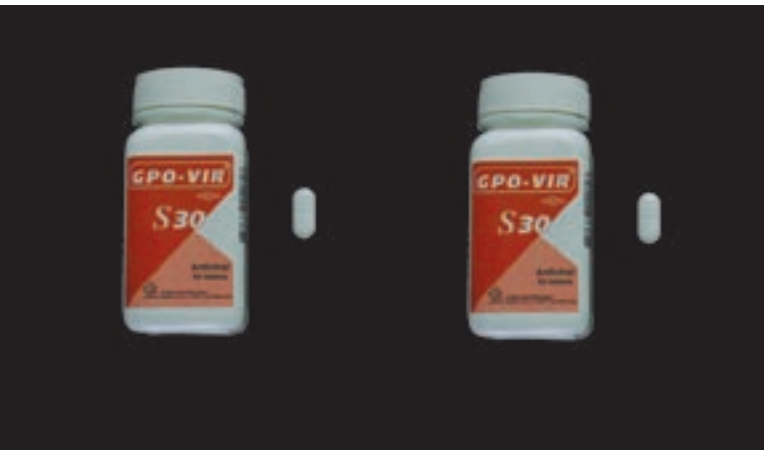
AHRN POSITION PAPER

SCALING UP ANTI-RETROVIRAL TREATMENT TO (INJECTING) DRUG USERS IN ASIA



In light of the endorsement of the AIDS Care Watch Campaign, led by Health and Development Networks (HDN), the Asian Harm Reduction Network (AHRN) believes that addressing issues related to injecting drug use (IDU) and anti-retroviral treatment (ART) is essential in the Asian context. Notably, AHRN believes that the provision of ART for IDUs is a fairly recent area which has not received due attention and deserves more research and consideration.

Although ART is not traditionally considered a central concern in the harm reduction agenda, from a global public health perspective, AHRN believes that ART remains a very important service within a comprehensive HIV/AIDS treatment and care model. As such, AHRN's analysis and experience in national, regional or international initiatives which have operational goals determined and evaluated through the provision of anti-retroviral (ARV) medications to people living with HIV/AIDS (PLWHA), demonstrates that we should applaud such treatment services on the principle that all people, regardless of ethnicity, religion, gender or sexual orientation, should receive quality treatment and health care.

Nevertheless, it has come to the attention of AHRN that principles are not enough to develop quality interventions; programmes and policies which seek to maximise access to ART might do so indiscriminately or without taking into full consideration the myriad of critical issues that surround this particular topic. Amongst those important issues related to ART, AHRN and other harm reduction organiastions are especially concerned with accessibility to ART for drug users (DUs) and injecting drug users (IDUs), as well as with the possibility of hepatotoxic reactions in current and recovering IDUs. Other issues of importance include side-effects, treatment compliance, market supply of ARV drugs and consequent market prices, drug resistance and human and medical resource support and allocation in health care systems.

Scaling up ART has become an important objective for many stakeholders who participate in the efforts to help and support people living with HIV/AIDS (PLWHA). This fact can be clearly observed through some initiatives like the ARV2ALL and Free by Five campaigns as well as the World Health Organisation's (WHO) well-known '3x5' programme. AHRN's endorsement of ARV declarations such those listed above warrant a few notes of caution that should be addressed and taken into serious consideration before supporting and endorsing such initiatives.

It is AHRN's observation and experience that although ART is an essential part of a comprehensive HIV/AIDS treatment and care model, not all PLWHAs may require these drugs; only in specific conditions where CD4 counts and viral loads reach a certain level should ARVs be administered. Given to PLWHA who do not need these drugs, such unwarranted use might result in biological damage (such as liver damage, lactic acidosis, etc.), and the onset of numerous negative side-effects (lipodystrophy, nausea, etc) due to the drugs' high toxicity. It is AHRN's position that ARVs should only be administered to people who have become immunocompromised. This diagnosis must rest on stringent evaluation from health professionals as well as necessary laboratory tests. Without providing proper accompanying education and counseling in local languages for health care professionals and PLWHAs, rapid scale-up and free ARV might encourage unnecessary administration, causing more harm than good. In such light, AHRN supports the development and implementation of mechanisms that monitor and ensure that only the people who truly need ARV receive this treatment, as well as the promotion and production of educational programmes and

materials to support those actors involved in ART.

Furthermore, a recent study document produced in part by International Harm Reduction Association (IHRA), managed by AHRN and released by the WHO has noted in the key findings that accessibility to ARV drugs for certain population subgroups remains a great challenge. In particular, injecting drug users in Asia (and outside the region) face stigma and discrimination which lead to unequal access to health services:

> *This report finds that just 1-5% of IDUs in Asia access any drug prevention or treatment at all (including outreach, needle and syringe exchange programmes, drug substitution therapy or even information materials or primary health care). It is evident that ensuring access to ARV for IDU in this region will be a difficult task; [...] Several small pilot programmes in the region are providing ARV but DUs are often excluded.* [1]

While this is true for injecting and non-injecting DUs, it is also the case for PLWHA, women, people from the lesbian, gay, bisexual and transgender community (LGBTC), ethnic minorities, inmates, sex workers and migrant workers and other marginalised groups. As such, scaling up ART access without developing and implementing overarching mechanisms to address these inequalities could lead to the reinforcement of the stigma and discrimination that is the basis for delays, second rate treatment or outright denial of treatment.

