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INTERNATIONAL JOURNAL OF **DRUG POLICY**

1995 VOL 6 NO 1

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NEEDLE EXCHANGE AND BLEACH DISTRIBUTION PROGRAMMES: THE AUSTRALIAN EXPERIENCE

Alex Wodak, Alcohol and- Drug Service, St Vincent's Hospital, NSW, Australia

INTRODUCTION

HIV/AIDS presents a major challenge to the international community. There is much to be learned from both positive and negative experiences of other countries. This article describes the current state of the HIV epidemic among injecting drug users (IDUs) in Australia. The Australian response to the HIV epidemic has been deservedly praised. Favourable comments have been made by international experts as well as local, independent, public health practitioners. When originally presented as a paper at a Workshop on Needle Exchange and Bleach Distribution Programmes, the aim was to present the Australian experience to an American audience to assist efforts to slow the spread of HIV infection among and from IDUs in the USA. Comparisons between the two countries have been drawn even if these appeared to be unflattering to the nation generously hosting the meeting. The temptation to echo anodyne and diplomatic platitudes was resisted. It was hoped that critical comments would be accepted as being offered in good faith and in the interest of protecting public health.

There are at least two very important connections between Australia and the USA that are relevant to this article. All of the earliest cases since the first case of AIDS was diagnosed in Australia in 1982 were homosexual/bisexual males who had lived for some time in the USA. Also, New York was the first city in the world to attribute a large proportion of AIDS cases to IDUs. From an Australian perspective, the response to this challenge seemed curiously minimal. The notion of 'preventing another New York' occurring in an Australian city was often discussed when responses to the threat of an IDU related epidemic in Australia were being developed. Australia learned from the negative US experience to the extent that Sydney has been included in a study of 'prevented' HIV epidemics among IDUs together with Glasgow (Scotland), Lund (Sweden) and Wacoma (Washington State) (DC Des Jarlais, unpublished data).

EPIDEMIOLOGY

HIV infection

There is a large and consistent body of evidence which indicates that HIV infection is still relatively uncommon in Australian IDUs. These data include published and unpublished HIV seroprevalence surveys of IDUs. A recent review (Kaldor et al., 1993) of all published HIV seroprevalence surveys indicates that prevalence of less than 5% has been found consistently in female and heterosexual male IDUs, although prevalence is far higher among homosexual/bisexual male IDUs. Seven studies published between 1985 and 1991 reported prevalence values of HIV of 1%, 4%, 5%, 1%, 3%, 2% and 4% among IDUs after excluding homosexual/bisexual males (Kaldor et al., 1993).

These findings are supported by HIV test results of prison entrants in several jurisdictions which continue to be well under 1%. HIV seroprevalence among prison entrants in New South Wales was only 0.59% inspite of an AIDS incidence of 35 7.9 per million. In Victoria, HIV seroprevalence among prison entrants was 0.47%. It is generally assumed that more than 50% of prison inmates in Australia are serving time for drug-related offences and an even higher percentage are IDUs. Anecdotal information from testing laboratories is also consistent with a low prevalence of HIV infection among IDUs. A low prevalence of HIV infection has also been reported in a number of studies of prostitutes.

The number of new diagnoses of HIV infection nationally was estimated to be about 1201 in the year to 31 March 1992 and 1031 in the year to 31 March 1993 (National Centre in HIV Epidemiology and Clinical Research, 1993). Of cases with a documented known exposure category among the 17 068 new diagnoses of HIV infection cumulative to 31 March 1993, 81.9% were attributed to male homosexual/bisexual contact, 2.8% to male homosexual/bisexual contact and IDU and 4.9% to IDU alone. It is estimated that there were only 600 new HIV infections nationally each year in the period 1989-1990 (National Centre in HIV Epidemiology and Clinical Research, 1992). These trends are shown in Figure 1.

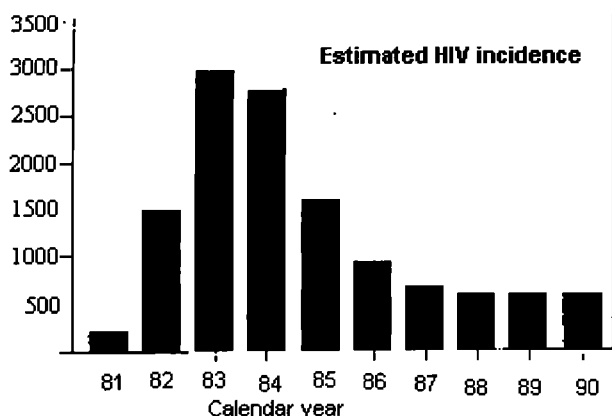


Figure 1: Estimated incidence of HIV infection in Australia, 1981-1990 for selected back back projection model. Source: National Centre in HIV Epidemiology and Clinical Research, National Working Group on HIV projection: Estimates and Projections of the HIV Epidemic in Australia, 1981-1994. Internal Technical Report 1, April 1992, Figure 3, p. 26.

