



**ANTIRETROVIRAL**

**TREATMENT**

**FOR INJECTING DRUG USERS**

**IN CENTRAL AND EASTERN EUROPE**

**BARRIERS TO ACCESS - AND WAYS TO OVERCOME THEM**



The **European AIDS Treatment Group (EATG)** was founded in 1991. It is a voluntary organization made up of 90 members from 34 different European countries. Our members are representatives of different communities affected by HIV/AIDS in Europe. Since its founding, **EATG** has been at the forefront of developing the civil society response to the HIV epidemic in Europe.

**EATG's** mission is to achieve the fastest possible access to state-of-the-art medical products, devices and diagnostic tests that prevent or treat HIV infection or improve the quality of life of people living with or at risk for HIV. In responding to HIV, **EATG** also addresses major HIV coinfections, as well as other health issues that increase the risk of HIV infection. **EATG's** primary geographic focus is the 53 member states of the WHO European Region. For more information, visit [www.eatg.org](http://www.eatg.org).

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## ABBREVIATIONS

<b>AIDS</b>	acquired immune deficiency syndrome
<b>ART</b>	antiretroviral therapy
<b>ARV</b>	antiretroviral (drug)
<b>CEEHRN</b>	Central and Eastern European Harm Reduction Network (now EHRN)
<b>EATG</b>	European AIDS Treatment Group
<b>EHRN</b>	Eurasian Harm Reduction Network
<b>EU</b>	European Union
<b>EuroHIV</b>	European Centre for the Epidemiological Monitoring of AIDS
<b>Global Fund</b>	Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>HCV</b>	hepatitis C virus
<b>HIV</b>	human immunodeficiency virus
<b>IDU</b>	injecting drug user
<b>MDR</b>	multidrug-resistant (said of tuberculosis)
<b>NGO</b>	non-governmental organisation
<b>OST</b>	opioid substitution therapy
<b>PLHIV</b>	person (or people) living with HIV
<b>TB</b>	tuberculosis
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNODC</b>	United Nations Office on Drugs and Crime
<b>UNGASS</b>	United Nations General Assembly Special Session on HIV/AIDS
<b>VCT</b>	voluntary counselling and testing
<b>WHO</b>	World Health Organization

# EXECUTIVE SUMMARY

A decade ago, antiretroviral therapy (ART) transformed the prognosis for HIV from a terrible, protracted death into a manageable chronic illness. A country that provides infected people with ART safeguards their right to health while enabling them to lead long, productive lives and minimizing their infectiousness. Now that the cost of antiretroviral drugs (ARVs) has dropped significantly, countries across the world are striving to honour their commitment to provide ART to everyone who needs it.

Central and Eastern Europe are home to nearly 2 million people living with HIV, and the vast majority of them contracted it by sharing contaminated injecting equipment. Yet despite the moral obligation and long-term cost-effectiveness of making access to ART universal, extremely few of the region's injecting drug users (IDUs) who would benefit from treatment are in fact being treated. This report explores a dozen key strategies that organizations and governments have been successfully using to expand IDU access to ART:

- **holding politicians accountable** to making good on their countries' international commitments to providing universal access to HIV treatment and care;
- **seeking outside support**, both financial and technical, from UN agencies and other international organizations;
- **making HIV services easy to access** through convenient hours, convenient locations, mobile service teams, a minimum of registration requirements and service integration;
- **helping IDUs navigate unintegrated public services**, including HIV and drug services, chiefly through better service linkages and case management;
- **educating IDUs, service providers and the general public about ART and injecting drug use**, particularly through the use of peer educators;
- **building trust between IDUs and service providers**, most notably through the use of peer counselors;
- **treating drug dependence**, especially with opioid substitution therapy (OST);
- **targeting users of amphetamine-type stimulants (ATS)**, which are increasingly popular but poorly researched;
- **involving IDUs in programme planning, implementation and monitoring**
- **combating stigma and discrimination** that both IDUs and people living with HIV (PLHIV) must confront; and
- **monitoring and evaluating HIV services for IDUs**, particularly ART.

The report concludes on p. 19 with an action map – a list of concrete steps to take in implementing each of the above strategies.

# INTRODUCTION

As the World Health Organization (WHO) and other groups have shown, antiretroviral therapy (ART) is effective in treating injecting drug users (IDUs) for HIV – *provided* they receive adequate support.<sup>1, 2</sup> The effectiveness of ART has been demonstrated for both active and former IDUs, including those on opioid substitution therapy (OST). The benefits are manifold and include cost-effectively improving both individual and public health, reducing HIV transmission and honouring everyone's right to health.<sup>1, 2, 3</sup>

Many countries in Central and Eastern Europe are finally beginning to scale up overall access to ART.<sup>4</sup> Although some of these countries, typically those with lower HIV prevalence rates, now provide good access, people living with HIV (PLHIV) in most still face substantial barriers in accessing ART. The obstacles are particularly daunting for IDUs, who comprise the majority of those in the region needing ART but must contend with disproportionately low access to treatment and care services in general. Fortunately, even the countries where ART access is negligible have set ambitious targets for improving it. Together with increased outside funding, substantial reductions in antiretroviral (ARV) prices and the availability of good practice models, these national commitments place major improvements in IDU access to ART well within reach.

This report examines the barriers that Central and Eastern European IDUs face in accessing ART, and it highlights some of the ways that non-governmental organizations (NGOs) and governments have found to overcome these obstacles. It is based on an extensive literature review, and on surveys and interviews conducted with activists across the region who work with this issue, including representatives from local PLHIV groups, IDU groups and other NGOs.

## HIV AND INJECTING DRUG USE

The HIV epidemics of Eastern European countries exhibit a substantially different pattern of development than those of Central Europe – and a correspondingly different impact on injecting drug users. In Eastern Europe, the HIV epidemic is growing rapidly, and the people affected most are IDUs and their sexual partners. Today, the area is home to an estimated 1.6 million PLHIV<sup>5</sup> and 3.7 million IDUs.<sup>6</sup>

Injecting drug use is the primary mode of HIV transmission for every country in Eastern Europe (see Table 1 in Annex 1). Ninety-one percent of Eastern European PLHIV live in Russia or Ukraine. In most of Eastern Europe, a rapid increase in the number of HIV cases was observed among IDUs in the late 1990s and early 2000s. In 2006, almost two thirds of the region's new cases with a known mode of transmission were attributed to injecting drug use, and almost all the rest to unprotected heterosexual intercourse. Meanwhile, the proportion of IDUs who are also PLHIV varies significantly throughout the area, from almost nothing in some countries and cities to more than 50% in others.<sup>5, 7</sup>

In Central Europe, on the other hand, HIV prevalence is low and not so strongly linked to drug injecting (see Table 2 in Annex 1). The overall HIV picture is more heterogeneous, with different transmission modes predominating

in different countries. Poland is the only Central European country to report injecting drug use as the primary transmission route; it also has the highest overall number of HIV-positive IDUs.

In countries where sharing drug injecting equipment is the major route of HIV transmission, the prison systems house especially large numbers of HIV-positive IDUs. In Lithuania, for instance, the prevalence of injecting drug use in the prison population is estimated to be 15.3%,<sup>8</sup> while more than 20% of the country's PLHIV were incarcerated in November 2007,<sup>9</sup> and the overlap is presumably substantial.

## COINFECTIONS

The countries where shared injecting equipment is the major cause of HIV transmission also record higher rates of tuberculosis (TB) coinfection, including multidrug-resistant (MDR) forms. The limited data available suggest that in some of these countries, TB is a major cause of death among PLHIV. For example, Ukrainian National Institute of TB data show that as much as 63% of the country's AIDS-related mortality is attributable to TB, chiefly among IDUs.

