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4TH IAS Conference on HIV Pathogenesis, Treatment & Prevention
Global Responses to HIV Prevention Among Injection Drug Users
International AIDS Society and Australian Society for HIV Medicine
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LISA MAHER, M.A., PH.D.: Let’s get started, we’re running a little bit late and I’m sorry about that. My name is Lisa Maher and I work at the National Center in HIV Epidemiology and Clinical Research in Sydney, Australia. I’d like to welcome you all to MOAC2, which Succession Global responses to as HIV Prevention Among Injection and Drug Users. I just wanted to make a comment before we start that we’ve been hearing a lot in Australia lately, and we heard a little bit yesterday, about criminalization in the context of HIV transmission and prevention. I think when you hear people at this conference talk about criminalization and stigma and discrimination, it’s important to remember that most ID use around the world confronts this on a daily basis. Despite the legality that often defines their vulnerability to HIV and other blood borne viruses, there’s overwhelming evidence that injecting drug users worldwide have shown an extraordinary sense of responsibility in responding to the epidemic. And as David Cooper pointed out in the plenary last night, his most substantiative epidemic of HIV among injecting drug users in Australia, I think we need to acknowledge and give credit that this achievement rests with injecting drug users and drug user organizations.

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Our first speaker today is Dr. Suphak Vanichseni. She is working in the group of BTSJ, the Bangkok Tenofovir Study Group, after completing the clinical trial of the AIDS vaccine in Thailand, she's a leading researcher, she's been around and working in this field for almost 20 years, and working a lot with injecting drug users in Thailand. Welcome.

SUPHAK VANICHSENI, M.D., M.P.H.: Thank you, Lisa. Good morning, ladies and gentlemen. First I'd like to thank the conference organizer for giving me the opportunities to discuss HIV associated risk behaviors among participation, participants in the Bangkok Tenofovir Study, and HIV [inaudible] being conducted in Bangkok, Thailand.

So the trial is a collaborated effort managed by the Bangkok Tenofovir Study Group, with the BTSG team includes the Bangkok Metropolitan Administration, the Thailand Ministry of Public Health, and the U.S. Centers for Disease Control and Prevention. It is important to point out that this trial would not be possible without the support of [inaudible] in Bangkok. We are grateful to those who come to stay and endo, and the members of community relations committee, who helped guide the study.

This is a map of Bangkok, the BTS has conducted in the 17 Bangkok Metropolitan Administration Drug Treatment Clinics, represent by red stars. Bangkok Metropolitan Administration Or

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BMA, the BMA clinic has provided HIV prevention package, of HIV risk reduction education and counseling on sex and injection behaviors with demonstration how to bleach, or cleaning the needles and syringe, and how to put on condom effectively, and distribute free of charge. And treatment for sexually transmission infections and other health services with round tree HIV testing, pre and post-test counseling, and methadone [inaudible] program, all free of charge.

Participant demographic characteristics and risk behavior were assessed at enrollment and these behaviors every three months during follow-up. In order to evaluate risk behavior, we compared a proportion of participant who reported injected drugs and sharing needle syringe at enrollment, at month three, six, nine, 12, and 18. We also used generalized estimated logistic regression analysis to identify predictors of injection and sharing. Risk behavior data are collected using audio computer assisted self interview, or ACASI. ACASI has been shown to increase validity and reliability of response to sensitive questions. Injection behavior assessed with the following questions, have to inject any drug in the past three month, yes or no; in the past three months, did you ever inject with needle or syringe that someone else had used, yes or no. Demographic data were available on 1,641 participants. Seventy eight-percent were male. The median age was 31 years,

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Forty-eight-percent had a primary education or less. Forty three-percent had completed secondary school, and nine-percent had post secondary school.

During the three months before enrollment at baseline, 25-percent were admitted on program, 62-percent inject with a relatively even distribution of methamphetamine, heroin, and needle syringe. Eight-percent inject daily, daily injection, and 22-percent weekly, 32-percent less than weekly, and 17-percent shared needles. Eighty-percent reported one or less than one sexual partner, and the majority did not have sex with casual partners.

Reports of injecting and needle sharing have fallen significantly during follow-up. Injecting declined since month three from 62-percent at baseline, to 32-percent; needle sharing from 17-percent to 3-percent since month three.

We include baseline demographic characteristics in multi varied analysis to investigate risk factors for injection or needle sharing. Male sex, more than 26 years and more than primary school education, were independent predictors of injecting. Male may be more likely to share needles, though this finding did not reach statistical significance.

In summary, the BMA treatment clinics provide IV users a package of HIV prevention and risk reduction tools. The research team is monitoring participation risk behavior. The

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proportion of participants reporting injecting and sharing, has declined significantly from baseline since month three to month 18.

Finally, I'd like to thank all those who help us launch this important trial, especially the volunteers for their courage and willingness to participate. Thank you for your attention.

ALEX WODAK, M.D.: Thank you very much, Suphak. And our next speaker is Dr. Carolyn Day, who's from the National Centre for HIV Epidemiology and Clinical Research, and she's now a post-doctoral fellow, and she's a senior lecturer at the University of Sydney. Her background is in public health and Carolyn is going to talk to us today about a decade of HIV surveillance among injecting drug users in Australia, the results from the Australian Needle and Syringe Program Survey. So thank you very much, Carolyn.

CAROLYN DAY, PH.D.: Thank you. Today I'm going to be talking about the results from the last 10 years of the Australian Needle and Syringe Program Survey. And firstly, I'd like to make a dedication to the late Dr. Margaret McDonald, because so much of the work that I'm presenting today is due to her dedication and hard work.

