SYRINGE EXCHANGE 3:
CAN INJECTORS CHANGE?

In this last of three reports the Monitoring Research Group fills in the bottom line of its study of the Government's 15 pilot syringe exchange schemes. The issue is whether the schemes' clients reduced their risk of HIV infection by changing their drugtaking and sexual practices. On the basis of all three reports the researchers then give their overall assessment of how the schemes have performed.

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SYRINGE EXCHANGE schemes aim to help drug injectors change their behaviour to reduce their risk of becoming infected with HIV or, if already infected, the risk of their transmitting the virus to others. In an earlier ***Druglink*** article (July/August 1988, p.8-9) we reported on the risk behaviour of syringe exchange clients around the time they first attended the schemes. In this article we look at the extent to which clients still at the schemes three months later reported that they had changed their HIV risk behaviour in two key areas — needle and syringe sharing, and sexual activity.

But before this it is important to put any such changes in context. People who come to exchange schemes report lower levels of syringe sharing than those reported in earlier research (see table 1 in the earlier ***Druglink*** article). We thought this reflected a general trend towards reduced risk behaviour among injectors in response to the extensive government anti-injecting campaign and other publicity about the dangers of injecting.

To check this we interviewed a comparison group of injectors *not* attending syringe exchanges. Between March and June 1988 we interviewed 220 injectors in 17 towns. About a third were reached through drug services, and the rest through informal contacts.

What we found forced a revision of our views. Over 60 per cent of these 'non-attenders' had shared in the previous four weeks compared to just 36 per cent of syringe exchange clients. The highest rates were found in Scotland (76 per cent) and among injectors interviewed outside service settings. A second survey between July and September found a similar result.

We now think syringe exchanges attract people already at a lower risk of HIV infection than is found among injectors in general. Other strategies will have to be developed to reach higher risk injectors.

Syringe sharing reduced

Given that syringe exchange clients already have lower levels of risk behaviour, are they capable of making further changes? To look at this we tracked the pilot schemes' clients for three months. We found that only 33 per cent of all attenders stayed through to the fifth visit, and only 6 per cent to the twentieth. It appears that the schemes' clients do not 'enrol' and become regular attenders — a fact which must force a revision of service planning to achieve more accessible, user-friendly services (see our article in ***Druglink*** May/June 1988).

Not all the drop-outs happened for negative reasons. For example, some clients went into treatment or stopped injecting, but others continued to inject or died or went to prison. We have little information about this because our research was not designed to follow those who dropped out.

What of those who stayed? Some were re-interviewed about three months later. A comparison of the behaviour reported at the first and second interviews (summarised in table 1) shows that needle and syringe sharing was reduced. The key measure — whether the person had shared in the previous four weeks — dropped from 34 per cent to 27 per cent.

This trend to less risky behaviour was found in all the measures of sharing. There was a fall in the number injecting with equipment previously used by someone else (risk of infection) and in those passing on used equipment (risk of transmission). Also reduced was the number of different people shared with on a single occasion.

While the number of sharing partners and the frequency of sharing are important, so too is the type of person shared with. There were reductions across various types of sharing partner. Those sharing with friends declined from 22 per cent to 17 per cent, with acquaintances from 13 to 8 per cent, with dealers from 11 to 8 per cent, and with sexual partners from 11 per cent to 5 per cent.

Clients were asked why they "might have had to share" needles and syringes (in the first interview over the last year, in the second over the last three months). Of particular significance was the major reduction in those who said they had shared because needles and syringes were hard to obtain (see table 2).

The overall reductions in syringe sharing reported above may hide significant variations in how individuals changed: some, for instance, may have actually increased their risk behaviour.

In fact we found that 21 per cent of the sample shared at least as much at the second interview as they did at the first. But this leaves many more — 79 per cent — who either sustained their non-sharing behaviour or cut the extent to which they shared (details in table 3).

Further evidence of reduced risk behaviour was found in the types of drugs injected. By the second interview decreased rates of injection of most drugs left amphetamine the one most commonly injected. The number of injections also decreased from an average of 53 to 45 in the previous four weeks.

Moves in sexual behaviour

By definition syringe exchanges emphasise drug use, and their staff reported difficulty in discussing sexual behaviour with clients. However, there were a number of changes in sexual behaviour, most on a scale similar to changes in syringe sharing (see table 4).

Over the three months since they were first interviewed at the schemes there was a fall in the number of clients who were sexually active. Down too was the number with multiple partners. Up slightly was the number with a regular sexual partner. This may indicate that clients were changing from casual towards regular relationships. (Though there was no further evidence to support this interpretation and the extent of the change was small.)

The increase in the proportion of clients who had sexual relationships with a non-injecting partner has two sides to it: for the client it reduces their risk of HIV infection; for their non-injecting partner, it may increase it.

