United Nations E/CN.7/2003/5

Economic and Social Council

Distr.: General
30 January 2003

Original: English

Commission on Narcotic Drugs
Forty-sixth session
Vienna, 8-17 April 2003
Item 4 of the provisional agenda*
Drug demand reduction

Human immunodeficiency virus/acquired immunodeficiency syndrome in the context of drug abuse

Report of the Executive Director

Contents

* E/CN.7/2003/1.

V.03-80724 (E) 280203 030303

I. Introduction

1. In its resolution 45/1, the Commission on Narcotic Drugs recognized that the spread of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), hepatitis C and other blood-borne viruses was linked with drug use, in particular injecting drug use; encouraged Member States to implement and strengthen efforts to raise awareness about the links between drug use and the spread of HIV/AIDS, hepatitis C and other blood-borne viruses; also encouraged Member States to strengthen efforts to reduce the demand for illicit drugs and to ensure that a comprehensive package of prevention, education, treatment and rehabilitation measures were accessible to all individuals who use and abuse illicit drugs, including those infected with HIV/AIDS, in accordance with the Declaration on the Guiding Principles of Drug Demand Reduction (resolution S-20/3, annex); invited Member States to consider the potential impact on the spread of HIV and other blood-borne diseases, when developing, implementing and evaluating policies and programmes for the reduction of the demand for and supply of, and to implement measures that reduced or eliminated the need to share non-sterile injecting equipment; encouraged the United Nations International Drug Control Programme (UNDCP) to work with other United Nations entities to play a role in promoting awareness of HIV/AIDS at the global, regional, national and community levels; called upon the Programme to continue to cooperate with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and other relevant United Nations entities in introducing and strengthening programmes to address HIV/AIDS; and requested the Executive Director of the Programme to submit to the Commission, at its forty-sixth session, a report on the progress made in the implementation of resolution 45/1. The present report is submitted in response to that request.

2. The present report provides an overview of the current status of the HIV/AIDS epidemic, and, in particular, its linkage with drug use, and highlights programmatic activities as reported by Member States through the annual reports questionnaire for the reporting period 2001, and the biennial reports questionnaire for the reporting cycle 2000-2002, and as undertaken by the United Nations Office on Drugs and Crime (formerly called the Office for Drug Control and Crime Prevention), in collaboration with other United Nations entities, to address HIV/AIDS as associated with drug use.

II. Current status of the epidemic, with particular reference to injecting drug use

3. At the end of 2002, an estimated 42 million people were living with HIV/AIDS, including the 5 million people who became infected with HIV in 2002, of which more than 95 per cent live in developing countries.[1] The epidemic claimed an estimated 3.1 million lives in 2002. One third of the people living with HIV/AIDS are young people aged between 15 and 24. Sub-Saharan Africa remains the most affected region, accounting for about 70 per cent of people living with HIV/AIDS, followed by South and South-East Asia, Latin America and East Asia and the Pacific, respectively.[1]

Table
Regional HIV/AIDS statistics and features, end of 2002

Region	*Epidemic started*	*Adults and children living with HIV/AIDS*	*Adults and children newly infected with HIV*	*Adult prevalence* rate[a] *(percentage)*	*Percentage of HIV-positive adults who are women*	*Main modes of transmission*[b]
Sub-Saharan Africa	Late 1970s, early 1980s	29.4 million	3.5 million	8.8	58	Heterosexual
North Africa and the Middle East	Late 1980s	550 000	83 000	0.3	55	Heterosexual, IDU
South and South-East Asia	Late 1980s	6 million	700 000	0.6	36	Heterosexual, IDU
East Asia and the Pacific	Late 1980s	1.2 million	270 000	0.1	24	IDU, heterosexual, MSM
Latin America	Late 1970s, early 1980s	1.5 million	150 000	0.6	30	MSM, IDU, heterosexual
Caribbean	Late 1970s, early 1980s	440 000	60 000	2.4	50	Heterosexual, MSM
Eastern Europe and Central Asia	Early 1990s	1.2 million	250 000	0.6	27	IDU
Western Europe	Late 1970s, early 1980s	570 000	30 000	0.3	25	MSM, IDU
North America	Late 1970s, early 1980s	980 000	45 000	0.6	20	MSM, IDU, heterosexual
Australia and New Zealand	Late 1970s, early 1980s	15 000	500	0.1	7	MSM
Total		42 million	5 million	1.2	50	

