Comprehensive HIV Prevention for People Who Use Drugs: Ways Forward for Inclusion of Needle and Syringe Exchange Programmes
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DANIEL WOLFE: I'm pleased to welcome you on behalf of myself and my co-chair Sergii Dvoriak, who you will hear from in a little while, to this session on evidence-based prevention for injecting drug users. I wanted to highlight that the program noted the return of the federal ban from the US government on needle-exchange funding.

The session today is going to do two things. It is going to touch briefly on what is lost in that ban and that is in the person of our first speaker, Steffanie Strathdee. Then, it is going to move on to hear from people form three different countries and three different perspectives talking about how we can move forward even without US government supports and some of the promise and challenges of their approaches as they do that.

I want to remind everyone that this session is being taped for the Kaiser Webcast series. If you ask a question your question will also be audible. We will have presentations first and then go to questions at the end.

Without further ado let me introduce our first speaker. Steffanie Strathdee is Associate Dean of Global Health Sciences, the Harold Simon Professor and Chief of the Division of Global Public Health in the Department of Medicine at UC San Diego School of Medicine. She's the recipient of NIDA, National

Institute of Drug Abuse Merit Award, a researcher known to many of you for her ground-breaking work in multiple countries on questions of needle exchange and its efficacy, HIV prevention, and HIV treatment for injecting drug users. I'm very pleased to give her the floor, Steffanie.

STEFFANIE STRATHDEE: Thank you very much. Before I begin my presentation I would like everyone in the room to stand in solidarity for all of the people who use drugs and are sex workers who have been excluded from the meeting. We respectfully ask the IAS to ensure that the meetings don't happen in countries that repeat these exclusionary policies. Thank you. [Applause]

Thank you for the very kind introduction. Thank you to a number of people who have contributed slides, data, information, and advice for this presentation. Let's start at the very beginning of the AIDS epidemic. This is a very familiar pattern of AIDS epidemic by risk population in the United States since the epidemic began.

I'll draw your attention to this blue line which are reported AIDS cases among people who inject drugs. Now, this epidemic peaked here, and this reported AIDS cases, in the early 1990s and then started to drop off. Some of that was obviously due to the introduction of HEART, as we've heard a lot about.

Something else very interesting and important was happening. Even though the first needle exchange program in the US was implemented in 1988 the North American Syringe Exchange Network started collecting data on the number of syringes exchanged in the United States. As you can see, that number has increased steadily since 1995. There are currently a 194 needle exchange programs known to NASEN in the United States with about 35 million syringes being exchanged.

That's extremely impressive if we compare this against the policy backdrop. As Daniel mentioned, a Congressional ban on federal funding for needle exchange programs began in 1988. This ban was to be upheld unless the Surgeon General could determine that needle exchange programs could reduce HIV incidence and prevalence.

The ironic thing that for a short time in the 1990s there was even a ban on funding for evaluation of needle exchange programs. It's the ultimate catch 22; you've got to show that their effective but you can't do the research. Luckily, this ban didn't last very long because this was actually a very pivotal time in the AIDS epidemic when the cases among injection drug users were rising their most steeply.

The ban played on. Decade after decade, this ban was upheld until 2010 with much fanfare the Obama administration

took the courageous route and overturned the ban. This was a moment of great achievement. However, at the very end of December in 2011, just a short while ago in back door conversations, when all of us had sugar plum fairies dancing over our heads, this ban was reinstated. We all woke up in 2012 wondering what the heck happened. We don't know what the impact of this is going to have on the HIV epidemic among people who inject drugs in this country but surely this can't be good.

Why the heck is there still controversy about needle exchange programs? Let's examine the data and make our decisions based on science rather than morality. The purpose of needle and syringe programs is that they provide sterile syringes in exchange for potentially contaminated ones in order to reduce syringe sharing and reduce the time that syringes are circulating in the community where they could infect people.

The other important role that they play is to provide contact for injection drug users to other health services for people who inject. We're talking about drug treatment programs, etcetera. We'll talk about those in a moment.

I could spend the rest of the day, even the rest of the week, talking about studies that have shown that needle exchange programs consistently are associated with reduced HIV prevalence and incidence. These are just a few of the papers that have been published on this topic. In fact, there is eight

Congressionally-funded studies and reports and several international reports that have concluded that needle exchange programs do consistently reduce HIV incidence and prevalence. This is a report from the WHO, the Institute of Medicine, and most recently a report from the Global Commission on Drug Policy.

In contrast, there is no evidence that needle and syringe programs are associated with drug use, crime, discarded needles on the street, permissive attitudes towards drugs among youth, and the formation of high-risk needle sharing networks at the needle exchange programs or, most recently, delayed cessation of drug use. These are all studies incidentally that have been funded by the National Institute on Drug Abuse.

Now, fanning the flames of this controversy were two papers, one from Vancouver which was my own work and that of Montreal that came out in the late 1980s. These studies showed that there was high incidence in these cities among injection drug users of HIV infection despite large scale needle exchange programs.

I can tell you the Vancouver report said that needle exchange programs are a very important component of what should be a comprehensive HIV prevention strategy, but they can't alone pretend that they're going to keep a lid on an epidemic in the absence of other programs such as drug treatment.

The Canadian response was a sensible one. They expanded needle exchange programs, they expanded opioids substitution therapy and voluntary counseling and testing, they removed restrictions on the syringes that were exchanged on needle exchange programs, and much later they have offered alternative harm reduction strategies such as safe injection programs.

In the United States, the response was the direct opposite. Here are just two letters of Congress that were sent around in 1988-89. In fact, my paper was entered into the Congressional records word-for-word with the opposite interpretation than the publication. This was certainly the low point of my career, and I've been fighting this interpretation ever since.