Another aspect of note regarding ART for current and recovering DUs and IDUs concerns hepatotoxicity. This condition is a form of liver damage caused by drug interactions.

> *Because of their complex metabolism, antiretroviral drugs often interact with methadone. Anti-HIV polytherapy [ART], in combination with other drugs, is difficult and carries high risk of complications, especially in heroin-addicted patients. Drug [users] have advanced liver pathology, associated with HCV, HBV, HDV, [...] complicating the primary toxic liver damage due to chemical components used in home-made poppy brew. Many of them receive hepatotoxic treatment for tuberculosis, systemic mycoses and other opportunistic infections, and almost all of them require interventional or chronic therapy with various psychotropic drugs. All these drugs interact both with methadone and with antiretroviral medication. Some drug users chronically or periodically abuse alcohol.*[2]

Unfortunately, few pharmacological studies have been performed to provide guidelines for the administration ARV to current and recovering DUs and IDUs. There are significant dangers related to prescribing and most importantly providing ART without having a knowledge base to determine its effects when combined with other drugs. Moreover, heaptotoxicity is more likely to occur for people who have contracted hepatitis B or C; knowing full well that hepatitis C prevalence in some Asian countries can reach as many 70% to 90% of IDUs[3], caution and diligence should be exercised when prescribing ARVs. More research is urgently needed to address the issue of drug interactions and develop evidence-based, effective guidelines before ART can be properly and safely provided to every current and recovering DU and IDU.

Treatment compliance is also a crucial factor in the success of ART services and related campaigns. Some suggest, probably rightly so, that provision of free ARV therapy might actually increase regimen observance while others indicate that pharmacotherapy (methadone or buprenorphine maintenance), special education programmes and strategic approaches (such as DOTS) achieve similar results. Yet, AHRN has more fundamental apprehensions that are linked with the overall poverty of the people throughout the Asian region, and the apparent lack of nutritional support in the current efforts and strategies. Adequate meals are essential to the success of ART: without proper nutrition and stringent adherence to the prescribed regimen, more harm than good can follow, such as drug resistance[4]. For people with opioid dependence, it is of critical importance to ensure access to pharmacotherapy in the first place. This will help recovering users to cut back on drug consumption and liberate additional resources to nutrition and treatment[5].

A related issue which is rarely mentioned concerns continuity of treatment. Inadequate supply, for example, resulting from low access to generic ARV drugs might cause treatment to be interrupted. Similarly international treaties on intellectual property rights, which often restrict the scope of ARV distribution at low prices, might lead to a drastic reduction in demand. Without addressing the issues of provision and production of ARV drugs in every unique national setting, scale up of free ARV might lead to a rapid depletion of current stocks and lead to a supply crisis, in turn increasing the price of the drugs.

AHRN considers the issues mentioned above as serious since unnecessary administration of ART and interruption of treatment can both lead to pharmacological resistance. Resistance increases short- and long-term costs of treatment and can lead to genetic mutations of HIV/AIDS viral strains, thus creating more short-term problems and exacerbating long-term treatment issues. Moreover, pharmacological resistance should entail access to and provision of second-line regimens. Without planning for access to other regimens, PLWHAs who become resistant will face difficult times due to rapidly deteriorating health.

In conclusion, the most basic requirement for the successful provision of ARV is a specialised, well trained and equipped health care infrastructure:

> *Most countries in the region lack the required infrastructure to deliver ARV [...] including laboratory equipment [and] trained medical providers. There is a large and willing human resource needing capacity building.*[5]

Other general requirements for adequate and efficient provision of ART include debunking stereotypes and addressing discrimination through education and legislation; promoting the development of evidence-based guidelines through scientific research on drug interactions for current and recovering DUs and IDUs and on the effects of regimen interruption; providing training for health care personnel and other care givers to ensure a non-discriminatory best practice service delivery; encouraging and supporting poverty alleviation to ensure that PLWHAs enrolled in ART have a balanced diet; and always providing some measure of counseling to people who receive ARV medications.

While AHRN agrees that provision of free ART to all those who need it would be a truly wonderful and positive step forward in the fight against the worldwide HIV/AIDS epidemic, AHRN also believes that actions to support PLWHAs and marginalised groups such as current and recovering DUs and IDUs should be part of a concerted and coordinated effort to eventually resolve all issues relating to HIV/AIDS. Within this context, scaling up harm reduction services for people using drugs is essential.

Notes:

[1] WHO, IHRA & AHRN. (2004). Scaling Up Provision of Anti-Retrovirals to Injecting Drug Users and Non Injecting Drug Users in Asia: Key Findings.

[2] Cholewinska, Grazyna. (2004). Pharmacokinetic Interactions of Methadone and Antiretroviral Drugs. *HIV/AIDS Review*, 3(2): 39-43.

[3] UNESCAP. (2003). Prevention, Care and Support: Stories from the Community. p 58.

[4] IFPRI. (2005). HIV/AIDS and Food and Nutrition Security: From Evidence to Action. See also International HIV/AIDS Alliance. (2005). ARV Fact Sheet #8 – Food for People on Treatment.

[5] HDN. (2005). Staying Alive with HIV/AIDS – AIDS Care Watch Campaign – Campaign Fact Sheet. www.aidscarewatch.org.

[6] WHO, IHRA & AHRN. (2004). Scaling Up Provision of Anti-Retrovirals to Injecting Drug Users and Non Injecting Drug Users in Asia: Key Findings.

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