To an even greater extent, countries with IDU-driven HIV epidemics report high rates of viral hepatitis, especially the hepatitis C virus (HCV), which is commonly transmitted by shared injecting equipment. Again, statistics on HIV/HCV coinfection in Central and Eastern Europe are limited, but one survey suggests that it varies substantially, ranging from less than 5% of all PLHIV (including non-IDUs) in most Central European countries to nearly 80% in Estonia and Ukraine<sup>10</sup>. Untreated, hepatitis B and C often end in liver failure, which evidence shows is a key cause of death among PLHIV in countries where HIV is transmitted primarily by drug-injecting behaviours.<sup>11, 12, 13</sup>

## ACCESS TO ANTIRETROVIRAL THERAPY (ART)

### ART in the general population

Eastern Europe made significant progress in scaling up ART access between 2002 and 2006, yet access remains quite limited. Though coverage has been very low in Russia and Ukraine, where most of the region's PLHIV live, both countries plan to scale it up dramatically by late 2008 - to 60% and 55%, respectively, of those in need.<sup>14, 15</sup> In Ukraine, the scale-up is funded largely by the Global Fund to Fight AIDS, Tuberculosis and Malaria and led by the International HIV/AIDS Alliance in Ukraine and the All-Ukrainian Network of People Living With HIV/AIDS, which have handed over treatment of 6000 ART recipients to the government and will hand over responsibility for many more by 2010. Russia has committed significant resources to supplement Global Fund treatment funding.<sup>16</sup> The Baltic states have also increased ART efforts substantially (e.g. a sevenfold increase in Estonia), while some Caucasian and Central Asian countries have recently introduced ART.

Nevertheless, Eastern Europe has the second lowest ART coverage of any global region of low- and middle-income countries - averaging just 15% of those in need at the end of 2006.<sup>4</sup>

In Central Europe, many countries were already providing "good" access to ART (defined as 75% of those in need) by 2004, similar to access levels in Western Europe.<sup>17</sup> Data on quality of care remain limited, however, and significant obstacles to access persist in the two Central European countries with large populations of HIV-positive IDUs, Poland and Serbia.

### **ART for IDUs**

According to unpublished WHO data, the number of Eastern European IDUs on ART was increasing at the end of 2006. Back in 2002 and 2004, IDU access to ART was extremely poor in Eastern Europe, notably in Russia, Ukraine, the three Baltic states and the Central Asian republics. Since then, antiretroviral therapy has become more accessible - and equitable - for IDUs in much of the region, though it still lags behind access for non-IDUs. Although ART tends to be more accessible for IDUs in Central Europe, they still face many access challenges too.

Many cities and countries in the region exclude active IDUs - typically defined as people who have injected in the previous four weeks, and frequently regarded as incapable of adherence - from ART, though in other localities they have been treated quite successfully (see Table 3 in Annex 2). Many local areas, including some in Russia, have in fact shown much more progress on this issue than national statistics indicate.

### **ART and opioid substitution therapy (OST)**

It is estimated that HIV prevention services, which include drug dependency treatment, reach less than 10% of the IDUs in Eastern Europe.<sup>18</sup> Of the 9534 people on OST in 16 Central and Eastern European countries at the end of 2005, more than half were concentrated in two relatively small countries with modest opioid-injecting populations, the Czech Republic and Slovenia. In most of the other countries, OST uptake did not exceed 5% of the estimated IDU population.<sup>19</sup>

Every country of the region that offers OST prioritizes the enrolment of PLHIV. It is worth noting that, at the end of 2005, OST clients comprised the majority of IDUs on ART in two countries - Bulgaria (67%) and Slovenia (60%). The figure is less than 31% for the other countries providing data (see Annex 2). Meanwhile, Russia continues to outlaw OST, and its drug dependence treatment services are fragmented, poor in quality and largely free from evidence-based approaches.<sup>20</sup>

### **ART for prisoners**

Prisons in the region merit special attention, since they have often served as “incubators” for injecting drug use, HIV, TB and hepatitis. Fortunately, their captive populations are relatively easy to reach with prevention and treatment services, and respondents from 9 of the 15 countries surveyed for this paper reported that access to ART was relatively good in prison - in some places, even better than outside. Nonetheless, prisoner access to ART is still not universal in most of these countries, and all but nonexistent in others. For incarcerated IDUs, OST is also absent or severely limited in most of the region, with the exception of Slovenia and a few other Central European countries.

# STRATEGIES FOR IMPROVING IDUS' ACCESS TO ART

There are no hard-to-reach populations - only hard-to-reach services.

-Participant, 2007 Correlation Network conference, Sofia, Bulgaria

Access to ART has been improving throughout Central and Eastern Europe. However, the region's IDUs still face great obstacles in accessing HIV care, especially in the countries with the most HIV-positive IDUs. It is therefore essential to examine the factors that impede such access - and the factors that facilitate it. While the region is home to a variety of initiatives that have proven effective in overcoming these obstacles, they remain limited in number and scope. This section highlights a few of these good practices, in the hope that they can inspire similar efforts elsewhere. They demonstrate that, when there is a political commitment to providing IDUs with appropriate health and social support, ART can vastly improve the lives of infected IDUs - *and* reduce HIV transmission. As a result, governments that reach out to IDUs who require treatment not only provide an invaluable humanitarian service and honour their international commitments; they also act to mitigate a major public health catastrophe.

Good practices in this field are built upon several crosscutting principles. They include:

- designing services around IDU needs;
- changing offerings that prove ineffective;
- proactively reaching out to IDUs where they gather;
- respecting the human rights and dignity of IDUs;
- supporting IDU and PLHIV communities and involving them in planning, delivering and evaluating services and policies; and
- promoting the treatment literacy of everyone who provides or receives ART.

## HOLD POLITICIANS ACCOUNTABLE

Providing IDUs with universal access to ART and other HIV services requires political will at the highest level. The governments of Central and Eastern Europe have all signed commitments to implement universal access to HIV treatment (including the UNGASS Declaration of Commitment) and uphold the right to health (including the International Covenant on Economic, Social and Cultural Rights). Regional commitments such as the Dublin Declaration, the Vilnius Declaration and many European Union (EU) policies also support these objectives, though their specificity varies. Civil society organizations can take an active role in encouraging governments to honour their commitments by invoking them and actively monitoring and evaluating their implementation.

Unfortunately, policies supporting universal treatment access and the right to health are rarely implemented fully. Decision-makers are too often unaware - or have forgotten, or postponed acting on - such commitments by their countries. For instance, in 2004, each of the 52 nations in the WHO European Region signed the Dublin

Declaration, obligating them (among other things) to provide universal access to ART to everyone who needed it by 2005, and to scale up IDU access to drug dependence treatment and harm reduction services.<sup>21</sup> Yet the low- and middle-income countries of Eastern Europe continue to have some of the poorest access to ART in the world.<sup>4</sup>

In the EU, several key papers are worth noting, including its drug strategy,<sup>22</sup> drug action plans (2005-2008 and 2009-2012)<sup>23</sup> and a high-level recommendation on harm reduction for drug dependence.<sup>24</sup> These documents focus on improving drug services (including evidence-based harm reduction and drug treatment) and addressing injecting drug use and injecting-related health problems in prisons. Several recent EU reports<sup>25, 26, 27</sup> indicate that while drug services are improving in the new EU member states of Central and Eastern Europe, implementation remains uneven, with prison services being particularly problematic.

Many Central and Eastern European countries have also established ambitious universal access targets for 2008 and 2010 for HIV prevention, treatment, and care. In some countries, civil society organizations have played a key role in establishing these targets. They also helped develop national reports on progress toward their fulfilment. In other countries, when an official progress report on implementing the UNGASS Declaration of Commitment misrepresented the national situation, civil society organizations have prepared a “shadow report” that highlighted areas needing further attention.<sup>28</sup>

### GOOD PRACTICE



In Russia, civil society organizations (including the Russian Union of PLHIV, the Russian Harm Reduction Network and the HIV NGO Forum) have helped establish national indicators and targets for achieving universal access to HIV prevention, treatment and care by 2010. When the country's UNGASS progress report neglected critical issues, these groups produced a shadow report describing key gaps, particularly in HIV care, and suggested ways to bridge them.<sup>28</sup>

Another way to assess implementation of universal access to ART and related commitments is to track the proportion of IDUs and prisoners on ART, both nationally and locally. Instruments for monitoring IDU access to essential HIV services (including ART) will be available in forthcoming guidelines from WHO, United Nations Office on Drugs and Crime (UNODC) and UNAIDS on monitoring universal access to HIV services among IDUs.

