so you can imagine the other places! Regular doctors in Brazil are commonly prejudiced - homophobia is one of the problems; transvestites, they hate; drug users, they actually don't want to see them.

So I think we need to start with the undergraduate students and then train people to be in less denial of the problem and less prejudiced. Of course, this is not easy because we have many different universities but we could offer brief refresher courses and training."

Operational research is guiding programme development in most settings — some of it is funded by the state or the programme providing services. For instance, the consortium in Ukraine deserves special mention for documenting the evolution of their ICS programme step by step in an attempt to understand what approaches to integrating services work best, and what gaps are remaining.

Meanwhile, in other settings, local academic institutions and community based organisations are serving a watchdog function by conducting research on the quality of services being offered.

Crucially, however, programmes are not documenting the local burden of TB or TB/HIV in people who use drugs — ***which contributes to the problem being ignored***.

Implementation of the key TB/HIV services

Most services for drug users in the four case studies are fully engaged with scaling up harm reduction and HIV prevention. But while some of the key activities to reduce the burden of TB/HIV are being introduced, they sometimes seemed added on as an after thought, if at all.

TB infection control

Without implementing good TB infection control practices, people who use drugs are at high risk of being exposed to TB in health services or in other settings where they are congregated (prisons,

© Copyright NAM — All rights reserved. Please photocopy and pass on.
NAM publishes a wide range of publications on treatment for HIV. For details contact:
NAM, Lincoln House, 1 Brixton Road, London, SW9 6DE, UK
tel +44 20 7840 0050 **fax** +44 20 7735 5351 **email** info@nam.org.uk **web** www.aidsmap.com
aidsmap

homeless shelters, injecting sites/crack houses, drop in centres and support groups).

Most clinical services in the countries visited are well aware of the risks of TB transmission to their clients and staff, and most of the facilities visited in these case studies claimed to be making some effort to introduce good TB infection control. The HIV facilities in Brazil had infection control plans and advanced ventilation systems, while CAPS AD sites, such as PROSAM in Sao Paolo had used their own funds to install ventilation systems. Similarly, according to Dr Konstantin Lezhentshev of the All-Ukrainian Network of People Living with HIV, they secured funding and took whatever steps were necessary to improve TB infection control in most facilities treating people with HIV in Ukraine — including remodelling some of them. However, he noted that it is not clear that TB infection control has consistently been considered within the OST units.

Indeed, in most settings, good TB infection control is not happening in drop-in centres or other facilities (including prisons) where people using drugs gather, nor are clients and staff of these facilities being educated about how to protect themselves from TB (except to some extent in Ukraine and Brazil).

In Zanzibar, people who attend support groups are afraid of being exposed to TB.

“We know that if you have TB, it is easy to give it out to another person. As you see, the room where we meet is small. The door is not open, and the windows are closed. Last week, one person came with TB and somebody said to him that you are not allowed to come into the room,” said one support group member.

“It was the right thing to do because his TB was still active, he had been on treatment for only five days,” said Ms Sukwa. “So allow him to stay home until the time he cannot infect others. But, yes we know this is not a good place — not only for the clients but for the staff here. Because when they are inside here, they close the door and there is no air circulation.”

In India, the National Framework For Joint HIV/TB Collaborative Activities recommend introducing ‘simple and feasible’ TB infection control practices into health facilities frequented by high numbers of HIV-infected persons — but, other than vague recommendations that drop-in centres for drug users should be ‘well-ventilated,’ TB infection control is not reaching the targeted interventions.

“What about TB infection control? We know this is a problem, but we don’t have the funding to do anything about it,” said Mr Shabab Alam, Project Director for the Sharan TI-1 site in New Delhi. “The government and NACO needs to think and talk about this — and the nurses and other healthcare staff also have their health rights to be considered.”

Intensified case finding for TB & HIV testing and counselling

Detection of TB and HIV in drug users is the first step to accessing treatment, and reducing mortality and disease transmission from both diseases. HIV testing and counselling can and should be available to people using drugs, preferably at the service sites where they first present, including the specialised services which countries develop to reach them.

