SYRINGE EXCHANGE 2
THE CLIENTS

How far do syringe exchange scheme clients need to change to avoid the risk of HIV infection, and how difficult will it be to achieve these changes? By extension, the answers suggest the dimensions of the task facing Britain's attempt to curb the spread of HIV throughout the population.

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SYRINGE EXCHANGE SCHEMES aim to provide sterile injecting equipment to people who inject drugs, along with advice on risk reduction, to enable them to decrease their risks of becoming infected with HIV and the risks of their transmitting HIV infection to other injectors or to sexual partners.

In the last issue of ***Druglink*** we reported on the way the schemes had been established and their success in reaching new groups of drug injectors. Some areas needing development were identified, including an improved ability to reach women, younger drug injectors, and those with a shorter history of injecting drug use. We also pointed to the higher than anticipated dropout from the schemes.

Later we will be examining whether the schemes enable clients to change their risk behaviour. To do this we needed to collect baseline information from clients about their current knowledge about HIV and AIDS, their views on the risks of infection, and their injecting and sexual behaviour. In this report we focus on these baseline attitudes and behaviour, revealed through interviews with clients during their first month of attendance at the schemes.

High-risk sharing in minority

Between 33 and 36 per cent of the 182 clients said they'd shared syringes in the previous four weeks. The lower level was reported at intake, the higher level at interview some time later. This apparent increase during early attendance is accounted for by the more detailed questions in the interview schedule, indicating that to elicit the full extent of sharing any study of injecting practices must go into considerable depth about the different types of sharing, the range of sharing partners, and the circumstances in which sharing takes place.

Clients who'd shared in the last four weeks divided almost equally into those who'd shared with only one person during those four weeks, and those who had shared with two or more. Most often the person shared with was described as a friend. As figure 1 shows, a significant minority engaged in extremely high-risk sharing, for example, with casual acquaintances, with two or more people over the four weeks, or even with two or more people on a single occasion. This suggests that counselling must be appropriate to the varying needs of this diverse client group. Developments here will require more accurate assessment of the information needs of different groups of injectors, their sources of information, and identification of gaps in that information.

When asked why they had shared in the last year, over half the clients said they'd shared because equipment was hard to obtain, half because they or someone else "needed an injection", and 40 per cent because there was a group using drugs together. Sharing "in custody" in the last year was reported by eight per cent. A fifth had at some time shared because the exchange scheme was closed.

The reported levels of sharing of injecting equipment are lower than levels reported in many studies conducted prior to the schemes (see table 1). But the fact that 36 per cent report sharing in the last four weeks indicates that substantial changes in behaviour will have to be made if risks of HIV infection are to be curtailed. We asked specifically about the number of times the person had injected "with a needle or syringe that had *already been used* by someone else". Thirty per cent of the clients interviewed had done this and on average each of these had done it 12 times in the last four weeks. If this behaviour is consistent and typical of people who inject drugs, then for every 100 who inject there will be about 4,700 occasions each year when they use someone else's equipment and are potentially at risk of HIV infection.

Urgent need for safer sex

The other key area with relation to HIV transmission is sexual relationships. Most people who came to the schemes were sexually active. Eighty four per cent had at least one sexual partner in the previous three months, and a third had several partners (figure 2). More than half of the interviewees' regular sexual partners were not drug injectors, which has important implications for the potential spread of HIV beyond the drug injecting population.

Condom use with casual partners was uncommon, highlighting the risk of HIV transmission to people at risk solely because of casual sexual contact with an injector. In our previous ***Druglink*** paper we noted that both staff and clients of syringe exchange schemes find it harder to discuss sexual behaviour than drug use and injection practices. There is therefore an urgent need to develop strategies for advice and information on sexual behaviour suited to drug injectors.

Risks known but still run

We do not yet know whether people have changed their behaviour after attending the schemes. Evidence for this must wait for further research. We *do* know that people who come to the schemes appear to be motivated to change their behaviour. Being "worried about AIDS" was the most common reason for attending. There is also evidence of changed behaviour in the period before and including the first few visits. Nearly three-quarters reported they had changed their drug using practices since hearing about AIDS, and around 40 per cent said they had made some change in their sexual behaviour. Most also said friends had made similar changes.

There is strong evidence that most of the clients know the dangers of HIV transmission through sharing syringes, yet a substantial proportion continue to engage in

KEY FINDINGS

■ Over a third of exchange scheme clients had shared injecting equipment in the last four weeks and one in eight had shared with a casual acquaintance.
■ 84 per cent had recently been sexually active but just 29 per cent had used condoms.
■ Three-quarters had changed behaviour because of AIDS but only eight per cent believed they ran a high risk of HIV infection.
■ Knowing the risks and having clean equipment available may not be enough — injectors may need help in acquiring the skills needed to sustain safer sex/drug use.

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5. Webb G. *et al.* "Epidemic of AIDS related virus infection among intravenous drug abusers." *British Medical Journal*: 1986, *292*, p.1202.
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8. Ghodse A.H. *et al.* "Effects of fear of AIDS on sharing of injection equipment among drug abusers." *British Medical Journal*: 1987, *295*, p.698-9.

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risky behaviours. This sort of gap between knowledge and behaviour has often been found in other types of health promotion campaigns.

The current approach to HIV prevention is based on the assumption that if people are provided with *knowledge* about the risks of certain behaviours, and provided with the *means* to change (ie, syringes, needles, condoms, etc), then they will be enabled to change. The fact that the desired changes are still far from complete may be because injectors have not yet been adequately supplied with the means to change — there is still an undersupply of syringes, even for syringe exchange scheme clients. Many people were not supplied with enough syringes to enable them to use a new one each time they inject.

