

Treatment for Injecting Drug Users: Making Calls for Universal Access Real August 14, 2006

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

RAMINTA STUIKYTE: And since we have five panelists, one more panelist will join us. I would like [inaudible] to start presentations with this.

We have wonderful panelists today and we will try to listen to presentations first, to keep questions at the end and to keep debate at the end. So that we still have time for sharing ideas.

And the first speaker that I would like to invite to speak is Mauro Guarinieri and it's my honor to present him.

He's interim chair of the Global Network of People Living with HIV/AIDS. He's member of AIDS 2006 Conference Organizing Fund and he works for International [inaudible] Program at the [inaudible] Society Institute and he's member in a number of organizations in sharing [inaudible] et cetera.

He was involved in many activities related to HIV treatment from [inaudible] starting from training in Eastern Europe and also providing technical advice to WHO. And Mauro, the floor is yours.

MAURO GUARINIERI: Thank you, Raminta, and thank you for inviting me for this satellite. As you know Hepatitis C is extremely prevalent in drug users, not only injecting drug users but drug users in general.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And in the most of the country where antiretrovirals treatment is widely available, end-stage lethal disease is becoming one of the first cause of deaths, non-AIDS related deaths, but in a way, we should start considering hepatitis C an AIDS-defining illness.

Most of the people wait in waiting lists for a liver transplant. And just the beginning was custom to give HIV patient a face or to show what it means to be in a terminal stage.

And this person is probably a former or current injecting drug user. This person is probably on a waiting list in a few countries where drug users or an HIV positive person can have access to a liver and this person was probably diagnosed for a decompensated end-stage lethal disease or a [inaudible] carcinoma six or 12 months ago.

So [inaudible] which is way more common. So in a way we see in countries like in Western Europe or in United States or old country where antiretroviral is widely available, we see the future of most of the countries, especially those regions in the country where HIV is more prevalent among injecting drug users.

So the question is first is whether Hep C is a real epidemic, whether Hep C is going to increase in the future years or decrease, and the answer to the first question is yes. Hep C is a real epidemic. An estimated 200 million

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

person, but it is a very conservative estimate, are chronically infected with HCV. Three to four million are newly infected every year at an estimate probably this number should be probably doubled.

And the vast majority is anywhere [inaudible] they don't know they're HCV positive because testing is not widely available and not very common and a referral from HIV centers to HIV testing is not that common.

So probably more than 80-percent and certainly more than 50-percent don't know they're HCV positive. And it is the leading cause of chronic liver disease and the leading non-AIDS cause of death in co-infected patients.

And the mortality is expected to triple over the next two decades or probably even more and in co-infected infected patients, we see that these numbers should be probably multiplied by five.

And [inaudible] strongly associated with intravenous drug use, but not only. Because HCV is a much more efficient, in a way, than HIV and transmission can be also related by sharing a straw, or by back floating, or by sharing the equipment that you normally use when you prepare the drug, which is information that is sometimes available but not always available.

As you can see, the prevalence in different regions of the world matches more or less the region where injecting

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

drug use is the main driving force behind the HIV epidemic, with the only exception of Africa, where probably transmission more related to reuse of needles in the hospital settings. But as you can see in Eastern Europe, we have 10 millions; estimate in Southeast Asia, 30 to 35 million.

So it's a big, big epidemic and it's not going to decrease. In some countries, like in Thailand recently being reported, 92-percent of incidents in injecting drug user in some part; in some region of China, almost 100-percent.

So it is a real epidemic and is really related to specific populations that are most vulnerable and more exposed to diseases and lack of support and treatment.

Transmission is, as I told you before, is related to contaminated blood. And prior to 1992 by transfusion is now is more to needle sharing or to sharing equipment and again straw or other equipment used during or related to drug use. Sexual transmission is not very common; is more common when people have multiple partners, but is still debated.

And of course there is a high occupational exposure and [inaudible] transmission more common in the case of co-infection. And before 1987, clotting factor were related to STD transmission but now this problem has been fixed and now is very uncommon to see transmission among this kind of transmission.

As you can see from this light, hemophilia is more

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

related to clotting factor. Injecting drug user, these are that from the United States, almost more than 80-percent and then decreasing from hemodialysis, sexual transmitted diseases, general population, pregnant women.

So it is clearly an infection that is happening in injecting drug users. The natural cause of the disease is normally 15-percent from [inaudible] virus. In 20-percent of the cases, they develop cirrhosis, usually over many years. That's in case of mono-infections.

Five-percent of the total will develop a hepatocellular carcinoma and, from that point, survival is expected to be between six months to two years. This number has to be multiplied by five in case of infection. Because it's proven that in HIV is, speed of progression of HIV by at least fivefold. And this is not a situation to get any better in the future.

As you can see by these slides, and these are again data from the United States, we expect an increase of almost 600-percent in terms of need of a liver transplant, almost 300-percent of decompensation, an increase of 300-percent of liver-related deaths, an increase of almost 100-percent of hepatocellular carcinoma and 61-percent of cirrhosis.

So you are going to see a major outbreak in the following years. And this is expected to happen by 2008. Considering a time span which is more wide than that, you can

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

see that the curve is going to increase and probably going to reach a peak in 2019.

So this is a real epidemic. It is going to increase, and a lot of people are at risk for either getting hepatitis C and to die in the future if some decision are not or treatment is not made available.

[Inaudible] is co-infection is, as you know, co-infection is a much more an issue than mono-infection and HCV is much more prevalent in HIV positive individuals than in the general population. In the general population, the average is around 2-percent but in HIV-positive individual, on average, is almost 20-percent.

This, of course, related to injecting drug use and there are still other possible causes that some explained, some unexplained. But it's true that HIV and HCV are two diseases, viruses that are going to compete, and the more you treat one virus, the more the other virus will prevail.

I am a person living with HIV for, since 1984 and have also hepatitis C and of course it doesn't apply to all my friends living in country where antiretroviral other treatment is not available.

But all my friends that live in Italy or in United States in the last two, three years, I can tell that most of the deaths were more related to hepatitis C than to HIV, and this is due to the fact that of course the more you are able

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

to control HIV, the more you have time to see hepatitis C progressing, people dying for hepatitis C.

So, the reality is that with co-infection, that HIV both accelerates and increases the risk of progression. There are conflicting data about a possible interaction between HCV and HIV. Some studies say that it is possible that HCV has an effect on the progression of HIV. But still this is not completed data.

But it is absolutely certain that HIV accelerates and increases the risk of HCV progression, which is a good rationale to push for the inclusion of hepatitis C or at least hepatocellular carcinoma as [inaudible] infection or even an AIDS-defining illness.

And you can see from this slide that this study data from France, over time in 1995, of course, most of the people were dying for HIV or AIDS-related mortality. In 2001, most of the people, most of related were dying for liver-related mortality.

