Drug policy and the HIV epidemic

Address by Tomas Hallberg in Geneva 19-20 December 2005

Let’s start with a little lecture in geography. There are some 9 million inhabitants in Sweden. Stockholm, the capital, has some 750 000 inhabitants and Gothenburg around half a million. The city of Malmö has 250 000 inhabitants and Lund some 100 000. This can be good to know in order to put the figures I’m going to present in a proper context.

Sweden was the first country in Western Europe to be struck by intravenous abuse of drugs of the epidemic type. Amphetamine was classified as narcotic drug already in 1944. In 1965, the number of amphetamine abusers was estimated to approximately 4000, and in the autumn of 1968 the estimate was 10 000. (1) The knowledge of what happened during this time is important for understanding the debate on needle exchange programs we have had in Sweden for almost twenty years.

In the beginning of the 1960ies, the Swedish newspapers started to write more and more about the increasing drug abuse in the country. Several major debaters propagated liberalisation of drug legislation, and allowing legal prescription of amphetamine. This also happened, with the result that the number of amphetamine abusers doubled within a couple of years. In 1967, the legal prescription of amphetamines was stopped, and a period of increasingly restrictive drug policies followed. Sweden developed a drug policy based on UN conventions with prohibition of all handling with illegal drugs. In 1988, a law was introduced which prohibited being under influence of drugs. Care and treatment was focused on abstinence, supported by compulsory legislation and prevention programs based on zero tolerance towards drugs.

The empirical experience of the failure of the 60ies experiment was one of the reasons behind the political attitude towards needle exchange at the time the HIV epidemic was first discovered in 1985.

AIDS is more dangerous than drugs, was one of the basic arguments for distributing needles to drug addicts. The same organisations, and to a certain extent the same individuals who had supported legal prescription, now raised their voices in the debate.

One of the opponents to needle exchange was the then Minister of Social Affairs Gertrud Sigurdson. She also was the Chair of the national AIDS delegation. She was heavily criticized when she, in a debate article in 1987, declared that the former predictions that 200 000 people in Sweden might become HIV-infected before 1990, were grossly exaggerated. Not even the prediction of 10 000 HIV-infected which the newspaper Expressen had published, was relevant. According to her, the figure should instead be 5000 or even lower. This was very much like swearing in church. (2)

Sigurdsson was amply proven right. It took additional 10 years before the number of 5000 HIV-infected was reached in Sweden. (3)
In spite of opposition at such a high level, two Swedish cities, first Lund and then Malmö, went against the legislation and opened clinics where drug addicts could change their used needles for clean ones. The clinics opened in 1986 and 1987. Both clinics were given legal status the year after, when the Board of Health and Welfare declared them to be trial projects.

Sweden therefore constitutes an interesting example with these two trials going on since almost 20 years, and a number of other cities as a control group for comparison.

Thus, it was the argument that Sweden was threatened by an approaching AIDS epidemic which brought the needle exchange trials into being. A massive HIV testing of intravenous drug addicts which started in 1984 and was further increased in 1985 led to the discovery of 262 HIV-positive intravenous drug addicts by the end of 1985 in Sweden. 250 of these had been tested in Stockholm. Malmö and Lund only registered a few HIV-infected intravenous drug addicts.

When we speak about an epidemic and the course it takes, it is important to recognise where it starts and how it spreads. HIV epidemic among intravenous drug addicts in Sweden is mainly a Stockholm phenomenon. Secondly, it is an imported problem, since a large part of this group (38% in 2003) became infected abroad. During the years after the outbreak of the epidemic, there are annually some 20 new registered cases of HIV-positives in this group, of which only a few in the rest of Sweden, and the rest in Stockholm.

Nevertheless it was in Lund and Malmö the needle distribution started. The advocates of these trial projects maintain that they have been very successful in fighting HIV among drug addicts, and point out that there have been only very few HIV-infected in the region.

A quick comparison with the city of Gothenburg, which shows even lower figures in spite that fact that they never had needle exchange, makes this argument fall flat on the ground. The same country, the same legislation, different methods with different results. Consequently, the low HIV-prevalence must depend on something else. The number of new registrations of in Stockholm HIV-infected among the IDU’s has during the years decreased to be less than ten. That Stockholm has higher figures than the rest of the country is logical, considering it was in Stockholm the epidemic started.

The Board of Health and Welfare has in several reports underlined the fact that there is no evidence of the needle exchange trials in Lund and Malmö having any effect on the spread of HIV among drug addicts in the region. Most people agree on that. Even several of the advocates of needle exchange programs are doubtful about their effect, but think that these projects should continue for other reasons.

Thus, the focus of the debate in Sweden has shifted. The advocates of needle exchange programs nowadays prefer to speak of humane care of drug addicts and that needle exchange clinics give a possibility to contact with the addicts and to offer them care and treatment. (4)

Why has the debate on needle exchange been so intensive in Sweden during all these years? In many other countries, there is no ground for similar debate because of the chosen drug policy. If drug use is allowed, objections can be raised that needle exchange programs are a waste of resources, or even charlatan, but if you think that it is up to each individual to abuse drugs, it is natural that you have fewer arguments against needle exchange.
In Sweden, use of illegal drugs is prohibited. The police has the right to arrest those suspected to be under influence of drugs, and those found guilty are fined. In Sweden, doctors, the police and social secretaries are requested to report those who are in danger of destroying themselves with alcohol, drugs or solvents, so they can be offered treatment. This is part of the compulsory legislation against drug abuse. Within the framework of this legislation it is possible to sentence the drug abuser to treatment for 6 months.