The sad thing is that because of this continued ban needle and syringe programs have difficulty providing other ancillary services that are just as important as the syringes themselves. While a good percentage of them include substance abuse treatment referrals, voluntary testing and counseling for HIV and Hep-C, far fewer are able to able to offer hep-B vaccinations, STD screening, onsite medical care or TB screening.

The ban plays on. We've had second and third generation needle exchange evaluations. This is a paper from Hannah Cooper and colleagues that shows the spatial access to syringe

exchange programs in 1995 in New York City versus 2006. The darker neighborhoods are neighborhoods where there is greater access to syringes. Dr. Cooper and colleagues showed that living in a neighborhood with better spatial access to needle exchange was associated with less needle sharing.

In Iran, there has been some interesting work comparing neighborhoods without needle exchange to those with needle exchange. Those without needle exchanges are much more likely to see higher levels of syringe sharing, higher network sizes of injection drug users in people who've ever shared injection drugs in prisons.

Moving on to China, we've seen very impressive data that's from Dr. Xing and colleagues that show in the Yunnan Province where some of the HIV incidence among injectors have been the highest. The annual HIV incidence without needle exchanges would have continued to climb but in the presence of needle exchange it has stabilized.

Some very interesting data has also been published recently by Dr. Vickerman and colleagues from the UK. Now, hepatitis-C prevalence is very hard to change because it's more infectious than HIV through the parenteral roots. Dr. Vickerman has showed that if you have optimal coverage of opioid substitution therapy and needle exchange programs, for example, over 10 years you can reduce hep-C prevalence by 60-percent.

If you move on to the Ukraine, we also see very interesting data; it's very impressive. This is from David Wilson and colleagues who are going to be presenting these data on Thursday at the conference. They have compared the outcomes of needle exchange programs on HIV and hepatitis C. As you can see, there's been a significant impact on prevalence, infections averted, quality-adjusted life years gained, and huge cost savings over the lifetime.

In fact, these same colleagues have examined the impact of needle and syringe programs on syringe sharing, HIV, and hep-C incidence not just in the Ukraine but in eight countries in Eastern Europe and Central Asia. They will show on Thursday, convincingly, that syringe sharing levels decreased with increases and per capita syringe distribution most impressively for the Ukraine but for all eight countries. In fact, needle exchange programs averted 40-percent of HIV infections. When hep-C was also considered, all of these programs were shown to be cost effective.

Finally, Degenhardt and colleagues showed that when there is optimal coverage of opioid substitution therapy, needle exchange programs, and antiretroviral therapy, that there could be up to a 63-percent reduction in HIV incidence over the next five years in a hypothetical epidemic.

Now, all of these data are certainly very convincing to me and hopefully to you. If we look at the coverage of needle and syringe programs and we look at the number of syringes that are provided per person who injects drugs around the world, we see an appalling figure; that it's unbelievably low coverage, only 22 syringes distributed per person per year. In black are the countries that absolutely have no evidence of having a needle and syringe program. The darker colors in red are those very few countries that offer more than 200 syringes per person.

All of this is even more worrisome when we realize that in the countries where we have PEPFAR activity. We're speaking here about Russia, Ukraine, Vietnam, Tanzania, and Kenya. These are some of the countries where HIV incidence among injectors is rising most rapidly. Unfortunately, PEPFAR funding cannot be used to support syringe exchanges at all, never has and with this ban it means that they never will. This is threat to an AIDS-free generation. PEPFAR funding needs to include syringes.

In conclusion, a quarter century of empirical research provides overwhelming evidence that needle and syringe programs can effectively reduce HIV incidence and are cost effective. Yet, globally coverage of needle and syringe programs is abysmally low. The reinstated ban on the use of Congressional funds to support these programs is a decision based on

politics, morality, and not science. Such deadly public policies fuel HIV epidemic rather than containing them. Now, the whole conference theme is about turning the tide. What we need to do as activists and as scientists is stand together in solidarity and make sure that this tide doesn't wash over us. Thank you. [Applause]

SERGII DVORIAK: Hello. Now, it's my pleasure to introduce next presenter. This is Anya Sarang who is a public health activist from Moscow and by the way my personal friend. She's absolutely a wonderful person. She's the founder of Andrey Rylkov Foundation for Health and Social Justice. For the past 15 years Anya's work has focused on developing and supporting the emerging harm reduction movement in Russia and she's working in really tough conditions. [Applause].

ANYA SARANG: Thank you very much, my friend. There is a timer, does it work? Okay, so yes, I will be talking – I hope it never happens to you guys in America, but I will be talking about our work, our attempts to provide access to needles and syringes in a very tough political situation without access to basically any funding or political support.

I will be talking about my own organization, the Andrey Rylkov Foundation for Health and Social Justice. In this presentation I will focus on our service provision to drug users in Moscow.

Just some brief information about the city: it's a huge city. The official statistic says it's 12 million people, but in reality, it's maybe between 15 and 16 million is the population of the city. It is like 10-percent of the Russian population and three populations of countries like Georgia four, Maldova's ten, the population of Estonia and so on.

It's really a huge city. Moscow remains one of the top most expensive cities in the world. Now it's the fourth after some Japanese cities, but it keeps moving from like the first to the fourth position on this list.

It's also the city with the most billionaires in the world. Our ex-mayor's wife is the third richest woman in the world. It's quite an advanced city economically. Now let's look at the epidemiological striation. We have an estimated around 1.5 million drug users of whom about 100,000 are injectors.

People mostly use opioid drugs such as Heroin, street Methadone, pharmacy opioids and poppy seed preparations. The official number of people with HIV is over 40,000, but we know that at least 25-percent of IDUs don't know about the HIV positive status.