In form of treatment; as you know, just standard care is a weekly dose of pegulated interferon with a daily [inaudible] for 24 to 48 weeks and that's the standard for co-infection, 48 weeks or more with two check points at 12 and 24 weeks for early virus [inaudible], with some very debilitating side effects, especially depression and anemia.

In form of the effectiveness; in the mono-infected

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

individuals, 40- to 50-percent have sustained viral response. So over time, they can clear virus and they define after treatment. And for genotypes two and three, the rate is even higher, close to 80-percent.

In co-infected individuals, of course, the results are much worse than this. The overall sustained viral response is between 27- and 40-percent and of genotype type - one which is more common in Western Europe and the United States and more common for some reason in injecting drug user - the response is very, very poor.

But still there are reasons to treat people because of the risk, especially in the presence of HIV. And there are a lot of studies showing that even when the treatment is not working, the treatment may also slow progress and reduce risk of liver cancer regardless of the sustained virus response.

So there is also a reason to treat people with or without a sustained viral response. And most of the reason why people are not treated are because they are not [inaudible] appointment, active substance abusers for active [inaudible] condition, medical contra-indication.

The good thing is the majority of those reasons are related to potentially modifiable psychosocial factor leading to non-treatment. So in form of challenges; well, the first one is that the special treatment rate response is much lower

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

in the community, is probably related to the fact that in clinical trial, the number of drug user, injecting drug user is very low and is very difficult, some pharmaceutical [inaudible] study actively excluding the drug users.

Some other HIV trial actively excluding co-infected patients. So we don't have the data. So when we transferred the result of the clinical search into the community, we don't have the same result. One of the problem is that [inaudible] include the present progression based on liver biopsy and it, of course, a very invasive intervention. Some people are really afraid.

They can be ready to start a treatment but they are not ready to go through two or three liver biopsies because one is not enough to have a real. So that's also an obstacle, especially in some specific settings.

And of course, many clinicians, they refuse to treat injecting drug user, exactly the population that should be treating, because they believe they are not a guarantee treatment for a number of reason. And specifically, they believe that they are not going to adhere to treatment, but as you can see, this are not proven.

Actually, a review of more than seven clinical trials found that drug user have a similar result to the first group in adherence of response. They can refuse to treat or they can deny treatment to active drug user because they believe

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

they will become re-infected.

But data suggests the re-infection rate is not high enough to jeopardize the potential benefit for most patients, or they can, and one of the more common arguments that they may relapse because they're going to prescribe an injectible drug. They're going to manage depression in the individual that may potentially have some [inaudible].

That is not proven, that there is any likelihood of relapse. Even so, it is not proven that relapse in drug use apply non-adherence. So, just to close, I just want to quote this is the result, the final statement of the European Consensus Conference. I was involved in the discussion. And at the beginning, the final statement was supposed to be completely against treating drug users.

So after a very accurate review of all the evidence, this is the final statement. That active drug use should not be an absolutely exclusive criteria, since full benefits of therapy of not compromise. The patient requires treatments of [inaudible] substitution treatment including [inaudible] maintenance where medically invariable. And if the patient is not willing to stop drug use, any assessment should be made case by case.

And this is, to me, just common sense, in a way. Because saying that people are not compliant, people are not adhering, it's just a false statement. The reality is just

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the medical system should adhere to the patient. And there any problem, and there are, of course, problem, the only thing the medical system should try to do is to just fix it. Thank you very much.

[Applause]

RAMINTA STUIKYTE: Thank you, Mauro, so much. And now I would like to invite Konstantin Lezhentsev, who is consultant for a number of organizations including Global [inaudible] projects in Russia and Pakistan, for all Ukraine a network of people [inaudible] AIDS, for [Inaudible] of the open society. He will speak more about cases and practical examples how to make HCV treatment possible for injecting drug users.

KONSTANTIN LEZHENTSEV: Thank you very much, Raminta. And it's always a pleasure for me to present on the sessions organized by Eastern European Harm Reduction Network because of really true commitment through all these years and all conference to highlight the issues that we committed to and use the multiple expertise both from community medical doctors and scientists to really push this issue forward.

So while pushing this issue forward, I would like to present on some experience from our region particularly from the countries of Russia and Ukraine. And I will stay more on Ukraine, about role of harm reduction services and attempts model projects on actually integrating the harm reduction

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

prevention originally isolated services into [inaudible] of comprehensive care for IDUS.

So the role of harm reduction problems in comprehensive care for IDUS limiting to HIV, not only limiting to provision of heart is quite well announced in policy document, in clinical guidelines, including the WHO guidelines for providing antiretroviral treatment to IDUS that we expect to be adopted by September and those who are describing the guidelines for doing hard utilization in CIS, former CIS, CIS region of Eastern Europe.

So it's, and for people doing effective and comprehensive harm reduction programs it's quite obvious that outreach strategies are a vital component of HIV care, getting proximal to the patients, getting all information treatment [inaudible], initial motivation to treatment right on the spot where you meet the patient.

Experience of prevention programs is vital for treatment who are developing motivation and breaking myths. Myths usually are the main barrier for people to turn for the treatment. And harm reduction actually is the front line in the continuum of fair [inaudible] use.

So starting from the standard [inaudible] of prevention, counseling, treatment information, going beyond to more higher levels of integrated care approach and trying to concentrate maximum need of services for particular

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

patient IDUS [inaudible].

And harm reduction, prevention, intervention should be available at each stage of care for IDUS. And this is a very important thing because why we are speaking about integrating harm reduction and treatment, we speak about how we can get treatment message, treatment knowledge to harm reduction and we forget that people are not taking illegal drugs in vacuum.

People are going to work, people are starting treatment, people are changing their decisions and the fact that the person using drugs are coming to the level of starting hard or doing any other medical intervention or getting other services. It doesn't mean that certain point they won't get back to injecting drug use and is still in need of prevention and we feel that it should be available on each side.

So, and for me also this announcement that you hear quite often about the treatment and prevention you cannot permit this artificial disintegration of these things. It's one single action against the epidemic.

And I think, particularly in comprehensive care for IDUS, this is very practical approach. Integration of harm reduction, originally prevention, serves inter care and treatment is a really practical example of getting treatment and prevention working together.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So in Ukraine, based on all this theoretical, practical model principals, we decided to use this and somehow to start this process of integrating harm reduction projects - originally very prevention-related, very isolated - into this continuum. And there were number of conditions for this.