AIDS data

A cumulative national total of 4102 AIDS cases (including 4073 people over the age of 13) had been reported up to March 31 1993, representing a caseload of 23.6 per 100 000 (National Centre in HIV Epidemiology and Clinical Research, 1993). Of the cases in adults, 3462 (84.4%) were homosexual/bisexual males, 128 (3.1%) were homosexual bisexual male IDUs, and only 78 (1.9%) were female or heterosexual male IDUs with an additional 405 (9.8%) consisting of heterosexuals, haemophiliacs, recipients of blood transfusions or blood products or undetermined. These data are consistent with seroprevalence data suggesting that HIV has not yet become established in heterosexual IDUs in Australia.

Comment

The low prevalence of HIV infection in IDUs in Australia allows multiple interpretations including late entry of HIV into the IDU population, limited pool of infection in other risk groups, limited overlap between risk groups, substantial spread remaining undetected and serendipity. All of these possibilities can be effectively discounted except the last. HIV infection has been present in the heterosexual IDU population in Australia since at least 1985 when one of 200 Sydney IDUs in drug treatment, a heterosexual male from the USA (resident in Australia for about a decade), tested seropositive but several of his sexual and needle contacts were HIV infected (Blacker et al., 1986). The area most associated with drug use in Australia is in eastern Sydney and is also associated with a very large community of homosexual/bisexual males constituting the national epicentre of the HIV epidemic. The geographical overlap of these two populations makes the low prevalence of HIV among Australian IDUs all the more remarkable. The gay community in Sydney has long maintained close links with the gay community in San Francisco. Not surprisingly, HIV entered the gay population of Sydney relatively early.

A steep gradient of HIV infection has been observed in a study of 1245 Sydney IDUs in 1989 (Ross, 1992) with 3.2% of heterosexual male, 12.1% of homosexual/bisexual male and 35.4% of homosexual male IDUs infected with HIV, suggesting that HIV entered the IDU population from homosexual/bisexual male IDUs. As 5.6% of male IDUs were homosexual and 13.1% were homosexual/bisexual (ANAIIDS, 1991), there was clearly considerable overlap with non drug-using homosexual populations.

The course of the HIV epidemic in Australia differs from that of many other Western countries in that a significant IDU component has not yet occurred. The first case of AIDS was diagnosed in Australia in 1982. In the early 1980s, Australia had a high per capita incidence compared with other OECD countries. In 1983, Australia ranked fourth among developed countries in terms of AIDS cases per capita with 1.1 cases of AIDS per 100 000 population. By 1991, Australia had slipped to sixth place with 16.6 cases per 100 000 being overtaken by Spain (23.3) and Italy (17.2). Both Italy and Spain have experienced an explosive spread of HIV infection among IDUs who now represent over 60% of all AIDS cases in those countries. If Australia had still retained fourth highest ranking of AIDS cases per capita among developed countries, this would mean that instead of 4073 cases of AIDS, as of 31 March 1993, 5717 AIDS cases would have been expected. Of all known AIDS cases in Australia at present, 64% have died. There are therefore an estimated 1052 Australians alive today because the epidemic appears to have run a different course in Australia than some other countries. The major difference has been the absence of an epidemic in IDUs. If the medical management of each AIDS case in Australia cost A\$50,000, and a figure of A\$100 000 is far more realistic, this represents a saving of 1644 AIDS cases, 1052 lives and A\$53 000 000.

It is reasonable to conclude that HIV entered the Australian IDU population early, that substantial HIV infection is present in other risk groups, that there is substantial overlap between IDUs and other risk groups, and that substantial undetected spread of HIV among IDUs can be discounted. Accordingly, the most parsimonious conclusion is that the course of the epidemic has been altered compared with other countries.