This is one of corner-stones of the Swedish humane, restrictive drug policy. There is an official consensus about the Swedish drug policy. However, there are of old a number of individuals who don't agree with this policy. They are against compulsory treatment of drug addicts, and counteract the law on prohibition against use of drugs. Many of these individuals have taken stance for needle exchange.

The conflict with the legislation is obvious. How can it be possible for authorities to give a syringe to a person who will use it for something that is against the law? How can it be possible for a doctor to distribute needles to heroin addicts in Sweden, when at the same time he/she is bound by law to report the addict for compulsory treatment? According to the legislation, in certain cases the addict should be taken to treatment immediately.

What in practical terms has happened in Malmö and Lund, is that the police has created a free zone for the drug addicts at and around the needle exchange clinics. The doctors responsible ignored the legislation by not reporting the addicts in needle exchange programs to compulsory treatment.

This conflict becomes all the more obvious, when still after 20 years there is no evidence that the trial projects have any effect on the HIV prevalence.

One can safely say that the advocates of the Swedish needle exchange programs in the middle of the 1980ies were wrong. The threat posed by HIV and AIDS among drug addicts in Sweden was far less serious than the threat posed by drug abuse itself. During the years, many times more drug addicts have died of and suffered from drugs than of HIV/AIDS. Those who pursued the line that the best way to counteract the spread of HIV among drug addicts is information, and testing combined with restrictive drug policies, were proven right.

The number of new registered HIV-positive intravenous drug addicts in Sweden is among the lowest in the world.

At this stage, the Swedish Minister for Public Health proposes that it should become free for each county council to introduce needle exchange programs. To be sure, certain requirements would have to be fulfilled, like that the programs must also be able to offer detoxification and treatment. The proposal will be put before the Swedish Parliament shortly, and will probably be adopted.

The conflict about needle exchange is serious for two reasons. Partly because many of those who advocate needle exchange do so as a means to pave way for softening and liberalizing drug legislation, and even legalising drugs. UN conventions prohibit all handling with drugs unless it’s for medical purposes. Free needles become a means of changing the drug addict’s status from illegal to legal. The free needle sticks a hole in the restrictive drug policy. The legalisation movement knows that. That is why the advocates of legalisation have kidnapped large parts of the HIV/AIDS movement.

A legalisation of drugs leads to more drug addicts, which leads to more people with risk behaviour, which leads to more risk of spreading various diseases.
The other very serious consequence is focusing on wrong issues. Instead of pursuing what works, that is offensive treatment of drug addicts with testing free of charge and counseling, and easy access to care and treatment, the resources are concentrated into a cheap and seemingly practical and visible solution.

Why doesn’t the theoretic model of clean needles to drug addicts as means to curb the spread of HIV work in reality? According to a survey among the clients to the needle exchange bus in Oslo, 75 % of drug addicts continued to share needles in spite of getting free, clean needles. Drugs are often abused in a group, which means that needles are shared for social reasons, or for getting more out of the dose. Furthermore it is usual to mix the doses in shared basins, which, and this is most important, may be the source of infection.

Also drug addicts have sex. A study conducted by the State Bacteriological Laboratory in the beginning of the 1990ies on infection channels among the drug addicts infected during the first years of the decade, indicated that almost half of those who initially reported infection through injection tools (5), in fact were infected heterosexually. Even more clear result can be found in a survey made in Florida in 2003, which shows that HIV prevalence (13 %) was the same among those who used heroin intravenously for less than four years, and those who only sniffed heroin (6).

The legalisation movement maintains that restrictive drug legislation is an obstacle to the fight against HIV. Sweden is an example of that it is possible to combine both prohibition and control with an effective HIV prevention among drug addicts.

I have followed the debate on needle exchange for almost 20 years. During the last 6 years I have studied the issue intensively. No studies have convinced me that distributing needles has any HIV-preventive effect. I have learned one thing however, and that is how important the issue is for the drug legalization movement. The same goes for propaganda for medical marijuana. The campaigners are not driven by their concern about sick people, but by the possibility to legalise cannabis.

George Soros, who in his book "Soros On Soros" writes that he wants to legalise all drugs except crack cocaine, has spent millions of dollars in both campaigns for needle exchange and for the so called medical marijuana.

Needle exchange follows its own logic. If you can give a clean needle to a drug addict, perhaps you should also control that he uses it in a correct way. To that end, so called safe injection rooms are opened, where authorities supervise the injection procedure itself. Having taking this step, it is not too far-fetched to think that authorities should also control the quality of what is injected with the needles, and move on to distribution of heroin (or other drugs). And finally, if narcotic classified substances are distributed to the addicts, there is no ground left for the prohibition.

Conclusion: Needle exchange has very little effect on global HIV prevention, but is all the more important for the legalisation movement as a tool to undermine the UN conventions on drugs.
1 Report Social Work nr. 62, 1992
2 Needle exchange, Bo Bergvall 2005
3 Swedish Institute for Infectious Disease Control Annual Report 2002
4 Mobilisation Against Drugs dnr 209/02
5 A Annell 2004-03-28
6 Chitwood DD, Comerford M, Sanchez J 2003