First of all, it's launch of [inaudible] project sites in Ukraine in seven regions [inaudible]. Previous effective scale up of IUD treatment programs and this is thanks to the advocacy for my comrades from all Ukrainian Network or People with HIV and International HIV [inaudible] Recipient of Global Funding Ukraine. Also it's a care and support component which All Ukraine and Network of People with HIV was advocating and designed and implemented that it's not only priority to provide [inaudible] it's also the continuum of care should be available to include adherent support social services home-based care. And this caring support component was already into place in this region. And also we were using the loophole for scaling up substitutions treatment because still it was not total green light to going on for substitution treatment. So first Methadone was demonized and there was option only for Brenner thing to start as a pilot. And the reason was actually to limit it as an adherence to for ARV treatments. So it was originally pushed to integrate.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And, at the same time, with all this positive side where I would like to say that in my region, Eastern Europe, it's historical isolation of most of harm reduction projects from care and treatment activities and more focused on only very narrow vision prevention activities.

So the integration, as it's called, the main objective of it, was to ensure proximity of IDU care projects by establishing link between some reduction and ARV substitution treatment projects in one region and try to introduce the case management model and patient outreach model.

So what is an integration, what we proposed as a program? We made our first official study tool of multidiscipline team of drug treatment. Dr. Dune [Misspelled?] ST ARV doctor team of outreachers from harm reductor and peer counselor from PWA Community who is working in the AIDs Center on adherence.

And I would like, most of you may know Community Health Care Van program of Yale Medical School. This is quite good model of integrated care of TB, H of E harm reduction and ST care.

And we made a full up ARV IDU trainings meaning basics of ARV and antiretroviral treatment for injected drug users for outreach team. So each people who were originally working on prevention, doing the very good work, have

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[Inaudible] in community with prevention message. We gave them the basics about ARV and particularly focus on ARV specifics injected drug users, meaning interactions with substitution treatment, interactions with illicit drugs, best models, et cetera and motivation on how to break the main myth in the community about treatment.

And then we made a small [Inaudible] integration kit salary for outreach walkers, upgraded salary for those who are experts also in treatment literacy, mobile communication transportation. And we were going on full on technical assistance with original and international technical advisors.

So six months passed and in this scale of broad substitution treatment, which was going very well we managed that people who are working in our outreach team, we brought the people from outskirts.

The people who five years ago got the HIV diagnosis in the AIDS center, signed the criminal responsibility paper and said, "I will never go back to this place. I would live somewhere in my place and do my business and will not talk about this."

But outreach is where the key people who could get to them, and they were able to deliver this message and bring these people into this continuum of care, Community Center,

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Substitution treatment which mean you see quite a big figures of 113 deaths in the cities in Ukraine.

[Inaudible] but you see also drop-out rates. And this is the very also important fact it's a very negative fact, but also it's very important fact. I do remember when the ARV was starting to scale up, lots of people were telling, "Okay we are providing dimensions. Where are the patients?" So in this case, nobody can say that we do not need to scale out substitution treatment because there are no patients.

There are patients. They're invading these and people are dropping out. By dropping out I do not mean that people are completely lost to fall out, but people lost this feeling of continuum of care. People lost this feeling of being adherent to other people who could give them counseling, who could break their myths, who could maybe solve there some legal problems et cetera because they're frustration, because we come to the treatment that we really wanted for years and then they couldn't get it because of no scale-up. Key problems of scale-up.

Low rates. There was no price reduction for buprenorphine down by their main primal recipient. It feels monopolization of the market. It's only one company who provides it, and its \$219 per patient per month, which is incredibly big price.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

It's still lack of understanding of harm reduction role in treatment by harm reduction establishment. By establishment, I mean the managers of harm reduction project. They're not so much integrated to actually support these things and be the leaders in getting integrated because it's they still have vision of clear separation of zones of [inaudible]. Here is your prevention. Here is your treatment.

And it's monopolized era. Harm reductions doing harm reductions assessing themselves, monitoring themselves and putting the result themselves. So it should be broken.

And absence of clear vision of case management. Case managers usually mix doubles outreach work, home-based care. So this model of case managed of taking person out of marginalized side and bringing him to care, getting him accommodated there and then going for another one is not yet installed.

And historically undeveloped outreach component. It's lack of investment into people, into community. So how to solve it, strategic directions, it's scaling up access treatment of esteem, access to methadone and all Ukrainian network and our program and clinical foundation and the Minister of Health of Ukraine is really working hard on weak registration. We are now in process of registering two forms of methadone from two companies.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Expanding standard care of harm reduction, so not only needles but also TB screening by BPD, treatment literacy, case management, flexibility, response to elicit drug market changes.

Harm reduction in our country, still working on the principles of OPA [inaudible] used it for seven decades years ago. And now it's a huge wave of amphetamine use.

Now the drugs are coming on the market. People have different needs. People have different social classes. People are mixed up with other cultural patterns like dance music and all other issues.

Younger generations, we need younger outreachers who can come to them. So harm reduction should not be stable, should be flexible. And the key point I would like to say is investing into people, not into the infrastructure.

We need to, when I say strengthening outreach component, it's investing into people, into making community experts: expert in treatment, expert in social care, expert in case management.

So I would say that based on this small quite pilot experience, we revealed a number of key challenges that I would say have been influenced a lot and were advocated a lot by all Ukrainian network and other partners to get fuller flexing in the Global Fund round six [Inaudible]. So this lessons learned during this period, I think are reflected

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

quite in this implication. And most devastating efforts, it's also vital lesson for myself.

The most devastating affect of the artificial separation of prevention and treatment has been revealed when faced with the challenges for organizing comprehensive care for IDU's. Because when we say the harm reductions not integrated, it doesn't mean that some two trends are not getting working together. It means that we do not outreach to people who need care most of all.

And now I will not speak too much about Russia. I would say that we are starting the same process there. It's quite successful implementation starting on an ARV components in Globus Run. It's Globus Run in Russian in 10 regions. So we also provide international technical assistance, mentoring visits. We prepare field experts who are working in the eight centers as part of multidiscipline team, and we are trying also to make a study to the best model sites of integration.

So situation in Russia is very much the same as in Ukraine regarding the harm reduction motivation, integration into care activities, commitment to this role. It's quite the same regarding the establishment of harm reduction project.

However, there is no substitution treatment component, which actually put more burdens on harm reduction

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

and more responsibility to take care about the people. And there was already good experience I will say before even project in [inaudible] or in St. Petersburg.

And I just want to take a lot of time and say the Aleksandra Volgina will also follow up and say more about practical problems and she's the key person who's visiting the site and assisting me in getting the full feedback and assistance to this. Thank you very much.

[Applause]

RAMINTA STUIKYTE: Thank you, Konstantin. And just before getting the word to Aleksandra Volgina, who has already presented by Konstantin, I wanted to ask if Alex Wodak is with us in the room, and if yes, please join us in the podium.

So the next the next [Inaudible] speaker, Aleksandra Volgina, some of you might also visited today satellite meeting in early morning where Aleksandra Volgina was also speaking about issues in Russia. And now this presentation will be more practical and more in detail to what is happening in Russia.