The only negative change in sexual behaviour was a decrease in the use of condoms. However, the fact that even at the second interview 31 per cent reported some use of condoms probably compares well with the general population.

Key Findings

- Syringe exchanges attract injectors already at a lower risk of HIV infection. Other strategies need to be developed to reach higher risk injectors.
- After attending the schemes for three months:
  - 27 per cent of the clients had shared in the last four weeks compared to 34 per cent when they came;
  - 45 per cent no longer said they'd shared because injecting equipment was hard to obtain;
  - 79 per cent had sustained non-sharing or reduced their sharing behaviour;
  - overall, sexual activity was slightly reduced.
- Despite these improvements, after three months 21 per cent continued to share at least as much as when they first came.

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Table 1. Needle and syringe sharing

	First interview %	Second interview %
Not shared in last 4 weeks	66	73
Shared in last 4 weeks	34	27
Shared with:		
— one	17	16
— two plus	17	11
Most people shared with on one occasion:		
— one:	20	18
— two plus	13	9
Shared by:		
— using syringes already used by someone else	25	19
— passing on used syringes	30	25

All percentages are based on the total number of people interviewed on both occasions — approximately 142 for each question.

Table 2. Reasons for sharing

	First interview %	Second interview %
Equipment hard to obtain	54	9
Equipment cost too much	16	2
Didn't like carrying equipment	17	6
You or someone else needed an injection	53	18
In custody	6	4
Group using drugs together	34	15
Exchange scheme closed	29	9

All percentages are based on the total number of people interviewed on both occasions — approximately 142. At the first interview they were asked about sharing over the last year; at the second, sharing over the last three months.

Table 3. Pattems of change in syringe sharing behaviour

Proportion of sample	Pattern of change: First interview → Second interview
79 per cent	Sustained non-sharing or cut sharing
Consisting of:	
— 53 per cent	Not sharing → Not sharing
— 20 per cent	Sharing → Stopped sharing
— 6 per cent	Sharing → Sharing less
21 per cent	Maintained or increased level of sharing

All percentages are based on the total number of people interviewed on both occasions — approximately 142.

Table 4. Change in sexual behaviour

	First interview %	Second interview %
No sexual partner in last three months	23	31
Sexual partner in last three months	77	69
Number of partners:		
— one	51	48
— two plus	26	21
Of those sexually active:		
— partners who do not inject	46	55
— used condoms	38	31
Current regular sexual partner	49	52
Of those with regular partner:		
— partner does not inject	54	61

Percentages based on the total number of people interviewed on each occasion — approximately 142 — unless indicated otherwise.

Syringe exchange schemes: an overall assessment

Syringe exchange was launched at considerable speed in a situation where urgent measures were (and still are) needed to prevent the spread of HIV, and where little was known about the operation and impact of such a service. Given the known link between syringe sharing and HIV transmission, the strategy aims to interrupt transmission at the key point where infection is possible. It has considerable potential as a relatively simple and cheap measure for preventing HIV infection. Like most social interventions, it also has potential negative effects.

When it was first introduced some people had expected syringe exchange would be the major intervention that would help drug injectors change their behaviour. Expectations were possibly higher than for any other strategy for helping drug users, meaning syringe exchange has been assessed against extremely high standards. Yet, compared with some other approaches to helping drug users (for example, many treatment programmes), syringe exchange is still in its infancy in terms of service development and the volume of research evidence.

▷First, what we *don't* know. We do not know the impact of supplying syringes on the prevalence of injecting drug use nor how the advent of syringe exchanges has affected the demand for treatment: the data needed to make these assessments is not available. This lack also limits our assessments of other AIDS prevention strategies.

▷We also do not know the impact of syringe exchange on the HIV status of clients. For various reasons (the timetable for the evaluation, the possible deterrent effect of testing, and the possible low uptake of testing) it was unlikely that the HIV test data could have been easily interpreted. We also do not know how having a syringe exchange affects HIV rates among injectors in the local community.

▷What we *do* know is that the results are encouraging and support the argument that drug injectors can be helped to make small changes in their behaviour which could be of cumulative importance in reducing the spread of HIV. Whether the changes are large enough for this to happen remains to be seen.

THE EVIDENCE appears to be that syringe exchange:

— reaches injectors who are not in touch with other services;

— does this at reasonable cost;

— is delivered in a way that is acceptable to most clients; and

— helps some drug injectors maintain low risk behaviour and some others to adopt it.

There are areas in which syringe exchange needs to be developed (to be expected in any innovative service) and it will not be suitable for reaching all drug injectors. Finally, syringe exchange has considerable potential as a low threshold contact point for drug injectors within an overall preventive and helping response. ■

The Monitoring Research Group's earlier ***Druglink*** reports dealt with the operation of the pilot exchange schemes (***Druglink***, May/June 1988) and with the HIV risk behaviour of clients at first attendance. (***Druglink***, July/August 1988).