### SEEK OUTSIDE SUPPORT

Finding the national resources to expand drug users' access to ART can be daunting, as can the challenge of developing and implementing effective programmes to provide such access. Fortunately, a substantial amount of international financial and technical assistance is available for addressing precisely these needs.

Over the last few years, the Global Fund to Fight AIDS, Tuberculosis and Malaria has funded more of the Central and Eastern European HIV response than any other donor. Global Fund resources are available for only part of the region, however, and its support will be phased out as national economies become stronger. National resources are thus becoming more critical than ever to ensure the sustained availability of HIV medicines and care.

Several UN agencies support the improvement of HIV services for IDUs, notably UNODC, which implements large programmes in the Baltic states, the Central Asian republics, Romania and Russia. The WHO Regional Office for Europe also provides technical assistance for some countries on developing, adapting and implementing clinical guidance on ART provision for IDUs. Together, WHO, UNODC and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have developed a series of papers on developing HIV policies and services for injecting drug users, which can be found at [www.who.int/hiv/idu](http://www.who.int/hiv/idu). UNAIDS and the United Nations Development Programme (UNDP) have also made the issue more visible on national and international political agendas and provided a variety of support to national stakeholders. For instance, UNAIDS has improved the efficiency and effectiveness of national HIV efforts by urging governments to implement the Three Ones model, which concentrates the national response to HIV in one national action framework, one HIV coordinating authority and one national monitoring and evaluation system.<sup>29</sup> In addition, the Open Society Institute (OSI) provides financial and technical resources for developing pilot HIV programmes for IDUs. Regional groups - such as the Harm Reduction Knowledge Hub of the Eurasian Harm Reduction Network (EHRN)<sup>30</sup>, and the Regional Knowledge Hub for the Care and Treatment of HIV/AIDS in Eurasia<sup>31</sup> - are also invaluable sources of technical assistance, training and networking.

Finally, for stakeholders in EU member states, the EU provides support in capacity building, sharing good practices and (to a limited degree) research through its public health, research and drug prevention programmes. Neighbouring countries can also obtain some limited assistance.

## MAKE VCT AND OTHER HIV SERVICES EASY TO ACCESS

Some HIV counselling and testing services require minimal effort to utilize - e.g. no forms or identification. Such low-threshold services are widely recognized as a critical entry point to the continuum of HIV care, especially for IDUs. Though some countries in Central and Eastern Europe test large portions of their populations - Russia conducts 20 million HIV tests each year, for example - these programmes are often not designed to reach risk populations. Several respondents mentioned that Voluntary Counseling and Testing (VCT) services were often inaccessible to drug users in their countries. Among the obstacles they mentioned were inconvenient opening hours (such as mornings only), lack of confidentiality, distant locations, stigmatization and the fear of being officially registered as a drug user. Others described how inadequate counselling further limits the benefits of testing, in both preventing transmission and promoting appropriate care.

Nonetheless, the respondents noted several good examples in the region of ways to make VCT more accessible to IDUs, most notably by providing it through harm reduction services. In St Petersburg, Russia, testing and counselling is available at needle exchange venues, along with referrals to a local hospital when appropriate. In Dnipropetrovsk, Ukraine, the introduction of rapid testing at a needle exchange point increased

### GOOD PRACTICE



DIA+LOGS ([www.diacentrs.lv](http://www.diacentrs.lv)), a Latvian NGO, provides low-threshold access to rapid HIV and HCV testing and other services, such as the provision of sterile injecting equipment and condoms, through both a stationary site and a mobile unit. It also offers its services during hours that are convenient for its clientele, including times that fall outside typical office hours.

overall testing uptake. Similar results were observed in Latvia, where most low-threshold IDU services provide rapid tests for HIV and HCV as well as referrals for confirmation testing. In Estonia, several VCT sites provide free, low-threshold services, such as the site run by the NGO Convictus, which is open from 10 am to 10 pm.

## GOOD PRACTICE



In Armenia, a multidisciplinary team increases access to services for 420 PLHIV who live outside of the capital city by using a mobile clinic to bring treatment to them where they live. The programme is the joint work of the National AIDS Center and a PLHIV group called Real World, Real People ([www.realwrp.net](http://www.realwrp.net)).

Many countries in the region make all HIV services unintentionally difficult for PLHIV to access, particularly those who are IDUs. As with VCT, there is a tendency for HIV treatment, care and other services to be geographically inconvenient. In some cases, HIV services are available only in large cities, which makes them costly and time-consuming for people living elsewhere to utilize. Hungary is one country that counters this difficulty by reimbursing travel costs, making services more accessible to patients. Such a programme was also available for a short time in St Petersburg until international financing ran out.

Other common barriers are limited hours of operation and the geographical separation of individual services. For example, though the Dnipropetrovsk needle exchange programme encourages IDUs to access HIV services by providing rapid testing on site, it remains difficult to access other services. Enrolment in ART requires patients to visit several sites for various tests, some of them available only at inconvenient times; moreover, IDUs know that they risk being excluded from ART because of their drug use.

Meanwhile, Russia's Global Fund Round 5 project trains harm reduction outreach workers in treatment literacy and helps harm reduction services develop mutual referral plans and integrate their offerings with local HIV services, as well as other health and social services. However, such efforts are only pilot programmes, rather than initiatives implemented systematically on a large scale. Moreover, IDU harm reduction services in the region have limited coverage, estimated to reach less than 10% of IDUs in Eastern Europe,<sup>18</sup> though a few countries report reaching around 47%<sup>32</sup>. Expanding IDU access to ART through harm reduction services will thus require expanding the coverage of existing harm reduction efforts.

## GOOD PRACTICE



In Kazan, Russia, an NGO called Renewal runs a drop-in centre providing various low-threshold services for IDUs, including needle exchange, blood-drawing for HIV monitoring, dispensing ARVs, intensive efforts to encourage adherence and other medical and social services. The presence of these easy-to-use services in one place makes ART available to IDUs who otherwise would not take advantage of it.

## HELP IDUS NAVIGATE UNINTEGRATED PUBLIC SERVICES

One of the most frequently mentioned but most difficult to address barriers to health care access for the region's IDUs is the vertical nature of many services - the fact that that HIV, TB, hepatitis, addiction and mental health care services are offered separately. While offering such services in the same location and thus giving patients "one-stop shopping" has proven optimal, it is rarely seen in Central and Eastern Europe. One respondent from Slovakia did mention that integrated services were available in three infectious disease clinics there, but such an arrangement is atypical, especially in Eastern Europe. One interviewee and survey respondent noted that inpatient services in Russia were becoming more integrated, though similar improvements have not yet been evident in outpatient care.

When cooperation between separate disease services is weak, it is difficult for doctors to coordinate prescriptions. For example, a respondent from Ukraine noted problems in coordinating hepatitis and HIV treatment. Several interviewees also said that, due to poor coordination between OST and ART programmes, opioid substitution dosages were not adequately adjusted for people on ART.

In addition to complicating interactions between health care professionals, separated services are difficult for patients to use. Their facilities are often located in separate parts of a city, and each typically requires its own paperwork. Respondents noted that the bureaucratic hassles of navigating the system lead many people to avoid it altogether. However, several promising methods have been developed to minimize the disadvantages of vertical services. The Globus project in Russia, for instance, uses multidisciplinary teams to look at the overall needs of each patient. Referrals between services have improved in some cities in the region, though they often remain informal and unsystematic.

