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The article amply revises the literature and discusses, based on available international evidence, questions relative to access for injection drug users (IDUs) to highly active anti-retroviral therapy (HAART). I will discuss, using data on the Brazilian reality, those aspects of the article that most caught my attention.

Given limited space, it may be valuable to create a point of reference by playing the devil's advocate with a word game using the key words in the article's title and proposition. While the debate continues between those that adhere to and those that resist *access* to HAART, death continues stalking IDUs and other excluded populations. With this, I would like to clarify that in my view, and in authors', the right to access to HAART by IDUs is not under discussion: from the ethical, scientific, programmatic and political points of view, it is the best route for deterring the epidemic and bettering the quality of life of those already directly affected. Accordingly, it is appropriate to discuss how to guarantee and extend this right, as well as its effectiveness in terms of access and adherence to treatment and extending survival time. This will be the focus of this short comment.

However, before addressing the issue of treatment, the article presents an interesting discussion of the role of IDUs in the epidemic, whether it be through needle and syringe shar-

ing, or through sexual transmission. In the state of São Paulo, for example, sexual engagement with IDUs and delayed implementation of effective prevention measures were decisive in the increase of heterosexual HIV transmission to women, subsequently causing an increase in vertical transmission of HIV.

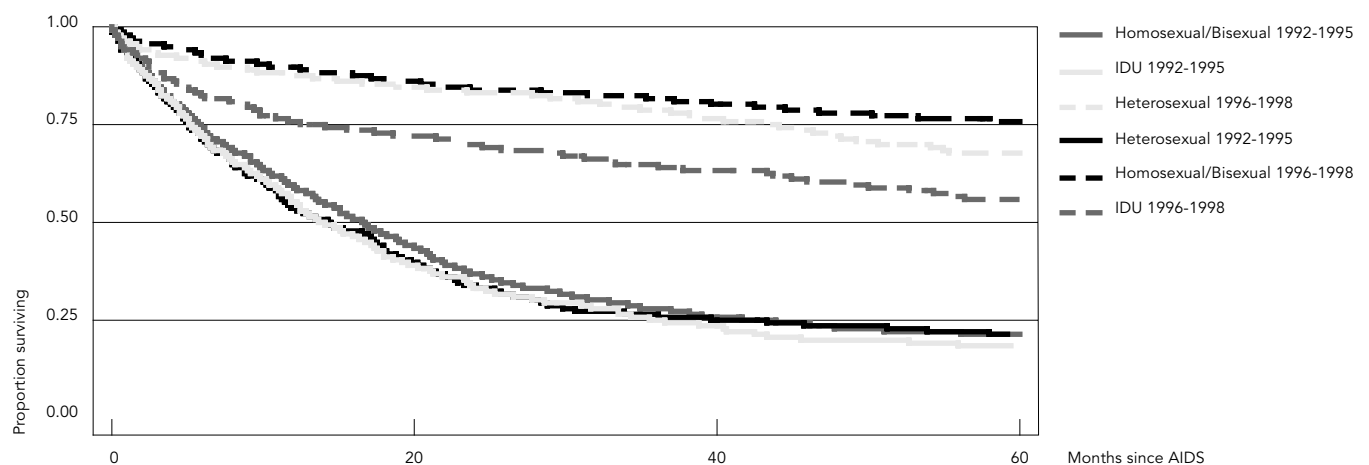
The article also discusses prevention, and points out the greater efficacy of multi-level individual and structural strategies, which take into account social norms, culture, and politics related, broadly-speaking, to drug use. These strategies bring to the table various response apparatus and a diversity of actors. As for the tools themselves, the article makes it clear that although dependency treatment may be the method most recognized in the literature, access to clean needles and syringes, that is, harm reduction, is clearly effective in reducing the incidence of HIV.

In availing ourselves of the effectiveness of HAART, we can and should appreciate that the sustainability of safer behaviors related to the prevention of infection among IDUs depends on changes in behavioral patterns at all levels.

Figure 1 shows the survival curves for two cohorts of patients with AIDS, diagnosed pre- and post-1996, distributed by risk condition. The three lines below represent survival curves for 1,690 patients diagnosed with AIDS between 1992 and 1995, distributed by risk condition. The three lines above represent survival

Figure 1

Survival by risk category and period.



Source: Kalichman et al. 1.

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-