ALEKSANDRA VOLGINA: I will talk about access to the treatment and what it means now in Russia. And so the access to the treatment means that sustainable and regular medicine supply in which is very important now in Russia because last month's situation become really worse than it was before

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

because of the interruptions in the treatment in many regions of Russia.

Like the first step, about the access to the treatment, it would have to be a sustainable and regular medicine supply. It's success to information about its availability, treatment literacy and comprehensive approach to care, support and adherence.

And there's just, very important also in Russia is that all that measures have to provided on non-discriminative basis with special attention to specific needs of marginalized groups, particularly IDU's.

What is declared nowadays in Russia? That there is a problem of HIV and there are people with HIV/AIDS, and they're mostly drug users. The government has decided [Inaudible] now that HIV exists in Russia, though it's still not accepted officially that we have an epidemic.

And there are people living with HIV/AIDS and they are drug users, and before it actually didn't exist, as it was with sex in former Soviet Union. It exists but the fact it was not admitted officially. That there is a treatment and that people with HIV/AIDS have rights too.

Now it seems wrong to say that IDU's are social and not productive and there is no reason to treat them as it was said before. And nowadays there is a political will. Still, government admit that it is their responsibility to provide

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

this treatment. The [inaudible] is devoted to solving this problems have increased in 20 times if it compared with previous years.

So called [inaudible] federal money on national federal project health is responsible for that funding. It took several years to work our, in advocacy to make these declarations true. I think that situation was changed because of two main factors.

[Inaudible] advocacy [inaudible] inside the country, right after [inaudible] radical movement from dates and international from outside help and pressure at the same time. Global Fund working in the country and G8. So, and that was the declaration. And what is the real situation now with access to the treatment, I mean, our supply without interruptions.

Before the local [Inaudible] were providing some not will be [Inaudible] but assume there were some people who are getting treatment from the local [Inaudible]. When it was announced that the federal project will start, this local [Inaudible] were closed so that they're waiting for this federal money.

These projects haven't, just started but it's not working actually because of a number of reasons, such as procurement problems, standards that didn't pass a number of

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

drugs. There's no expertise in applying for cost, delivery and of course there is corruption.

So I want to speak about [inaudible] treatment. But I want to speak first about sustainable supply of medicine to the regions based on their needs. The only regions nowadays that perhaps sustainable ARV delivery are global regions.

Actually the last thing I was doing when I was leaving for this conference, I was sending the [inaudible] to [inaudible] people who have interruptions in it. Our [inaudible] is to be rushed not in the process together [inaudible] as weaknesses to the reality of treatment as said.

But this will [inaudible] as the treatment in the regions even in global sites we see a number of problems. With implementation after the drug supply is insurance. And we should be proactive and use the experience to prevent negative practices in national project realization before I started.

So here are that main barriers to IDU access to treatment on the ground. It is the specific pf medical infrastructures, eight [inaudible.] Main priorities still control an epidemic [inaudible]. Focus on epidemiological data, collecting statistics reports about [inaudible] with AIDS.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So in some [inaudible] like six epidemiologists who are actually forgotten how patients look like and one clinician. So called collision of cases are going well. And also the other problem is low salaries don't always inform [inaudible] to treat anyone.

Totalitarian approach, which was one of the stereotypes of eight central works in the previous years when the access to the treatment was really poor and committees that decide to treat or not to treat rather than how to treat effectively.

And at the same time, in section is unlikely a colleagues from narcologists sector are sharing ideas about substitutional treatment. However they are still part of the system and they couldn't be walk off only after permission.

Talking about the patients; usually they have a very negative experience of interaction with any state institution. Usually it is the most motivated group to work with IDU's is police. So due to this motivation and sincere feeling the practice of interval universal for all sides.

So that the main referral system nowadays is referrals to the police when the people are entering any state institutions, and starting from pharmacies ending on the eight central.

Usually the first experience of conducting health care institution is very negative. Health care providers

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

refuse to use drug users, discriminate against them and report them to the police.

Ideals is necessary to group so they have a very of seeking help of any kind. They don't believe that they have any rights or that fighting for their right to help them.

And I was talking about this case [inaudible] she was changing the antiretrovirals for the fourth time and she is saying like, "I'm not going to talk about that officially because I'm saying because the situation could become worse, and the situation can become worse." It is already too bad.

So there it's hard to spread information among underused and often there are a lot of needs. And for instance such means that the antiretrovirals are clinical trials that will make people sicker or that antiretrovirals are addictive and like millions of them.

The other variable to the access to the treatment is that there's no any drug treatment support. In order to receive free drug treatment you must be registered officially. So treatment is limited to detox.

The waiting period for this treatment can be as long as two months in some regions. And there are often long waiting lists. Substitution treatment is legal in Russia and rehabilitation is usually expensive more than \$1000.

Free rehabilitation is only provided for a religious groups. Narcologists are a corrupted profession and

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

narcologists are more interested in making money than in providing effectiveness treatment or reforming the system.

For them the fail of the treatment only means no profit. In innate groups, HIV is very stigmatized, and those living with HIV are not able to disclose their status.

Also there are specific [inaudible] of harm reduction projects first. Because of the harm reduction projects sometimes are usually are [inaudible] eight centrals on narcologists departments. That's why they have all the specific I was talking earlier.

Also the salary of the hourly wage workers is very low. They are not taking part in any decision making. And that brings to really hard burnout syndrome, and also of course they have the problem with the drug use.

And the other variety was a problem of accepting peer counsel as equal members of healthcare team. That really took a lot of time and to work that out. But nowadays, I think that the strategy of involving peer consults is really working already.

And the other thing is discoordination among key stakeholders and [Inaudible] between this institutions. So the main problem now in Global Fund regions are that clients are not looking for help. And low level of adherence among those starting treatment drop or out trade. And these

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

problems are not surprising when we work with such hard groups of patients as IDU's.

So people even don't know that treatment exists and it is available. [Inaudible] about enter a lot of trust of [inaudible,] a system that pushed them away since the first day of diagnosis. Patients who start treatment do not receive adherence support that consider the special needs of IDU use.

So [inaudible] are related to the need to get information about treatment to marginalized communities. The last case managing model and a lot of intervention for adherence support and care for people stuck in treatment. It's real important to speak about these problems now rather than simply report about good indicators or showing good model. We have to talk about it now so that when we will start to work out the national model. We'll have already that experience.

So what is the grand activities now? Informational working trainings and [inaudible] training that will show for peer counselors and outreach workers was very practical training on consulting on a burnout process counseling present treatment of take and supporting adherence.

In creating funding for treatment programs. Peer counseling and outreach's are also technical assistance through the site visits. One of the main things, I think is

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

monitoring. Documenting a patients needs is a tool for advocacy.