POLICY RESPONSE

AIDS was identified as a priority issue early in the epidemic. A National AIDS Task Force was established rapidly. A highly controversial national advertising campaign in 1987 on a 'Grim Reaper' theme succeeded in its aim of raising awareness of AIDS as an issue. The Health Minister at the time described AIDS as 'the greatest threat to public health in Australia since Federation' (i.e. 1901). The role of prevention was given particular emphasis and the need to maintain control of HIV among IDUs was well accepted (Wodak, 1992). Prevention strategies were identified early, adopted with broad support and implemented vigorously. IDUs (and other high-risk groups) were involved in the identification of prevention policies and their implementation. Parliamentary all-party AIDS committees were established at Federal and State levels with explicit agreement to refrain from party political conflict. A national drug policy of minimisation of harm had been declared in 1985 at a meeting of the Prime Minister and State Premiers, and facilitated the adoption and implementation of sensitive HIV prevention strategies even though AIDS had not influenced consideration of the original drug policy. The Prime Minister's wife set a prominent example in the mid-1980s indicating that discrimination against people with HIV infection was unacceptable.

The Prime Minister's wife also launched a 'Never ever share needles' pamphlet in December 1987. This campaign made no mention of abstinence from drug use. It was well known that one of her daughters had been an IDU and this endorsement of harm minimisation by such a prominent member of the community was a critical development in the nation's response to the impending threat of an epidemic. IDUs became aware of the hazards of needle sharing

before HIV had gained a substantial foothold in this population.

In 1989, a National HIV/AIDS Strategy was agreed following lengthy consultation (Department of Community Services and Health, 1989). This document endorsed needle and syringe exchange and distribution programmes, and resulted in policy and financial commitments covering a 3-year period. In 1991 it was noted that:

'programs for IDUs receive a larger share (37.4%) of total education and prevention funding . . . than programs for any other target group. Funding grew substantially in all States and Territories from 1989-90 to 1990-91 with a 36% increase overall.'

Inter-Governmental Committee on AIDS (1992)

Adoption of HIV prevention measures within prisons, however, has been slow, difficult and incomplete. A communiqué covering strategies to prevent the spread of HIV in prisons was unanimously endorsed at a national conference in November 1990 (Douglas, 1991) but has had little effect.

NEEDLE AND SYRINGE EXCHANGE PROGRAMMES (NSEPs)

Development and expansion

A vigorous and at times acrimonious debate about needle and syringe availability as a prevention strategy took place in 1985-1986 with covert support for implementation coming from senior political and Health Department figures. A pilot (illegal) programme was established in Sydney in November 1986. In December 1986, the New South Wales Department of Health established a drug store-based needle and syringe distribution scheme with NSEPs set up from 1987. All other jurisdictions (except one) rapidly established drug store schemes and NSEPs. The last jurisdiction to introduce needle and syringe exchange has permitted NSEPs to be established unofficially while waiting for some years for the appropriate legislation to be passed. Sterile injecting equipment has been readily available in all major cities and large towns in Australia since 1988-1989 (Table 1). Providing NSEP services to rural IDU populations has often been difficult because of logistical problems and the more conservative nature of small towns.

Several years were required for most NSEPs to reach maximum through-put and begin to achieve efficiencies. For example, an NSEP in western Sydney recently increased its throughput more than ten times (from 3000 to 40 000 units per month) over a 2-year period within a constant budget by building up a fixed outlet at the expense of a mobile unit. A survey in October 1992 of 43 clients of this service found that 84% rated the service as excellent with the remaining 16 rating it as good (Duckett et al., 1993). The cost of distribution per unit declined from A\$2.86 in 1991 to A\$1.04 in 1992 and is expected to decline to A\$0.96 in 1993-1-99.4. Similar trends are occurring elsewhere in the country. In some places, mobile units operate from cars with paging devices or portable telephones. This presents a difficult balance between the higher unit cost of providing mobile NSEPs and the need to service more vulnerable and less mobile populations. Mobile units were recently scrapped in one state as a cost cutting exercise.

It is difficult to estimate the quantity of injection equipment made available in Australia each year but it is likely that at least 3-4 million sterile needles and syringes are distributed or exchanged each year. In 1991, New South Wales (population 6.5 million) had 32 primary and 90 secondary outlets while Victoria had 102 outlets (Inter-Governmental Committee on AIDS, 1992).

Table 1.