The prevalence of HIV in injecting drug users, while lower than in many other cities of Russia, continues to grow. So, from 14-percent in 2004 it grew to almost 20-percent last

year. Also, HTV incidents are quite high and also prevalent in IDUs; almost 70-percent and we have the epidemic growing.

In terms of politics, we don't have any political support to harm reduction programs whatsoever on the federal level. So, for example, the opioid substitution treatment is illegal in Russia, and needles and syringe programs are considered as a threat to the national drug control strategy.

However, unlike substitution treatment, needle and syringe programs work in Russia with the support of Global Fund and some are supported by [inaudible]. Legally it's a grey zone, so none of the programs have been sued for providing needles and syringes, but the government always assumes that it's not a very legal activity.

Especially this policy is very hard in Moscow where, traditionally, since in the late '90s the city government was opposing needle and syringe programs and harm reduction programs. There was even a myth that needle and syringe programs are illegal in Moscow, so for many years none of our organizations were even attempting to do these programs.

Or those who attempted focused on advocacy and trying to convince the decision makers on the necessity of this program. All these attempts have failed. However, this is not true. Needle and syringe programs are not illegal in Moscow, although they are not supported at all.

We do have accommodations – what is called an Order from the Moscow Department of Health which prohibits the realization of harm reduction programs on the basis of their Municipal Medical Institution. So it doesn't relate to us because we are not a governmental organization, but the municipal medical institutions cannot run needle and syringe programs. So, as you can understand, the city would never fund us or anyone who is doing the work like that.

We at the Andrey Rylkov Foundation, we are a very small, grass root NGO, we are fighting for health and human rights of people who use drugs in Russia. Our mission is to promote and develop humane policy based and tolerance, protection of health, dignity and human rights. We focus a lot on advocacy and human rights campaigns, but we also have the small needle and syringe access program in Moscow.

Like we are really tiny we don't have an office and we don't have facilities, so we work in the mentality of on foot outreach and we go to the outreach visits every day in the evening. We provide our clients and participants with syringes, condoms, we do HIV rapid tests, we give them ointments, bandages, Noroxin and we council on the issues of HIV and drug dependency and refer them to medical institutions. We also help them to get in to the institutions because it's very challenging for drug users in Moscow.

We have a medical specialist who also is almost a volunteer - he goes out with us one or two times a week – and we have legal counseling and other services on request. We also do training for drug users, which is also – may be challenging because we don't have our own space, but we try to organize it either in the school or flats of drug users or in some convenient locations.

We're not like a huge program as you can understand because we basically operate on a very partisan, small scale level, so the numbers are not huge. Last year we reached almost 800 people of whom 300 were women. We provided 40,000 needles and syringes and 3,000 condoms [inaudible] - but I think we actually did more, it just didn't go into the report – and provided consultations on HIV. Also, on drug treatments, we do a lot of counseling on drug treatment and referral to the local neurological clinic and NA groups and whatever help – little help – is available for people on this issue.

Now, challenges. I must say that we've operated this program for three years. We never had problems with the local police or whatever governmental scary people. They just don't show up in the same places where we are, so we've never had these kinds of problems. Of course, it's not convenient sometimes that we don't have an office or convenient storage of materials, so people have to store everything in their own

places. Therefore, for each visit they cannot carry enough materials. The visits are two hours, three hours maximum because we cannot carry enough syringes for those.

We don't have regular spaces for training which is also a solvable problem. Of course, one of the most serious challenges for us seasonal because, for example, last winter the guys couldn't just be outside on the street for more than a half hour. It was -40 Celsius and when they were trying to do HIV rapid tests, the buffer would just freeze. It was impossible, of course, to talk to people and this weather went on for two months or at least one month and then it got a little bit better.

Also, in Moscow, while it's the richest and hugest city, there is a lack of any services for IDUs or homeless people. Of course, I said that there is not always [inaudible], and so it's very difficult for people to stay in hospitals and so the station with people is actually horrible. One of our main challenges is unsustainable funding because - this is just one picture from our work – well, because we are not funded – we don't have any regular funding from foreign sources as well.

We have Global Fund in the country, but the managers of the Global Fund program also refuse to fund us because we don't have good relations with the city authorities because of the

political station in Moscow. We operate – sometimes we don't have funding at all for months; sometimes we receive some random money or some donations. Last year we received a big donation, the Crystal of Hope Award, and that keeps us going for this year.

There are also good sides and I'm sure that many people who work in needle and syringe programs could appreciate many of them. For example, we don't have to code our clients, which we think is the greatest achievement, and we are all very happy about it because we don't have strict donor requirements.

We don't have to fill 100 forms, write 1,000 reports, so we just report by e-mail to each other every night and say what's new on the drug scene. We don't have to clearly emerge into bureaucracy and the stupid requirements of the clients. We have horizontal self-management. We don't have bosses and someone telling us what to do and that's why we also love each other. There is not much work related stress and so not much burnout.

I already mentioned the funding; we were funded by UNDC for two years when they had the HIV prevention program. Now we are funded from the Crystal of Hope Award, about which we are very happy. Now we've also decided to try a small micro-donation campaign. It's kind of like both fundraising and

[inaudible] campaign, so we distributed the information about our program and our challenges throughout the world.

We will collect in money through this global giving, a very convenient website and we've already collected one-sixth of the sum we needed for the mobile exchange unit. This unit we want to buy just to be able to provide some sort of assistance in winter and take care of our clients. This is just some political card that we made for this campaign; I made them.

The Russian government is going a bit absurdly crazy. We now have censorship of the internet, and our own website was closed in the beginning of this year by the government; just illegally shut down by the Federal Drug Control Service.

We also have cracked down on the NGOs, and this law was accepted just two days ago, and now the local NGOs that work in Russia using the foreign funding are considered foreign agents. Crazy things are going on. We have no money from the federal budget for HIV prevention among drug users and now it's also illegal to protest at all. For any kind of public protest, there can be very strict punishment.

