12 myths about HIV/AIDS and people who use drugs

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People who use drugs too often face stigma, discrimination, and mistreatment in HIV prevention, treatment, and care. Some societies consider such users less deserving of compassion than others with HIV who are not drug users, because users' health problems are self-inflicted or their substance use is judged as a moral or personal failing. Even among health-care providers, many preconceptions prevail about people who use drugs and are infected with HIV. What are these myths (panel)?

Drug users are non-compliant—In a meta-analysis of adherence to antiretroviral therapy from 38 studies and nearly 15 000 patients, of whom 76% were drug users, overall adherence was similar to that reported for other populations with sexual exposure histories that were taking antiretrovirals.[1] Better outcomes with antiretrovirals were associated with being on opioid-substitution therapy, receiving psychosocial support, or both. The meta-analysis concluded that HIV-positive drug users tended to be inappropriately assumed to be less compliant and unlikely to achieve desirable treatment outcomes than non-drug-using cohorts.

Drug users do not respond as well to antiretrovirals as do non-drug-using patients—A comparison of survival rates in 3116 antiretroviral-naive patients started on antiretrovirals (in Vancouver, Canada), of whom 915 were injecting drug users, showed similar all-cause mortality by 84 months after starting antiretrovirals.[2] In a multivariate time-updated Cox's regression, the hazard ratio of mortality did not significantly differ between injecting drug users and those who did not inject drugs (1·09, 95% CI 0·92–1·29). Injection drug use was not associated with decreased survival in patients who had started on antiretrovirals.

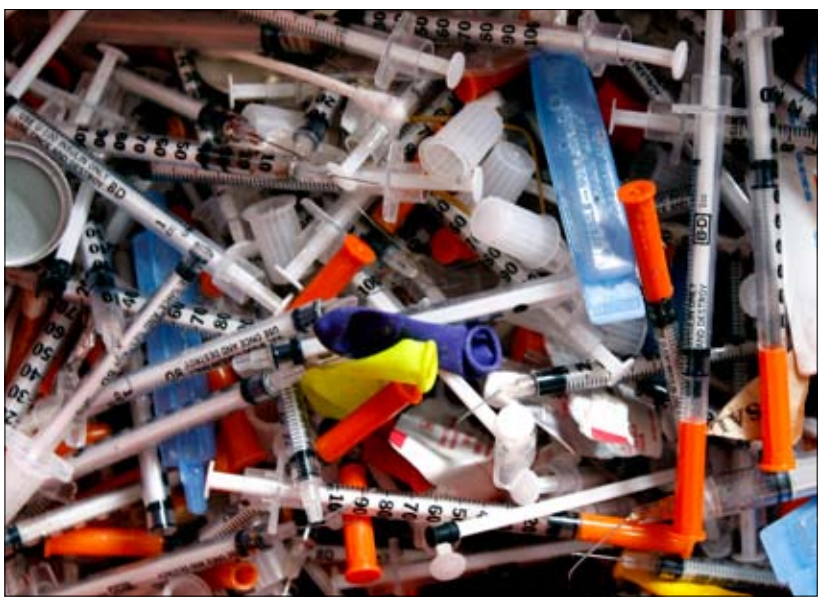
Drug users are difficult to study and have poor retention rates in cohorts, making prospective research studies with drug users difficult or impossible—The first phase 3 HIV-vaccine efficacy trial in a developing country was the AIDSVAX B/E (VaxGen) trial in 2546 injecting drug users in Bangkok, Thailand.[3] Although the vaccine failed to elicit protection, the trial was successfully conducted with 2295 (90·1%) of participants retained at 36 months and an overall HIV incidence of 3·4 per 100 person-years. Such excellent retention shows the willingness of people who use drugs to enrol and stay in prospective studies.

Drug users are more concerned about getting high than using injecting equipment safely—In a study of 760 participants who used a supervised injecting facility in Vancouver, Canada, more consistent use of the facility was associated with safer injecting behaviours than was less consistent use, including less syringe re-use (odds ratio [OR] 2·16, 95% CI 1·48–3·16), use of clean water for injecting (3·15, 2·26–4·39), safer disposal of syringes (2·22, 1·54–3·20), and less injecting outdoors (2·99, 2·13–4·21).[4] Given the choice, people who use drugs preferred safe and clean equipment.