	Median	Mean	s.d.	n
Sydney	95.0	84.3	20.7	1225
Brisbane	50.0	58.6	27.6	582
Perth	90.0	83.4	20.0	194
Melbourne	75.0	72.0	24.4	349

Percentage of new needles and syringes easily obtained in four cities (1989)

ANAIUDS (1991) H1>Unintended negative consequences

After 6 years of NSEP in Australia, there have been relatively few unintended negative consequences. Littering of public places with discarded used equipment was briefly an issue which threatened to jeopardise (then) fragile public support. This problem was overcome by a series of measures including specialised collection of used equipment, special disposal bins and the marketing of specially developed plastic boxes ('Fitpack') which contain sterile equipment and a tamper-resistant device for retaining used equipment. The Fitpack was designed with the assistance of members of a government-funded drug users' organisation. Staff of NSEPs have been detected using these facilities also to distribute illicit drugs on two occasions. In one state, an NSEP was operated by a government-funded organisation of drug users. Following allegations of embezzlement, the operation was handed over to a government agency (with subsequent decline in through-put). A study of urine analysis specimens obtained from two methadone units, one of which was immediately adjacent to a pilot NSEP, concluded that sterile needle and syringe availability did not appear to increase the frequency of drug use in patients of methadone programmes (Wolk et al., 1990).

Table 2: Usual source of new needles and syringes (n = 2422)

	Source (%)	Response (%)
Drug store	47.9	70.9
Needle exchange	22.0	32.6
After hours drugstore	14.3	21.2
Using friends	9.21	3.6
Non-using friends	1.2	1.8
Hospitals	1.2	1.8
Dealers	1.1	1.6
Doctors	0.9	1.4
Veterinary surgeons	0.5	0.8
Other	1.7	2.5

ANAIIDUS (1991)

EVALUATION

The mean frequency that sterile needles and syringes were used by IDUs (n = 2451) when injecting drugs ranged in four cities in 1989 from 69.1% to 79.6% with the overall mean for respondents being 72.6% (ANAIIDUS, 1991). Respondents were also asked 'how easy do you think it is to obtain new (sterile) needles and syringes at the present time?'. The mean percentage of the time respondents in three cities in 1989 who reported finding it easy to obtain new injecting equipment ranged from 72.0% to 84.3%.

The Queensland government introduced exchange and distribution schemes after the other states and thus availability in Brisbane lagged behind other cities in the study. Male respondents found it significantly easier to obtain equipment than female respondents (ANAIIDUS, 1991).

The importance of drug stores as outlets was emphasised in responses to the question 'where do you get your new needles and syringes?'. Drug stores, NSEPs and after hours drug stores were the most important sources (Table 2).

The mean number of needles and syringes obtained in the most typical using month (n = 2422) in 1989 was 54.2 + 91.6. The most important time to obtain equipment was mid-afternoon to midnight with the period 9 p.m. to midnight being especially important (ANAIIDUS, 1991). When asked to indicate how needles and syringes could be made more available, a range of responses was obtained but more drug stores selling needles and syringes, vending machines, and special needle and syringe exchanges were the most common answers received (ANAIIDUS, 1991).

Availability of injection equipment had further improved in two of the cities 12 months after the original data collection (ANAIIDUS, 1992), with the mean number of respondents reporting that it was easy to obtain new equipment in Sydney increasing from 84.3% to 93.0% (Table 3). Drug stores were still the major source of new equipment but NSEPs were nominated as a more important source than 12 months earlier.

Needle and syringe exchange schemes have broadened the scope of their activities without diminishing the enthusiasm of their staff. They now often prefer to be known as HIV prevention units and in some areas have become involved in AIDS co-ordination and HIV prevention advocacy. Vending machines have been introduced in small numbers but are still undergoing evaluation. Their introduction took much longer than anticipated. Vending machines are unlikely to ever replace NSEPs but are being used to provide an affordable 24-hour service in areas with a particularly high incidence of drug use.

IDUs who usually attended NSEPs or drug stores to obtain sterile injecting equipment were compared (Wodak A, Stowe A, Dolan K, Ross MW, Gold J, unpublished data). Discriminant function analysis correctly allocated 75% of respondents. Those whose usual source of supply was NSEPs obtained more than twice as many needles and syringes per month, injected alone less frequently, were more likely to reside in the inner city than outer suburbs, injected with new needles and syringes more frequently than those whose usual source was drug stores, and were less likely to be in drug treatment. NSEP attenders reported that they found it more easy to obtain injection equipment a significantly greater percentage of the time, were younger, less likely to inject with a needle and syringe used by someone else, and spent more money on drugs per week than respondents whose usual source of supply was drug stores. Almost twice as many drug stores as NSEP attenders were employed (although unemployment was common in both groups). NSEPs attracted a greater proportion of women. These data suggest that some IDUs were deterred from obtaining injection equipment from drug stores by modest prices, whereas others in drug treatment prefer to obtain their equipment from the (presumably) more anonymous setting of a drug store. Different kinds of IDUs appear to use different kinds of needle and syringe outlets.