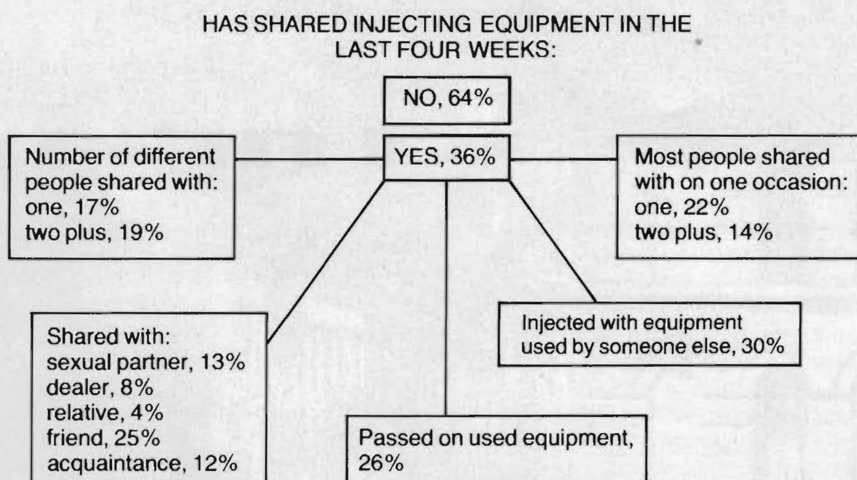
But the position is probably more complicated than this. Despite knowing the risk of HIV, many people did not see themselves as being at risk. Only a minority (eight per cent) believed they were at high risk of HIV. A further quarter believed they have "some" risk. Most saw themselves as having a "low" (43 per cent) or "no" (24 per cent) risk of contracting HIV. There are parallels here with smoking and cancer, where people who smoke know the risks but do not see themselves as personally at risk.

It is also conceivable that other factors inhibit behaviour change, despite a willingness to change. Many situations in which people find themselves could make it difficult to avoid risky behaviour. For example, much of the routine round of raising money, buying drugs and finding a place to use them, requires collaborative effort and the sharing of resources: syringe sharing may be an inevitable side effect. In the case of sexual behaviour, professional prostitutes might find it easier to insist on safe sex than drug users engaged in casual prostitution. We need to know much more about the context of risk behaviour in order to identify the obstacles to change.

If we are right about the existence of these obstacles to change, it may be necessary to consider a prevention strategy which moves beyond knowledge- and means-based approaches. Drugs/AIDS workers may have to help people develop the social skills for using safer injecting and safer sexual practices with their contacts and partners, and help them learn to avoid situations where risky behaviour is likely to occur.

PREVENTING THE SPREAD of HIV entails encouraging and enabling change in the character of drug subcultures so that less risky practices are accepted and commonplace. Despite the relative success of syringe exchange schemes in attracting clients, there is still an urgent need to reach the majority of drug injectors. Helping them to change their behaviour requires the development of strategies that are appropriately targeted in terms of the needs of injectors, enhance their ability to change, and are realistic about the many practical obstacles to change that arise in the everyday context of drug use. The task now is to identify and overcome further obstacles to adopting safer practices. □

Figure 1. Sharing injecting equipment

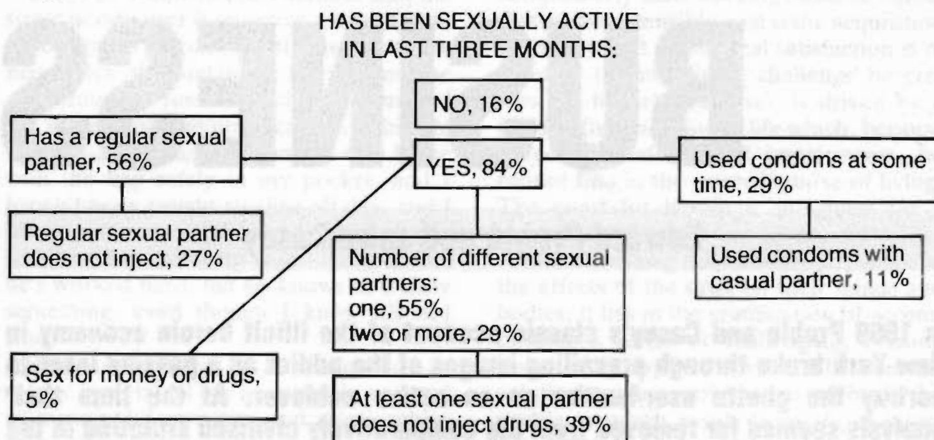


Percentages are all based on the total number of people interviewed — approximately 182 for each question.

Table 1. Syringe sharing found in various recent studies

Place	Date	Sample	Extent of sharing
Edinburgh[1]	Probably 1985-6	Patients attending a screening clinic	63% shared at least once a week
Edinburgh[2]	1985-6	Patients attending a screening clinic	76% shared at least monthly
Edinburgh, Glasgow[3]	Probably 1985	GPs' patients	Mean number of occasions when equipment was shared in the last month was 46 (Edinburgh) and 15 (Glasgow)
Edinburgh[4]	—	Patients at a general practice	83% reported having shared
London[5]	—	Patients at a drug clinic	34% shared in the last three months
London[6]	—	Patients at a drug clinic	67% had shared with another person
London[7]	1984-6	Drug users seeking treatment for the first time	Of those who had injected, 59% had shared in the last four weeks
London[8]	1987	Patients at three drug clinics	30% had allowed someone else to use their equipment after themselves

Figure 2. Sexual behaviour



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