I don't know what will happen in Russia and, as I said, I hope that despite the federal ban, this kind of situation will never happen in the United States, but that's how we

operate and I hope this information could be useful for you guys. Thank you. [Applause].

DANIEL WOLFE: Thanks, Anya. So we've heard about the U.S. ban and we've heard about the Russian not quite ban on needle exchange, but ban on many things related to getting information out to drug users or to operating effectively.

You may say, well, that's what happens when you have a big, powerful government, but our next speaker is going to complicate that picture a bit because China is a country that simultaneously has pursued a fairly strict anti-drug policy, but also livened that or mixed it with a great measure of pragmatism.

We have heard a lot about the scale up of methadone in China, but relatively little about the scale up or the operation of needle and syringe programs. So our next speaker, Xiaobin Cao, will talk to us about that.

He has worked on HIV and needle exchange programs for more than ten years including on a number of NIH funded interventions. He's a member of the National Methadone Working Group on China. He's affiliated with NCAIDS, his colleague from NCAIDS is speaking at another session next door, so for those of you who came to hear about China, we're very grateful to you for coming to this one. I'd like to give the floor to Xiaobin Cao.

XIAOBIN CAO: It's my great pleasure to be here to talking about the China's needle exchange program among the drug user. First of all, I want to thank Dr. Wooseyo [misspelled?], the director of Central for AIDS Control and the Prevention, China CDC, and his team, the China's national needle exchange program Working Group, with hard work of the team, China's government is support needle exchange program is possible.

I also want to thank for the greatest support from the Ministry of Health of China and also from the international community for [inaudible] Global Fund, United State and the U.K. and also really appreciate the conference gave me an opportunity to be here to share China's experience of the needle exchange program and I want to hear your comments and suggestion on China's needle exchange program.

When China starts EP, there are so many drug user are living in China, there are more than 1 million drug user and the HIV-positive is quite high. It's about 6-percent nationwide. In some area, the HIV-positive among the drug user is more than, is higher than 15-percent and at the same time, the high risk behavior among the drug user is quite high, for example, they like to use the drug with their friends, share the needles with their friends, but they dislike to use condom when they have sex, so it's very dangerous for them to get HIV

infection. EP have been approved and very successful strategy to reduce HIV infection among the drug user so when China take action to combine the HIV spread among the drug user, the EP is one option for China.

I think China initiated an EP based on the small experience and design the large scale experience. For example, in 1997, Dr. Woo did a very, very small panel to start and look at if the village as a community member decided to do HIV intervention among the drug user or not, and at the same time, the first workshop on an EP was hosted by the Chinese Arevention Medicine Academy and also with the support of the Ministry of Health of China in 1999 with a scale-up independent was conducted in two provinces.

The result of this panel study show that the EP can reduce HIV risky behavior among the drug user and also community members can say, oh, EP, it's okay, EP, it's okay, it's accepted, so in 2000, with the support from the International Community, China contacted an EP for provinces and designed in 2003 after the announcement For Free One Care Policy, an EP was scaled up nationwide.

From this slide we can see that with the progress of an EP in China, Chinese government has issued very key policy and documented support of leaders for an EP. For example, free five years AIDS action plan and also in 2008, the webs based

management system was set up nationwide. The two documents on the left side of the slide is the issue of the Counsil is the central government of the China which is the key policy to support China and the gentleman is picture is former Minister of the House of China. He visit to the EP side to look at the operation of the EP and he talking with the staff there.

In this slide, the yellow color represents provinces that have set up EPs. So we can see that so far there are about 1,000 EPs nationwide and there are more than 44,000 drug users are being covered monthly.

I want to talk about the appreciation of EP in China. In 2010, China's EP was supported by Chinese government and also supported by the international community. After 2010, we saw from the international community [inaudible] that now China's EP is mainly supported by the government budget.

In China because China is huge and in a different place, the EP is operated by a different organizations. For example an EP is operated by a peer educator, by the CDC staff or the NGOs and the drug user in the community, if they wanted to join the EP, then they can find EP very easily.

I mentioned in the previous slides, China has data management system and EP is one component of this system or EP side in China are requests to report the data monthly. For example, how many drug users came to decided to exchange

needles and how many needles and condoms distributed and how many needles have been returned? So through this system, the national EP working group can have an overall picture of an EP in China.

In terms of challenges, I think misunderstanding and the debate on drug use and the EP matters the most one. People might have an opinion on drug user and the other may think that an EP encourage drug user in community. Also in China, we don't have the computer enhancer evaluation in EP and HIV prevention and there's another issue, we don't know which operation mode in China is better. Peer education is better? Or CDC staff is better? Or other NGO? We don't know.

In the future, I think more effort need to be decreased in attitude toward the drug user and EP in China and we have to do the computer enhancing evaluation on the EP in HIV prevention in China and also we wanted to encourage target population, for examples, the drug user and other NGO tool participants for an EP. I want to end here. Thank you.

DANIEL WOLFE: After China and Russia, we will go back to the United States. Let me introduce the next presenter, Paola Barahona. She's project director at the District of Columbia Appleseed Center for Justice where she works on health policy issues including HIV/AIDS and syringe success. Before that, she directed Harm Reduction Advocacy Campaign for

Physicians and Human Rights and for the following executive director for prevention works, and syringe exchange and harm reduction organizations that operated here in the District of Columbia and her presentation, titled Addressing the Needle Exchange Program Shortfall in the USA: Local Problems, Local Solutions.

PAOLA BARAHONA: Thank you very much. How do I do this? What do I do? Okay.