### GOOD PRACTICE +

The Ukrainian NGO VIRTUS in Dnipropetrovsk ([eatg.org/Projects/vulnerable-populations/Injecting-drug-users/HIV-treatment-for-people-who-use-drugs-in-new-EU-member-states-Eastern-Europe-and-Central-Asia](http://eatg.org/Projects/vulnerable-populations/Injecting-drug-users/HIV-treatment-for-people-who-use-drugs-in-new-EU-member-states-Eastern-Europe-and-Central-Asia)) is a group led by people who use drugs. It meets the multiple needs of 44 IDUs through case management activities such as recovering lost identification documents, helping enrol children in school, accompanying IDUs to health care facilities and visiting them in inpatient settings.

Some NGOs and self-help initiatives have also started to provide case management, guiding infected IDUs through the myriad medical and social services they must utilize to access ART. Case managers help patients with paperwork, accompany them to appointments and serve as patient advocates, among other functions. A case manager may be a trained medical nurse, a social worker or a peer counsellor, typically at an AIDS centre or an NGO. Most respondents reported that case management was available at just one or two sites in their countries. Where case-management approaches *are* being developed, interviewees said that there was not yet a clear model for practicing it, nor was its position within the existing health care system well defined. Several respondents also mentioned that, like peer counsellors, case managers were often poorly paid and subject to very high turnover.

## EDUCATE IDUS AND THE GENERAL PUBLIC ABOUT ART AND INJECTING DRUG USE

Questionnaire respondents frequently mentioned IDUs' poor knowledge and misconceptions about ART as a major barrier to access. The general population is likewise often uninformed about the existence and availability of HIV treatment. Respondents from Bulgaria, Lithuania and Russia reported that people often do not know - or believe - that ARVs are free in their countries.

Among IDUs, myths or incomplete information about ARV side effects and interactions with street drugs and opioid substitution medicines often discourage those who are HIV-positive from beginning ART. It is true that people on ART often require higher doses of certain OST drugs to achieve the same results as people who are not,\* making many IDUs hesitant to start or continue HIV treatment.<sup>33</sup> Moreover, consistent with many of the "counter-culture" beliefs current in drug-using communities, many IDUs regard ART with great suspicion as an instrument of control or harm, often citing side-effects (especially those that start right after initiating treatment) as "proof". In countries with a history of interruptions in the supply of ARVs, theories and fears about future interruptions further inhibit treatment uptake, as has been reported in Russia and in Serbia and Montenegro.<sup>34</sup>

One widely recognized prerequisite for successful ART enrolment and adherence is therefore patient education.<sup>1,35</sup> One Russian doctor mentioned that, once peer educators in his city began engaging in treatment literacy activities in the IDU community, misconceptions interfered less with treatment uptake. Central and Eastern Europe is home to several innovative ART education programmes for IDUs, though most are still in the pilot stage, and interviewees mentioned that information materials for people on ART are often in short supply. In addition, it is often difficult to find sustainable funding for promising programmes such as patient schools, in which patients can attend classes with other PLHIV to learn about ART and other aspects of living with HIV.

### GOOD PRACTICE +

In Tatarstan, the Open Health Institute has invested substantially in adherence support mechanisms including treatment literacy efforts in order to encourage IDUs to enrol in ART. By late 2007, IDUs represented 76% of the 584 people there on ART - a percentage far above that for the rest of Russia.

## EDUCATE SERVICE PROVIDERS ABOUT ART AND INJECTING DRUG USE

Adequately training health care staff is vitally important in providing quality care. Unfortunately, HIV service personnel in Central and Eastern Europe are usually poorly educated about drug dependency - a situation with profound implications for not only the clinical aspects of treating IDUs, but also for addressing their psychological and social needs during treatment. While drug-dependency specialists in the region tend to have some knowledge of infectious diseases, it is seldom adequate. They are often ignorant about interactions between ARVs and opioid substitutes (methadone and buprenorphine) and do not adjust substitution drug dosages for people on ART, who then frequently abandon their ART regimens to avoid withdrawal symptoms.

14 \*There are significant interactions between some ARVs and other medications, as well as between some ARVs and narcotic drugs. For instance, ARVs can increase or decrease the body's metabolism of methadone, requiring adjustments in methadone dosage. For more information about such interactions, see the WHO clinical treatment protocol for IDUs living with HIV.<sup>33</sup>

One indispensable set of clinical guidelines in the WHO protocols for HIV treatment is devoted to the special needs of IDUs with HIV.<sup>33</sup> It gives explicit guidance on their clinical management, addressing concerns such as ARV toxicity and side-effects, interactions with other medications and with opiates, hepatotoxicity (which is much higher among IDUs than non-IDUs), severe opportunistic infections and comorbid psychiatric disorders, including depression.

One interviewee also emphasized the strong need for training health care workers in effective patient communication, noting that they often do not realize the importance of making patients feel welcome and building trust.

### GOOD PRACTICE



At Botkin Hospital in St Petersburg, Russia, relations between PLHIV and staff improved substantially when peer educators began to work in the hospital.

## BUILD TRUST BETWEEN IDUS AND SERVICE PROVIDERS

Trust is a crucial element of effective adherence support. Unfortunately, as many respondents noted in their questionnaires and interviews for this report, mutual mistrust between health workers and drug users is widespread, and the IDU community tends to be suspicious of state-run services in general. Effective ways to build trust include improving health staff communication skills, making IDU and HIV programmes more client-oriented, utilizing peer educators to forge stronger connections with the IDU community and encouraging the formation of patient groups.

Peer counsellors have proven to be especially important in encouraging IDUs to enrol in ART - and adhere to it.<sup>1</sup> Their personal experience makes it easier for them to win the confidence of clients, explain medical information in readily understandable language and strengthen relations between patients and doctors. The Russian doctor mentioned above noted that with the introduction of PLHIV peer educators, including drug users, doctor-patient relations improved markedly. He said that some doctors who had initially misunderstood the role of peer educators, and had even resisted the prospect of working with them, came to appreciate their counselling efforts, realizing that they actually improved the doctors' own communication with patients.

Respondents also noted that peer counselling was not sufficiently available in most countries. Where they exist, peer counsellors must contend with poor working conditions including low wages, a lack of professional recognition, high turnover, training that is sometimes inadequate, limited social benefits and burnout.<sup>36</sup> Several respondents emphasized the need to address burnout, as it led not only to high turnover but put the counsellors at risk for renewed drug use. In addition, some peer programmes started strongly but, as detailed by Russian

### GOOD PRACTICE



Convictus ([www.convictus.ee](http://www.convictus.ee)) and the Estonian Network of PLHIV ([www.ehpv.ee](http://www.ehpv.ee)) organise self-help groups, counselling and peer education for inmates in all Estonian prisons. Both NGOs also work outside prisons as well, providing adherence support and after-release care.

and Ukrainian respondents, were forced to discontinue their activities as soon as foreign funding ran out. One respondent questioned the cost-effectiveness of spending so much money on training counsellors, only to lose them and their skills because their salaries and benefits were so poor.

## TREAT DRUG DEPENDENCE

While access to drug dependency services has been minimal in much of Central and Eastern Europe, it has improved in many countries, albeit slowly. The EU accession process has been helpful in this respect, for by twinning candidate countries with existing members, it has exposed acceding countries in the region to ways of improving IDU health and well-being that have proven effective in Western Europe - and challenged them to develop comprehensive approaches of their own.

### GOOD PRACTICE



In Chorzow, Poland, OST and ART programmes collaborate closely with each other and understand interactions between opioid substitutes and ARVs. The two programme facilities are also located next to each other in the same building, which not only facilitates collaboration and referrals, but also increases the number of HIV+ and drug-dependent people who can take advantage of both programmes.

In contrast, Russia has continued to employ long-disproven Soviet methods of treating opiate addiction while resisting evidence-based reforms.<sup>20</sup> The vertical structure responsible for drug-dependency services focuses nearly entirely on detoxification - treating withdrawal symptoms - rather than rehabilitation. Moreover, criminalization and systematic registration of drug users drive them away from the services they can benefit from most. And despite having the region's most IDUs in need of dependency treatment, Russia remains one of only 5 countries in the region - of 30 total - where OST is not available anywhere. (The others are Armenia, Kazakhstan, Tajikistan and Turkmenistan.)