Likewise, routine TB screening is a simple activity that could help flag possible TB cases. The guidelines recommend, at a minimum, that trained counsellors or other lay health workers can administer a brief questionnaire on TB symptoms to screen for active TB, referring those who screen positive to a microscopy centre. Identifying TB suspects is also an important activity to protect workers at community-based organisations and health facilities from TB.

The site visits found that HIV testing and counselling were more widely available, offered at clinical sites and the specialised services in Zanzibar, Ukraine and Brazil. However, in India, people using drugs who are clients of the Targeted Interventions must be referred to a testing and counselling centre.

TB screening tends to only be provided at clinical facilities. In Zanzibar and most of India, outreach workers provide accompanied referrals to get the client to a facility that can screen for and/or diagnose TB. If they make it there, there is a high likelihood that they will be screened in Zanzibar — ICAP supported sites in Tanzania report routinely screening 99% of their clients using a simple TB symptom checklist (see annex ?).

However, with the exception of a couple of sites in Northeast India, CBO staff and outreach workers are not routinely screening for TB. Another problem in India is that the TB programme is oriented towards diagnosing smear positive TB — people with HIV often have smear-negative or extrapulmonary TB, and have to pay out of pocket for further tests to get diagnosed — which means many cases may be missed.

Treatment for TB, HIV and co-management of TB/HIV

People using drugs have the right to effective TB and HIV treatment in accordance with international clinical guidance — and even though treatment can sometimes be complex when people have multiple concurrent illnesses (including TB/HIV and hepatitis), standard treatments, including OST, can be given concurrently.

Programmes visited are attempting to improve access to medical care for drug users — which is a positive first step — and having some limited success at getting people who use drugs onto TB or HIV medication.

In Zanzibar, increasing numbers of drug users are being referred for treatment, but there are no data yet on how effective referrals to TB or HIV care are — but without OST, which encourages people to come in for care, URRAP concedes that keeping drug users in care long enough to get on treatment is a challenge.

“It’s not easy for the drug user to stay on TB treatment because most of them want to get the next fix,” said one outreach worker. “To treat an active drug user for TB, you also need to provide him with shelter and counselling.”

In India, site visits found a number of people who inject drugs who were on HIV or TB treatment, usually together with OST. Even though it is policy in India, it was harder to find people with TB/HIV coinfection on simultaneous treatment. Better funded TI sites in the Northeast, where the TI sites are closer to referral centres — and which sometimes can directly provide TB treatment — seem to be having more success at this. Elsewhere, however, people have to pay out of pocket for transport to referral facilities that can be several kilometres from the TI or OST sites.

Many never reach care. TB care in India is more decentralised than ART and so in theory, should be more accessible but the TB programme requires that people have an address to get treatment, putting drug users who live on the streets at a disadvantage.

A couple of NGOs serving people who use drugs have reached an understanding with local TB officers to get around this requirement, but this in only happening on a site-by-site basis and similar understandings need to be reached nationwide. Finally, although it is against policy, many doctors still resist prescribing antiretrovirals to drug users, even when the client is on substitution therapy and thus could use better training.

In Ukraine, the intensive phase of TB treatment can still only be delivered by a TB facility, but some have begun offering OST in order to keep people using drugs in the hospital and on TB treatment. As for antiretroviral therapy (ART), some integrated care sites have placed an infectious disease doctor on staff who can deliver treatment. Co-management of TB/HIV during the intensive phase of TB treatment is only possible at TB facilities with an infectious

© Copyright NAM — All rights reserved. Please photocopy and pass on.

NAM publishes a wide range of publications on treatment for HIV. For details contact:

NAM, Lincoln House, 1 Brixton Road, London, SW9 6DE, UK

tel +44 20 7840 0050 **fax** +44 20 7735 5351 **email** info@nam.org.uk **web** www.aidsmap.com

aidsmap

disease doctor on the team. The integrated care sites at TB dispensaries visited for these case studies were only beginning to put people on both TB treatment and antiretrovirals.

Finally, in Brazil, antiretrovirals are only available by referral to specialised facilities but if coinfected, clients should receive co-treatment.