I would like to thank the IAS inviting me to speak about syringe exchange in Washington D.C. The alternative title or more what I think of this is syringe exchange in Congress's backyard. I'm going to tell a bit about the story of how syringe exchange has evolved in this particularly unique location.

Having worked on this, I've been working on an advocacy at the local level in DC for 14 years, so I've seen a lot of change and back and forth and quite a lot of battle.

It starts off with the fact the District of Columbia is subject to oversight by the United States Congress, so that's where the trouble starts. So what that means is that we have locally elected officials. We have the mayor here and we have the district council. The mayor prepares a budget for the city based on what he sees us as the priorities.

The council passes it and that's where things should go, but no after that point it then has to be approved by the House, the Senate and then signed by the President. That's where things get a little bit mucky. So this is where if you hear some local advocates and we talk about budget autonomy, this is what we're looking for where we can set our own budget and not have any intrusions. I'll show you how that has worked to our disadvantage.

Some of the background on needle exchange in Washington DC, it started like most places, sort of mid-late 80s by grass roots activists sort of doing what they need to do, act up, showing up and recognizing how we need to fight the epidemic and then in '92 was our first attempt to have a legal needle exchange. It was a failure. It was very government oriented. You had to go down to the Department of Health, answer a bunch of questions, and get your syringes there.

About 50 people enrolled in that, it was not very effective, so then the next attempt in 1994, the legislations allowed community based organizations to operate these services. Then you kind of got bogged down in bureaucracy and it took a couple of years for the money to get through, but then we might have had actually community based syringe exchange program at Whitman Walker clinic, a large AIDS

organization in the District of Columbia with funds from the District of Columbia.

Now, Stephanie had made mentions of the federal ban in 1988, which banned the use of federal dollars to fund syringe exchange. It included two criteria for waiving that ban. It was that SUPs were proven and didn't increase drug use. So then there was all the research into that

Ten years later, I think it was April, they were all the demonstrations in town, the Surgeon General, there was all the lit review of all the science that had taken place over the last ten years, and it was all very conclusive that we had met the criteria. It was effective in reducing HIV transmission and not increasing drug use.

Yay, this is great, this is working, but the Clinton Administration didn't exercise the waiver finding the issue politically divisive, so they maintained the ban on the use of federal dollars, emphasizing more the local control issue, that is if the current district finds that this is something we need to fund locally, then it's up to their discretion to use local state dollars.

Now remember the government control over Dc that I mentioned? In that same year, in 1998, we're talking the FY budget for the district; they prohibited DC from spending any of its money on syringe exchange program. Now remind you that

Whitman Walker had been providing for two years the syringe exchange programs with district funds, a perfectly legal program, supported by the community, supported by our own locally elected officials.

It also prohibited any entity receiving local funds from operating syringe exchange programs. So not only could you not use the local dollars and use the local dollars, but it also put in jeopardy any other local or federal funds that you have, so if you're a large AIDS service organization, you have a lot of grants from the federal and local government, so those would be in jeopardy.

So in October of '98, preempting when this was going to be signed by the President and go into effect, the staff, those of us who were working in our clinic the needle exchange program were laid off by Whitman Walker Clinic and hired by this new organization no one had heard of the day before called Prevention Works that was created to continue the program under these new situations.

Mind you, so there was a lot of media and fanfare about this. It got a lot of attention locally about this about the separation and all this stuff. What didn't get attention in there in the media in October was that Prevention Works still didn't have the authority from the Department of Health to

operate syringe exchange because, and I was wondering what this was.

And I called the Health Department and I talked to the director of the Department of Health and they had to call the legal counsel on the phone because anybody, someone sitting at their computer and writing the authorization letter and someone signing it, those are salary dollars, those are local dollars going towards syringe exchange in the District of Columbia, so anyway, we sort of worked that out with a call to the Washington Post.

That all worked out. So it took a couple of months, but it did come out. Some obstacle, immediate obstacle in this situation, funding, obviously, we can only be funded by private funds, we had to research what are those available, and there are several, but they're not super plentiful. They certainly aren't into multiple year grants.

Collaborating with other community-based organization was also very difficult, I mentioned all the media attention with the separation from Whitman Walker and the threat to call their fund, you know, other programs were very wary of collaborating even though they had in the past, they knew that this was a natural partnership, but that was another very difficult situation.

Another odd thing for a couple of years, I'd go to meetings, community meetings, planning meetings, prevention meetings and I'm talking about the needs for syringe exchange in the community so that was all fine and then after the meeting was over, all the government officials would come, but the president would say, I can't really say it when the mic's on. So it was all a very interesting situation over here.

In FY 2000, the following year, the head of the committee that oversees the D.C. budget in the Congress on the House side wanted to continue that very strict restriction, which basically banned local, federal and private dollars. President Clinton actually vetoed this bill twice on many issues, but he did actually particularly mention the onerous restriction on D.C. syringe exchange.

So the compromise was to continue the local funding ban, but it would allow private funding as long as there were strict accounting of the federal dollars and local dollars for the funds for the syringe exchange. So everyone was really excited about taking on syringe exchange then.

It continued with that in 2000, there was a follow-up lit review from the Surgeon General and found again that syringe exchange is very effective in reducing HIV transmission, not increasing drug used and in addition, it's very effective in actually getting people into drug treatment

and keeping people in drug treatment when compared to areas where there weren't syringe exchange programs. Again, this is great, good news.

That had backlash on D.C. Somehow good news about the effectiveness means oh, we need to mess with syringe exchange in D.C. They added new restrictions to syringe exchange in D.C. There could be no syringe exchange within 1,000 feet of any school. If there were any syringe exchange operating within a D.C. housing project, the district that to sent a report to Congress every month on drug activity in that area. So they learned not very much from those reports.