In Ukraine, another country with a large IDU population, the Global Fund has been instrumental in making OST available. While scaling OST up, Ukrainian programme implementers have had to face many challenges in achieving adequate quality, coverage, client friendliness and ease of access. However, as survey respondents for this report have pointed out, other countries with more than 10 years' experience in providing OST still struggle with many of the same problems.

Moreover, despite the fact that OST is found in nearly every country in the region, the fraction of the potential beneficiaries of OST who actually can access it is very small. The programmes in these countries thus remain only pilot efforts, reaching very few of the many IDUs in need.

## **TARGET USERS OF AMPHETAMINE-TYPE STIMULANTS (ATS)<sup>37</sup>**

For a large and growing number of IDUs, the drugs of choice are not opiates but amphetamine-type stimulants, including methamphetamine, methcathinone and amphetamine. Yet health and harm reduction services for IDUs, with few exceptions, ignore ATS users.

In Central and Eastern Europe, the consequences for ART providers are significant. To begin with, the user profile for ATS is much more diffuse. On one hand, the drugs' energizing effects make them popular party drugs for young club-goers, who tend to be socially well integrated and often middle or upper class. Their use is typically recreational and occasional, which means that they are more likely to share needles - and less likely to identify themselves as problem users who may need help. On the other hand, homemade ATS are cheap, readily available and easily synthesized, making these varieties especially popular among marginalized groups such as the poor and the homeless.

As a result, IDU services need to familiarize themselves with the nature and extent of ATS use in their country, and experiment with different ways of reaching users. Unfortunately, the phenomenon of ATS use is poorly understood, nor is there any body of research on potential interactions between ARVs and ATS. Moreover, there is a corresponding dearth of interventions aimed at this group of IDUs, and in order to provide them with full access to beneficial services, health and social providers will need to develop and try a variety of approaches.

## **INVOLVE IDUS IN PROGRAMME PLANNING, IMPLEMENTATION AND MONITORING**

One highly effective way to improve HIV and addiction treatment services for IDUs, including OST, is to encourage IDUs to assist in their development, implementation and evaluation. Mobilizing the experience and insight of these people can be invaluable in making services more effective and better connected to the communities they serve. A multi-stakeholder coalition may also be uniquely placed to address broader policy issues and service shortcomings - such as a lack of OST and needle exchange in prisons, or the absence of support for IDUs who have been released from prison.

While meaningful involvement of PLHIV in the planning, implementation and evaluation of HIV efforts is still not fully implemented in the region, it has been widely recognized as both a moral obligation and a way to improve the efficacy of HIV initiatives.<sup>38</sup> Although equally ethical and effective, the meaningful involvement of IDUs in IDU programmes is substantially less common - and less prioritized. Even in countries where injecting drug use forms the main route of HIV transmission, IDUs still tend to be excluded from assisting HIV efforts. One significant exception is the use of peer educators, since both doctors and patients tend to recognize the benefits of their contributions fairly quickly.

While some good models exist, IDU networking and mobilization still do not receive sufficient support. The resulting lack of solidarity is especially noticeable in low-prevalence countries where most PLHIV are not IDUs.

## COMBAT STIGMA AND DISCRIMINATION

It is hard to overestimate the negative impact of stigma on access to ART, either globally or in Central and Eastern Europe. Every respondent surveyed for this report mentioned it as a barrier to access, as did much of the literature reviewed. IDUs living with HIV are doubly stigmatized, having to deal with the stigma associated with injecting drug use as well as that associated with HIV. Negative attitudes of the general public towards drug users are exacerbated by drug prohibition and anti-drug campaigns, which frequently seek to prevent drug use by unconditionally condemning not only use but users, often portraying them as criminals.<sup>39</sup> The resulting social exclusion heightens the vulnerability of IDUs by alienating employers, landlords, family and friends.<sup>40</sup> Likewise, the fear of stigma can keep IDUs from seeking services, employment and social interactions. Two respondents mentioned that some PLHIV avoid collecting social benefits connected with HIV because they fear breaches of confidentiality. Others reported that one significant stigma-related issue in prisons was prisoners' ability to identify ART recipients because of how treatment is provided.

Because stigma inhibits many infected IDUs from disclosing their HIV status to family and friends, it eliminates what is commonly a strong source of support for ART adherence - the encouragement of loved ones. In low-prevalence countries, where HIV knowledge tends to be poorer, stigma is often worse than high-prevalence countries. Most low-prevalence countries also have fewer services to counter the effects of stigma, such as PLHIV self-help groups. The situation is particularly difficult for IDUs, since most PLHIV in the region's low-prevalence countries are not IDUs, and IDUs are unlikely to feel welcome in self-help settings that focus on non-IDUs.

Health workers' stigmatization of IDUs and PLHIV has been widely reported in the region.<sup>20, 34, 35, 40, 41, 42, 43, 44, 45, 46</sup> It can be expressed in many ways, ranging from rudeness to denial of services. Of course, when staff rudeness drives people away from health services or discourages them from adhering to treatment, it becomes equivalent to denying treatment access outright. The potential damage becomes clear in considering how crucial trust is in facilitating ART adherence. HIV-associated stigma is typically stronger in facilities that do not provide much HIV care. A Russian respondent noted that in some AIDS centres, as health personnel gained more experience treating PLHIV and working with peer educators, their attitudes towards patients improved greatly.

As a result of drug-associated stigma among the general public and medical professionals, IDUs with HIV are especially prone to self-stigmatization, sometimes believing themselves unworthy or incapable of starting and sticking with ART. Community mobilization and treatment literacy initiatives can counter this tendency, but such efforts are unfortunately limited in coverage. Again, it is important to encourage IDUs to participate in providing meaningful services to their community and advocating improvements. Such involvement empowers not only the particular IDUs involved, but also other IDUs who observe the results of their efforts.

### GOOD PRACTICE +

After obtaining client permission, peer educators at a harm reduction service targeting IDUs in Kazan, Russia, provide ART literacy education to family members. This initiative has helped assuage families' fears and enabled them to provide better adherence support.

# A MAP OF ACTION

Improving IDU access to ART is a complex challenge. It requires familiarity with local IDU culture, national laws, social norms, drug interactions, resource availability and much more. Yet as detailed in the previous chapter, certain approaches have proven successful in a broad variety of European and global contexts. For your convenience, we list below some of the practical, concrete steps you can take to implement these strategies.

## HOLDING POLITICIANS ACCOUNTABLE

- Familiarize yourself with the international commitments your country has made to PLHIV and IDUs (see Annex 3). Research comparable national commitments as well, such as laws, policies, campaign promises and party platforms.
- Publicize the relevant commitments through the media. Run a public information campaign to make major stakeholders - IDUs, PLHIV, health and drug policy- and decision-makers, health and social workers (particularly those working with infectious diseases, prison health, drug treatment or harm reduction), key donors and the general public - aware of the gaps between promises and performance.
- Challenge politicians to make good on their commitments. Provide them with examples of successful approaches elsewhere.
- Appeal to compassion and justice on the one hand, and cost-effectiveness on the other (note that ART is a proven HIV prevention tool, and a way to keep infected people productive members of society).
- Advocate for the inclusion in national strategy documents of explicit statements promoting HIV services for IDUs and addressing HIV in drug services.
- Call for costed national HIV and drug action plans with specific targets for IDU access to HIV treatment, as well as funding for areas of under-funded IDU treatment like hepatitis C.
- Raise the issue and engage in dialogue with the appropriate EU bodies (including the European Commission (EC), the EC Think Tank on HIV/AIDS and the European Centre for Disease Prevention and Control (ECDC)) and at relevant regional and international meetings.

## SEEKING OUTSIDE SUPPORT

- Identify which international organizations - especially UN agencies and the Global Fund - work with HIV and with drug use in your country, and what their plans are for improving IDUs' access to HIV treatment and care. (See the list of essential resources in Annex 3.)
- Contact international PLHIV and IDU networks that provide their core constituents with support, knowledge and technical assistance. (See Annex 3.)
- Publicize your country's needs in developing HIV and drug services in the international donor community, and work actively with donors to develop costed HIV policies and programming with adequate, integrated technical support.