A related issue is the availability of cotrimoxazole, which is an essential and lifesaving medication for people with active TB who are co-infected with HIV, but sites visits found that this wasn't always prescribed in Ukraine and India, despite international and national guidelines.

TB prevention using isoniazid preventive therapy (IPT)

People with HIV who have been exposed to TB are at high risk of developing active TB disease — but studies show that a course of isoniazid preventive therapy (IPT) can significantly reduce this risk. In some countries, such as India, it is not yet national policy to provide IPT to people with HIV. In others, IPT may be policy but is rarely done.

A case in point is Brazil, where it is policy to offer IPT to people known to be latently infected (shown by a positive tuberculin skin test). Some HIV centres have had more success than others at putting people with HIV onto IPT. However, some doctors are reluctant to prescribe the drug, while the requirement to have a positive skin test (which means coming to the clinic once to receive the test, and then a few days later to have the test read). Many people do not make it through this process to get onto treatment, and, at present, there are no data on the number of drug users who actually receive IPT.

Preventing HIV transmission

Drug users need access to HIV prevention services to protect themselves and their contacts from HIV. Although sharing contaminated injecting equipment is the most common means of HIV transmission among drug users, in many settings drug users are also at high risk of sexual transmission. For instance, drug users in India are far more likely to report unprotected sex with sex workers — and many have passed HIV on to their wives. Meanwhile, in Brazil, people who use drugs frequently, such as crack users, are also at high risk of HIV, presumably by sexual transmission. Dr Bastos reported that in his studies, there appeared to be a significant overlap between crack use and sex work (for drugs or money).

Most of the programmes in these case studies are geared to do HIV prevention work. In India, CBOs focus on condom distribution and clean syringe/needle exchange — although there are complaints from some TI's that they were not receiving enough needles for their clients. India's programme also promotes universal precautions to protect staff from needlestick injuries.

Clean needle kits are widely available in most Brazilian states, even though drug injecting is no longer common. Other community based organisations in Brazil are now more focused on how to reduce sexual transmission among crack users, and some are offering clean sniff kits and crack pipes to reduce the risk of hepatitis transmission from sharing.

Outreach workers report challenges promoting harm reduction and condom distribution in Zanzibar's conservative Islamic society. However, even though the community does not yet support needle exchange, the CBOs have sensitised pharmacists to at least sell syringes to drug users (which they would not do previously).

In Ukraine, the National Law on AIDS that endorses a harm reduction approach to prevention and the package of preventive services is widely available to drug users. In addition, scaling up access to OST is partly to reduce the demand for injecting opiates and to prevent transmission of HIV and other infections via unsafe injection practices.

Barriers — and overcoming them

The special services being employed in Zanzibar, India, Ukraine and Brazil are designed to overcome barriers drug users face, getting effective treatment. However, the case studies identified other remaining challenges that each country must tackle.

Models of service delivery

People using drugs suffer a number of challenges accessing care, from stigma to harassment from law enforcement, to the need to attend multiple facilities for the care that they need, so the guidelines stress that diagnostic and treatment services need to be made as convenient as possible — by collocating services if possible. Barring that, referrals should at the very least be accompanied to make certain that effective linkages to care are made.

Collocation of services varied by setting. Increasingly TB treatment is being provided at HIV facilities (except in Ukraine), and Brazil's HIV programme is now offering Hepatitis C treatment as well. However, only in Ukraine is the full integration of services being achieved — and even then it is only at a handful of sites.

"When all of these medical services were offered and rendered on the same spot at the same place, it was extremely convenient, it was great for the client," said Vasiliy Chervenkov, a social worker with the Rainbow Veselka Charity Fund, describing the Integrated Care Centre (ICC) piloted at the Odessa Narcological Dispensary which was temporarily suspended due to interruptions in funding "Now when the client comes here, he gets substitution therapy but unless someone accompanies him, the chances that he will go to the different facilities to be diagnosed, to be treated, are very low. But if a person could still come and have a chance to see the specialists here and receive all of the necessary medical help and support and medications here — that would be the best thing, the best solution."