Legal impediments to HIV prevention have recently been comprehensively reviewed including obstacles to NSEP operation (Inter-Governmental Committee on AIDS, 1992). The Legal Working Party made recommendations covering repeal of self-administration and other offences, the need for more non-custodial sentencing options and supported further research including the investigation of drug policy reform. **TABLE 3: Percentage new needles and syringes easily obtained in two cities, 1990**

	Median	Mean	s.d.	n
Sydney	99.0	93.0	14.3	544
Perth	90.0	85.5	17.1	148

ANAIIDUS (1992)

NON-NEEDLE AND SYRINGE PROGRAMMES

During the 1980s, considerable efforts were made to develop effective policies and review progress. In more recent years, the attitude that the epidemic of

HIV among Australian IDUs has been prevented has become commonplace and is often accompanied by a sense of complacency.

Explicit education campaigns directed to IDUs began in 1987. A number of education campaigns have been conducted including mass-campaigns which may have also contributed to the broad support existing for HIV prevention activities. Homosexual and homosexual/bisexual male IDUs have been specifically targeted in education campaigns. Social marketing approaches have been used to raise and maintain a high level of awareness about HIV/AIDS in sub populations of IDUs. A low level campaign targeting homosexual male IDUs has been running in NSW for some years using the slogan:

'FIT FOR A QUEEN. NEW OR CLEAN.'

Expansion and improvement of drug treatment began in 1985 with national methadone capacity increasing in the last 8 years more than six times. The most rapid expansion of methadone capacity has occurred in NSW (Gaughwin et al., 1993) which has 34% of the national population and almost 60% of the nation's AIDS cases. The national methadone guidelines have been revised a number of times in recent years in an effort to liberalise programmes to increase their attractiveness, improve retention rates, reduce costs and assist national efforts to contain HIV infection in IDUs. The unit cost of providing methadone programmes has been falling in real terms and is now about A\$ 1200 per person per year. Other modalities of drug treatment have also been

expanded and improved. AIDS research is regarded as a priority area and is still funded separately.

Organisations of IDUs have been established in most jurisdictions with government support and funding. The Australian Prostitutes' collective was established in 1985. IDU representatives are invited actively to participate in policy development and implementation.

National efforts were made to increase bleach availability and use. Many NSEPs had difficulty distributing bleach to IDUs because sterile injection equipment was so available that there was little interest in obtaining alternatives. Since the biological effectiveness of bleach as a decontamination agent began to be questioned publicly in the USA in 1993 (National Institute on Drug Abuse, Community Alert Bulletin, March 1993), the wisdom of advocating bleach decontamination has been reviewed. Decontamination practices of IDUs in Australia fall far short of acceptable and are a further reason for reviewing exhortations to IDUs to use bleach.

EVALUATION

There is some evidence that high-risk injecting practices are becoming less common but, as in other countries, baseline levels of unsafe injecting practices were very high and unsafe sexual practices appear to have declined only slightly. HIV prevention policies are widely regarded as having successfully prevented the spread of HIV among IDUs, although rigorous scientific proof of their effectiveness is unavailable, probably unobtainable and was wisely not regarded as a prerequisite for adoption and expansion of prevention programmes. HIV prevention policies for IDUs continue to have very strong community and political support.

In 1989, one-sixth of a Sydney sample (17%) were at low risk of HIV infection because they had never shared injection equipment, cleaned injecting equipment effectively 100% of the time it was shared, and were celibate, monogamous or had not had unsafe sex in the last 6 months (Wodak et al., 1995). Half (51%) had either unsafe injecting or sexual behaviour, with the remaining third (33%) engaging in both unsafe injecting and sexual practices. Comparison of two large and consecutive (1989 and 1990) samples of Sydney IDUs recruited in non-treatment settings were consistent with major risk reduction (Ross et al., 1995) (Table 4).

