This analysis[3] also addresses the comments from Karin Swart and colleagues. We struggle to see any role for bias in explaining the results, but an alternative hypothesis, that screening affected other behaviours in those identified at high risk, is possible; further analyses, including the effect of screening on incident falls, are underway. However, as interventions targeted at incident falls require multicomponent strategies for success,[4] we believe the reduction in hip fractures is predominantly mediated through osteoporosis medication. Finally, the relatively small difference in the percentage of patients receiving treatment between the groups during the study, as noted by Swart and colleagues, is possibly misleading because initiation of treatment in the control group was perhaps more likely to have followed an incident fracture already captured within the study outcome.

Screening for high risk of hip fracture by FRAX with BMD, combined with appropriate management, appears to be a highly cost-effective strategy[5] with the potential to substantially decrease the burden of hip fractures.

LS declares no competing interests. EM is a member of the FRAX development team.

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The global health and equity imperative for safe consumption facilities

The first safe consumption facility (SCF) opened its doors in 1986, in Bern, Switzerland, intending to curb drug overdose-related deaths and prevent other drug-related harm in people who inject drugs (PWID).[1] Since then, communities who have adopted the SCF approach have seen decreases in HIV incidence, injection-related litter and disorder, and drug overdose.[2,3] Use of SCFs is also associated with uptake of treatment for drug use and other recovery assistance services.[4]

Mounting evidence that SCFs are both highly successful and cost-effective has made them a core public health response to problematic drug use and its sequelae.[5,6] Nowadays, more than 100 SCFs are in operation across Europe, Australia, and Canada, with Canada having recently approved dozens of additional facilities to address the country's overdose crisis.[7] Although several US locales have made concrete steps towards opening SCFs, progress has been dismally slow, and the ultimate fate of these efforts remains uncertain.

Shockingly, not one such programme operates in low-income and middle-income countries, despite the reality that these countries bear a disproportionate burden of the harm to public health associated with drug use. For example, the prevalence of HIV infection in PWID living in Latin America (35·7%), South Asia (19·4%), and eastern Europe (24·7%) is markedly higher than the global average (17·8%). Although technically a high-income country, Russia now has the third highest HIV incidence in the world, driven primarily by injection-related transmission.[8] Moreover, abusive law enforcement practices are prevalent in areas with a weak rule of law and widespread informal settlements.[9,10] Adverse encounters with police and other security personnel exacerbate the health risk to PWID, while limiting the accessibility of harm reduction services.[11] In such contexts, the human rights and public health imperatives of safe consumption spaces are especially pressing, whereas their absence plainly offends global equity principles.


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Tijuana, Mexico is illustrative of a global setting where the potential benefit of SCFs is readily evident. As a border node in the international drug trade, rates of drug consumption, injection-related infectious disease, and overdose are high.[12] Reflective of many other places in low-income and middle-income countries, access to naloxone and opioid substitution therapy in Tijuana (and elsewhere in Mexico) is limited. If operated at scale, a SCF could substantially decrease overdose-related morbidity and mortality while faciliatating access to appropriate drug treatment.[12] Tijuana's street market for opioids does not yet appear to be dominated by fentanyl, but such a shift would almost certainly cause a surge in overdose fatalities.

Existing drug consumption dynamics and the proliferation of informal and unsafe injection sites leave PWID in Tijuana vulnerable to police harassment.[10,11] In the context of structural challenges and poor coverage of high-quality and accessible harm reduction programmes, a SCF could save lives and reduce drug-related harm. The integration of SCFs with a range of assistance programmes would also catalyse the connection of marginalised drug users to other essential services. Analogous to several jurisdictions in the global South, Tijuana's legal environment is

already favourable to the operation of a SCF because small-scale drug possession is decriminalised.[10] Finally, a department-wide police education programme in Tijuana has built a foundation for better alignment of law enforcement with harm reduction programmes like SCFs.[13]

In Tijuana, as elsewhere, SCFs provide an opportunity to integrate a suite of key harm reduction services under one roof. However, these spaces potentiate much more than access to sterile equipment and basic medical help. In contexts where the lived experience of PWID is characterised by pervasive exposure to police violence, poor availability of stable housing and basic sanitation, and little ability to vindicate one's rights, SCFs can create a rare oasis of structural safety and empowerment. The diversity of models for SCF—ranging from simple pop-up and mobile sites to fully-integrated clinics—create an opportunity to tailor interventions to particular environments and resources available globally.

Despite barriers to operating SCFs in high-income settings, advocacy and persistence have supported the diffusion of this intervention throughout Europe, Australia, and Canada.[1] With pressing public health and global equity imperatives to support this cause, the time to scale SCFs globally has long arrived.

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Rifampicin in treating *S aureus* bacteraemia

The deduction that severely ill patients benefit from combination therapy might be tempting, but evidence supporting such an intensified treatment approach is controversial. This was once again shown by Guy E Thwaites and colleagues (Feb 17, p 668),[1] who are to be commended for completing the ARREST trial, investigating possible benefits of adjunctive rifampicin in *Staphylococcus aureus* bacteraemia. The trial findings did not show a significant difference between the rifampicin and placebo groups concerning the composite primary endpoint (bacteriologically confirmed treatment failure or recurrence or all-cause death at week 12). However, a reduction in bacteriological failure or recurrence was observed (three [1%] of 370 patients in the rifampicin group *vs* 16 [4%] of 388 patients in the placebo group), translating into a number needed to treat to prevent one failure or recurrence of 29. Subgroup analyses revealed more drug-modifying adverse events and drug interactions in the rifampicin group than in the placebo group.

Should rifampicin now be put aside when treating patients with *S aureus* bacteraemia? Two aspects need to be discussed before drawing final conclusions. First, in the subgroup of patients with meticillin-susceptible *S aureus* bacteraemia receiving flucloxacillin plus rifampicin, a significant reduction in the primary endpoint rate was observed (16 [9%] of 176 patients in the intervention group *vs* 38 [20%] of 191 patients in the placebo group with flucloxacillin only; hazard ratio 0·45, 95% CI 0·25–0·81; p=0·01; figure 2a in the appendix).[1] Notably, this subgroup analysis included 48% of the entire cohort. Those patients receiving rifampicin with a second drug different from flucloxacillin (including other β-lactams or vancomycin) had a worse outcome (primary endpoint, 29 [23%] of 127 patients), suggesting