Future advocacy and monitoring the inclusion pf peer counselors and outreach workers in the design and implementation of the programs as an expert advisor for improved program effective. And also there are other products we need to work more and we are working already is advocacy, spreading information about this work.

And [inaudible] interest in performing this treatment system and for support in peer counseling is [inaudible]. So where we are going from now? For each political wheel not through organizers [inaudible] strategy but through desperation and anger.

The hope for collaboration and partnerships make treatment effective and available for all. To get over the existing barriers we have to get back into our business. And it's not a matter of beginning for reforms to committing us to stay alive. Staying alive is our policy, policy of immediate and vertical changes in the system for all [inaudible]. Thank you very much.

[Applause]

RAMINTA STUIKYTE: Thank you, Aleksandra, so much. And now we will move over to our Asian region. And it's my pleasure to invite Karyn Kaplan, who is co-founder of the

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Bank of Base Tai AIDS treatment action group PTAC whom we know very well, usually.

She's the [inaudible] policy and development. And Karyn worked in Asia AIDS in direct field in Thailand since 1988. And even before that she was working also in the US in that field. So she is really veteran, as we call in Eastern Europe.

[Interposing]

KARYN KAPLAN: Thank you. So actually it was supposed to be someone else speaking here today. But ironically or not, he will be starting hepatitis C treatment in a couple of days and is preoccupied with that. And he himself is a former injecting drug user. Do I control the slides? Sorry I don't know how to -

RAMINTA STUIKYTE: Like this.

KARYN KAPLAN: Oh, thank you. As we all know, ARV has changed the face of AIDS. It has drastically reduced mortality and increased people's quality of life. In Thailand the recent introduction of ARV and rapid expansion has led to a 50-percent reduction in HIV related mortality.

There has also been a record commitment of funding over the past years through the Global Fund, allowing many countries to scale up access to treatments. In a recent [Inaudible] progress report, treatment was described as an unprecedented opportunity for national responses where care

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

prevention and impact mitigation efforts delivered in comprehensive and neutrally reinforcing manner.

And universal access, which is now the banner under which we're all working has really loft goals of 80-percent coverage of treatment reduction of new HIV infections by 50-percent. And regarding injection drug users, a leading expert from the WHO sitting somewhere here - I thought I saw him - said that there is no reason that IDU should be - there's no excuse for excluding IDU from lifesaving drugs.

However, moving from rhetoric to action has not been an easy road this morning for those of you who say Chris Fires plenary speech, you saw that of the 13 million-plus injectors in the world with HIV, we've got about 34,000 on ARV, 30,000 in Brazil.

And so I think the failure of treatment is also a reflection of our failures in prevention to date. For IDU, often we face even the minimization of the importance of treatments for IDU, even the existence of IDU in Thailand. As they see a new methamphetamine epidemic, they're just ignoring the needs of IDU that have been present since the late 1980s with 50-percent prevalence. That's the only group that hasn't gone down since then.

And the approaches that we know are proven to improve the quality of lives of people who use drugs are under attack. Harm reduction is a dirty word at the U.N. And for

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the United States government, our biggest funder of AIDS-related projects, and this is unacceptable. And we have to fight this.

It's ironic that we're excluding vulnerable groups, injecting drug users and not thinking about them from in our plans to improve access because we know I know this is a disgusting and unsavory word but we've got reservoirs. If we don't address IDU epidemics, they will continue to be there.

It's like the same with Burma in Thailand. They try to ignore it, but what we know about Burma is that it's a source of four-fifths of China's HIV/AIDS cases. It's the source of the most of the world's HIV strains. We can't ignore these groups that some people would prefer to go away.

The problem is also the human life situation, that we are undermining our efforts by not paying attention to the human rights environment, the legal and policy environment. We're pouring money into harm reduction or quasi harm reduction projects. And at the same time, we're not talking about the need to repeal criminalizing laws and policies.

Also we are not bringing up the human rights obligations to balance our efforts to repress drugs which is a problem in the UN drug conventions already. Balanced with our public health efforts, we need to look at the U.N. conventions and we need to pay more attention to the human rights principles that should be underpinning our work.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

But there's a huge faction that's moving against these very principles. And we have to pay attention to them too. It is unacceptable that I heard that Peter Piat refused to utter the word harm reduction to the General Assembly twice in New York last June.

Our punitive approaches are actually increasing HIV. We know that by sending people to jail we increase their risk of HIV, we increase their risk of multi drug resistant TB. And we totally undermine their ability to have fulfilling lives, get jobs afterwards people have terrible times coming out of prison and often go right back to using drugs.

I know this is not a problem that's easy to address. And I'm talking, I live in a country now that doesn't have a whole lot of money. It has more money than some of the least developed countries. But regardless, there's always money for military. And there's very little money, interest, or capacity to put money into health.

And then you go down from there, HIV/AIDS has even harder time to get funding or interest from the government. And then we get to drug issues, which are never seen as health issues. They're seen as law enforcement issues.

And so it's rare to get money for the kinds of things that we're talking about here today, access for treatment for drug users. And of course, politicians get a lot of political mileage from focusing on national security and

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

stepping up, you know, the tough stance on drugs and zero tolerance.

In Thailand, I spoke about this morning the lateralization of a drug war that left thousands of people murdered by government-sanctioned measures to control drugs. And HIV still runs rampant and no one is speaking out for drug users.

What we know this morning we already heard from Konstantin and Aleksandra and everybody here the kinds of things that we need to reach drug users. But again, those things are being undermined. We have countless studies from hundreds of cities across the world that show needles do not promote drug use but they do prevent HIV infection.

Yes, many funded projects are unable to implement these kinds of interventions. Quality evaluation drug treatment is still missing in many countries. It's illegal in some places as well. People can't even get therapy because methadone is not considered therapeutic, it's considered an illegal substance.

User-friendly services. Treatment is typically meted out as punishment in the guise of treatment. We have methadone tapers for detox, supervised urines for methadone clients. All kinds of things that humiliate and undermine any possibility for equality in a doctor/patient relationship.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

We're also seeing now, with the advent of ARV scale-up, this criteria that's nonmedical. And assessments that go on about the ability to adhere to the ARV. We have limited resources, we have limited ARV, so we're going to look at who deserves the ARV. In some places, they actually have exclusion criteria if you're a high-risk behavior person.

The doctors are afraid that they're going to look bad if their patients don't succeed. They don't want to waste their budget. Drug users are immoral bad people anyway and they don't deserve these high-tech treatments. And they'll spread infection if they don't adhere and spread super infection.

And all of this is an assumed attitude. So the kinds of things that let me just move on - sorry, I know we have very little time. Some of the urgent issues that we have to look at are educating, simply educating more and more people whether they are AIDS organization allies who often don't understand harm reduction issues.