In India and Brazil, ART treatment is still only available from specialised facilities, which limits access, especially for drug users. Some experts in Brazil think this must change.

"The CAPS AD are a major achievement. But what I think is still missing in Brazil is what they call "co-location of services. So you can go to one place and can get everything you need in the same place. This is very very uncommon in Brazil. But only the accredited clinic could deliver ARVs. CAPS AD cannot deliver ARVs. So far there is no solution integrating everything yet," said Dr Bastos during one meeting

"They often must be linked to at least two or three services for diagnosis, and treatment of multiple conditions. But it's quite painful and hard for the patient to go into so many different places," Veriano Terto, Jr, Executive Director of the Associação Brasileira Interdisciplinar de AIDS (ABIA) in Rio de Janiero said in agreement.

"My concern as a citizen and as a researcher is that we fought, all of us and from different institutions and civil society, for years and years and years for what we call universal access to ARVs. My concern is that we can have universal access - that's true, the drugs are available - but that we have created a new divide between people who know how to navigate the system i.e. the best informed people and the people that cannot navigate the system well. So instead of improving the equity of the system we can have the opposite, we can just give the best care for the people less in need and the worse care for those most in need. Because if you are co-infected with many different things, you are most in need of very

© Copyright NAM — All rights reserved. Please photocopy and pass on.

NAM publishes a wide range of publications on treatment for HIV. For details contact:

NAM, Lincoln House, 1 Brixton Road, London, SW9 6DE, UK

tel +44 20 7840 0050 **fax** +44 20 7735 5351 **email** info@nam.org.uk **web** www.aidsmap.com

aidsmap

good quality care. It's too complicated if you are poor and you have no money for the bus," Dr Bastos concluded.

Prisons and other places of detention

Given the greater risks of HIV, TB and other infections such as hepatitis B and C in people placed in overcrowded and poorly ventilated prisons, people who are admitted to prison should receive a medical examination upon entry and whenever needed afterwards. They should receive care that is equivalent to what civilians receive — and there should be mechanisms put in place to ensure continuous care upon being transferred in and out of places of detention.

However, there is no equivalence of care in the prison system in Zanzibar or any of these countries, although there are pilot projects in some countries such as in Tihar Prison in India, and Manaus in Brazil.

Adherence

While many doctors are afraid to administer TB treatment or ART to drug users because they are afraid that they won't take their medications and could develop drug-resistance, but interventions tailored to their problems can achieve high treatment adherence rates [it would be good to have a citation or two here]. These could include adherence reminders, adherence counselling, contingency management, supervised therapy, OST and ancillary services.

OST in particular can help retain people in care. For instance, in India, some OST sites have made arrangements with local DOTS (TB medication) providers to allow them to give the medications together with OST. In Ukraine, there is increasing interest in using OST to keep people who use drugs from developing multi-drug resistant TB and even more resistant strains. However, the scale-up of OST remains too limited — it really is an essential tool to keep people who use opioids on care and in services.

"The AIDS Centre is far away and it's still a hassle to get and stay on treatment," said one client at the Odessa Narcological Dispensary. "If we were not receiving substitution therapy, we wouldn't care, we wouldn't be bothered about all of this. Because we would be busy with other things like looking for money, and looking for ways to find drugs."

In other settings where stimulants are the preferred drug, there is no comparable drug dependency treatment. Furthermore, the adherence problems may actually be more associated with living on the street, and trying to simply survive. So at the Centro de Referência e Treinamento-DST/AIDS (CRT) in Sao Paolo Brazil (an AIDS reference centre), they have an in-house multidisciplinary team of social workers, psychiatrist, art therapists, psychologists and counsellors who work to find solutions that work for the individual.

"Right now, we have 3 adherence groups, some in harm reduction, some just using alcohol/drugs. If you add it up, about 400-450 heavy drug users," said one counsellor at the site. "We are working with what the patient can do at that moment — we work with whatever baggage they have. But we don't push abstinence — we have a very non-judgemental approach."

Managing co-morbidities

As already noted, drug users can have many health problems that need care and treatment but these do not contraindicate HIV or TB treatment, nor should mental health problems or active drug or alcohol use be used as a reason to withhold treatment.