In fiscal year 2002, we have a new chair of the Committee, Joe Knollenberg from Michigan, he continues the local funding, but he actually removes those other restrictions about the location, about the reports on the drug use in the public housing projects.

In that same year, Mary Landrieu on the Senate side, same Committee there, so the processes are going up on both sides, they're in the House and in the Senate, she passes under her Committee, they pass a bill that doesn't have any restriction on local funding for syringe exchange in D.C.

That is new, because prior to that it had been in both versions. In Congress, what happens when you have different language in the House bill and the Senate bill, they come to

conference and they negotiate what's going to be in the bill that goes to the President and so in that year, the House version won and did every subsequent year. After that the Senate really kept what we call a clean bill as far as D.C. funding for needle exchange the House kept it in and that's what came through.

In 2007, things changed. We had José Serrano from the Bronx was chair in the Committee in the House that oversees the D.C. budget and he introduced a bill that didn't have the ban in it at all for local funding. On the House floor however, a Republican, Mark Souder, a Republican from Indiana, was challenging this and trying to get the restriction back into the D.C. appropriations and I can remember this day very well, because it was the weeks before was making all the calls.

I'd never really thought these were very effective, everybody call your representative, but phew! I'm telling you, we called and it worked and we squeaked by. The amendment was defeated and at the end of that year, President George Bush signed a 2008 appropriations bill that allowed D.C. to fund syringe exchange with local funds, so finally.

That was the big change. In 2008, with the creation of what the city under the Department of Health their DCNEX, our then mayor, Adrian Fenty, promised $650,000 of D.C. funds for syringe exchange at the beginning of 2008, he had a big press

conference with one of those big checks, one of those sweepstakes checks for $300,000 for Prevention Works to expand its syringe exchange program, so that had been the program that I had been running before. I wasn't running it at that time to expand its services. So it was all very, very exciting.

Following that in March, there was a request for applications which was going to offer money for new programs to take on the syringe exchange program, and in April, we offered three new programs that would offer syringe exchange programs; family and medical counseling services doing. Prevention Works has been a mobile, generally a van-based program. Thus the van in front of the Congress in the opening picture.

HIPS, which had been working with sex workers and was expanding its harm reduction work to drug users as well and bread for the city, local health clinic.

More recently, as I mentioned the federal ban was removed temporarily, although then it was reinstated. On the local level, we have the portfolio with Prevention Works, which had been the original needle exchange program actually closed in February of last year. It just wasn't able to survive as a small standing harm reduction organization.

The three other organizations still remain and that's still our harm reduction needle exchange portfolio, Family Medical HIPS and Bread for the City, which two the programs, of

Family Medical, you can actually visit downstairs. It's in the global village. One of their outreach vans is there. You can go meet the fabulous staff there. HIPS is also in the Global Village and Bread for the City is actually located about five blocks from here so you can visit them as well.

I hope that since 2007, those programs are getting pretty good support from the Department of Health. They're surviving with local dollars, although the truth is you still have that looming challenge of Congress deciding that they're going to limit the funding again. Hopefully I won't be back with an update that it's back in and we can just put this into the storybooks as a historic lesson and move onto really strengthening these services so they're more effective in reducing HIV in the city. Thank you so much. [Applause.]

DANIEL WOLFE: Thanks. We have allowed, we asked the presenters to cut things short so that there would be time for your questions. There are microphones in the aisles and I would now invite you to come up and direct questions to the panelist.

Ideally, we will take a few questions to see the range of concern. You can come forward and line up at the microphones if you have a question and we will take you from different sides of the room. First question from this side,

and if I could ask you to identify yourself and where you come from, that would be great.

KEVIN REBE: Thank you very much to the panel. I'm Kevin Rebe, I work for Health4men in South Africa in Cape Town. This is a comment for Stephanie in the global map that we were shown on sharing needle exchange programs in South Africa. Our program has actually been running a needle exchange program since 2010 when the federal ban was lifted. We were to stop it when the federal ban came back, but we've actually continued service and now found funding and have up scaled it. We will be up scaling the program further. So that's good news that there's a program running successfully in Cape Town.

DANIEL WOLFE: Thanks and can we ask you, was that program funded by the U.S. government? You say you had to stop it when the ban came back.

KEVIN REBE: That depends is there's anybody from USAID in the room.

DANIEL WOLFE: I think there may be so —

KEVIN REBE: The funding is separate and we don't use USAID funding for needle exchange.

DANIEL WOLFE: Thanks. Yep. Please.

PETER HERZOG: Good afternoon, Peter Herzog is my name. I'm on the National Institute on Drug Abuse and I have had the albatross around my neck for over 25 years of pushing needle

exchange research. Stephanie talked about the ban against research back in the battle days. The way we broke through that ban was to get through church going in secret. We got it going at Yale University.

Once people found out what it was, they tried to kill it and then Congress says the U.S. GAO to do a report on it and actually the GAO gave it total thumbs up. The asked the CDC to do an evaluation. CDC gave it total thumbs up. They asked the National Academy of Sciences to do an evaluation and I was the project officer on that too. Total thumbs up.

The research is fantastic. It showed that it didn't create more crime or more drug abuse or whatever. And we didn't set out to show—let the scientific chips fall where they would fall. If it was shown to be bad, we would say that. If it was in between, we would say that.

Well, despite all of this research, and a lot more, we still saw the ban against the Federal money going to supporting services. But, guess what? The states took our research, the federally—funded research, and they used it as a rationale for getting their own programs going. So this comes from the first talk, which you gave, Steff, to the last room, which was a local scene. You get around by doing it locally, and by using the best science possible, which we did fund through the Federal government.

There are ways to get things done. Hopefully, someday—I've already said more than I should. I appreciate what the panel is doing, and what you all have done. We haven't seen the end of this. And it's a very volatile subject, even after all the research has shown what it has shown. And thank you all. Thank you.

