

search designs (“Does treating IDUs result in control of infection?”) exhaust the demands for appropriateness in the decision about whether to treat IDUs?

When we adopt the human rights perspective, the answer is no, because otherwise we will be violating a set of rules that our civilizing experience identifies as fundamental for good human life. What the human rights treaties and conventions express as a formal imperative – everyone is born and dies with equal rights to health, which requires our societies to provide treatment for all – in fact is the crystallized, institutionalized experience of an “appropriateness” that has reached an extremely high degree of consensus. Therefore, we must treat IDUs.

Still, is the degree of association between drug injecting and treatment difficulties a kind of unnecessary information? Certainly not. On the contrary, this is essential information if we are really concerned about having effective treatment for everyone who needs it. Still, it will only be effective in fact if the scientific studies do not dwell exclusively on detecting and describing the risk and measuring the association. If we focus exclusively there, the only advantage we derive from the correctness of such knowledge is the following question: who will we treat, and who will we not treat, or can we decide to treat everyone, even though such a practice is “incorrect”? However, if based on the identification of this association, we derive the questions of “how?” and “why?”, if we seek to understand what this association means (having the human community as our references) and the specific difficulties identified among IDUs, will we not be in a better position to answer the practical questions about how to treat IDUs, rather than simply having to decide between treating or not treating? Will it not be indispensable for us to develop vulnerability studies, in addition to risk studies, in order to guarantee IDUs the human right to be less exposed to HIV and less susceptible to developing and dying from AIDS?

A relevant spin-off of the reading of Vlahov & Celentano, beyond the above-mentioned scientific correctness of beliefs on treatment for IDUs, is thus the reinforced conviction that good practice in the field of prevention and care in HIV/AIDS requires both a clear normative horizon for judgments on appropriate actions and strategies and a set of comprehensive and interpretative investigations on the associations. In other words, the vulnerability of given population groups, grasped by means of reference to their situation vis-à-vis rights, remains on the order of the day and can provide practical elements in order to establish con-

crete responses to the need identified by the authors to overcome the medical community’s stigma and discrimination towards IDUs, in order for effective treatment to take place.

The authors reply

Os autores respondem

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We appreciate the opportunity to offer our perspectives on the management of HIV infection in drug users, and to respond to the views of the multiple distinguished contributors reviewing our essay. Rather than address each separately, we summarize some themes across the contributors and offer our reflections.

A key theme was access to HIV care. Most of the contributors commented on this as a human right that trumps stigma and discrimination. In public health, this is a truism. The issue becomes complicated when considering resource limitations. Regardless of whether countries are wealthy or less wealthy, resources are finite. What is the basis for providing treatment for some but not for others? On what basis are priorities made for treatment decisions – at the policy level or at the bedside? Drug users come under suspicion for a number of reasons: illegality of drug possession and use, impact of addiction on actions related to risk behaviors that put others at peril, and effects of compulsive drug seeking and consumption on ability to focus on other normative activities such as attending to one’s health and medication adherence. The typical societal response is that drug users are detested and marginalized; resources for them (and in some cases for their families) are restricted. The fault in this line of thinking is that stigma and discrimination are typically applied categorically; in the case of drug use, the threshold for categorization starts at experimentation and extends indefinitely beyond cessation. This view holds that “*once a drug user, always a drug user*”, and persons who have used drugs are then perpetually scorned. Our early data showed that even persons who had stopped using drugs were less likely than non-drug us-

ing populations to receive HAART. This categorical treatment of drug users ignores variability and institutionalizes discriminatory policies.

With respect to HIV care, the ability to predict those who can benefit most from therapy is poorly appreciated. Our early study noted that the increased survival benefit of HAART in drug users was dramatic; it held regardless of whether a person was a current or former user, had high or low frequency of use, or type of drug used (primarily cocaine and heroin). The survival benefit of HAART in this population was comparable to other populations. While adherence was not reported in this study (which is somewhat irrelevant given the dramatic survival improvements), this is an important issue in discussions of treatment eligibility. Clinicians are expected to make treatment decisions, but clinical decision-making is imperfect; several studies comparing physician prediction of adherence and documented patient adherence have shown low correlations. Thus, some drug users can benefit from treatment, but individual and provider factors that predict treatment success are imperfectly understood. Categorical exclusion of drug users from treatment ignores variability within (and between) groups and ultimately denies hope.

Another theme raised in the commentaries relates to tradeoffs between benefits and risks of medical therapy for HIV infection. HAART provides clinical improvement, and many clinicians report that this increased survivorship is accompanied by improved quality of life. Likewise, much has been made about the public health value of the reduction in HIV viral load that can result from HAART, which may reduce risk of inadvertent transmission to others. However, several questions remain: improved response may lead to beliefs of non-transmissibility and therefore relapse to higher-risk behaviors. As noted in the commentaries, this problem is not limited to drug users; in fact it has been reported in studies of women and men who have sex with men. While the concern is real, a recent meta-analysis concluded that the overall problem was relatively minor. This is not to minimize the potential, but as the contributors commented, this is not a basis for exclusion but a call for education. Likewise, another concern is that HAART is associated with toxicities and side effects that could impair adherence and contribute to development of resistance. However, this problem is not limited to drug users; rather than excluding patients, it requires clinical monitoring and the medical art of therapeutic titration.

Another theme raised was primary prevention. While the case was made that the literature argues for drug abuse treatment to remove users

from infection risks (by not using needles, or not using drugs), the availability of drug abuse treatment is uneven. In the U.S., data noted that only one half of users had ever been in drug abuse treatment, and at any given time the proportion in treatment was about twenty percent. Multiple courses of treatment are generally necessary before abstinence occurs, with the user remaining at risk between treatment episodes. Thus, drug treatment can be beneficial to an individual, but the public health impact is diminished by lack of widespread availability of high-quality treatment. Thus, we need additional, complementary strategies for primary prevention methods, including outreach education and wider access to sterile syringes' HIV prevention components that were already viewed as scientifically valid by the U.S. Secretary of Health and Human Services nearly eight years ago.

Increasingly, attention has turned to the recognition that individual drug user behavior is influenced not only by peers but also by more upstream influences such as health care and social service providers and community attitudes. Engaging in prevention activities is not merely a series of pilot or model programs, but scaling up of multi-component interventions that are reinforced through multi-level engagement to generate norms of improving public health and safety with respect to HIV and other infections. An example of such a program was recently completed in Harlem within New York City through a partnership with multiple community-based organizations, several academic institutions, and local and state health departments. The intervention was a neighborhood-level array of activities in multiple areas (outreach to drug users, pharmacists, and community residents) to provide expanded access to syringes (after legislation to enable such access was enacted). Measures of knowledge, attitudes, and practices at each level were performed before and after the intervention in the target and comparison communities. The results showed an increase in drug users obtaining sterile syringes at pharmacies and a reduction in needle sharing. This promising program of community mobilization toward a common public health goal focusing on drug users deserves consideration for expansion to different locales, cultures, and public health problems. In essence we call for new strategies to prevent HIV (or other important diseases like tuberculosis, as well as outreach for immunization) that go beyond the drug user, incorporating healthcare providers to ultimately affect norms in the neighborhoods to mobilize toward healthier communities. We propose this direction for intervention research to effectively address the public's health.