While there were reports in each country that doctors use co-morbidities such as hepatitis as an excuse not to put people who use drugs on multiple treatments, access to care for drug users in India, Ukraine and Brazil has improved where specialised services have been put in place. However, unaddressed co-morbidities do create challenges to effective treatment.

For instance, to date, the Indian AIDS programme doesn't see hepatitis as their problem and instructs outreach staff to refer drug users with hepatitis to the general health services. However, India's public health service does not see hepatitis C as a problem of public health significance to the general population and so does not offer treatment. Hepatitis C is a problem specific to people who inject drugs who simply are not receiving care. Left untreated, it can complicate HIV and TB management.

In contrast, in Brazil, the AIDS programme has taken on responsibility for treating viral hepatitis as well, although there are logistical challenges that still must be worked out to collocate diagnosis and treatment in some settings.

Also in Brazil, there is an understanding that the universal right to treatment applies to *active* drug users as well.

"Even using drugs, you are a citizen and you have rights. The fact that you take drugs doesn't mean that you don't have a right to treatment," said Dr Marcio Barbeito, Director of the CAPS AD Centro Rio.

Global lessons and remaining barriers

Overall, many of these specialised services for drug users are recent developments, and the case studies found that no one is fully following the guidelines yet. However, there are some examples of best practice that may be useful to countries in similar situations. For instance, for settings with no services for drug users, Zanzibar may offer an example of how to capacitate local CBOs to begin to engage people using drugs and the health services. India takes this a step further, by integrating and supporting the CBOs working with drug users into the government's response to help drug users access services.

The integrated care sites in Ukraine serve as examples for countries saddled with very verticalised health programmes. In Brazil, the AIDS programme has taken a harm reduction approach to provide support and treatment to drug users seeking HIV services, and the government has also recently set up dedicated clinics for drug users. Brazil is also an interesting study for evolving practices working with crack cocaine/stimulant users.

However, the case studies found a number of remaining barriers in each setting.

In Zanzibar, things like needle exchange are still considered very controversial and support services are only 'recovery' abstinence-based.

In India, the scale of services is limited by funds (there is fierce competition for resources for health in India) and the targeted interventions for drug users are minimally resourced. Nevertheless, the bulk of responsibility for making sure that drug users reach services has been placed on community-based organisations, staffed by poorly-paid people and often they have to use their own funds to help patients.

In Ukraine, the vertical programmes are still very entrenched and facilities have to be both very determined and creative to piece together a multidisciplinary team on a site-by-site basis. It is an almost parallel system supported largely by outside funders that may not be sustainable in the long run until the government takes ownership of the programme and changes policies that keep the system so rigidly vertical. Another problem is that TB care is not really in line with global guidelines. Finally, restrictive policies, paperwork, and patient registration limits OST scale up, and continuity of care is threatened by funding gaps and police actions.

Brazil faces the problem that there are limited evidence-based treatment options for people who use crack. Another problem is that although harm reduction is the Ministry of Health's policy, policy is implemented at the local level, and some state and municipal

© Copyright NAM — All rights reserved. Please photocopy and pass on.
NAM publishes a wide range of publications on treatment for HIV. For details contact:
NAM, Lincoln House, 1 Brixton Road, London, SW9 6DE, UK
tel +44 20 7840 0050 **fax** +44 20 7735 5351 **email** info@nam.org.uk **web** www.aidsmap.com
aidsmap

governments have cut off funding from harm reduction programmes. Although many of the CAPS AD follow a harm reduction approach, not all do.

But the most clear and troubling finding was that ***TB/HIV is not receiving adequate attention anywhere***. grammes have been primarily concerned with scaling up outreach services for drug users, and have primarily been led by stakeholders working in HIV or mental health. The TB programmes simply have not been engaged — and in some cases, have shown little interest. One potential reason for this could be that, outside of Ukraine there is little local data on the burden of TB or drug resistant TB among drug users.

The result of failing to address TB/HIV is inevitably unnecessary illness, increased TB transmission and deaths from TB. But consistently, at each site visited, drug users were very worried about TB — much more than the policy makers. Many had had TB themselves or knew someone who had died of TB.