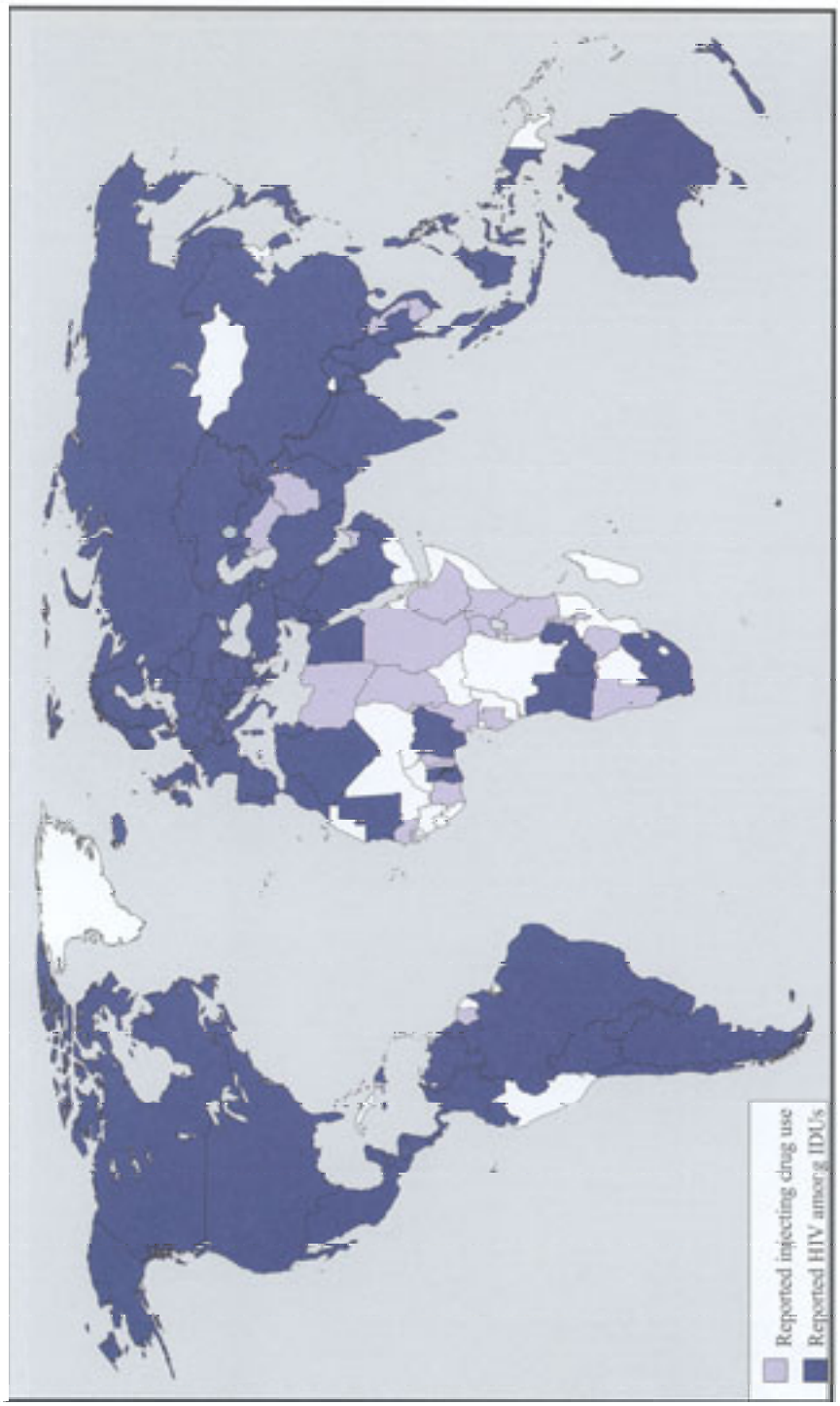
Source: UNAIDS/WHO, *AIDS Epidemic Update* (Geneva, December 2002).