We can't expect people to just understand them without spending time on informing people about the benefits into spelling myths that my friends here discussed about harm reduction and ARV for IDU. The media, public stakeholders, everyone needs to learn about harm reduction so they can advocate for it.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And advocate for the human rights protections that we need in order to effectively implement harm reduction. In Thailand, they're taking things like pure outreach, benign activities that they like at the expense of needles. As if you can pick one without the other.

It demonstrates a total lack of understanding about how all of these interventions fit together. And it also puts drug users out into the streets without any protections from the law from the police expecting drug users to do the work of bringing in clients without thinking about their own needs.

This is why we want drug users to be involved because they are the ones who care the most about their communities. But not be used by AIDS programs. Drug users don't only think about HIV or think about reaching out to their peers only about HIV. Often they're not thinking about HIV at all. And it's not our business to force them to.

But the kinds of advocacy, things that I think weren't mentioned yet but I think are important, thinking about IDU and ARV are the lack of attention to things like hep C which Mauro talked about very importantly. The person who was supposed to speak here today has hep C and didn't know that having a hep B vaccination would be really helpful. A hep A vaccination would be really helpful.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

ARV's, while we say that injecting drug users with hepatitis can tolerate the existing first-line therapies in developing countries which is essentially like B4T, 32C and nevirapine even though we know nevirapine is hepatotoxic [Misspelled?].

The truth is in other countries, in richer countries, we see different first-line regimens. Why shouldn't poor people have the same access as rich people? And we hope that we can see generic treatments of all kinds for hepatitis C, for ARV reaching the people when there are 35 million hepatitis C-infected people in Southeast Asia.

There are also a lot of HIV-positive people and these treatments are urgently needed. So finally, the kinds of things that we can do is to support drug users directly to help us understand how to develop effective programs.

And to work with the UN. One of our biggest problems at the country level is that there is literally no capacity. There is no one in the UN practically, in UNH and WHO, who are experts on harm reduction who can be there when we need them to review methadone maintenance guidelines that are coming out in Thailand for example.

Why is Geneva not focusing on this? Southeast Asia has an IDU-driven epidemic. Let's see a little more investment by the UN or is there dissonance within the UN

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

that we also have to be talking about. About the need to repress, do drug suppression and demand reduction.

And then to promote harm reduction, on the other hand. I don't think that that's been resolved. We need to work with more NGO's. And we need to work with governments to see the value of providing treatment to all.

And that we need to raise our voices about these issues. This is not meaning that we have to be angry but when you're watching people die and get sick when other people are starting to have more and more access to more and more services we can't talk about equity until we're thinking about people who use drugs, migrants, men who have sex with men, and all the various people who have been most deeply affected by HIV to begin with. Thank you.

[Applause]

RAMINTA STUIKYTE: Thank you. Thank you, Karyn, and thank you to all wonderful panelists who treated us with what are the challenges, what are our opportunities and what are the practical models how to deliver HEB treatment to injecting drug users. And thank you also to panelists for keeping the time. Now we will have almost half an hour for questions, comments and discussions.

Please use microphones. There are two microphones, one over there, and another one over there. Oh, three now, even, mics. Please, Henning.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

HENNING MIKKELSEN: I'm Henning Mikkelsen from UNAIDS. I want to congratulate the organizers for making this very important session here. I think this issue is extremely important, especially, of course, in the conscious. There are large numbers of the people who are living with HIV are also injecting drug users.

We see the situation very seriously, especially in countries like Russia. A little bit better in Ukraine, but we are still long way to go to make sure that there will be universal access to treatment also for people who are injecting drugs.

So this is very welcome. From the last presentation I will take back to the UNAIDS family, the call for better capacity or [inaudible] within UNAIDS to assist this. I just want to say a little bit about our positions on [Inaudible] all to committed there.

I think it's important for you all to know that both in the declaration of commitment, which was agreed by all the member states of the Union back in 2001 and also in the recent political declaration on AIDs, which was agreed at the high-level meeting in New York, there's a very clear and specific reference to the need to intensify efforts to prevention programs including harm reduction.

What is missing in the political declaration from this year is there's no explicated reference to substitution

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

treatment. This is from the viewpoint of UNAIDS, regrettable because we published a new Points on Paper on prevention called, *Intensifying HIV Prevention*.

And there we had an agreement from all the countries and societies who are part of our program called [inaudible] that there should be a strong call also for harm reduction, including all sorts of substitution treatments. So this is very much our policy line.

Peter Piot, when he spoke at the winter AIDS conference in Moscow in May, there was also very explicit about his support for harm reduction including substitution treatment. He's very vocal on this currently, and he has always been, I would like to say. Thank you.

RAMINTA STUIKYTE: Thank you, Henning, and we will take two more questions and then go back to panelists.

And also, I wanted to mention that there is a possibility to pass questions also using cards, which volunteers have. So you just approach them and they will help assist you. Okay, please.

IRVING DAGLE [misspelled?]: Thank you. I'm Irving Dagle from the Global Fund. I have a question to Sasha. The background of the question is that there is one grant in Russia from the Global Fund, which is referred to as the Globus run, which is more or less HIV prevention program, which has a little treatment component. This grant will

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

bring up to 4,000 people on the treatment.

But there is also a second grant of the Global Fund to Russia, which explicitly is a treatment grant and over five years this grant will bring 75,000 people on the treatment. Now the question is, what is the strategy of the Russian harm reduction network to ensure that the appropriate proportion of drug users are getting treatment under the second grant?

RAMINTA STUIKYTE: Thank you. And then we will have the next question and go back to -

BRUCE MARSHALL: My name is Bruce Marshall. This question is perhaps for Mauro. HIV has been around for 25 years. I graduated from medical school in 1978, which predates the appearance of HIV disease. In the middle states we talked about this non-A, non-B hepatitis.

So it's been around for longer than HIV disease. There are three, four, perhaps five times as many people in the world infected with hepatitis C as are infected with HIV disease.

There are 20 antiretroviral medications available to us now and a multiplicity of different therapies. Yet there are only two anti-H hepatitis C drugs and only one that particular kind of therapy and it's not very satisfactory at that.

And I was just wondering, Mauro, if you'd like to

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

comment on those differences and the fact that though hepatitis C has been so much longer, so many more people are infected and yet, not much development has occurred in the way of hepatitis C therapies.

RAMINTA STUIKYTE: Thank you so much. Mauro, would you like to start?

MAURO GUARINIERI: Well, I believe that one of the reasons that we see a dramatic increase of that were to - Hep C in some countries. I think it is the future for older countries are introducing a reason right now. And of course, there is little research. There's some new treatment, new protease inhibitors in the pipeline. There are some options for the future.

But I think that probably little interest is true that in modern fact of mortality is not that high in HIV infection. And for many years, hep C was not a priority, because simply people are dying from AIDS. The urgency was just to treat AIDS.