So first of all, a little bit of background about HIV in Australia. The first HIV, or AIDS cases as it would have

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been, were reported in 1982, and by 1985, there were reports of cases among injecting drug users. Nevertheless, it appears that the epidemic in Australia has really followed on where it's been largely among gay men, or men who have sex with men. The prevalence of HIV among injecting drug use has been from the early days somewhat variable. The first data from 1987 found a 12-percent prevalence rate of HIV among injectors, and by 1994, there was a seven-percent prevalence rate. But when cases of people reporting homosexual or bisexual contact were excluded, that prevalence rate was only two-percent. And with that very first study, the one in 1987 showing 12-percent, there was some sampling issues, which may have inflated that figure, for example. Some of the people were recruited through AIDS clinics, etc.

So what we know about HIV in Australia is that among injecting drug users, is that there's been overall a fairly low prevalence. But there have been some things that have occurred over the last 10 or so years, which may or may not have impacted on this. So we know that there's been some significant changes in the drug market, we know that there's been a big decrease in use of heroin, and some fairly significant increases in use of methamphetamine. And these may or may not have had an impact. And we also know that there have been some recent increases in HIV diagnoses in Australia.

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So this is part of the reason why we thought that it was a good idea to look over the last 10 years at the surveillance data.

Some background around needle and syringe programs in Australia. The first program commenced in 1986, so almost 21 years ago, by our chair Dr. Wodak. And since that time, there have become reasonably wide spread and a largely publicly funded, obviously there are pockets where the availability of needles and syringes is not particularly good, but for the most part, we can say that they are reasonably wide spread. Needle and syringe programs have bipartisan support in Australia, and there's some evidence that there is a lot of general public support as well for the programs. The programs are delivered through a range of different models, including fixed site, so sort of shot front site needle and syringe programs, where people can go in and get their syringes, and there's outreach, there are vending machines, and they are also delivered through some pharmacy programs. And it's a program of distribution, rather than one of exchange. So people don't need to be returning their used syringes, they're obviously been, etc, and that's encouraged, but people can just simply come in and request new equipment, they don't need to be returning equipment.

So the aims of the National Needle and Syringe Program, which was set up in 1995, is to monitor HIV prevalence and risk

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behavior among injecting drug users in Australia. It also aims to look at hepatitis-C as well, but I'm presenting data today on HIV. So in terms of this talk, what I'd like to do is look at trends in HIV prevalence, and risk behaviors for the period 1995 to 2004, and also look at some of the correlates of HIV infection.

So the methods, it's a cross sectional survey, and it involves a brief survey that collects information on demographics, drug use, and treatment history, injecting and sexual risk, and previous blood borne virus testing. It's a self completed questionnaire, but assistance is available were required, so if people have difficulty with literacy or vision or whatever, there is assistance required, assistance available. A capillary blood sample is collected and that's tested using standard HIV testing. The survey is conducted during one week in October, sometimes that may flow out a little bit into the following week, but usually it's the first, I'm sorry, usually it's one week in October. The eligibility is basically anyone attending the needle and syringe program during the study week, is eligible to participate in the survey.

For the purposes of today, we have duplicated the data, they are obviously over the 10 years, a number of people have participated more than once, so in order to do that, there's a

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unique identifier, which is the first two initials, by the first name and surname. So using that, along with the birth month and year, I'm sorry, year of birth, and sex, and indigenous data, so we have excluded multiple entries. And in terms of what I've done, is I've done some trend analyses, and then finally some aggregated data to look at correlates.

So in terms of participation, you can see that it started as the survey started out, including 21 sites in 1995, and recruited over 1,000 people, and in 2004, it had 43 sites, and recruited just over 2,000 people. The main response rate has been reasonably low, I guess, at 47-percent, but it's ranged from 41-percent in 1995, through to 60-percent in 1997. I should add, at this point, which hasn't been included on the slide, that there's no incentive to participate in this survey. People are simply asked to take part and they don't receive anything for taking part. The median age has been 29 years, about two thirds are male, and 34-percent are female, with under less than half a-percent transgender. Seventy eight-percent of participants report their sexual preference is heterosexual, which makes it 68-percent reporting either homosexual or bisexual sexual preference. The participants were injecting for a median of nine years, and the last drug injected was mainly heroin, at 45-percent, and 28-percent methamphetamine, and then the other drugs are really much more,

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methadone, cocaine, et cetera, are much lower proportions and only around, sort of, five-percent, certainly less than 10-percent, in terms of the sample. Fifty-percent of the sample report daily or more injecting, and eight-percent report having been paid for sex in the last month.

So just looking here at some of the trends in sample characteristics, if you just have a look, and I guess the easiest one to look, is this legend K here, and I've just put whether or not there's been a decrease or increase in trends. So, for example, with males, you can see that there's been no trend; it's been fairly consistent over time. There's been an increase, a slight increase, in the median age, and that's consistent with other Australian data on injecting drug users, it appears we have an aging cohort. The daily injecting has remained fairly steady, it's sort of gone up and down a bit, but it's overall, over time, remained reasonably steady. Heroin use is significantly decreased, and once again, that's consistent with what we know about the Australian drug market. Similarly with methamphetamine, which is significantly increased. And sex work, there has been a very slight increase in sex work over the past 10 years of people reporting sex work.

In terms of actual HIV prevalence, it doesn't really look like much here, but there has, in fact, been a significant

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decrease in HIV over the last 10 years. There has also been consistent with that, a decrease in the number of people reporting homosexual or bisexual preference, and there's been an overall decrease in people reporting having shared a needle or syringe in the last month. Similarly, a decrease in condoms used in the last sexual episode, and an increase in the number of people reporting having had casual sex in the last month.

