

curves for 1,312 patients diagnosed between 1996 and 1998, distributed in the same way. The following considerations about the article are based on this operational study conducted at the Center for STDs/AIDS Reference and Training (CRT) of the State Secretary of São Paulo.

The data prior to 1996 show no differences between risk conditions in survival times following AIDS diagnosis, among patients followed by CRT. This supports the idea that there is no difference in the natural history of AIDS, nor in the efficacy of HAART, due to risk condition. However, the survival curves post-1996 already show that there are differences in natural history, or better, in the effectiveness of HAART, due to risk condition, after its availability at our center in the same year.

As can be seen, survival time increases significantly for all risk conditions, yet effectiveness is greater for those infected through sexual means than for those infected through injection drug use.

As in the international articles cited by the authors, our multivariate analysis shows how survival time was associated with independent variables related to access, besides injection drug use. Reduced survival time was associated with less access to HAART, lower CD4 values at the time of AIDS diagnosis, less education and fewer visits to CRT. When compared to those patients, IDUs accessed HAART significantly less, had a lower average CD4 value at the time of AIDS diagnosis, less education and fewer visits to CRT. In other words, IDUs have a profile of less and later access to services than other patients and, therefore, worse clinical conditions. Their greater vulnerability is reflected as much in their life history, as, taking education as a marker of social inclusion, in their relationship with health services.

This study did not address whether IDUs were actively using drugs or not, nor whether this was associated with greater survival time or adherence to treatment. At this point, it is appropriate to note that in Brazil, the use of methadone is not possible, given that cocaine is the drug of choice by the great majority of IDUs. Thus, service providers for the clinical management of HAART among IDUs should develop other mental health strategies for harm reduction. It appears that certain systemic changes will be fundamental to achieving greater success in IDU healthcare, including working in interdisciplinary teams, standardizing and defining service protocols that take into account the possibility and the necessity of drug abstinence as well as harm reduction in drug use, and partnering mental health with other

apparatus and public and private IDU assistance services.

In addition, we also did not analyze, nor did the authors of the article cite, other variables that may be related to survival time, such as the great prevalence of HVC/HIV co-infection among IDUs, and death involving violent circumstances, drug use, or other causes not associated with AIDS.

In this way, ours agrees with other studies showing that the effectiveness of HAART among IDUs, although highly significant, could in the end be less than among other patients.

To conclude, it is worth mentioning again the notion that changes to the model at multiple levels, which are necessary for the sustainability of safer behaviors related to the prevention of infection among IDUs, also may contribute to the effectiveness of HAART. Thus, we might speculate that this is the reason for the greater equality in effectiveness of HAART among IDUs and other HIV/AIDS carriers reported by the Swiss HIV-carrier cohort and EuroSida studies, cited by the authors. In these locations, the more liberal social conditions and politics specifically related to drug users articulate with a culture whose norms appear to enable the emergence of effective and synergetic strategies for the prevention and treatment of HIV/AIDS among IDUs.

1. Kalichman AO, Gianna MC, Bueno SM, Basso CR, Ruiz EAC, Tayra A, et al. Survival among AIDS patients by situation before and after HAART availability at STD/AIDS training and referral center, São Paulo, Brazil. In: XIV International Conference on AIDS, Abstract MoOrD1088, v.1. Bangkok; 2004. p. 157.

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Access to AIDS treatment: appropriateness and correctness in the pursuit of good practice

When Vlahov & Celentano demonstrate that there is no evidence to exclude injection drug users (IDUs) from antiretroviral treatment, they make an extremely relevant contribution to the debate on HIV-related prevention and care. And they do so not only in their affirmation itself, which is plenty, but in the way they make it.

The defense of non-exclusion is welcome at a time when powerful stigma overlap in a global atmosphere of conservatism and despair, appearing to justify each other and virtually taking blatant discrimination for granted as ac-

cepted practice. Still, the way the authors reject such discrimination (by drawing on epidemiological evidence) makes their contribution especially interesting.

The idea is not to justify the feverish (often quasi-irrational) pursuit of “evidence” as the basis for decision-making concerning health “challenges”, either in clinical medicine or public health in general. Quite to the contrary, on various occasions we have contended that without denying the rationalizing potential of the search for evidence, it is necessary to maintain critical and reflective clarity on the meaning of the data produced, stored, and disseminated by the international “medical and scientific complex” and the various orders of paradigmatic economics, technology, coercions, inclusions, and exclusions. In other words, we have sought to highlight the amount of relevant non-evidence that exists in all “evidence”. In addition, we have emphasized that health practices are such that the elements needed to establish judgments and proposals concerning what takes place and what should be done are not reducible to the narrow application of scientifically backed techniques. At least since Aristotle, we know (although we have tended to forget recently) that health care involves a practical dimension (*praxis*) which is irreducible to an art of producing artifacts (*techne*), much less to manipulating specific situations of general laws (*episteme*). Still, while it also appears clear that if the identification of what is appropriate to know and do in health practices (*praxis*) transcends the mere utilization of available scientific evidence (*episteme*), it is undeniable that the scientific validation of our beliefs constitutes a powerful ally for the production and application of preventive and curative measures (*techne*) that respond correctly to what we expect of them. Thus, if we understand the analytical distinction between these various aptitudes and skills in our rational activity, we will be capable of further perceiving their indissolubility and the importance of each of these dimensions.

In short, good health practices require an active search for appropriateness, in the sense of practical validity (ethical, moral, and political) and correctness, in the sense of propositional validity, for objective truth (inter-subjectivity, sharable by means of free use of the senses and rational faculties). There is no good health practice without appropriate knowledge vis-à-vis the subjects and circumstances, no matter how scientifically based it may be. Furthermore, our likelihood of achieving appropriate knowledge increases to the extent

that we are capable of utilizing correct procedures.

Indeed, Vlahov & Celentano masterfully seek elements for an appropriate set of beliefs, allowing us to make decisions in relation to the complex problem of relations between treatment access, adherence, resistance, and control of infection among IDUs. And the authors do so with an extent and appropriateness responding to the main needs for formulating judgments that permeate the debates concerning the elaboration of treatment protocols around the world. They thus provide us with priceless elements for decision-making, with correct criteria for our judgments, even though the latter may be provisional and subject to challenge, like any scientifically-based beliefs.

However, there is a point we wish to add to the debate. This point can actually be divided into two aspects. One aspect, referring to the core correctness of knowledge that can orient our approaches, relates to IDUs’ vulnerability to HIV infection and AIDS. The other, shifting towards the pole of appropriateness, relates to the issues of how to reframe the problem of access-adherence-resistance when we focus on it from this human rights perspective. What the two aspects have in common is the following question: although scientific evidence shows that all IDUs patients demonstrate low adherence and are thus “promoters” of viral resistance, does such evidence justify excluding IDUs from antiretroviral treatment protocols?

The rich set of evidence raised by the authors is thus situated predominantly in the terrain of studies on risk associations or analyses. Such studies focus on associating certain attributes linked to IDUs identity to target outcomes for decision-making concerning the amount and timing of antiretroviral prescription. But from the practical point of view, are they the only relevant questions? And are they the most relevant ones?

We said above that there are various important forms of non-evidence beyond each piece of scientific evidence produced. Concerning this point, it is important to be alert to something behind the risk analyses we have accumulated in the AIDS field. When we ask ourselves whether there is an association between a given population subgroup’s identity trait and some outcome (unfavorable, in this case), there is also an underlying practical question: given this identity, should this treatment be prescribed or not? But we need to reflect a bit on this point. Can this decision be made based on this kind of criteria? Does discussing the underlying instrumental efficacy in these re-

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-