

for this population. In their words, “*reduced access to medication can not be an a priori condition, for once barriers to access are resolved through various means, treatment should be considered*” (p. 711).

The problems of access and of quality of treatment for socially marginalized groups, such as IDUs, remind us of the stigmatizing and alarmist views that have long accompanied the AIDS epidemic. Marked by the division between those blamed for the dissemination of the virus (homosexuals, “deviants”, “promiscuous”, “junkies”, Africans, sex professionals) and defenseless victims (children and homophiles), these perspectives reveal the stigmas associated with gender, race/ethnicity, class and sexuality relationships. Besides promoting discrimination, such perspectives collaborated to disseminate the virus among diverse segments of society, including those “beyond risk”. Without doubt there were important fights and some advances with respect to fatalistic and discriminatory perspectives. Nevertheless, prejudices still exist that impede access to health prevention and assistance by marginalized social groups. Evaluations of the effectiveness and potentiality of integrated approaches for prevention and control of HIV including for drug users, mentioned above, reveal the viability of establishing alternatives for segments that live at the margins of society, favoring their social integration. The discussion presented by Vlahov & Celentano thus constitutes an important and opportune consideration of the possibilities in the field of public health for confronting challenges involving stigmatized social groups and illicit activities.

To advance this debate, I believe the authors’ argumentation could be furthered by additional social science field investigations, enabling a deeper understanding of the world view and social practices of drug users with respect to health and other aspects of life. In the case of AIDS, the socio-anthropological approach has revealed the diversity of cultural manifestations in modern societies, in terms of variations in identity, gender and social perceptions and practices, thereby contributing to discussions of sexuality in ways that may (re)orient programs for combating the disease. Expanding studies concerning the particularities of the drug user universe may complement broader discussions regarding the adequacy of educational and health assistance strategies.

1. Parker RG, Easton D, Charles HK. Structural barriers and facilitators in HIV prevention: a review of international research. *AIDS* 2000; 14 Suppl 1:S22-32.

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HIV infection, injection drug users and bioethics

This article offers us opportunities for reflection about questions involving the injection drug user population in relation to their health, the community and health services. Being a topic of global interest, especially for community health, it highlights questions involving the diagnosis of situations and strategies for confronting the problem of HIV infection among injection drug users. Our comments seek to contribute to a bioethical analysis of the situation.

To start, we consider that the population under discussion is vulnerable and has special care needs. This secondary vulnerability is characteristic of excluded populations and, as Kottow¹ (p. 72) affirms, “*has specific causes, (...) requires corrective solutions for its unfortunate circumstances, through a struggle to reduce or eliminate its permanence*”. It is a marginalized population, due to a behavior that, in the majority of countries, opposes the legal norms in place, powerless against obstacles to access to the healthcare system. Due to these very difficulties, and the consequent inadequacy of standard solutions, it is necessary that appropriate strategies to confront the problem be developed.

This is a population that has been set aside relative to health care access, but this is not to say that it is a group of people entirely isolated from the rest of the population, as the authors well point out. Or, as it may be, the non-attention to the infected injection drug user (IDUs) population is implicated in the rise in HIV infection risk for a population far larger than this limited group. Furthermore, although the option that offers the greatest benefit for IDUs may be drug abuse treatment, from the point of view of the health sector and of its responsibility for health efforts, unlinking treatment of abuse from treatment of STDs is an option that could benefit the entire IDU population, those that accept treatment for abuse and those that do not, and others. In addition, it is not possible to confront the problem of the association between drug abuse and HIV infection without adopting strategies at multiple levels.

As the authors show, there is nothing proving that drug users would not benefit from treatments recommended for the general population. AIDS mortality in this group is more strongly linked to lack of access to treatment and adherence than to the action of the drugs themselves. Thus, according to the authors, what could explain low utilization of recom-

mended antiretroviral therapy (greater risk to blacks and Latinos, without health insurance) is poor utilization of health services, seeking care late, after the appearance of opportunistic infections, and, once accessed, doctors prescribing less antiretrovirals if the subject is a drug user. Whether it be due to fear of a user doing the treatment inadequately and thus being infected by multi-resistant viral strains or be it fear that the viral load will fall to undetectable levels and thereby lead to unsafe sexual behavior, treating IDUs with something other than is customary for the general population has no ethical justification.

In fact, this is a discussion that leads us to a very current topic, the double ethical standard: what is good for white men who do not use drugs is not good for blacks and drug users. This question is linked to the exploitation of vulnerabilities whether they be with populations in peripheral countries or with discriminated populations in central countries. To not treat drug users with the best proven treatments appears to be a moral choice, which is not justified by scientific knowledge. This is the same motivation that leads doctors to obstinately prolong treatment, prolonging the suffering of patients despite their own desires to die in peace. Or, that which leads health professionals to exclude inner-city patients from waiting lists for organ transplants. It is fitting, from the point of view of the greatest respect owed to human beings, to affirm that the offer of AIDS treatment, whether or not it be for drug users, should be accompanied by an ample education program regarding what the disease is, how it should be treated, how to avoid infecting others, controlling the use of medications, and strategies for increasing adhesion to the treatment, whether it be among poor Brazilians using public health services or in Norway, whether it be among IDUs or not. Understood in this way, social or secondary vulnerability does not preclude individual responsibility or absolve one's obligation to consider the conditions in which the population is encountered, to redress or minimize the conditions that make them vulnerable. Or, in other words, it is not appropriate for the caregiver to decide whether or not to treat based on his beliefs regarding its benefits to the other. The decision about treatment should not have as its only parameter the moral values or convictions of he who occupies the role of caregiver.

It is also interesting to emphasize that this question is intimately linked to the education of health professionals. Special attention should be given to the development of a certain moral

competency during the course of professional education, so that caregivers may more easily identify the moral questions involved in the decisions they make during the course of health practice and research. Further, to be able to reflect on what is correct and just, on appreciation of human dignity, on moral plurality and on respect for the other's autonomy.

Another indispensable line of reasoning in the analysis of the IDUs-HIV association is to consider justice in the distribution of health investments. Is it just to invest greater financial resources in the treatment and care of HIV infected people, but not show interest in caring for their health in an integrated manner, thereby sustaining not just risky behavior but also behavior that is frankly harmful to their health?

It seems clear that if we restrict our evaluation to a utilitarian point of view, in an economic sense, the hypothesis of refusing assistance to this population may appear reasonable, but it is not. To establish a policy that denies appropriate care because an individual does not adopt a healthy lifestyle is morally condemnable, even though the behaviors may be deviant according to society's legal standards. Whether we consider those individuals who voluntarily use legally available drugs, such as nicotine or alcohol, or those who lead unhealthy lifestyles, such as excessive consumption of fat, whether we consider criminals, all have the same right to State protection for the simple fact of being human.

Another important point is the imperative for epidemiology to become ever more permeable to ethical reflection from the early stages of research project elaboration, including the formulation of adequate objectives and methods, to the later application of research findings. In the case of some examples of research on this topic, we might question if seemingly strongly associated variables may not in fact be expressions of researcher prejudice in the formulation of the project. In this sense, one proposal could be ethical analysis of research protocols by research ethics committees in this field, with user participation to ensure that their point of view be understood.

In conclusion, it is appropriate to point out the inclusive character with which the topic is addressed in the article and that it well considers what is proposed as research and what is offered as treatment and prevention strategies.

1. Kottow M. Comentários sobre bioética, vulnerabilidade e proteção. In: Garrafa V, Pessini L, editors. *Bioética: poder e injustiça*. São Paulo: Loyola; 2003. p. 71-8.