These data are drawn from two cross-sectional samples and therefore the possibility that the differences observed were the result of sampling cannot be discounted. Nevertheless, the strength and consistency of the behavioural differences, the similarities in demographic characteristics and drug use of the two samples, and the similarity of findings in comparable studies in other countries suggest that these behavioural differences are real. They are all the more remarkable when it is considered that the two samples were recruited less than 12 months apart.

Attributing benefit to any single intervention is impossible when multiple strategies have been implemented at about the same time, the intensity of implementation is difficult if not impossible to measure and the effect of interventions is in all likelihood synergistic. In a categorical sense, these methodological problems cannot be resolved without a controlled trial of communities randomly allocated to a single intervention or no intervention. The ethical, logistic, financial and public health problems of attempting such a study are such (Des Jarlais and Friedman, 1993) that there is no alternative, especially given the urgency of the epidemic, to making a judgement on the grounds of plausibility, feasibility, cost and international experience. At issue is whether authorities in a particular country prefer to be roughly right or precisely wrong. Australian authorities, perhaps reflecting a characteristically pragmatic and non-ideological national approach, preferred the former option. So too did most other developed countries.

LOOMING PROBLEMS

Hepatitis C and other blood-borne viruses

Continuing high levels of unsafe injecting practices and international spread of the HIV epidemic within and to an increasing number of countries suggest - that complacency about the possibility of future spread of HIV among (and from) Australian IDUs is unwarranted. There is increasing concern in Australia that the magnitude of the hepatitis C (HCV) epidemic and its consequences has been seriously underestimated.

High incidence levels of HCV in Australian IDUs, especially young IDUs, evidence of annual incidence rates for hepatitis B and C of between 10% and 20% in Victorian inmates with more than one occasion of prison entry (Crofts and Wodak, 1993), and recent estimates that there are five times more people in Australia infected with HCV than HIV and at least a 15 times higher incidence of HCV than HIV (Crofts et al., 1993), may lead to a reassessment of the public health threat of IDU related blood-borne viruses. Evidence of continuing high incidence levels of hepatitis B and C among IDUs in Australia also indicates the potential for spread of other blood-borne viruses including HIV.

Although the morbidity and mortality associated with HIV exceed that of HCV, the much larger pool size and higher incidence of HCV in Australia suggest that far more attention should be directed in the future to the containment of blood-borne viruses in addition to HIV. It is estimated that about 20% of HCV-infected individuals will develop cirrhosis within 20 years with up to 5% developing hepatocellular carcinoma.

Prisons

There is some evidence that HIV spread in prisons has been underestimated in terms of documented seroconversions. The relatively short mean duration of

imprisonment in relation to the 'window period' for seroconversion suggests that entry-exit testing of HIV infection underestimates the extent of the problem. A network of IDUs who became infected with HIV while in prison is currently being investigated with at least one of these cases being virtually certain (K. Dolan, personal communication). There are about a dozen published cases of HIV infection in prison world-wide but none of these cases can be regarded as definite.

IDUs enter correctional facilities from diverse geographical and social backgrounds. They usually remain within correctional facilities for relatively brief periods during which time they are often moved frequently, mixing with many other prisoners. In contrast, unsafe injecting practices among

IDUs in the community are increasingly restricted to small social networks. HIV infection within such a network has far less public health impact than infection of a prison inmate with the potential for wide dissemination of HIV within correctional facilities and subsequently following release.

Unsafe injecting practices in prison are less frequent than in the community but may be more hazardous for several reasons. Injecting equipment is less available in prison and is therefore likely to be shared between a larger number of partners. Bleach is also less available inside prison. Drug injecting and equipment decontamination are also likely to be more furtive with less opportunity to carefully decontaminate injecting equipment.

Evidence of an unofficial needle and syringe exchange programme successfully conducted for almost a year in several prisons in NSW has emerged recently and has been presented to a committee of enquiry. This unofficial strictly 'one for one' trial involved over 100 prisoners and was conducted by an HIV-infected prisoner with covert assistance from some health professionals and possibly with the knowledge of some correctional staff. The existence of a prison NSEP lasting almost 12 months raises the possibility of considering this intervention more widely at a time when the effectiveness of current decontamination strategies relying on bleach have been called into question.

In 1990, an HIV infected prisoner stabbed a NSW prison officer with a syringe filled with the inmate's blood. The prison officer seroconverted over the next months becoming the first documented case of occupational exposure of a prison warder. It is anticipated that recommendations to consider a pilot NSEP in an Australian prison will therefore meet much resistance and accordingly should not be supported at the risk of endangering more likely interventions.