Looking at correlates of HIV infection, basically all of those factors that I've gone through were put into the model, they were all significant on unvaried analysis, and they were put into the model, and you can see here that age, the risk of HIV risk increases slightly with age, bearing in mind this is a cross sectional data. So these are really just relationships, they're not necessarily predictors. As we would expect, there's an association with male gender, and a very strong association with reporting homosexual and bisexual sexual preference. There's an association, too, with methamphetamine, you now, HIV positive people are more likely to report methamphetamine as the last drug they've injected, but they're less likely to be reporting daily injecting. And they are also less likely to report condom use in the last sexual episode, or rather more likely.

So in terms of limitations of the study, as I mentioned, it's a series of cross sectional surveys. And one

of the key, I guess, limitations, is that needle and syringe programs are a point of prevention, so it may not necessarily seem like the best place to be targeting this group, but as many of you here will know, that accessing injecting drug users, given the hidden nature of the behavior and the legality of it, can be very difficult, and because needle and syringe programs are so wide spread in Australia, it provides a useful central point of surveillance, and certainly that the data is consistent with other studies that don't necessarily go to needle and syringe programs to recruit participants. The low response rate is obviously a somewhat of a problem, being less than 50-percent overall, but recent work that we've done, which I won't go into today, has shown that the respondents are not atypical, or what I would say entirely representative of the needle and syringe program, using a group that they're certainly not atypical of the service users. And obviously, with any of this sort of research, particularly around risk behavior, there are issues with social desirability, and particularly perhaps over time, but we've shown once again, with this survey, and recently that because it's self reporting, that people are more likely to report honestly or report honestly being a self report instrument.

So, in conclusion, we've noted a decrease of HIV prevalence, which has remained at less than two-percent over

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the last 10 years. The epidemiology of HIV among this group therefore appears to be very much like what we know about the broader Australian population. There have been some variation in risk factors across the years, particularly in terms of patterns of drug use, and decreasing risk behaviors are consistent with other indicators. And finally, needle and syringe programs are a crucial component of Australia's successful HIV surveillance mechanism, and this is a very simple and very cost effective way of doing HIV surveillance among this group, which otherwise would be a very difficult task. Thank you very much, and I'd just like to acknowledge the various people who have been involved in this data collection, particularly the participants who received nothing for taking part in this and do it of their own bat, and also particularly for the people I'm working with in the needle and syringe programs who put a lot of effort into that one week of the year, when the survey is conducted. Thank you very much.

LISA MAHER, M.A., PH.D.: I'd like to introduce our next speaker, who is Dr. Seyed Abbas Motevalian. He's from Iran, he's a medical doctor and an epidemiologist, he's also Associate Professor of Epidemiology in the School of Public Health, Iran University of Medical Sciences in Tehran.

SEYED ABBAS MOTEVALIAN, M.D., M.P.H.: Distinguished colleagues, ladies and gentlemen, first of all I take this

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opportunity to thank the International Scholarship Program for supporting me to come here and present the findings of our research, which is about HIV Prevalence and Risk Behaviors in Inmates of a Prison, in Tehran, the capital city of Iran. Also, I would like to thank my colleagues in this research and whatever organizations this [inaudible] office for supporting this study.

Let's have a look to some facts about HIV AIDS in Iran. Iran, with a population of over 70 million, have a more than 50,000 of notified HIV cases, which are and it is estimated that 80-percent of HIV cases are not, have not been notified, so there's a record number of all HIV cases is about 70,000. More than 2,000 AIDS cases have been died since the beginning of the epidemic. The first wave of the epidemic began in the 1980's, by transfusion of infected blood products, then in the mid 1990's, the second wave of epidemic emerged among injected drug users. At present, two thirds of all notified cases are transmitted through sharing needle and syringes, and seven-percent of cases are through sexual contact.

In this slide, we can see that the distribution of notified HIV cases is not homogenesis in the country, also the mode of transmission is different in different regions. For example, in western high prevalence provinces, the majority of cases are IV use, while in south provinces, there are

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considerable number of heterosexual transmission because of men traveling to nearby countries, and having sex with HIV infected sex partners.

Drug abuse, especially opium addiction and misuse, is a huge public health issue here in Iran. It is estimated that at least two million drug users, 1.2 million addicts, and 200,000 of injecting drug users, are living in the country. Seventy-percent of injecting drug users have a history of shared injection. In the present, at each time, there are 130,000 prisoners; almost half of them are because of drug related crimes. And if you consider the incarceration numbers of the whole number of prisoners, we'd be the total number of 600,000 annually.

The objective of this study was to determine the prevalence of HIV and risk behaviors in one of the prisons in Tehran, each have one of the highest number of drug related crime prisoners. This is a cross sectional study and they studied subjects who were prisoners who had an evidence of drug injection, and signed an informed consent after a counseling session. The study subjects were two groups of prisoners, and inmates of the prison, residing more than one week. We call the first group as a new entrant, and the second one as the old prisoners. We had a questionnaire for demographic and behavioral questions, and we did a test and reliability study

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for the evaluation of this questioner. And also we had taken blood samples for both ELIZA and resting blood lab exams.