[a] The population of adults (15 to 49 years of age) living with HIV/AIDS in 2002, using 2002 population numbers.

[b] IDU (transmission through injecting drug use), MSM (sexual transmission among men who have sex with men).

4. Globally, more than 130 countries have reported the injecting of illicit drugs, and more than 110 of those countries also report HIV infections among drug injectors (see figure I).[2] Between 5 and 10 per cent of all HIV/AIDS cases are estimated to be attributable to injecting drug use. Injection of a substance directly into the bloodstream is by far the most efficient mode of HIV transmission, much more so than through sexual intercourse. The chances of contracting HIV infection through the injection route increases when injecting drug users (IDUs) share contaminated injecting equipment, solutions, pots or containers. In particular, injecting drug use has been identified as a major driving force of the epidemic in the regions of East Asia and the Pacific, as well as Eastern Europe and Central Asia. Injecting drug use also plays a significant role in HIV transmission in the regions of

Figure I
Countries and territories reporting injecting drug use and HIV infections among injecting drug users



Source: *Global Illicit Drug Trends 2001* (United Nations publication, Sales No. E.01.XI.11), p. 278.
Note: The boundaries shown on this map do not imply official endorsement or acceptance by the United Nations.

North America, Western Europe, South Asia, Latin America, North Africa and the Middle East.[3]

5. The HIV/AIDS epidemic continues to expand the fastest in the region of Eastern Europe[4] and Central Asia,[1] where, in some places, 1 per cent or more of all adults inject illicit drugs, especially opiates and amphetamines, and many have already become infected with HIV. In 2002, there were an estimated 250,000 new infections in that region, most of them among IDUs. In the Russian Federation, where estimates of the number of IDUs range between 1 million and 2.5 million, the HIV epidemic only emerged in 1996. Approximately 90 per cent of new infections continue to be among IDUs, with more than 100,000 infections reported in the course of the year 2001. Almost 60 per cent of HIV infections in Ukraine[1] are related to injecting drug use, but a steady rise in the level of sexually transmitted infections has also been reported. With the exception of Kazakhstan, where the epidemic is growing, in Central Asia, where the prevalence of HIV has until recently been relatively low, more substantial spreading of HIV is now also evident in Azerbaijan, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan. For example, in Uzbekistan, in the first six months of 2002, there were almost as many new HIV infections as had been recorded in the whole of the previous decade. The epidemic is concentrated among opiate injectors and their partners, and the large and growing populations of as yet uninfected injectors are at immediate risk of infection.[1] Some recent city-based studies conducted in the Eastern European and Central Asian region report that many female IDUs are involved in commercial sex, with prevalence among drug-injecting sex workers reaching 30 per cent and more in some cities.

6. In the East and South-East Asia region, the epidemic is also spreading rapidly through injecting, as that mode of administration is becoming more prevalent. The 2001 data for China,[5] where there are estimated to be between 600,000 and 1 million IDUs, indicate that 70 per cent of all HIV cases were due to injecting drug use. In Viet Nam,[6] HIV infections among IDUs accounted for 65 per cent of the total reported HIV cases in 2000, and the prevalence rate of HIV among IDUs was also around 65 per cent. Myanmar,[7] with an estimated 150,000 to 250,000 IDUs, recorded a 63 per cent prevalence rate of HIV infection among that population in 2000, up from 54 per cent in 1997. In India,[8] the overall rate of HIV infection among IDUs is 4.2 per cent, but it is much higher in certain areas, for example, 80 per cent in Manipur, 45 per cent in Delhi and 31 per cent in Chennai. Official estimates suggest that between 124,000 and 196,000 Indonesians are now injecting drugs in Indonesia.[1] Data from the largest treatment centre in Jakarta shows that about 50 per cent of IDUs were HIV-infected in 2001, up from zero per cent in 1998.[1]