But it's certainly great need for new drugs, especially drugs that can offer real much higher rate of, especially for co-infected individuals, especially for genotype one and four.

They're more prevalent in most of the countries, in Asia or Eastern new world, and for some reason are more prevalent in the injection drug users.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

One of the problems, I just want to mention, that recently the problem of the inclusion of the population who most need of those treatments, injecting drug user are proactively excluded from most of the trials.

Recently, Sharon Cloud put a very strange criteria for African-Americans in one trial related to protease inhibitors. The explanation was very strange. Assumptionally they were saying that the response rate is different in African-Americans, which is not a rationale for excluding.

So this attitude by pharmaceutical company to make their trial look good, but at the same time to make impossible to transfer the results to the real community. Because of course, if you look for a very improvable individual that doesn't exist in trial, then when you transfer the result to the rigid community you see the results of very, very different.

So they are also want the proposals to push and advocate for the inclusion of the [inaudible] really reflect the people with hepatitis C and especially for co-infected individuals. The same for HIV trial in most cases co-infected individual are not included, are not eligible for the trial. So there's great problem.

RAMINTA STUIKYTE: Sasha.

ALEXSANDRA VOLGINA: [Speaking in Russian]

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

MALE SPEAKER 1: [Speaking in Russian].

RAMINTA STUIKYTE: I will ask Konstantin to translate, because Sasha answered in -

KONSTANTIN LEZHENTSEV: I have a huge experience in the Slavic Interpol. I would never answer it again. The first question that was a question by Irving about the strategies that are harm reduction and [Inaudible] in terms of overcoming the problems existing, especially envisioning the 75 solvent indicators for existing treatment in the next Global Fund proposal that is ongoing, starting to go now.

And Aleksandra's response was she's working as a technical advisor to Globus on peer counseling. And Globus reached quite substantial affective model on peer counseling and integrated peer counseling and to model disciplinary teams.

But the problem is in outreaching to our views, as she said. And for these, the strategic direction is to involve as much as possible educate harm reduction projects into this process.

She doesn't represent the harm reduction network and that's why she cannot speak on their behalf. But at the same time from, I will add that recently there was a presentation from Russian Harm Reduction Network where they specifically emphasis the need in expanding harm reduction activities and getting more in treatment.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

How it will be in practice, I wouldn't say. I do not know, but from our behalf as a technical assistance we will do the focus and priority for international harm reduction programs to educate specifically these harm reduction components on treatment issues.

RAMINTA STUIKYTE: Thank you, and if I may add to this. I'm not from Russian Harm Reduction Network, but I'm from Central and Eastern European Harm Reduction Network. And I want you to know in that application there are two other organizations involved, which is very important.

And one of them is Community of People Living with HIV/AIDS, and another organization is Recluser Collidex [misspelled?] and I'm sure that involvement of community would lead to much better understanding of needs and much better addressing of needs of people are we need to be?

MALE SPEAKER 2: [Speaking in Russian].

ALEKSANDRA VOLGINA: [Speaking in Russian].

KONSTANTIN LEZHENTSEV: [Inaudible] so the next answer to the question that was sent in Russian, it was Sasha, prioritized in Russian, is which organization do you represent and what source of information do you use for giving difference situation about our being Russian, meaning that Aleksandra is giving not exact information.

And Aleksandra's answer was technical advisor to Globus, to Project of G.F. third round, but also she's an

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

active member and leader of the community of the people in this city.

And her information based on a number of letters, which I actually saw myself as well. And those people who are linked to international treatment preparedness group also saw these messages and call of despair from a number of regions of Russia.

I can name the regions myself, so I have a full credibility as well.

MALE SPEAKER 2: [Speaking in Russian]

RAMINTA STUIKYTE: Okay, thank you. Maybe you would like to continue, because there are a number of other questions that were sent in these forms.

MALE SPEAKER 2: [Speaking in Russian]

RAMINTA STUIKYTE: In English, please.

MALE SPEAKER 2: So, and I will speak in English. So for Konstantin, could you please address the importance of methadone treatments' legality in Russia? Does it vary from region within Russia? So Sasha maybe can add, but in all our presentations we say that this is a critical issue for Russia having this heavy of an epidemic, having substitution be illegal, and methadone illegal status in Russia really influences a lot of the whole activities, not only in terms of effective care of use, meaning that the drug treatment services and such a state about the current status of drug

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

treatment services, but also it's the key issue about IV access and affective hard utilization by users.

And if the situation vary region from region, my personal observation that as much as we broaden the number of practitioners, medical practitioners outside the drug treatment circles involved in understanding what substitution stands for in and what are the standards and their lives we can have more and more allies.

And we would definitely have more allies, in my personal opinion, from infectious, from A treatment doctor, and from B treatment doctors. If the narcological field, drug treatment field stays so much conservative and couldn't be proactive for advocating for substitution treatment, it doesn't relate to their for sure activists and the leaders of scientific drug treatment community from Russia like [speaking in Russian], basically defend the right of the scientist and the doctor to educate and to speak about the treatment that is internationally recognized.

The second question is how injected drug users are getting involved into IV treatment. The note comes from Ukraine, so I mean, people, mean Ukraine? By the end of the year my second GFATM grounds so it's Ukraine right, so we should reach the indicator of 17,000.

So I said about the case study what is done. I'm not sure it would be effectively addressed during this period. I

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

said that for the Global Fund six round it would definitely be addressed and their application would be accepted. But how the users are covered are involved, this is my strategy is what I was speaking about involvement affecting the harm reduction project.

But right now the big involvement for this All Ukrainian Network that installs the peer counselor community centers that are involving people who are also using drugs. And also the priority of All Ukrainian Network as was said by Irina during the previous session in this call to actually address specifically marginalize communities and people actually using drugs people co-infected [inaudible].

RAMINTA STUIKYTE: Okay, and Karyn. Could you address also the question that you received?

KARYN KAPLAN: The question is what is the role of the drug user community in delivering care to drug users in your opinion and in practice in Thailand?

And basically drug user community, there are a lot of drug users in Thailand. But there is one organized group of drug users called The Thai Drug Users Network that organized during the end of 2002. A lot of them were HIV-positive drug users who have been leaders in the PWA movement, but saw their issues totally ignored and sidelined.

And the government ignoring and sidelining their issues and they couldn't stand it anymore. In particular

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

they had been watching their friends die of AIDs, but now through the drug wars they were watching people be even further stigmatized, criminalized and had to stand up because they felt they had nothing to lose.

And basically what they want to be doing and what they do do is to advocate, to be involved in the development of programs and policies that affect them, to have a voice in the places where people are using money to develop programs and policies that control them.

And so to make those programs and policies meet their needs and improve their lives. And I think, basically that's what they want to be doing. Thank you.