The study setting was [inaudible] Prison in Tehran province, and the time period was September 2003. It's interesting to note that in the study period, 1,532 new prisoners entered and 26 of whom were injecting drug users. From this group, 91-percent signed an informed consent to enter this study. The most important finding of the study was that the HIV prevalence in new entrants was 22-percent, and in old prisoners, it was 24-percent. On average, the age of the, these are showing the age at first injection in the first group was 25 years, and the second group 28 years. Seventy two-percent of the new entrants had injection in the past month, and 20-percent of the daily injection in the last injection was shared injection device. And in all prisoners, 29-percent of the subjects had an injection in the past month, and 43-percent of them had shared injection in the last drug injection.

When we asked the subjects about the usual habits for drug injection, 64-percent of the first group said that they inject more than once a day, while 50-percent of the second group, less than once a day. And almost 35-percent of the new entrants had a history of sharing injection, and 49-percent in the second group had a history of sharing injections.

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Eighty one-percent of the first group had a history of imprisonment before this time, and 28-percent of the new entrants ever injected inside the prison, while 54-percent of the second group had ever injected inside the prison. Six-percent of the new entrants and 21-percent of all prisoners started the injection inside the prison. We had problems with hand made injection devices, and 23-percent of new entrants, and 45-percent of old prisoners, told us that they had used hand made injection devices.

About the sexual behavior of the subjects, about 50-percent of both groups were single, and one third of them had sexual contact with their wives in the last year, and 16-percent of the new entrants and nine-percent of the old prisoners, had sex with a commercial sex worker in the last year. It is important, the important figure here is that more than 60-percent of all of the sexual contacts of both groups, had never used condoms.

When we conducted multiple logistic registration analysis to show what the factors associated with HIV infection in the new entrant group, the factors were younger age at first age injection, lower education level, longer duration of drug injection, frequency of the injection device, and longer duration of imprisonment.

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It's an important finding that HIV prevalence among the new entrants, who had no history of imprisonment, was about six-percent, which is much lower than all of the other groups, which are more than, most of them are higher than 20-percent.

This shows, this can be concluded as the prevalence of HIV among IV use in the community, who have not been imprisoned.

Factors associated with HIV infection in the old prisoners were longer duration of drug injection, frequent sharing of injection device, injection inside the prison, and having a tattoo.

The results of this study, as has other complimentary studies, have been used as a strong advocacy tool, and was translated to some strong actions in the country. In 2005, half of the 600,000 inmates benefited educational programs in prisons about HIV AIDS, different types of education. Method of treatment started in the country in 2005, with 4,500 people, and in 2006, it expanded to more than 10,000, which covers about 20-percent of IV users in the prisoners. And this survey has been expanded even more than these figures.

A documented needle and syringe distribution guideline for the prisons have been prepared, and it's been approved and implemented by the judicial system in the near future, and

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prisons can provide condoms upon demand, but no program for condom distribution in carnal visit has existed.

Future actions needed, decriminalization of drug abuse and releasing the flow of drug users into the prison, expansion of centers, condom distribution for carnal visits, which are 45,000 carnal visit each year in prisons of Iran, and specifically, and most important of all of these, special programs for social, for commissioned sex workers, and partners of injecting drug user, are needed to prevent the HIV epidemic among these women, their other partners, and their children.

Thank you very much.

ALEX WODAK, M.D.: Thank you very much, sir, that certainly gives us all a little bit of hope listening to the wonderful things that are happening there in your country. Our next speaker is Dr. Sergii Dvoriak, I hope I pronounced that correctly, he's, Dr. Dvoriak is a psychiatrist, he's been working with drug users for more than 30 years in the Ukraine, where he comes from. The last six years, he's been working in public health, and the main focus of his activity is providing a good substitution treatment with Buprenorphine for drug users, and the particular objective is to control HIV infection spread among injecting drug users in the Ukraine. Dr. Dvoriak, the floor is yours.

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SERGII DVORIAK: Thank you, Dr. Wodak. Ladies and gentlemen, I'd like to present data about substitution treatment in Ukraine, which started relatively recently, and has some problems and obstacles, but at the same time, we had some good success and their group of researchers who work in this program, you can see on the screen. It's not enough time to mention everybody of them, but I would like to say that this is product of big change work.

Shortly, about drug statistic in Ukraine, during the last 15 years, we experienced some great increasing of drug users, and you can see that estimated data last period in 2006, it's about more than half million. And before we had not estimated that in the register, drug users much less number than the 15 years. This is trends during 1994, and plateau after 2004. HIV transmission in Ukraine, this is mostly through injections and amongst drug users, and only after 2006, the situation little bit changed, and relatively more-percentage people get HIV through sex. But unfortunately, most of them, this is people who had sex with IV users or with their partners. In fact, still now, drug injections, this is aging of the epidemic in Ukraine. On this slide, you can see a relationship between injection drug using and HIV in different regions, in different cities, and almost everywhere, the more people use drugs, the more people have HIV.

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Unfortunately, political context regarding to treatment of a drug addiction, and particularly substitution treatment, is very unclear and ambivalent. We had positive factors and negative. Positive, this is national program of HIV AIDS prevention, when mentioned the substitution treatment should be main method of prevention HIV infections amongst drug users, and as it documents, which mostly prepared by medical professionals. From other side, negative factors, this is activity of Ministry of Interior service of so-called enforcement ministries, people has big power to stop dissemination of substitution treatment. Unfortunately, a lot of deputies, and other politicians to gain substitution treatment still now, too. It's a situation very similar, like in Russia, but I think a little bit better because our constitution and our legislation not so strictly against substitution treatment.