7. In many Latin American and Caribbean countries, the spread of HIV through the sharing of injecting drug equipment is of growing concern. IDUs, mostly cocaine injectors, account for an estimated 40 per cent of reported new infections in Argentina and 28 per cent in Uruguay. If partners of IDUs are taken into account, proportions of drug-related HIV are even more significant.[9] For Brazil, partially as a result of the effective interventions being implemented in the country, and possibly because drug consumption patterns are changing, the proportion of IDUs among the total number of AIDS cases has, however, gradually declined from 26 per cent in 1991 to 12 per cent in 2000. Twelve countries in the Latin American and Caribbean

region have an estimated HIV prevalence of 1 per cent or more among pregnant women, and some national estimates suggest very high HIV prevalence among the adult population (for example, 6 per cent in Haiti and 3.5 per cent in the Bahamas).[1] Some of those infections are related to risky sexual behaviour associated with the use of non-injectable illicit drugs, such as crack cocaine.

8. In Western Europe, the HIV epidemic among IDUs is most concentrated in the south, where IDUs account for an estimated 66 per cent of AIDS cases in Spain, 64 per cent in Italy and 61 per cent in Portugal.[10] Since the mid-1990s, the incidence of drug-related AIDS cases has been reduced in most European countries from a peak of about 28 persons per million inhabitants in 1994 to 10 per million inhabitants in 1999.[11]

9. Most other high-income countries are also contending with HIV epidemics concentrated among IDUs. With regard to North America, in the United States of America,[12] where injecting drug use is a prominent route of HIV infection, 28 per cent of AIDS cases reported in 2000 were associated with injecting drug use. The overall HIV prevalence in Canada[13] remains very low. However, IDUs accounted for between 29 and 33.5 per cent of AIDS cases between 1995 and 1998.

10. Although the Middle East and North Africa region is one of the least affected by the HIV/AIDS epidemic,[1] injecting drug use represents a major or significant mode of transmission in some of its countries. For example, recent reports indicate that IDUs constituted 91.7 per cent of the registered 4,439 HIV/AIDS cases in the Libyan Arab Jamahiriya in 2001.[14] Proportions of IDUs among reported AIDS cases in Bahrain (2000), Tunisia (1999) and Algeria (2000) were 73 per cent, 34 per cent and 18.4 per cent, respectively.[15] In the Islamic Republic of Iran, most HIV transmission is occurring among the estimated 200,000-300,000 IDUs, about 1 per cent of whom are believed to be living with HIV.[1]

11. In Sub-Saharan Africa, pockets of IDUs have been reported in a few countries, including Kenya, Mauritius, Nigeria and South Africa. For example, in Nigeria,[16] a World Health Organization (WHO) study conducted in Lagos in 2000 revealed that more than 20 per cent of some 400 street users of heroin and cocaine were injecting. The HIV rate among IDUs (11 per cent) in the Lagos study was higher than the national average (5.4 per cent).