Drug users don't have much sex; their HIV risks are largely or entirely from needle sharing—One of us (SAS) with others[5] explored sex differences in HIV seroconversion in 1447 male and 427 female injecting drug users in Baltimore, MD, USA, over 10 years. Incident HIV infection in men was associated with young age, recent needle sharing with multiple partners, and daily use; but the incidence of HIV infection was double in men engaging in recent sex with other men compared with men who did not engage in this behaviour. For women who injected drugs, risks related to heterosexual sex

Panel: 12 myths about HIV/AIDS and people who use drugs

1 Drug users are non-compliant
2 Drug users do not respond as well to antiretrovirals as do non-drug-using patients
3 Drug users are difficult to study and have poor retention rates in cohorts, making prospective research studies with drug users difficult or impossible
4 Drug users are more concerned about getting high than using injecting equipment safely
5 Drug users don't have much sex; their HIV risks are largely or entirely from needle sharing
6 If drug users keep using, it is almost inevitable that they will acquire HIV infection
7 Unlike gay men or sex workers, drug users don't have strong communities, so community interventions are unlikely to work
8 Rates of drug use are higher among minorities in the USA and other industrialised countries
9 Needle exchanges encourage drug use
10 Methadone (or buprenorphine) treatment just exchanges one drug for another
11 People who use stimulants are all heavy, out-of-control users who won't change their risky behaviours
12 Fear is an effective deterrent for drug use



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were more closely associated with HIV infection than were drug-related risks.

If drug users keep using, it is almost inevitable that they will acquire HIV infection—The most recent data from the US Centers for Disease Control and Prevention (CDC) on new HIV infections in the USA among men and women who inject drugs show there has been a decline in the number of new cases in injecting drug users of both sexes from 1998 to 2007,[6] although the prevalence of injecting drug use has been stable or modestly increasing across the USA since 2000.[7]

Unlike gay men or sex workers, drug users don't have strong communities, so community interventions are unlikely to work—The Thai Drug Users Network organised hundreds of drug users across Thailand to protest human rights violations against people who use drugs during the 2003–04 crack-down which led to thousands of drug users being executed.[8] The Network engaged in local and regional advocacy, and successfully obtained a Global Fund grant.

Rates of drug use are higher among minorities in the USA and other industrialised countries—According to the 2006 National Survey on Drug Use and Health,[9] African-Americans and whites have similar patterns of illicit drug use. According to the 2006 findings from the Monitoring the Future study, African-American students in the 8th, 10th, and 12th grades have substantially lower rates of use for most illicit drugs than do white students.[9] A 2009 CDC report found that white injecting drug users had higher rates of needle-sharing than did minority-group users.[10] Incarceration rates for offences related to substance use, however, do differ by race; with the highest rates of incarceration being among African-Americans.[11]

Needle exchanges encourage drug use—There is no evidence to suggest that, after the introduction of a needle-exchange programme, rates of drug use or starting to inject increase.[12] A study of 600 injecting drug users in Alaska, USA, randomised users to receive access to needle exchange compared with training on buying needles and syringes from pharmacies, to test whether access to needle exchange increased the frequency of injection.[13] There was no difference in the amount of injecting drug use between these two groups at 6 or 12 months (p=0·0001).

Methadone (or buprenorphine) treatment just exchanges one drug for another—A Cochrane review that included 1969 participants in six randomised trials showed that methadone was superior to non-pharmacological approaches in retaining patients in treatment, and in reducing heroin use, measured by self-report and urine or hair analysis (relative risk 0·6, 95% CI 0·56–0·78).[14] Another Cochrane review showed that medium and high doses of buprenorphine were more successful than placebo alone at decreasing heroin use.[15]

People who use stimulants are all heavy, out-of-control users who won't change their risky behaviours—Mausbach and colleagues,[16,17] showed reductions in sexual-risk behaviour by HIV-negative heterosexuals and by HIV-positive men who have sex with men, despite ongoing use of methamphetamine. These behavioural interventions show that users of stimulants can reduce their risks for sexual acquisition of HIV infection, even if their drug use continues.

Fear is an effective deterrent for drug use—The US Institute of Medicine report reviewed the evidence for fear-based campaigns as deterrents for substance use and found they had no effectiveness.[18]

Biases and stigma against those who use drugs, are drug-dependent, or have a history of injecting are common. Such biases have no place in the practice of medicine or in the allocation of public health resources. The myths about HIV acquisition and people who use drugs are straightforwardly countered by scientific evidence, but like so many forms of prejudice, they persist despite the evidence. It is past time for these

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prejudices to change. Providers, decision makers, and all engaged in the global fight against HIV infection have an obligation to examine biases against people who use drugs, learn the facts beyond the myths, and let evidence drive responses.

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