According to data during mission of joint mission of WHO, [inaudible], which provided special assessment in the Ukraine in 2004, about 30 or 40-percentage of IV use dependent from opiates, should have access to substitution treatment. In Ukraine now, we have three, four hundred thousand who need substitution, who have problem with injection drugs, and accordingly, we need 60 from 62 to 200,000 courses of substitution treatment.

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Our first project, which provided substitution treatment with Buprenorphine, was organized with the supporting of UNDP, in Kiev and Karsone [misspelled?], in 2004 and 2005. It was relatively small project, not more than 87, 90 clients, to participate in this. According to the WHO multi site prospective study, we used this data and collecting the data from our first project, and the analyzed it in frames of this multi site prospective study. You can see participants of this study and it was organized in seven countries, Indonesia, China, Thailand, Iran, Latonia, Poland, and Ukraine. This was prospective observation of study assessment at baseline, and three and six month follow-up. The main age of outcome revelation were to explore changes in the following domains, health status and well being of individuals in substitution treatment, community social benefits, and program performance. General vertical of the study was prepared by Dr. [inaudible], Professor [inaudible], and Professor [inaudible] from Adelli [misspelled?] University. And data collection sites was Kiev Hospital and Karsone Regional Hospital. Demographics treatment entry, 76 participants, most male, and age mean was about 38, 30 years, and most of them used popistro [misspelled?], it’s so called home made heroine, which is very popular in Ukraine and Poland.

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Drug use during lifetime, it was as an opiate, I mean, popistro, 10.3 and other substances like alcohol, 13 years and pannambus [misspelled?], six years.

Changes in well being, and I just show some data from Poland and California, for comparing, because it's very interesting, we got in different settings, but in fact, we received very similar data. Drug use was 30 days, we had at baseline almost 12, in three months, or we were wanting to go two, and in six months almost zero. Drug use was three days, dramatically decreasing, especially in first three months. Other opioid, this is popistro, comparatively in three countries, this is in Latonia, this is Ukraine, and this is Poland. You can see absolutely the same trends. Amphetamine use decreasing also.

Health status at baseline, number of physical symptoms, 18, eight in three months, almost in three times less, in six months less again. And for depression, a little bit decreasing of depressive symptoms. This is graphs of physical symptoms and depression.

Quality of life, according to WHO questioner, at baseline, in three months, in six months, situation became better, not so dramatically in social domain. Quality of life in three countries, you can see very similar trends. Quality of life psychological domain, quality of life social domain,

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its result, serious changes in Latonia, and more important for us, blood borne virus risk behavior.

Injection practices in Ukraine, we've got from 13, almost in 12 times less, injection activity in three months, and in six months. Very similar data from blood borne virus risk behavior, this is graphs, and this is in three countries.

Criminal employment activity decreased also during three and six months. Community social benefits, this is self reported criminal activity, decreased dramatically. Program performance in six months, 66-percent of retention. In Ukraine, we got order of Minister of Health in effort of 2005, for role out the substitution program from small size to more broadly, and finally we got project supported international HIV AIDS alliance in Ukraine, with money of global funds, and pilot size were in Kiev two sites, [inaudible], projects started, Buprenorphine substitution treatment in October 2005. And you can see development of substitution treatment during the last three, four years, from 2004, when we had 30 persons in treatment, until 2007 when we have 500. But never mind, it's much less than we need according to recommendation of WHO. It's not more than one in 12-percentage of our real need.

This is retention, most of people continue two year substitution program, and only left the most part of people who left program, it's according to own wish. Number of clients in

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left project, 522, most of them male, and big number of patient reported positive, 63-percentage of people with hepatitis, 63—percentage, and number of drop out, about 30-percentage, and retention during six months, 70-percent.

We provide money during and evaluation of this pilot phases, and 200 clients in six sites were under observation. Instruments which we used for this purpose, for monetary, eligibility check list, patient recruitment table, and staffing table. For evaluation, [inaudible].

Demographic, very similar, like in previous research, drug use lifetime, positive opiate, it means popistro 13.5. At baseline, according to edition index, 19-percent, 19 day during 30 days, and one day in six months.

This is drug use trends, edition 30 index, dramatically decreasing of drug use, and blood borne viral behavior from 12 to 0.7.

The prices of Buprenorphine in this country, relatively high. And one course of 60 mg tablets, $340, and total expenditure on substitution maintenance therapy, about 400 per person, per month.

Conclusions, Buprenorphine is effective for substitution maintenance therapy in terms of retention in treatment, reduction of opioids use, health status, and quality of life improvement, reduction of risk behavior, decrease of

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criminal involvement. In fact of stabilization, effective dose of Buprenorphine is from eight to 10 mg per day. Ukrainian data are similar to Poland and other participants of project, which analyzed effectiveness of substitution treatment. Political context is still ambivalent and not supportive in our country. Public health decision makers still are not active in terms of development of substitution treatment in Ukraine, and influence of HIV epidemic. And the country needs a new strategy and practice reduction substation maintenance therapy to promptly respond to the epidemic changes, firstly, to broad access to substitution treatment, providing methadone.

Thank you for your attention.

LISA MAHER, M.A., PH.D.: And our last speaker for today is Dr. Thomas Kerr. Thomas is a research scientist at the British Columbia Centre for Excellence in HIV AIDS. He's also an Assistant Professor in the Department of Medicine, university of British Columbia. He's going to talk to us about responding to the HIV epidemic among injection drug users in Vancouver, evidence of best practice in needle exchange to prevent HIV risk behavior.

THOMAS KERR, PH.D: Thank you, Lisa. It's an honor to be speaking to you today. Really what I'm going to present to you today, I think is probably best described as more of a story than a study, but the good news is that it's a story that

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didn't start out well, and has certainly improved in recent years. I'd like to acknowledge my coauthors, including our partners at Vancouver Coastal Health.