12. Both hepatitis C virus (HCV) and hepatitis B virus (HBV) infections are also highly prevalent among IDUs. An estimated 170 million people, 3 per cent of the world population, are infected with HCV. Areas of highest HCV prevalence can be found in Africa, the eastern Mediterranean, South-East Asia and the western Pacific. In Europe, where injecting drug use accounts for the majority of new HCV infections, 40-90 per cent of the injecting subpopulations monitored are infected with the virus.[17] Of the people who have been infected with HBV, more than 350 million have chronic (lifelong) infections. In sub-Saharan Africa and most of Asia and the Pacific, the majority of people become infected with HBV during childhood and 8 to 10 per cent of the general population become chronically infected. Data on HBV among IDUs in Europe indicate prevalence varying between 20 and 60 per cent.[18]

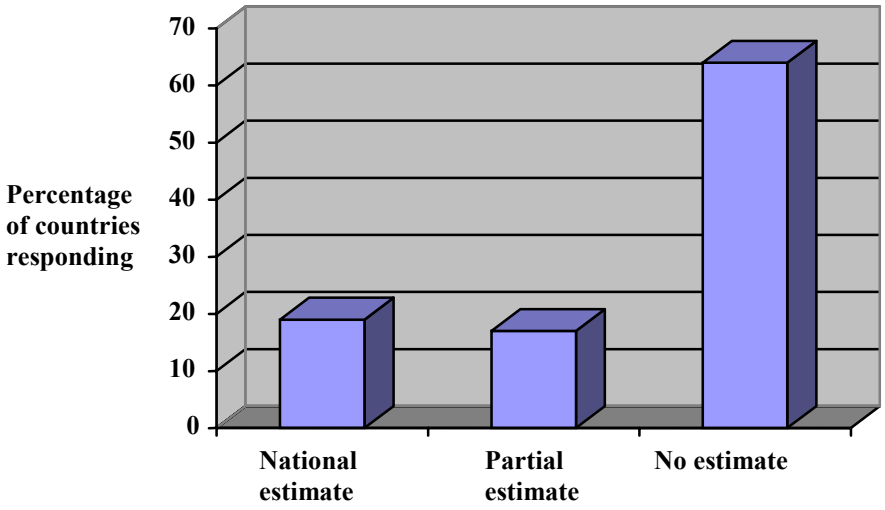
III. Brief overview of activities of Member States in addressing the spread of HIV/AIDS, hepatitis C and other blood-borne viruses linked with drug use, in particular injecting drug use

13. In the annual reports questionnaire, part II, for the reporting year 2001, 72 countries reported on the existence of injecting drug use. Of those countries, 43 (60 per cent) reported the existence of HIV infection among drug injectors, while the existence of hepatitis B or C among IDUs was reported by 38 (53 per cent) countries. Sharing of injecting equipment appears to be common among IDUs, being reported by 48 countries (67 per cent) of those reporting on injecting drug use, and of those countries, 11 (23 per cent) indicated that there had been an increase in the sharing of needles or syringes among IDUs during 2001. It is noteworthy that many countries do not have robust estimates of the prevalence of HIV or other blood-borne viruses among IDUs. Nearly two thirds, that is, 56 out of 88 countries (64 per cent) responding to the question, indicated that estimates for the number of IDUs with HIV, hepatitis B or hepatitis C infections were not available (see figure II).

Figure II

Percentage of countries reporting on the availability of estimates for injecting drug users having hepatitis B, hepatitis C or HIV infection

(Based on the annual reports questionnaire, 2001)



14. The biennial reports questionnaire submitted by Member States for the reporting period 2000-2002 provides some information on the activities implemented in some of the States to address the problems of HIV/AIDS associated with drug abuse. Information collated from the latest returns of 115 biennial reports questionnaires in the current reporting cycle covering 2000-2002 indicates that condom distribution programmes exist in 51 per cent of the States, followed closely by outreach programmes (50 per cent), testing for infectious diseases reported (48 per cent) and dissemination of information on safety procedures (41 per cent).

That such fairly high proportions of countries report the presence of those four service areas is not surprising, since those areas are globally the most advocated and generally the best accepted anti-HIV/AIDS programme components.

