



Established in 1989, Vancouver's Eastside needle exchange grew to be the largest NES in North America, distributing over two million needles and syringes a year. But by 1995, Vancouver's low rate of HIV infection suddenly tripled within 18 months. Researchers moved in to find out why. **Mike Ashton** details what they found



The downside of Eastside

DOWNTOWN Eastside in Vancouver is not only the poorest neighbourhood in the city, but one of the most deprived areas in Canada. Most of the city's chronic drug using and homeless population gravitate to this area to occupy tiny, cheap single-person hotel rooms. Crime and prostitution are rife. In 1989 a needle exchange opened which grew rapidly, distributing clean works to thousands of clients a year. Compared with many other cities when injecting was widespread, Vancouver could boost low rates of HIV infection, a state of affairs for which the exchange could take some of the credit. Then in 1995, rates of HIV infection soared to seven per cent (a worrying three-fold increase within two years). The Vancouver Injecting Drug User Survey (VIDUS) attempted to find out what was happening.

From 1996 the study recruited injectors who were interviewed and tested for HIV and Hep C and then re-contacted every six months. A disturbing four in 10 became newly infected with Hep C over an average period of 16 months. Compared to injectors who avoided infection, they were more often involved in prostitution, had multiple sexual partners, borrowed or lent needles, injected at least daily, and injected cocaine or cocaine/heroin 'speedballs'. Infection was also about twice as common in injectors who had attended a needle exchange at least once a week – the opposite of what was expected.

WAS IT THE MAGNET EFFECT?

Before jumping to the conclusion that the exchange was counter-productive, another possibility has to be considered. Studies have consistently found that higher risk injectors are drawn to needle exchanges, creating the illusion that attending the exchange

actually elevated risk – the 'magnet effect'. Despite the study's attempts to account for excess risk, this could have been happening in Vancouver. But there was one unpalatable certainty: even if it did not increase the risk of infection, neither did going to the exchange weekly or more often reduce it to anywhere near acceptable levels. Each year nearly 12 per cent of frequent attenders became HIV positive, 40 per cent became infected with Hep C, four in 10 had recently injected in shooting galleries, and the same proportion had re-used someone else's needle.

COCAINE TIPS THE BALANCE

What had caused the sudden upsurge in HIV and why had the exchange failed to control the epidemics? It was not just the social and economic environment in which drug users were living (this was desperately poor but had been the case in the years when HIV was dormant). In 1994, the year the HIV epidemic took off, into this environment came an upsurge in cocaine injection.

This seemed to be the point at which an already fragile dynamic between the exchange, the clients and their lifestyle and environment broke down. Local drug users often injected it several times a day for days at a time. Frequent injecting associated with cocaine 'binges' aggravated distribution shortfalls, greatly heightening the chances that exchange users would share needles and syringes. One in five local injectors shared needles even when they reported no problems getting fresh supplies

A peculiarity of the area's housing set the seal on the epidemics. Commonly hotel managers locked buildings at night and charged for re-entry, encouraging residents to stay in their rooms. Communal binge injecting developed, especially on

Mike Ashton is editor of *Drug and Alcohol Findings*. The Vancouver experience is one of six city case studies of needle exchange and Hep C available for free download from the magazine's www.drugandalcoholfindings.org



Vancouver's famous skyline hides a chronic drug problem

the days when the injectors (the same day for them all) received their welfare cheques, turning the tiny rooms into ad-hoc shooting galleries. Sterile needle/syringe stocks would have become rapidly depleted at a time when obtaining fresh supplies was obstructed. Ill-furnished rooms with no bathrooms and often no cooking facilities made adequate injecting hygiene difficult and lent themselves to intoxication-induced confusion over whose syringe was whose.

INADEQUATE RESPONSE

In the face of this development the exchange moved neither quickly nor far enough. Though its syringe output was prolific by North American standards, it was not prolific enough. It handed out two million needle/syringe sets a year but up to ten million were needed to give each injector a fresh set each time.

On average just six syringes/needles were handed out at each visit. A typical customer would have needed to visit at least three times a week. A third would have needed about 50 sets a week, a quantity normally available only by travelling to the office carrying 50 used sets to exchange. Most would prefer to avoid the risk this posed if stopped by the police. Visitors to the fixed-site exchange also feared police surveillance and personal experience of this affecting drug supplies was linked to a near doubling of the odds of someone sharing needles.

Important as it was, inadequate distribution of injecting equipment was not the whole story. In a situation which cried out for 'assertive' harm reduction, the exchange's management and the city's health funders saw its role as expediting "requests" for intervention, not prompting them. The emphasis was on gaining trust and attracting customers by being "accepting" and "non-intrusive". It was hoped that customers would respond by becoming more responsible in their drug use.

Very soon, even if the exchange had wanted to do more, it would have been held back by the conjunction of escalating numbers and resource constraints. Demand rapidly outstripped initial projections by more

“
In a situation which cried out for 'assertive' harm reduction... management ...and... funders saw [their] role as expediting "requests" for intervention, not prompting them.
”

than ten-fold. Observers described exchange transactions as "cursory and on-the-run". Van drivers spent barely more than a minute with each contact in an exchange centring on the negotiation of the one-for-one rule preceded by a brief greeting and ending in a well-meaning injunction not to share.

INADEQUATE SUPPORT

Lack of resources was in turn associated with public opposition to the exchange, making it hard to gain political support. Budget restrictions mandated limited opening hours (also forced by the community's resistance to late-night concentrations of injectors at the exchange site), led to cutbacks in the mobile service, and contributed to limits on supplies. The effect was that the service fell well short of its customers' needs and prevented them passing on sterile syringes to their contacts.

The exchange was pressured into operating on the basis of 'worst case scenarios'. A constant concern was that customers would collect sterile equipment for re-sale (ironically, if they had this might have helped reduce disease spread), so at first usually just two syringes and needles were handed out at each visit. The limit was later raised but not abandoned for many years. The one-for-one rule was at first flexibly implemented but later hardened, partly due to community concerns about syringes and needles being left in public spaces. There was also concern that supplying free needles would encourage more frequent injecting.

MORE NEEDED

Far from casting doubt on the value of needle exchange, the overriding impression left by this and other similar scenarios is that we need far more exchange and far greater support for this work. If they are to meet the challenge of Hep C, the burdens of financial cutbacks, community resistance, misplaced morality and outdated working traditions must be lifted from exchanges. The Vancouver model of a transitory interaction in the street or a hands-off exchange in the office may still be a choice made by the customer, but should not be one forced on them by under-resourcing or misplaced reticence on the part of services.

There is also a need to move beyond the model of exchange as a 'service' 'delivered to' injectors to one in which injectors use exchanges to achieve health promotion objectives through behavioural change rooted in and supported by their own social networks. In this endeavour, even more so than in their conventional role, exchanges will find themselves working against the grain of broader drug policy within which communities of injectors are targets to be shunned or attacked rather than nurtured and engaged as partners in achieving health gains. ■

→ For the full text from which this article was adapted, go to our new website feature **Druglink Plus** at www.drugscope.org.uk/druglink/