It's, I'm sure, well known in this audience that needle exchange has now been very well studied and associated with reductions in syringe sharing and incident of HIV infection, hepatitis, and hepatitis B and C, as well as increased rates of entering to detox vocation and addiction treatment programs. And as well, there's now an extensive body of research showing that NAP's have had no discernable, negative, societal effect, such as increases in drug use, crime, or discarded needles. This body of evidence has now been very well summarized quite recently in two reports, one led by Alex prepared for the WHO and another put out by the institute, US Institute of Medicine and if you haven't seen them, I strongly encourage you to have a look for them.

Despite this large body of evidence, it's important to point out that the US has maintained a ban on federal funding for needle exchanges now for two decades and many observers believe that this contributes greatly to the fact that real comprehensive needle exchange programs exists in fewer than half the countries reporting HIV infection amount injecting drug users. Despite, again, this growing body of evidence, we too often see media reports like this. This is a recent one

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from our setting and these continue despite the fact that most major international medical and public health organizations have issued consensus statements supporting the implementation supporting needle exchange as an essential HIV prevention service for injecting drug users.

Unfortunately, some, our setting in Vancouver and some of the early of the early work undertaken there has been the subject of considerable controversy. In particular, we, in Vancouver, documented a very explosive HIV epidemic among injecting drug users in the presence of a very large needle exchange program. In 1996, 97, the annual incidence of HIV infection was approximately 18-percent and this controversy also was partly due to, related to this one study which showed an association between frequent needle exchange use and HIV prevalence. This controversy continues to this day, it’s largely perpetuated by people who failed to understand what this study really said and is also perpetuated by those [inaudible] logically opposed to harm reduction. It’s also sad to note that this study was actually followed up by a very nice paper by Dr. Schechter Scrafe [misspelled?] and colleagues which showed that it was a variety of risk characteristics of injecting drug users other than their needle exchange use that really explained this association.

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As well, we sort of sought, to find out what's really driving high risk syringes sharing in this community and data from the Vancouver injection drug user showed that individuals who reported difficulty accessing clean syringes were about 3.4 times more likely to share their syringes and those who used needle exchange as an exclusive sort of syringes were half as likely to support syringe sharing.

There's also been some work, looking at why people who are having difficulty accessing syringes and in this analysis, led by Evan Wood, you can see that the main reason people reported difficulty accessing syringes was the fact that the needle exchange was closed. Ironically, the only fixed needle exchange in the downtown east side, which is home to an estimated 7,000 injecting drug users, closed at 8:00 p.m. each night. There was this odd belief that this would somehow denocturnalize the neighborhood and people would stop using drugs at eight o'clock if the needle exchange was close.

The data also shows here that people were having difficulties catching the couple of needle exchange vans that flew around the neighborhood handing out syringes, people simply didn't have needles to exchange and therefore didn't go to the fixed site.

As is often the case, it was drug users themselves who were many steps ahead of the bureaucracy recognizing the

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problems with difficulty accessing needles. The Vancouver Area Network of Drug Users established this needle exchange tent and needle exchange outreach based services. This tent would operate when the needle exchange closed in the evening and subsequent analyses showed that factors associated with receiving needles from the Vando Needle Exchange Tent included frequent cocaine injecting, injecting in public, requiring health injecting characteristics associated with HIV risk behavior and HIV infection in our setting. Fortunately, partly in response to the growing body of evidence explaining the very pathetic deficiency in needle exchange delivery in our setting, the [inaudible] started to take some action and between 2000 and 2002, the Local Regional Health Authority decentralized and expanded the needle exchange program and also moved away from a focus on exchange toward the focus on distribution. More specifically, there was an expansion in the number of sites and methods used for distribution. Most of the primary health clinics and NGO's providing services to injecting drug users in the neighborhood were quick to provide needle distribution and a variety of outreach services were supported including the drug user initiated outreach program.

Also, very important, the limits on the number of syringes that could be obtained were removed.

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What we've sought to do with this very simple preliminary analysis is to determine the impact of this policy change on access to syringes and syringe sharing amount local IDU in Vancouver.

Individuals included in this analysis are participants in the Vancouver injection drug users study, also known as VIDUS. VIDUS is a prospective cohort study that began in May, 1996 and over 1500 injecting drug users have been enrolled through self-referral and street outreach. At baseline and a semiannual visit, participants provide blood samples and complete a lengthy interview of administered questionnaire that assess a range of factors including access to syringe exchange.

In addition to just graphically assessing the proportion of people who were receiving syringes from the fixed needle exchange, we also assessed rates of syringe borrowing and lending between 1998 and 2005, using GE logistic regression. Include in this analysis were 1481 participants, of which 37-percent were female and the median age of enrollment was 33.4 years. At each six-month follow up, we restricted the analysis to active injectors.

This first slide shows you the proportion of participants reporting that they are getting their syringes exclusively from a fixed needle exchange and these arrows show when the program changes were implemented over about a 2-year

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period and as you can see, there was a substantial decline in the proportion of people getting their syringes from fixed needle exchange sites and that probably reflects the fact that now they were getting them from other locations including the various outreach services in the neighborhood.

When we look at syringe borrowing in this period and considered the period during which the program changes were implemented, again, you also see a very substantial decline in syringe borrowing. When we looked at syringe borrowing in our multi [inaudible] GE analysis, you can see that the period after the policy change was associated with greater than 50-percent reduction in syringe borrowing after adjustment for a variety of potential profounder.