15. Thirty-eight per cent of Member States reported implementing low-threshold services, 55 per cent of them being in the "medium/high" service coverage category. Low-threshold services are specifically designed to attract drug abusers, who are otherwise marginalized in the society, and to provide affordable and user-friendly services. The implementation, specifically, of needle and syringe exchange programmes was reported by 38 per cent of Member States, with 63 per cent of them stating that services are of "medium/high coverage". From sources other than the biennial reports questionnaire, including reports of WHO and UNAIDS, it is evident, however, that the majority of IDUs in low-income countries do not have access to or are not enrolled in needle and syringe exchange programmes (or drug abuse treatment). On the other hand, it is interesting to note that, despite its political sensitiveness, that modality of intervention is being implemented by over a third of Member States, including some high-income countries, in order to mitigate the spread of HIV through the sharing of contaminated needles.

16. Oral drug substitution treatment programmes, which, besides providing an additional drug abuse treatment option, also serve to reduce the injection of illicit drugs and HIV and hepatitis risk behaviours, are reported to be available in general and psychiatric hospitals and in specialized residential and non-residential addiction treatment (in one in four Member States reporting), while coverage within correctional institutions and primary care facilities is medium to high in one in five Member States reporting. Several low-income countries have started to introduce such programmes during the last two years. However, in most countries, such services do not yet appear to be accessible to large proportions of opiate injectors.

17. Furthermore, vaccination, presumably against infections such as hepatitis B, which may also be transmitted by sharing injecting equipment, was reportedly offered by 38 per cent of mainly high-income Member States, with about three quarters of the services classified as being of "medium/high" coverage.

18. Financial constraints, reported by 62 per cent of States, topped the list of difficulties faced in the implementation of programmes targeted towards reducing the negative health and social consequences of drug abuse. That was followed by a lack of appropriate systems and structures, a lack of coordination and multilateral cooperation, a lack of technical expertise, and problems with existing national legislation, as reported by 37 per cent, 33 per cent, 32 per cent and 18 per cent of States, respectively.

IV. Programmatic activities of the United Nations Office on Drugs and Crime in the area of HIV/AIDS prevention associated with drug use

19. The work of the United Nations Office on Drugs and Crime in the area of HIV/AIDS prevention as associated with drug use is shaped by several policy documents and strategic guidelines, namely the following:

(a) The Declaration on the Guiding Principles of Drug Demand Reduction (resolution S-20/3, annex), adopted by the General Assembly at its twentieth special session, devoted to countering the world drug problem together. The Declaration states that demand reduction activities should cover all areas of demand reduction, from discouraging initial use to reducing the negative health and social consequences of drug abuse for the individual and the society as a whole. In that regard, it is widely recognized that HIV/AIDS constitutes one of the serious potential harms of drug abuse;

(b) The position paper of the United Nations system on preventing the transmission of HIV among drug abusers, which was endorsed, on behalf of the Administrative Committee on Coordination, by the High-Level Committee on Programmes in Vienna, in February 2001, and subsequently taken note of by the Commission on Narcotic Drugs at its forty-fifth session in March 2002. The position paper points out that a comprehensive package of interventions for HIV prevention among drug abusers could include AIDS education, life skills training, condom distribution, voluntary counselling and HIV testing, access to clean needles and syringes and bleach materials and referral to a variety of treatment options. The paper also cites several reviews highlighting the effectiveness of syringe and needle exchange programmes in reducing the transmission of HIV. It is also noted, however, that the benefits of such programmes increase considerably if they go beyond syringe and needle exchange to include AIDS education, counselling and referral to a variety of treatment options;

(c) The Declaration of Commitment on HIV/AIDS (resolution S-26/2, annex), adopted by the General Assembly at its twenty-sixth special session, on HIV/AIDS. The Declaration sets out targets for Member States on HIV prevention in general, and specifically among groups with high or increasing rates of infection, including IDUs. It also calls for the provision of a wide range of prevention programmes aimed at reducing risk-taking behaviour; the expansion of access to essential commodities, including condoms and sterile injecting equipment; efforts to reduce the harmful consequences related to drug use; expanded access to voluntary and confidential counselling and HIV testing; and early and effective treatment of sexually transmitted infections;

(d) A joint position paper of the United Nations Office on Drugs and Crime, WHO and UNAIDS, currently in preparation, that will clarify the role of substitution therapy in drug dependence treatment and HIV prevention.