PROHIBITION UNDER INCREASING SCRUTINY

The Australian experience with HIV prevention among IDUs has stimulated a more critical appraisal of prohibition. There has been increasing support for the view that prohibition is expensive, ineffective, counterproductive and impairs the effectiveness of efforts to control the spread of HIV. The number of influential members of the community calling for a review of drug policy in recent years has been steadily growing. The Australian Parliamentary Group for Drug Law Reform was established in 1993 and includes representatives of the major parties, with members drawn from Commonwealth, State and local levels of government.

A debate about the fundamental nature of drug policy has been slowly intensifying with fundamental reform strongly supported by many leaders of the medical and legal professions and most doctors involved in delivering HIV prevention or treatment services. The National Centre for Epidemiology and Population Health, Canberra is investigating the possibility of a trial of controlled availability of currently illicit drugs and was awarded a grant of A\$0.5 million by the Australian National University to further this work. This trial followed from a recommendation made by an Australian Capital Territory Legislative Assembly official enquiry into HIV, illicit drugs and prostitution.

Whether a debate about drug policy reform would have developed in the absence of adoption of needle and syringe exchange programmes is arguable. However, the fact that liberalisation of availability of injection equipment has been so beneficial, and virtually unaccompanied by unintended negative consequences, has certainly drawn attention to the lack of evidence of effectiveness, high costs and major adverse consequences associated with prohibition.

Prohibition is seen by some to keep street drug prices high and purity of street drugs low, and thus reduce the possibility of IDUs making a transition to non-parenteral modes of administration. Prohibition also delayed the adoption and slowed expansion of NSEPs and also impeded the implementation of many other programmes needed to control the HIV epidemic.

RELEVANCE TO OTHER COUNTRIES

These conclusions may be of interest to other countries especially those which share many similar characteristics such as the USA. However, the many major differences between Australia and the USA must also be borne in mind.

The USA and Australia were both colonised by Great Britain. When the USA declared independence, Great Britain lost a favoured storage site for surplus prisoners. The search for a new gulag led to the establishment of a colony in Australia. The two countries have similar political systems and the curses and blessings of a federal system of government. The Australian political system is sometimes referred to as Westminster, reflecting the debt to both Westminster and Washington. The USA and Australia have been parliamentary democracies without interruption. English is the main language spoken in both countries. The area of the continental USA is only fractionally larger than Australia. Both countries have populations drawn from diverse cultures. US drug policies have been a dominant influence on Australia drug policies since soon after the turn of the century. In both countries, the drug policy is essentially prohibition, although this takes a kinder and gentler form in Australia.

However, there are many differences between Australia and the USA. Australia has only about 6% of the population of the USA. Like most other Western countries, Australia has a universal health care system. A policy of harm minimisation for illicit drugs has been adopted at the highest political level in Australia. This policy states that the aim 'is to minimize the harmful affects of drugs on Australian society'. In contrast, US drug policies have been dominated (explicitly) by attempts to reduce drug use. Although poverty and severe social disadvantage exist in both countries, Australia has never had a large urban under class as is seen in a number of

major US cities. Furthermore, policy-makers and injecting drug users in Australia come from the same racial group and speak the same language. Moreover, injecting drug users and policy-makers in Australia are in contact with one another. In recent years, some injecting drug users have been employed on Government projects because they were currently injecting drug users.

Social policies are markedly different in Australia and the USA. In Australia, abortion is readily available and ceased to be an issue several decades ago. Capital punishment was last carried out decades ago. In 1992, it was decided that sexual orientation of male and female military recruits would no longer be taken into account (in spite of the strenuous opposition of the military). All Australian jurisdictions have laws restricting the availability of guns which are much stricter than in the USA. Crime rates and rates of imprisonment are much lower in Australia than in the USA.

In most Western countries, including Australia, the questions policy-makers ask about the availability of sterile injection equipment for injecting drug users is not whether this is a legitimate strategy to prevent the spread of HIV infection or even whether this policy contributes to improved control of the epidemic. Improving the availability of sterile injection equipment is assumed to make a most important contribution to the control of the epidemic even in the absence of categorical proof. In Australia, the standard of proof required for evaluating the contribution of needle and syringe exchange programmes to improve control of the epidemic was commensurate with the speed of spread of the epidemic and the magnitude of the consequences of an uncontrolled epidemic.