When we looked at syringe lending, we see yet again, a very similar effect. With the program changes being followed by a substantial decline in syringe lending. Again, in our multivariable GE analysis, the period after the policy change was associated with the greater than 60-percent reduction in syringe lending.

In conclusion, despite the obviously limitation associated with this type of analysis, due to its observation and the self reported nature of the data, we feel that these finding show that efforts do improve needle exchange services through the decentralization of services and removal of

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distribution limits were accompanied by declines in syringe borrowing and lending. We believe these findings have implications for best practices in HIV prevention for IDU. Specifically, these data show that needle exchange programs can be improved upon and more effectively delivered when they are decentralized and removals on limits are when limits on the number of syringes are moved and also when the injection drug using community is involved in the delivery of this type of program.

However, our findings also indicate the need for additional complimentary policies and programs to address ongoing rates of syringe sharing in this community.

I would just like to acknowledge the [inaudible] participants, our study team and our funders, the US National Institutes of Health and [inaudible] Institute of Health research. Thank you.

ALEX WODAK, M.D.: Thank you very much Thomas and we are now going to open the floor for questions and invite you all to, if you have questions, I think there are some microphones somewhere, yes? And I ask you to keep your questions short and the presenters, I'll ask you to keep your responses short. So, the first question comes from Thomas Kerr

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THOMAS KERR, PH.D.: I have a question, I guess for Caroline, but I would also be interested to hear form Alex or Lisa. I'm aware that there's been quite a bit of discussion in the [inaudible] about the Australian drought, which we understand has started around 2001 and the results have been quite a bit of interesting discussion about the causes of that, whether it a domestic or global phenomenon. In the data you showed, there was quite a noticeable decline in heroine use that occurred starting 2001 and continued to 2004 and during that same period there was a increase in methamphetamine use, but your data ended in 2004, I'm wondering if any of our Australian colleagues here could comment on what's happening now, has heroine use remained low, has it made a comeback and what's happening with methamphetamine use.

FEMALE SPEAKER 1: My rating of the [inaudible] is those patterns have continued so, heroine use is still lower than it had been in previous years and methamphetamine use has continued to increase, or at least continued at a rate [inaudible]

FEMALE SPEAKER 2: I think the last survey that was the first year ever in 12, 13 years that methantheline was the most commonly drug reported as [inaudible] injected drug, so it actually superseded heroine for the first time and also, we've

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seen a lot of increase in the injection or reported injection among that group of deviated preparations.

ALEX WODAK, M.D.: Okay, do we have any other questions from the audience or the panel? Please state your name and where you are from .

MALE SPEAKER 1: [Inaudible] Blans [misspelled?] from Sydney, Australia, in the presentation of Dr. Motevalian [inaudible] in prison in addition to [inaudible] are condoms provided for prisoners or in those prisons isn't there any man to man sex in your country?

SEYED ABBAS MOTEVALIAN, M.D., M.P.H.: [Inaudible] This is a first summer we have, as I told before about the sexual contact and sexual transmission of HIV from these [inaudible] among them. We have done something's and it's not difficult to justify the alternatives to, I mean, to distribute condoms or to easily access condom distribution in the prison, but we are going to, at least, give condoms for [inaudible] to use if they have [inaudible] visits with their spouses in the prison. Who knows even, how large is this problem, men are having sex with men in the prison and how much important it is in the transmission of HIV in the prison.

ALEX WODAK, M.D.: Any other questions? Yes Sir.

MALE SPEAKER 2: Yes, Hans [inaudible], I'm from Holland but I'm supporting an Indonesian program which is also

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preparing reduction while in prison and a question for Dr. Motevalian, we are least, it seems very difficult to select prisoners eligible for [inaudible] in our city and I would like to have [inaudible] very different from outside because many people don't have access to [inaudible]. Many tests are negative even though we suspect people are really injecting and I was just wondering if you could [inaudible].

SEYED ABBAS MOTEVALIAN, M.D., M.P.H.: As I mentioned in my presentation, it was voluntary basis and how we defined the IDU in the prison, if it was true [inaudible] of injecting drug uses, one was the first was self report and the second was the physical signs of drug injection, especially for the new entrants. We didn't perform any urine analysis to confirm the cases or to search for the cases of IDU's within the prison.

MALE SPEAKER 3: [inaudible] from Italy, question for Dr. Dvoriak. One of your first lines when you were introducing the issues, it looked like transmission in injecting drug [inaudible]. This is one of the main arguments for especially [inaudible], in the belief that the epidemic is moving to the general population. Do you believe that in the reality of what happened is that [inaudible] has improved and do you think that [inaudible] this new that we are facing is mostly concentrated at the [inaudible], therefore the main response would be

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[inaudible]. Could you mention some political environment is not very supportive?

SERGII DVORIAK: Thank you for your question. It's really very interesting [inaudible] and now it's a subject of [inaudible] between professionals. According to our estimation, it's really proves that HIV moves step by step to general population, but that does not mean that it became less active amongst IDU's. Amongst IDU's we still have about 60, 65 different regions, 50 different regions, 75-percent of all IDU's, HIV infection and they have sex partners and several sex partners and they spread HIV more broadly than in previous years, like [inaudible], and anyway, the HIV concentrated amongst IDU's or their sex partners and we tried to convince our policy makers that issue of treatment of drug use, this is the main issue of prevention of HIV, including general population, because the more people involved in epidemic is the more people from general population put in this group, but anyway, still IDU's on [inaudible].