- Insist that major HIV care programmes invest equitably - and achieve equitable results - in treating all affected groups. Such programmes should use common indicators where possible to facilitate assessment of overall equity.

## **MAKING HIV SERVICES EASY TO ACCESS**

- Work to make HIV testing, treatment and other services anonymous and confidential.
- Ensure the adequacy of the counselling component of VCT by expanding the capacity of VCT providers and establishing national standards for it.
- Lobby against the registration of drug users, in both policy and practice. Urge your government - and, through a public information campaign, your fellow citizens - to treat drug dependency as a public health challenge, not a law enforcement issue.
- Expand the number of sites offering HIV services to make them more geographically convenient. Set up mobile teams to reach IDUs where they live, and reimburse PLHIV (including IDUs) who must journey far to access services.
- Find out which opening hours would be most convenient for the populations served and implement them.
- Provide VCT through IDU harm reduction services - or conversely, provide harm reduction services at VCT sites.
- Work to ensure that prisons and other closed settings have adequate HIV and drug services.
- Expand services for IDUs in order to meet their most pressing needs for legal and social assistance.

## **HELPING IDUS NAVIGATE UNINTEGRATED PUBLIC SERVICES**

- Advocate reforms to integrate the various types of services that HIV-positive IDUs need most, including VCT, ART, OST, needle exchange, hepatitis, TB and mental health services, as well as peer support, legal counselling and social support. Use multidisciplinary teams where possible; “one-stop shopping” should be the goal, especially in high-prevalence locations.
- In locating new service facilities, consider proximity to other types of services as well as client convenience.
- Improve referrals between different types of services. It is especially critical that OST and ART providers are aware of clients who are receiving both so they can adjust dosages accordingly.
- Encourage better medical record sharing between services to minimize unnecessary duplication of effort (e.g. repeating medical histories and tests), while still insisting on patient confidentiality.
- Expand case management services to provide HIV-positive IDUs with personal advocates to help them navigate the various clinical and social services they require.
- Develop clear guidelines for case management and clarify its role in service provision. Work to improve conditions for case managers and provide them with adequate compensation and support.

## **EDUCATING IDUS, SERVICE PROVIDERS AND THE GENERAL PUBLIC ABOUT ART AND INJECTING DRUG USE**

- Use peer educators wherever possible to gain the confidence and cooperation of IDUs.
- Support peer counselling through adequate compensation, professional recognition, high-quality training and efforts to prevent burnout and the resumption of injecting.

- Conduct a public information campaign to let the public know that ART *is* available in your country - and that it brings tremendous benefits. Make a concerted effort to reach the communities most affected by HIV, including not only IDUs but also sex workers, men who have sex with men, prisoners and migrants.
- Reach out to IDU groups and address their fears and concerns about ART, correcting misconceptions and being forthright about difficulties such as side effects and adherence.
- Improve training of HIV service staff so they are adequately informed about the clinical consequences that injecting drug use and OST have for HIV treatment. Familiarize them as well with the psychological and social implications of injecting drug use and OST.
- Similarly, make sure that the training of drug-dependency professionals addresses the implications that HIV and ART have for their clients, particularly the interactions between ARVs and opioid substitutes, and between ARVs and street drugs.

## BUILDING TRUST BETWEEN IDUS AND SERVICE PROVIDERS

- Make sure that HIV specialists - and policy- and decision-makers for both the health and the prison systems - understand that with proper support, IDUs on ART adhere well to treatment.
- Establish clear national guidelines on treating IDUs for HIV. The WHO clinical protocol on the topic,<sup>33</sup> available in both English and Russian, provides an excellent foundation.
- Again, use peer counsellors wherever possible; it improves communication and trust between IDUs and health care professionals.
- Train health staff how to communicate better with patients, particularly IDUs.
- Make IDU and HIV treatment programmes more client-centred by involving IDU community representatives in their planning, implementation and evaluation.
- Tackle the problems that give rise to the most common IDU concerns about ART - e.g. poor communication between ART and OST services, treatment interruptions, side-effects, breaches of confidentiality and reporting IDUs to law enforcement.
- Encourage the formation of drug user and PLHIV groups and networks.

## TREATING DRUG DEPENDENCE

- Lobby for the broad expansion of harm reduction services, including needle exchange programmes, OST and other evidence-based treatment services for drug dependency.
- Where injecting drug use is a major contributor to the HIV epidemic, use the UN technical guide on setting national targets for IDU access to HIV prevention, treatment and care<sup>47</sup> for each of its nine recommended interventions. (For example, the suggested minimum coverage target for needle exchange programmes is 60% of all IDUs, and for OST, 40%.)
- Lobby for free, readily available drug detoxification services.
- As with HIV services, work to make drug dependency services universally accessible: low-threshold, geographically close and open at convenient times.
- Make a concerted effort to provide adequate drug dependency treatment and other harm reduction services in prisons.
- If you work in an EU country, use the EU's Action Plan on Drugs (2009-2012)<sup>23</sup> and its *Recommendation on the prevention and reduction of health-related harm associated with drug dependence*<sup>24</sup> in your efforts.

- Use pharmacies to make sterile injecting equipment and OST drugs widely available.
- Urge the governments of Armenia, Kazakhstan, the Russian Federation, Tajikistan and Turkmenistan to introduce OST promptly.

## TARGETING USERS OF AMPHETAMINE-TYPE STIMULANTS (ATS)

- Establish the extent and nature of ATS use in your country. ATS are growing in popularity across Europe, but ATS users have a more diffuse user profile and are more likely to be recreational users than opiate injectors are, making them harder to reach.
- Develop appropriate HIV and drug services and programmes to target ATS injecting.

## INVOLVING IDUS IN PROGRAMME PLANNING, IMPLEMENTATION AND MONITORING

- In countries where IDUs comprise a major HIV risk group, exhort policy-makers to consult with IDUs and make good on their international commitments to use members of major risk groups in developing, implementing and evaluating the national HIV response.
- Make HIV and IDU services much more effective by (again) utilizing IDUs - and PLHIV - as peer educators and involving them in the services' planning, implementation and evaluation.
- On similar grounds - insight, effectiveness and empowerment - facilitate the development of PLHIV and IDU groups, local, national and regional. Such encouragement should include providing these groups with the financial resources and technical assistance they need to develop and engage their constituents.

## COMBATING STIGMA AND DISCRIMINATION

- Decriminalize and depenalize the use and possession of street drugs.
- Run a public information campaign to shift popular - and governmental - perception of drug use and drug dependency from being crimes to being public health concerns.
- Avoid condemning or blaming IDUs for their addiction.
- Strengthen legal protections for the rights of IDUs and PLHIV as tenants, employees, patients, benefit recipients, prisoners et al. Strengthen antidiscrimination statutes, explicitly mentioning both groups.
- Promote ART literacy among the friends and family members of IDUs.
- Encourage PLHIV groups to seek IDU members and address their needs; encourage drug user groups to include PLHIV and address HIV prevention and care.
- Explicitly address the stigmatization of IDUs and PLHIV in training health workers, and in training employees from other workplaces where IDUs and PLHIV encounter stigma, including prisons.
- Mobilize the IDU and PLHIV communities to provide services that target their own communities.

## MONITORING AND EVALUATING HIV SERVICES FOR IDUS

- Keep standard national statistics on IDUs and ART, as set out on p. 196 of the WHO protocol on treating IDUs for HIV, to enable national and regional monitoring of the situation over time.<sup>33</sup>
- Establish a national body to evaluate progress on providing ART to IDUs. Ensure that this body includes representatives from the IDU community.

# CONCLUSION

Every government in Central and Eastern Europe has committed itself to providing universal access to HIV treatment and care. The great majority of the region's PLHIV were infected through injecting drug use, yet even in countries where ART access is already quite good, services targeting IDUs and their special needs are often minimal at best. A variety of good practices, many of them initiated by local NGOs, have proven successful in reaching IDUs, though they tend to be isolated exceptions. Funding and expertise is often available from international donors to develop similar programmes on a national scale, but they require political will and the readiness of service providers to implement, often involving fundamental changes in policy and practice.