STEFFANIE STRATHDEE: Thank you, Peter.

DANIEL WOLFE: Thanks. One more and then we'll pause to let the panelists reflect back.

BRIAN KELLY: Brian Kelly from Perdue University. My question is for Xiaobin, actually. A map you put up at one point showed a fairly uneven distribution of syringe exchange programs in China. The Northeast, in particular, looked fairly barren. I was hoping you could talk a little bit about the role of local politics, in terms of how the distribution of syringe exchange programs has shaken out in China.

DANIEL WOLFE: So Xiaobin, why don't you go first.

XIAOBIN CAO: Yes, it's huge in China and from the [inaudible] that there are about ten provinces where there is no EP program yet. But, the local government—if the HIV epidemic is heavy, the local government thinks, EP is okay to control the HIV epidemic among drug users. But, if there are a lot of HIV—positive drug users, maybe the local government has a different opinion on the EP. In some areas, the CDC provides

needles to the drug users directly. And in some areas, the needle is provided by the peer educator, actually, the drug user and also some [inaudible].

DANIEL WOLFE: Thanks. I don't know if any of the other panelists want to comment on the question that was raised about research, and how research – even if the Federal ban is in place, for example in the U.S. – research can be used to bolster the local efforts. Steff, I don't know if you want to say anything about that?

STEFFANIE STRATHDEE: That's true, but in fact it's very difficult to get needle exchange evaluation research funded these days. In fact, I see that Dr. Friedman is at the mic and he and others have been actively trying to do more research in this area and the review panels at the NIH actually think that all the research has been done and policy needs to change. Obviously, it's this vicious circle. Sam, did you want to make a comment?

SAM FRIEDMAN: Not to that.

DANIEL WOLFE: Let me just say, on that and on the South African colleague's comment. The U.S. restriction is only on the purchase of needles. So, technically, in fact, if you are doing needle exchange, and you're buying the needles not with U.S. money. But U.S. money can still go to, for example, pay for the peer outreach workers, and things. I

wouldn't want people to think that the situation that Paolo described, where you can do any needle exchange with any money obtained to you if you are receiving U.S. international AIDS dollars.

STEFFANIE STRATHDEE: Well, that is true, Daniel, but I have heard that with the latest reinstatement of the Congressional ban, that local needle exchanges have had an even tougher time, doing the work that they were doing with state and private funds. For example, the needle exchange, Clean Needles Now, in Los Angeles – which is an excellent program – is having that very problem. So, let's hope that, at the state level, they will get wise, at least, while we wait for the federal ban to be overturned yet again. And let's hope is once and for all, this time.

PAOLA BARAHONA: I wanted to add, as well, that the research is definitely very helpful and useful in making our points. But with many of our opponents, they don't care about the research.

DANIEL WOLFE: Dr. Freeman, would you like to ask question?

SAM FREIDMAN: I would. Two quick questions. Sam Freidman. I grew up in this town, by the way. First question is, we are not in a battle about science any more than the climatologists are. We are in a battle of power. So my first

question is, how do we mobilize the power in those jurisdictions where, clearly, we need to mobilize power in order to get the needed harm-reduction and other programs established, funded, and no longer harassed by the police. Or, as in Russia, even other forces.

And, my second question, as a follow-up to that, since this is a scientific congress, is what research would be helpful to get funded around the world in order to answer the first question reliably? That is, how can we do the research to figure out and to do experiments and learn from the experiments systematically, about how we can get this situation to change.

DANIEL WOLFE: Who will answer the question? Steffanie?

STEFFANIE STRATHDEE: Sam always asks the toughest questions. I think it obviously very difficult to change policy at this level. And I think, hopefully in November we'll have some good news. We'll have a government voted in that's been supportive and hopefully we'll have the leadership to move forward and to overturn the ban once and for all, as I mentioned. So first, I think that in an election year, that's going to be very critical.

But I think that there are other things that can be done. I mean, you heard today, very eloquently, from Elton

John, about his history, personally, with addiction. And when we have people like that, who have the courage, and the leadership and the appeal to the public, or we have someone who stands up as a politician who says, my son is an addict. And if he was denied access to sterile syringes, he'd be dead. That's, I think, very compelling.

So, I don't know. I'd like the other panelists to comment. I do think there's leaders that we can solicit for our cause.

DANIEL WOLFE: And Steffanie, how about the second part of the question? What research questions should we be asking to figure out how to mobilize people more effectively?

STEFFANIE STRATHDEE: I think some of this work is actually being done by people like Donna DeGerle [misspelled?] and Brian Etland [misspelled?], have actually looked at opinion leaders and policy makers to try to see what are some of the factors that affect communities where change is taking place, versus communities where change hasn't taken place? And I think that's very instructive.

DANIEL WOLFE: Other panelists? Thoughts on how to mobilize power to support harm-reduction more effectively? Anya, Russia's in the middle of, what has been an interesting sort of mass-mobilization not around harm-reduction. Have you

engaged with that process of the demonstrations on the streets, and what do you feel like the future holds in that direction?

ANYA SARANG: Yes, we have. We participate in the street movements, and when there was the Occupy Moscow camp, we did a lot of talking and seminars for people on harm reduction and what we're actually doing in Moscow. We also did one action on Hepatitis C awareness, and [inaudible] testing for Hepatitis C. So it's more and more like activist and other communities that know about the issues and are more compassionate with drug users now.

The problem is that the opposition in Russia is not very strong, so it's not a strong political movement. Of course it's good that more people are more—like media is more supportive to our issue. It does mean that we will be able to influence the policy, because now crazier things are going on in Russia.