20. Some field offices of the United Nations Office on Drugs and Crime have been engaged since 1994 in the implementation of various HIV/AIDS prevention projects related to drug use. Especially since becoming a co-sponsor of UNAIDS in 1999, the Office has been gradually increasing its programmatic activities in HIV/AIDS prevention associated with drug use, with a focus on advocacy, documentation relating to best practice, support to pilot projects and the collection of specific data on HIV and injecting drug use.

21. In Central Asia and Eastern Europe, activities relating to both data generation and diversification of treatment services have been undertaken. For example, HIV/AIDS prevention issues were integrated into drug abuse needs assessment projects in Central Asia, as well as in the geographical entity comprising the Russian Federation and the newly independent States of Belarus, the Republic of

Moldova and Ukraine. A more specific exercise to improve existing estimates of the number of IDUs in those countries is currently under way. The data generated from those needs assessments will be utilized for the training of different categories of professional people working in the area of drug use and HIV/AIDS prevention in Central Asia. The findings will also inform the planning and implementation of projects on diversification and expansion of HIV prevention and drug dependence treatment services for IDUs due to commence soon in those two regions. A first case studies booklet on lessons learned and best practice with regard to drug abuse and HIV/AIDS has also been published jointly with UNAIDS.[19]

22. In East Asia and the Pacific, in South Asia and in the Southern Cone region of Latin America (including Argentina, Brazil, Chile, Paraguay and Uruguay), the Office has embarked on the implementation of projects designed to foster a broader response and exchange of experiences and best practices with regard to drug abuse and HIV/AIDS prevention among the participating countries. The projects have brought increased visibility and advocacy to issues relating to drug abuse and HIV/AIDS prevention in those countries, and are facilitating the mainstreaming of those issues into all aspects of demand reduction at the country level. In each region, the Office has taken a lead role in bringing together partner agencies in a collaborative effort to strengthen HIV prevention among IDUs.

23. The Office has also initiated projects on capacity enhancement and sharing of best practices in regions where HIV/AIDS associated with injecting drug abuse is of relatively low importance. For example, training and dissemination of best practices through the establishment of web sites are being organized for the coalition of Central American youth organizations in the area of drug abuse and HIV/AIDS prevention. In Africa, an action plan on drug abuse and HIV/AIDS prevention for the continent has been developed. Operational research on the linkage between drug abuse and HIV/AIDS has also commenced in selected African countries. In another ongoing project conducted by the Office, government officials, representatives of non-governmental organizations and journalists in 10 East African countries are being trained in drug demand reduction, including HIV/AIDS prevention.

24. At the global level, the Office is increasingly mainstreaming HIV prevention aspects into its work on drug abuse treatment and its legal advisory services. Model laws being developed by the Office incorporate HIV prevention aspects and advocacy for the expansion of drug abuse treatment as a further contribution to the prevention of HIV/AIDS. The Office has recently released the first three parts of its drug abuse treatment toolkit, one of which is a discussion paper for policy makers, making the case for investing resources in treatment and presenting examples of cases in which treatment has been demonstrated to be effective in HIV prevention, as well as in other respects.

25. The United Nations Office on Drugs and Crime has also become more actively involved in global coordination of activities in partnership with the UNAIDS secretariat, WHO and other UNAIDS co-sponsors, research institutions and various other relevant groups. The Office is the convening agency for the inter-agency task team on HIV prevention among IDUs, which brings together various United Nations agencies and jointly oversees a technical advisory group on injecting drug use. The inter-agency task team has developed a work plan designed to assist United Nations agency staff at the country level in strengthening drug-related HIV prevention programmes in the countries in which they are based.