# ANNEX 1: IDUS AMONG HIV CASES: NATIONAL STATISTICS

The data in Tables 1 and 2 below should be considered with caution, especially in countries where HIV among IDUs is reported to be low. The transmission statistics are based on self-reported behaviour among registered HIV cases. The proportion of all HIV cases that remain undiagnosed is estimated to be around 30% for the EU and 50% for the entire WHO European Region.<sup>48</sup>

The high percentage of HIV cases with unknown transmission routes in some countries - e.g. in Poland, 71% of newly reported cases in 2006 - may reflect the stigma associated with certain risk behaviours, including homosexual activity, drug use and sex work. Moreover, transmission statistics rarely permit the recording of multiple risk behaviours, nor is past behaviour consistently distinguished from present behaviour.

**Table 1. Reported HIV cases among IDUs through the end of 2006: Eastern Europe**

Country	Primary transmission route, cumulative	Reported HIV cases, cumulative	Reported HIV cases among IDUs, cumulative	% of HIV cases, with a known transmission route attributed to drug injecting	
				2006	Cumulative
Armenia	Injecting drug use	429	224	36%	55%
Azerbaijan	Injecting drug use	965	573	86%	69%
Belarus	Injecting drug use	7 747	4 928	33%	64%
Estonia	Injecting drug use	5 731	2 396	na	83%
Georgia	Injecting drug use	1 156	716	57%	63%
Kazakhstan	Injecting drug use	7 402	5 422	77%	81%
Kyrgyzstan	Injecting drug use	1 070	807	69%	77%
Latvia	Injecting drug use	3 631	2 368	50%	77%
Lithuania	Injecting drug use	1 200	928	72%	82%
Moldova	Injecting drug use	3 464	2 099	38%	62%
Russia	Injecting drug use	369 187	166 044	66%	85%
Tajikistan	Injecting drug use	710	435	66%	81%
Turkmenistan	Injecting drug use	2	0	0%	0%
Ukraine	Injecting drug use	91 057	59 619	56%	68%
Uzbekistan	Injecting drug use	10 015	5 571	73%	78%
<b>Overall</b>	<b>Injecting drug use</b>	<b>503766</b>	<b>252130</b>	<b>61%</b>	<b>79%</b>

na: not available.

**Note:** Transmission route data were derived through comparison of the EuroHIV tables.

**Source:** European Centre for the Epidemiological Monitoring of AIDS (EuroHIV). *HIV/AIDS surveillance in Europe: end-year report 2006* [draft version]. Saint-Maurice, Institut de Veille Sanitaire, 2007 (No. 75; [http://www.eurohiv.org/reports/index\\_reports\\_eng.htm](http://www.eurohiv.org/reports/index_reports_eng.htm), accessed 23 November 2007).

**Table 2. Reported HIV cases among IDUs through the end of 2006: Central Europe**

Country	Primary transmission route, cumulative	Reported HIV cases, cumulative	Reported HIV cases among IDUs, cumulative	% of HIV cases with a known transmission route attributed to drug injecting	
				2006	Cumulative
Albania	Heterosexual	211	1	0%	1%
Bosnia and Herzegovina	Heterosexual	133	19	18%	16%
Bulgaria	Heterosexual	689	66	38%	10%
Croatia	Homosexual	604	35	6%	9%
Cyprus	Heterosexual	518	6	0%	1%
Czech Republic	Homosexual	920	43	6%	5%
Hungary	Homosexual	1 366	17	0%	2%
Macedonia	Heterosexual	96	9	6%	10%
Montenegro	Heterosexual	68	3	0%	6%
Poland	Injecting drug use	10 555	5 461	52%	81%
Romania	Blood transfusion*	6 613	16	2%	1%
Serbia	Homosexual**	2 104	66	10%	17%
Slovakia	Homosexual	185	3	4%	2%
Slovenia	Homosexual	316	13	3%	5%
Turkey	Heterosexual	2 544	124	3%	7%
<b>Overall</b>	<b>Diverse</b>	<b>26 922</b>	<b>5 882</b>	<b>17%</b>	<b>40%</b>

\*Primary route in 2006 was heterosexual.

\*\*The reporting system for HIV is known to have been inaccurate; among Serbians who developed AIDS by the end of 2006, the primary transmission route was injecting drug use.

**Note:** Transmission route data were derived through comparison of the EuroHIV tables.

**Source:** European Centre for the Epidemiological Monitoring of AIDS (EuroHIV). *HIV/AIDS surveillance in Europe: end-year report 2006* [draft version]. Saint-Maurice, Institut de Veille Sanitaire, 2007 (No. 75; [http://www.eurohiv.org/reports/index\\_reports\\_eng.htm](http://www.eurohiv.org/reports/index_reports_eng.htm), accessed 23 November 2007).

# ANNEX 2: IDUS ON ART WHO ARE ACTIVELY INJECTING OR ON OST

Table 3. IDUs on ART who are active IDUs\* or on OST, December 2005

Country	Active IDUs on ART (% of all IDUs on ART)	OST clients on ART (% of all IDUs on ART)
<b>Eastern Europe</b>		
Armenia	3 (19%)	0 (0%)
Belarus	5 (10%)	0 (0%)
Estonia	13 (8%)	Not available
Georgia	11 (15%)	0 (0%)
Kyrgyzstan	Not available	10 (23%)
Latvia	15 (19%)	15 (19%)
Lithuania	1 (8%)	4 (31%)
Moldova	29 (24%)	2 (2%)
Ukraine	Not available	208 (13%)
<b>Central Europe</b>		
Bosnia and Herzegovina	0 (0%)	2 (50%)
Bulgaria	2 (67%)	2 (67%)
Croatia	Not available	13 (62%)
Czech Republic	10 (67%)	2 (13%)
Hungary	0 (0%)	0 (0%)
Poland	175 (16%)	75 (7%)
Serbia and Montenegro	10 (5%)	50 (25%)
Slovakia	1 (25%)	0 (0%)
Slovenia	2 (40%)	3 (60%)

\*Active IDUs are defined as people who injected drugs in the four weeks before beginning ART.

Source: Bollerup A, Donoghoe M, Lazarus JV, Matic S. *Access to HAART for injecting drug users in the WHO European Region 2002-2005*. Copenhagen, WHO Regional Office for Europe, 2006 (summary available at [http://www.euro.who.int/Document/SHA/ACCESS\\_TO\\_HART.pdf](http://www.euro.who.int/Document/SHA/ACCESS_TO_HART.pdf), accessed 25 October 2008).

# ANNEX 3: ESSENTIAL RESOURCES

## International commitments

*Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia* (Actions 9, 10, 21). 2004.

[Available in EN & RU.](#)

[www.euro.who.int/aids/treatment/20051018\\_1](http://www.euro.who.int/aids/treatment/20051018_1)

*Political Declaration on HIV/AIDS*. United Nations General Assembly, 2006. [Available in EN & RU.](#)

[www.unaids.org/en/aboutunaids/goals/2006declaration](http://www.unaids.org/en/aboutunaids/goals/2006declaration)

EU Drug Action Plan 2009-2012 [Available in EN.](#)

[www.ec.europa.eu/justice\\_home/fsj/drugs/docs/com\\_2008\\_567\\_en.pdf](http://www.ec.europa.eu/justice_home/fsj/drugs/docs/com_2008_567_en.pdf)

Action on HIV/AIDS in the European Union and neighbouring countries 2006-2009. [Available in EN.](#)

[www.europa.eu/scadplus/leg/en/lvb/r12545.htm](http://www.europa.eu/scadplus/leg/en/lvb/r12545.htm)

## Advocacy guides

*Advocacy in the HIV/AIDS field*. Russian Harm Reduction Network. [Available in RU.](#)

[www.advocacy-manual.ru](http://www.advocacy-manual.ru)

*Advocacy in action - a toolkit to support NGOs and CBOs responding to HIV/AIDS*. International HIV/AIDS Alliance/ICASO, 2002. [Available in EN.](#)

[www.aidsalliance.org/custom\\_asp/publications/view.asp?publication\\_id=142](http://www.aidsalliance.org/custom_asp/publications/view.asp?publication_id=142)

## Epidemiology and monitoring

Injecting drug use and HIV. In: Progress on implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia. WHO/UNAIDS, 2008. [Available in EN.](#)

[www.euro.who.int/aids/treatment/20051018\\_1](http://www.euro.who.int/aids/treatment/20051018_1)

(A policy brief summarizing key findings and recommendations is also available from the same web page in both English and Russian.)