One outreach worker in Zanzibar complained about the difficulty getting an active drug user onto TB treatment.

"I meet with people who are drug users with both TB and HIV who I can't convince to come into care, and I've wondered whether I could perhaps deliver the medications to them," said one peer outreach worker.

"I know a lot of drug users with HIV or TB who have died. Some people die of TB or a mix of different things. Many who are ill simply give up and inject themselves, have overdoses," said another outreach worker.

The roll of community and next steps

Implementation of the complete guidelines is urgently needed but someone has to catalyse the process. In some settings, such as Brazil, the federal government initiated programmes such as CAPS AD although these need to be expanded and, potentially, made one-stop shops for care. In Zanzibar, one progressive international NGO (ICAP) got the ball rolling.

But in settings such as Ukraine and India, it has clearly been civil society and the drug using community which has started the process — with the goal being that government will, one day, buy-in to the programme, as it has in India.

"Sharan has been running this programme providing a comprehensive package of care for injecting drug users - basically the street-based injecting drug users — since 1993. Our organization is in fact the pioneer in India - the first one to offer such services," said Shalini Singh at Sharan's headquarters in New Delhi.

"SHARAN started out as a community-based organization working with the migrants and the population which was not being accessed by the other public healthcare systems. And the work started with providing them with basic healthcare facilities and education. After we encountered drug use in this population, through our interaction with them, through our dealings with various communities - we found out that they are really at the lowest rung of society's ladder and often they are shunned away from the public health facilities. And that's how we discovered that that is where our role needs to be - to cater to what is it that will improve their health status and bring them to a position where they will be able to do something about themselves."

It was the example of Sharan and other groups like it, that demonstrated to the government in India that people using drugs can be reached and brought in for health services.

"Now the government has taken on responsibility for running many of the sites we started, said Ms Singh, "but the continued engagement of community in the planning and implementation of the programme is essential to maintain the quality of the services."

In Ukraine, civil society fought for the National AIDS Law which, in theory, enshrined universal access to treatment and a harm reduction approach — and when the government failed to efficiently manage funding for treatment and services, civil society organisations like the International HIV/AIDS Alliance and the All-Ukrainian Network of People Living with HIV and AIDS stepped in to make sure that the ART programme and other services could begin scaling up. Civil society has also advocated tirelessly for the provision of OST for people who inject drugs, and have been major players in the effort to develop integrated care sites.

In Brazil, although the federal government pursues and funds drug-user friendly policies regarding treatment and prevention, local governments sometimes do not disburse the money. So now civil society organisations, such as ABIA in Rio, have begun to take the local government to court, to demand withheld funding.

"They say, 'No we cannot raise the salaries of the health professionals because we don't have funds available', or 'We cannot buy those medicines or the interferon because it is very expensive,' said ABIA's Mr Terto. "So we denounce them publicly, and say 'Show at the court that you don't have money! Bring your budget to the court!' And the judges must do that, must ask them to prove that they don't have the money."

Civil society has been amazingly effective at getting HIV services for drug users introduced into these and other settings. But now it is time to demand the involvement of the TB programme.

Civil society needs to demand access to TB/HIV services and raise political commitment. One way of doing this will be to monitor access to TB care by drug users, as Indian Network for People Living with HIV (INP+) has done. Civil society can also work with academia or encourage the AIDS programme to perform a situational analysis providing a general idea of the extent of the TB burden and other illnesses among it's drug using clients. This could help make a case that gets the national TB programmes attention, and could provide leverage to bring necessary sectors in government together for joint planning and service implementation.

Nevertheless, community needs to be talking to the TB programme, whether it wants to talk back or not.

© Copyright NAM — All rights reserved. Please photocopy and pass on.

NAM publishes a wide range of publications on treatment for HIV. For details contact:

NAM, Lincoln House, 1 Brixton Road, London, SW9 6DE, UK
tel +44 20 7840 0050 **fax** +44 20 7735 5351 **email** info@nam.org.uk **web** www.aidsmap.com

aidsmap