26. A thematic evaluation of the activities of the Office in drug abuse and HIV/AIDS prevention was concluded in October 2002. The evaluation report highlighted the critical issues that need to be addressed to strengthen the role of the Office in the prevention of HIV/AIDS associated with drug abuse, including the need for increased human and financial resources at headquarters and at the regional and field levels, and for capacity-building and training in issues relating to HIV/AIDS prevention.

Notes

[1] UNAIDS/WHO, *AIDS Epidemic Update* (Geneva, December 2002).

[2] *Global Illicit Drug Trends 2001* (United Nations publication, Sales No. E.01.XI.11).

[3] UNAIDS, *Report on the Global HIV/AIDS Epidemic* (Geneva, June 2000).

[4] K. L. Dehne and others, "The HIV/AIDS epidemic among drug injectors in Eastern Europe: patterns, trends and determinants", *Journal of Drug Issues*, vol. 29, No. 4 (1999), pp. 729-776.

[5] G. Reid and G. Costigan, *Revisiting "The Hidden Epidemic": a Situation Assessment of Drug Use in Asia in the Context of HIV/AIDS* (Fairfield, Victoria, Australia, The Centre for Harm Reduction/The Burnet Institute, 2002), pp. 46-59.

[6] T. H. Nguyen and others, "The social context of HIV risk behaviour by drug injectors in Ho Chi Minh City, Vietnam", *AIDS Care*, vol. 12, No. 4 (2000), pp. 483-495.

[7] Reid and Costigan, *Revisiting "The Hidden Epidemic"* …, pp. 140-151.

[8] Ibid., pp. 76-89.

[9] G. Touze, "HIV prevention in drug-using populations in Latin America", *2000 Global Research Network Meeting on HIV Prevention in Drug-Using Populations, Third Annual Meeting Report, July 2000, Durban, South Africa* (Washington, D.C., Department of Health and Human Services, 2001), pp. 109-112.

[10] A. Ball, "Epidemiology and prevention of HIV in drug-using population: global perspective", *1999 Global Research Network Meeting on HIV Prevention in Drug-Using Populations, Second Annual Meeting Report, August 26-28, 1999, Atlanta, Georgia* (Bethesda, Maryland, National Institute on Drug Abuse, 2000), pp. 8-11.

[11] European Monitoring Centre for Drugs and Drug Addiction, *Annual Report on the State of the Drugs Problem in the European Union* (Lisbon, 2000).

[12] Centers for Disease Control and Prevention, "Drug-associated HIV transmission in the United States": http://www.cdc.gov/hiv/pubs/facts/idu.htm

[13] Pan American Health Organization, *HIV and AIDS in the Americas: an Epidemic with Many Faces* (Washington, D.C., 2001).

[14] M. A. Sammud, Libyan Arab Jamahiriya report, presented at the Twelfth Inter-Country Meeting of National AIDS Programme Managers, 23-26 April 2002, Beirut.

[15] WHO Regional Office for the Eastern Mediterranean, *The Work of WHO in the Eastern Mediterranean Region*, Annual Report of the Regional Director (Geneva, 2001).

[16] M. L. Adelekan and others, "Injection drug use and associated health consequences in Lagos, Nigeria: findings from WHO phase II injection drug use study", *2000 Global Research Network Meeting on HIV Prevention in Drug-Using Populations, Third Annual Meeting Report, July 2000, Durban, South Africa* (Washington, D.C., Department of Health and Human Services, 2001).

[17] WHO, “Fact Sheet No. 164: Hepatitis C” (revised October 2000).

[18] WHO, “Fact Sheet No. 204: Hepatitis B” (revised October 2000).

[19] *Drug Abuse and HIV/AIDS: Lessons Learned*, Case Studies Booklet, Central and Eastern Europe and the Central Asian States (United Nations publication, Sales No. E.01.XI.15).