*2007 annual report: the state of the drugs problem in Europe*. EMCDDA, 2007.

[Available in all EU languages.](#)

[www.emcdda.europa.eu/html.cfm/index44682EN.html](http://www.emcdda.europa.eu/html.cfm/index44682EN.html)

### Clinical guidelines

HIV/AIDS treatment and care for injecting drug users [Protocol 5]. In: *HIV/AIDS protocols on treatment and care for the European Region*. WHO Regional Office for Europe, 2007. [Available in EN & RU](#).

[www.euro.who.int/aids/treatment/20060801\\_1](http://www.euro.who.int/aids/treatment/20060801_1)

### Service guides and best practice

*Delivering HIV care and treatment for people who use drugs*. OSI International Harm Reduction Development Program (IHRD), 2006. [Available in EN & PL](#).

[www.soros.org/initiatives/health/focus/ihrd/articles\\_publications/publications/delivering\\_20060801](http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/delivering_20060801)

*Breaking down barriers: lessons on providing HIV treatment to injection drug users*. OSI IHRD, 2004. [Available in EN & RU](#).

[www.soros.org/initiatives/health/focus/ihrd/articles\\_publications/publications/arv\\_idus\\_20040715](http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/arv_idus_20040715)

*Policy brief: antiretroviral therapy and injecting drug users*. WHO/UNAIDS/UNODC, 2005.

[Available in EN & RU](#).

[www.who.int/hiv/idu/idupolicybriefs](http://www.who.int/hiv/idu/idupolicybriefs) (scroll to second group of policy briefs)

*Interventions to address HIV in prisons: HIV care, treatment and support*. WHO/UNAIDS/UNODC, 2007.

[Available in EN & RU](#).

[www.who.int/hiv/idu/idupolicybriefs](http://www.who.int/hiv/idu/idupolicybriefs) (scroll down almost to bottom)

*Policy guidelines for collaborative TB and HIV services for injecting and other drug users: an integrated approach*. WHO/UNAIDS/UNODC, 2008. [Available in EN](#).

[www.who.int/hiv/pub/idu/tbHIV](http://www.who.int/hiv/pub/idu/tbHIV)

*Training for harm reduction programs: delivering antiretroviral therapy for injecting drug users*.

EHRN Knowledge Hub. [Available in EN & RU](#).

(Available on request from [hub@harm-reduction.org](mailto:hub@harm-reduction.org))

*Code of Good Practice for NGOs Responding to HIV/AIDS*. [Available in EN & RU](#).

[www.hivcode.org](http://www.hivcode.org)

### Drug user and PLHIV involvement

*"Nothing about us without us": greater, meaningful involvement of people who use illegal drugs: a public health, ethical, and human rights imperative*. Canadian HIV/AIDS Legal Network/International HIV/AIDS Alliance/OSI, 2008. [Available in EN & RU](#).

[www.aidslaw.ca/publications/publicationsdocEN.php?ref=845](http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=845)

*"Valued voices" GIPA toolkit: a manual for the Greater Involvement of People Living with HIV/AIDS*.

APN+/APCASO, 2005. [Available in EN](#).

[www.hivpolicy.org/bib/HPP001337.htm](http://www.hivpolicy.org/bib/HPP001337.htm)

### Addressing stigma and discrimination

*Understanding and responding to HIV/AIDS-related stigma and discrimination in the health sector.*

Pan American Health Organization, 2003. [Available in EN.](#)

[www.paho.org/english/ad/fch/ai/stigma.htm](http://www.paho.org/english/ad/fch/ai/stigma.htm)

*Stigma, HIV/AIDS and injecting drug use.* Health & Development Networks (HDN), 2004. [Available in EN.](#)

[www.hdnet.org/v2/Files/detail.asp?iData=22&iCat=196&iChannel=4](http://www.hdnet.org/v2/Files/detail.asp?iData=22&iCat=196&iChannel=4)

*Reducing stigma and discrimination related to HIV and AIDS: training for health care workers [trainer's manual].* EngenderHealth. 2004. [Available in EN.](#)

[www.engenderhealth.org/pubs/hiv-aids-sti/reducing-stigma.php](http://www.engenderhealth.org/pubs/hiv-aids-sti/reducing-stigma.php)

### Web resources

EurasiaHealth Knowledge Network

Publications and brochures for clinicians and patients on HIV/AIDS, STIs, TB and more in [English and Russian](#)

[www.eurasiahealth.org](http://www.eurasiahealth.org)

Eurasian Harm Reduction Network

[English and Russian resources](#) on harm reduction, OST, hepatitis and HIV among IDUs

[www.harm-reduction.org](http://www.harm-reduction.org)

European AIDS Treatment Group (EATG)

Daily updates on HIV treatment, position papers, patient information

[www.eatg.org](http://www.eatg.org)

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

EU drug situation and response assessments, legal drug database

[www.emcdda.europa.eu](http://www.emcdda.europa.eu)

Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

[Information in English and Russian](#), including regular narrative and financial reports from the major funder of work on AIDS, plus publications on civil society's role in GFATM funding and decision-making

[www.theglobalfund.org](http://www.theglobalfund.org)

International Drug Policy Consortium (IDPC)

Briefs and overviews of current international and national drug policies in [English and Russian](#)

[www.idpc.info](http://www.idpc.info)

International Harm Reduction Development Program (IHRD) of the Open Society Institute

Policy overviews, news and good practice materials in the areas of drug policy, harm reduction, and HIV treatment and care for people who inject drugs

[www.soros.org/initiatives/health/focus/ihrd](http://www.soros.org/initiatives/health/focus/ihrd)

International HIV/AIDS Alliance

Various resources for developing advocacy, services and community engagement in the HIV field, [including in Russian](#)

[www.aidsalliance.org](http://www.aidsalliance.org)

International Treatment Preparedness Coalition (ITPC) in Eastern Europe and Central Asia

Treatment advocacy and literacy materials in Russian; calls for action with some information [available in Latvian, English and other languages](#)

[www.itpcru.org](http://www.itpcru.org)

The People Living with HIV Stigma Index

Resources for measuring HIV-related stigma

[www.stigmaindex.org](http://www.stigmaindex.org)

POLICY Project

Toolkits and materials for building political commitment and addressing stigma in HIV and reproductive health

[www.policyproject.com](http://www.policyproject.com)

Transatlantic Partners Against AIDS (TPAA)

[Russian language resource on HIV policy](#)

[www.hivpolicy.ru](http://www.hivpolicy.ru)

United Nations Office on Drugs and Crime (UNODC), HIV/AIDS Unit

Policy and service guidance on addressing HIV among IDUs, including in prisons and among female IDUs

[www.unodc.org/unodc/en/hiv-aids/index.html](http://www.unodc.org/unodc/en/hiv-aids/index.html)

UNAIDS (Joint UN Programme on HIV/AIDS)

Policy and service guides, epidemiology around HIV

[www.unaids.org](http://www.unaids.org)

[www.unaids.ru](http://www.unaids.ru)

WHO (global headquarters)

Clinical and service guidance, evidence, database of OST producers and prices

[www.who.int/hiv/idu](http://www.who.int/hiv/idu)

WHO Regional Office for Europe

European Region reports and updates on HIV, STIs, prisons

[www.euro.who.int/aids](http://www.euro.who.int/aids)

[www.euro.who.int/prisons](http://www.euro.who.int/prisons)

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