MALE SPEAKER 3: And I have a question from [Inaudible] Fund from Indonesia about side effects and what happen if HIV and HCV positive person has to stop treatment, if there is a reason for resistance?

Of course the answer is yes, if the treatment is to be stopped. But as Karyn mentioned before, the problem is that there are some drugs that should be avoided on Hep C treatment. There is a risk for increased anemia because of an interaction with revibrain [misspelled?] There is a [inaudible] is not the best drug, and unfortunately the options are very limited for, especially for poor countries.

So the typical first-line combination specially generic is not the best option, well one of the problems is

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

it's very unlikely at the moment that co-infected patients in a poor country have access to hep C treatment, because there's no generic alternative and the treatment is really, really expensive. But even so, there is a purpose for switching the drugs. So we're still on a very early stage.

And then I just wanted to follow up on the previous question, because I think another reason why there's so little research on Hep C, also related to, because I believe that most of the research was the result of a lot of pressure by the community. So now we have FastTrack. We have a lot of drug, not because of the pharmaceutical company and government were willing to produce a drug. There was a lot of pressure.

So hep C is really affect a group that we're not even sure if a drug user is real community are they strong enough to push for, if you see now one of the most visible awareness campaign is a NoFo campaign funded by pharmaceutical company.

So there's no if your face look this way, now instead of your liver, now using some act up language. They're Schering Plough. You cannot see anywhere they were Schering Plough. That is incredible, the most widespread in the awareness campaign.

So in a way, there's not enough pressure, I believe. And that's probably a good question also in term of community, how to build a real community around drug use and

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

push in the same way very effectively know that the gay community and other know that really no build up the sense of community did in term of pushing for a good drug for HIV and Aids.

That's probably one or the other explanation with enough much research and why we have to see this awful campaign funded by pharmaceutical company want to put everybody in treatment because of [Inaudible] sub drugs.

RAMINTA STUIKYTE: Okay, and the last question, Konstantin, by chance?

KONSTANTIN LEZHENTSEV: Well, very quick, the question is about my information feedback from Ukraine, given the resources what would you choose, I think of substitution drug with Branif in the matter.

Well, there is no such diversion. The affective substitution treatment program should have both. But if we speak about raising the resources and I said this, and it's even cited in all the strategy that without access to methadone right now there is no scale-up. And we will not reach the indicators of the Global Fund and rural [Inaudible].

Methadone is the cheap effective of drug. I do not know, but for sure a focus for price reduction for neurophine should be done and neurophine should have its place and also taking into consideration that a small, shy they could be

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

accessible because of its classification.

But right now the methadone is approved as a really cheap, affective, very easy to scale up medicine. In terms of I either also think maybe we can proceed, but I will not step on this about interactions IV methadone. But is also not a problem both the [inaudible] and methadone.

MAURO GUARINIERI: Can I make just a short comment about this issue about the version? I think that the best answer a drug about this question was in the conference in Ukraine from French doctor and Saint Royce, too.

In France, it is estimated 10-percent of [inaudible] is diverted. So what? So benzodazepine are diverted every single day. So 10-percent mean that 90-percent of the patient are treated. So that's really a non-issue.

KONSTANTIN LEZHENTSEV: Yes, I wasn't speaking actually about this, more about the access to prescribe the antidotes of general health care, which gives certain. But I also will decide following up, because it's very important issue the [Inaudible] thing is that, for example in Ukraine to sell the three, the chosen amount of the whole amount of the drugs illegal were 27 tons taken one year. That's one report.

And when they were in debate about [Inaudible] [misspelled?] coming and starting this very limited seven sides, the whole amount of [Inaudible] was around 3 kilos.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So if it will always be diverted how will it change the drug market? So what, 300 kilos. Come on.

RAMINTA STUIKYTE: Okay. We will have the last question and we will close the session in about five minutes. Please introduce yourself.

BRUCE MARSHALL: Bruce Marshall again. Methadone and heroin, they go together. We've talked a lot about this. I would like to know what role is played by cocaine in Europe, in Eastern Europe.

Certainly, cocaine is a big problem in the injection drug use business here in Canada, and of course there is no substitute drug for cocaine as there is methadone for heroin.

KONSTANTIN LEZHENTSEV: I was thinking about what Mauro said about Western Europe, but also the data. It's the hugest Western European epidemic of cocaine use.

But in Eastern Europe I mentioned that the changes of the drug scene and particularly the cheap amphetamine market how the market is coming and it should be definitely about the harm reduction. Cocaine, we do not have a huge market for cocaine, both because of economic reasons, logistical reasons. So it's still limited to certain groups as it was maybe a decade ago in Western Europe and in Canada.

But access to cheap amphetamines. Powder amphetamines are really a huge wave, especially among young injectors. Plus to this we have homemade super active

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

amphetamine, which is all injectible solution from called turpentine, which is really is not addressed by any types of comprehensive care for users, which are still on embryo stage.

And for this, one of the important issues we are advocating for is to add the psychiatric care component and counseling to their comprehensive care model.

RAMINTA STUIKYTE: Mauro, do you want to add something. I will just add this. There are some issues that address about coffee and stimulant use in the book that was released, actually today, *Delivering HIV Care and Treatment for People Who Use Drugs*. And there are some examples of how it might be delivered. And those examples are not only from developed countries, rich countries, but also from Latin America.

And Latin America, as we know, had huge epidemics related with vein injected drug use and with drug use, with cocaine actually used. And here -

KONSTANTIN LEZHENTSEV: I would recommend this book, *Alcohol, Crack, and Cocaine Issues Are Very Much For a Person to Bear*.

RAMINTA STUIKYTE: And this book, we can make available. I will repeat. The book is available downstairs in the exhibition hall. The booth of The Open Society Institute. And we can try to make some books to available

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

for the next session, which will be, again, on injecting drug use. On harm reduction evidence, which will be taking place here in half an hour the same room.

And using the opportunity I also wanted to make one small announcement related to harm reduction. And as we know harm reduction needs a lot of support of different people. and one of the issues that we want you to help us with is this Declaration of Unity, which identifies key issues what we should challenge our governments ourselves, including harm reduction programs and also UN systems.

These declarations will be available here and be also available, I think, in [inaudible] booth and also in their networking zone on harm reduction in the Global Village.

Thank you so much and the last announcement, sorry. The last announcement is you see those beautiful T-shirts of these three beautiful people.

KONSTANTIN LEZHENTSEV: [Interposing] dreams, no.

RAMINTA STUIKYTE: And if you wanted to support the group, which is called Franta [misspelled] AIDs and to buy tee shirts contact either Sasha or Konstantin here. And also if you have any additional questions I will ask speakers to be here around at least for five minutes. So if you want it just please come here. Thank you and this is really everything.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Treatment for Injecting Drug Users: Making Calls for Universal
Access Real
08/14/06

57

[END RECORDING]