MALE SPEAKER 4: I'd like to make a comment. I'm from Ukraine too and I'd like to compliment my colleague, Sergii on a very good presentation and that you should acknowledge him operating under rather severe circumstances. I sit on the CCM or the NCC of the National HIV Foundation Board and there has been a big see-saw between the, those of us that would like to

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see substitution therapy with methadone to become the standard in therapeutic modality to rest the epidemic of HIV among the injecting drug users. As Sergii said, the power [inaudible], the finance, the justice, they're against us. They have their own political agenda to solve and while Sergii may not be able to speak as candidly as I, I think one should share with you the need and how to [inaudible] it, from just the level of a science paper into an issue of policy development and policy advocacy. The one redeeming factor in this struggle is the global side. The Global Fund has said to you [inaudible] Thou shalt have methadone substitution therapy or thou shalt not have money and this effort [inaudible], I think will eventually tip the scales so that Ukraine will have methadone therapy and [inaudible] Sergii to implement it. Thank you.

MALE SPEAKER 6: [Inaudible], Sydney, question is a general question for the panel, it's around the potential differential impact of therapies on HIV incidences in the [inaudible] enormous reactions in injection [inaudible] we had, is that sort of a randomized evaluation [inaudible] that study already been done is it feasible to do such a study?

MALE SPEAKER 7: The question is, is the not reduction in risk reduction among people receiving [inaudible] in Ukraine open the possibility of having an randomized control trial to look at this in the Ukraine. I think that's the question.

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MALE SPEAKER 6: Against methadone.

MALE SPEAKER 8: Is there some special reason against methadone?

MALE SPEAKER 6: Yes, comparing [inaudible] and methadone in randomized controlled trial looking at risk behavior.

MALE SPEAKER 8: But we do not use methadone in our studies.

MALE SPEAKER: [Inaudible] in terms of risk reduction that in a setting of very high HIV incidence [inaudible] might be the [inaudible] in terms of reduction incidences.

MALE SPEAKER 8: I think reduction in our study connected with the situation that it was very first pilot project and clines were enthusiastic to participate [inaudible] and maybe this is why we got so dramatically changes and in other studies, maybe we cannot observe so big difference between baseline and follow up. But we did not work with methadone and unfortunately, I cannot say something about methadone treatment in our country.

FEMALE SPEAKER 1: Can I just add to that Gregg, the available data on the comparison between, in terms of the way methadone works and HIV reduction [inaudible] is that it reduces the amount of injecting and therefore reduces people being put at risk and the comparative data between methadone

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and buprenorphine today, shows that methadone intends to perform a little better the than buprenorphine on the front, [inaudible].

MALE SPEAKER 9: I want t ask my college Lisa Maher to ask the next question.

LISA MAHER, M.A., PH.D.: I would just be interested to hear more from Dr. [inaudible] about the very important study in Thailand and about, to perhaps elaborate on what you think might have driven those declines in injecting risk behavior in the drug users in the [inaudible].

FEMALE SPEAKER 2: Yes, they are falling off their injection frequency of infection significantly and they're sharing other equipment has [inaudible] significantly also.

LISA MAHER, M.A., PH.D.: And why do you think that happened among the drug users in your trial?

FEMALE SPEAKER 2: We have a package, a prevention file for them, we have counseling, education and distribution of [inaudible] and condoms and we have HIV testing with pre and post test counseling and also methadone [inaudible].

FEMALE SPEAKER 3: [Inaudible], my question is a follow up to Dr. Myers which [inaudible]. I wonder if you could speculate about what the impact of providing these condoms and clean needles would be to your population that obviously would have a significant impact with your [inaudible] if you

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increased the comprehensiveness by providing clean needles, what would the effect be, what do you think some of the [inaudible] political excuse are [inaudible].

FEMALE SPEAKER 4: Needle exchange are not provided in Thailand because it is against the law in Thailand and Bannock [inaudible] administration has been providing an extensive package of proven [inaudible] including [inaudible] intensive risk reduction and counseling and condom and bleach distribution [inaudible] in a recent HIV vaccine trial conducted in the same [inaudible] treatment clinics and as I have just described, they appeared to be a reducing risk behavior in their current trial.

ALEX WODAK, M.D.: Are there any other questions? No other questions. In that case, I might just make some concluding remarks. We've heard presentations from five countries and regrettable in four of those countries had they [inaudible] spread of HIV among injection drug users in many of those countries the infection has spread beyond the injecting drug users to other members of the community. One country [inaudible] has so far been spared this terrible result. But now we're seeing that in at least four of these countries, we have seen vigorous efforts now to try and stem the HIV epidemic. In three of those countries, it's been quite a struggle as you hear. I think what we are reminded of I think,

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particularly from the last exchange about the importance of doing the entire package, so now it's really beyond scientific debate [inaudible] adds considerable power to the HIV prevention efforts and so we hope that more countries that are threatened by this terrible epidemic among IV drug users is that that whole package will be [inaudible] and there won't be cherry picking of things that are acceptable and the less acceptable things will be left to one side.

I'd like you to join in thanking all of the speakers, it's been an outstanding session and it's a testament to the wide spread progress that's occurring around the world.

I'd like to finish on an optimistic note, I'm quite intrigued in the words of President George W. Bush, he said when it comes to Iran, all options are on the table and as we heard today, maybe not in the way that President Bush intended it, at least when it comes to HIV prevention among IV drug users in Iran, all options are on the table and we can be very grateful to the wonderful example that you and your colleagues sharing [inaudible] country in your region and around the world about what can be done. Thank you, all speakers and presenters. It's been an excellent session.

[Applause]

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