The critical question for policy-makers in Australia regarding needle and exchange is how needle and syringe availability can be implemented more effectively and at lower cost. There is a strong desire to focus on improving availability particularly for groups of major public health importance such as homosexual/bisexual male injecting drug users. After seven years of needle and syringe availability, political, bureaucratic and community support is still overwhelming.

Alex Wodak, Alcohol and Drug Service, St Vincent's Hospital, NSW, Australia. REFERENCES: Australian National AIDS and Injecting Drug Use Study (ANAIUDS) (1991). Neither a borrower nor a lender be. First Report of the Australian National AIDS and Injecting Drug Use Study, 1989 Data collection. Sydney. Australian National AIDS and Injecting Drug Use Study (ANAIUDS) (1992). Not in a Fit. Third Report of the Australian National AIDS and Injecting Drug Use Study, 1990 Data collection. Sydney.

Blacker P, Tindall B, Wodak A, Cooper D (1986). Exposure of intravenous drug users to AIDS retrovirus, Sydney, 1985. Australia and New Zealand Medical Journal 16: 685-90. Crofts N, Wodak A (1993). Prevalence, carriage and incidence of HCV among IDUs in Australia [abstract]. National Symposium on Hepatitis C. St Vincent's Hospital, Melbourne, 8 October.

Crofts N, Hearne P, Stewart T, Breschkin AM, Locanini SA (1993). HCV among prison entrants in Victoria [abstract]. National Symposium on Hepatitis C. St Vincent's Hospital, Melbourne, 8 October.

Department of Community Services and Health (1989). National HIV/AIDS Strategy. A policy information paper. Australian Government Publishing Service, Canberra.

Des Jarlais DC, Friedman SR (1993). Research. In: J Stryker, MD Smith (Eds), Dimensions of HIV Prevention: Needle Exchange, pp.63-75. Menlo Park: The Kaiser Forum.

Dolan, K, Hall W, Wodak A, Gaughwin M (1994). Evidence of HIV transmission in an Australian prison (letter). Medical Journal of Australia 160: 734.

Douglas R (1991). AIDS in Australian prisons. What are the challenges? In: J Norberry, M Gaughwin, S-A Gerull (Eds), HIV/AIDS and Prisons, pp. 23-30. Australian Institute of Criminology, Canberra.

Duckett M, Moore T, Ramsay J, Wodak A (1993). Review of Western Sydney HIV/AIDS prevention and Outreach Service. May, 1993.

Gaughwin M, Kliever E, Ali R, Faulkner C, Wodak A, Anderson G (1993). The prescription of methadone for opiate dependence in Australia, 1985-1991. Medical Journal of Australia 159: 107-8.

Inter-Governmental Committee on AIDS (1992). The final report of the legal working party of the Inter Governmental Committee on AIDS. Australian Government Publishing Service, Canberra.

Kalder J, Elford R, Wodak A, Crofts JN, Kidd S (1993). HIV prevalence among IDUs in Australia: a methodological review. Drug and Alcohol Review 12: 175-84.

National Centre in HIV Epidemiology and Clinical Research (1992). National Working Group on HIV projections: Estimates and Projections of the HIV Epidemic in Australia, 1981-1994. Internal Technical Report 1 April.

National Centre in HIV Epidemiology and Clinical Research (1993). Australian HIV Surveillance Report 9(3), July.

National Institute on Drug Abuse (1993). Community Alert Bulletin, March. Inter-Governmental Committee on AIDS. Report on HIV/AIDS in Australia 1993. Australian Government Publishing Service, Canberra.

Ross MW, Wodak A, Gold J, Miller ME (1992). Difference across sexual orientation on HIV risk behaviours in injecting drug users. AIDS Care 4: 139-48.

Ross MW, Stowe A, Wodak A, Gold J (1993). Changes in equipment sharing in injecting drug users in Sydney 1989-1990. Drug and Alcohol Review 12: 277-81.

Wodak A (1992). HIV infection and injecting drug use in Australia: responding to a crisis. Journal of Drug Issues 22: 547-60.

Wodak A, Stowe A, Ross MW, Gold J, Miller ME (1995). Extent of HIV risk exposure of injecting drug users in Sydney. Drug and Alcohol Review in press.

Wolke J, Wodak A, Guinan J, Macaskill P, Simpson JM (1990). The effect of a needle and syringe exchange on a methadone maintenance unit. British Journal of Addiction 85: 1445-50.