Like the law that I mentioned on the NGOs that will be considered foreign adjuncts now, or this anti-freedom of assembly laws that were passed just last week, or the law that will criminalize any public information about officials, or the law that will criminalize drug propoganda.

Our website was closed illegally in the beginning of the year because we were putting some drug propoganda on the website, which is WHO protocols and [inaudible] recommendations

on substitution treatment. So it's a lot of crazy things going on in Russia to which the opposition cannot resist, unfortunately, at the moment.

So, we hope that – I mean, it's good that people are supporting us, but it doesn't really [inaudible] to cope, in terms of turning the political tide, at the moment.

PAOLA BARAHONA: I think another effective tool which is underutilized is elected officials and policy makers actually talking with drug users, themselves, and hearing – I mean just having a conversation and humanizing and not feeling so separate.

DANIEL WOLFE: One question? Please. Tatiana Diskoh [misspelled?].

TATIANA DISKOH: Thank you. Tatiana Diskoh International HIV/AIDS Alliance in Ukraine. My question is about treatment as prevention in the context of injecting drug users. You have an epidemic. Very often, it's about the choice, either the one or the second, that the discussion finally comes to. And in Ukraine, there are now some calls to reprogram harm-reduction program to give much stronger focus on prevention. So the question is about where the balance is?

DANIEL WOLFE: To whom this question?

TATIANA DISKOH: Maybe to Steffanie and maybe to yourself?

DANIEL WOLFE: Okay. [Interposing.] You are interested in focusing on prevention, harm-reduction and treatment for ideas?

TATIANA DISKOH: Yes. The question is—very often when we discuss anti-retroviral treatment and syringe exchange, it finally comes to the discussion, either one or the other. And this is the way it is now happening in the Ukraine. Should we reprogram the needle and syringe program to actually limit it to minimum, rather providing treatment to people who inject drugs?

STEFFANIE STRATHDEE: Thank you for restating your question, because now I understand it and I know what I think. All of us would agree that it should never be either, or. In fact, nowadays, we're talking about treatment as prevention, in addition to prevention as prevention and treatment as treatment.

But needle exchange programs, if they operate in the vacuum, like you saw with the Vancouver example that I spoke about briefly, that is limiting their ability to do more. So there's a synergistic effect of adequate coverage of a needle and syringe program, [inaudible] substitution therapy and anti-retroviral therapy. And the Degenhardt slide that I showed towards the end, shows that if there is optimal coverage of all

three, that they act in synergy to reduce incidents dramatically over the short-term.

I think that, for example, needle exchange programs are often a site where people can receive anti-retroviral therapy, as well. And yet, obviously, if they aren't staffed with medical personnel, they're not going to have the ability to do so. But I think their capacity to be able to offer treatment as prevention would be outstanding. And in fact, that would be an excellent research question to examine in the future.

DANIEL WOLFE: Let me add a couple of words. According to our study and our observations, we suggest that drug treatment is incredibly effective in the Ukraine in terms of prevention of HIV transmission, especially if you are talking about methadone program, buprenorphine program, it's absolutely proved.

But, unfortunately, we have not so clear data about syringe exchange program in Ukraine, but I think it's because of different factors. First, this is difference between Ukraine and United States, with absolutely different conditions for drug users and access to syringes. Because in Ukraine, as you know, everybody can buy a syringe in pharmacies. It's not the case in Canada or in United States.

And second thing, we have very low information about quality of this service—sometimes quality of service is not

very good. Additionally, I should say, the coverage is very low, despite the huge efforts which provide Global Fund Alliance and many other organizations.

In Ukraine, coverage is not really enough which can change a situation. Because, when we look at a community that serum conversion is still very high—25, 28, in some regions, 38-percent of people become HIV-positive. And methadone programs help us achieve much better results. I think the problem we need to develop the service and look at quality of service and coverage.

TATIANA DISKOH: Thank you. Just to add, I think there is enough data showing the effectiveness of syringe exchange program in the Ukraine over the years, which indeed has an impact on the HIV-AIDs epidemic development in the country, which was outlined in the first presentation.

DR. MARHAMEE: Thanks. I'm Dr. Marhamee [misspelled?] from Montreal, Canada. It's a question for Anya. I won't ask any political question. As there is so much opiate user and [inaudible] in Russia, can you tell us about this new drug called desomorphine krokodil? First, is it true there is so much krokodil in Russia? Second, did you see a difference between the needs for syringes, as they need much more injections? And would that be an argument for the government

for you to ask for the needle exchange program? Do you know about this drug?

ANYA SARANG: Yes. Krokodil is the new trend—well not really new trend. It's been around for two or three years now in my city, [inaudible]. In our program, we don't see many krokodil users. There are in Moscow, but we don't reach out to this group. But throughout Russia, about 50-percent of opiate users are using krokodil, or were using krokodil.

Because, just about one month ago, the Ministry put—there was a restriction on the sale of codeine-based drugs from the pharmacies. Before, they were sold OTC. Now they will be not available OTC from the pharmacist. So, we don't know where the drug scene will shift, and will people still continue to use this drug, or not.

It does increase frequency of injection. And it does, as you probably know and you read, but it does increase the harms related to drugs. Basically, people just rot in just a couple of months, or years. We actually have clients from other cities who we had to hospitalize in Moscow and who have to have their jaw replaced.

It's really dangerous, but our government is perfectly aware of the situation. It's a lot of press coverage to the krokodil terror, but—the only moral that the government takes of any drug-related information is more scare and more terror

towards drug users. So now they want to—the prohibited the sale of codeine. And I think that the government will expect that the problem will just disappear.

DANIEL WOLFE: So, we'll take one more question, and then well give the panelists any final words and come to a close.

MAXINE DAVIS: Hello, I'm Maxine Davis from the Dr. Peter Centre in Vancouver. I just wanted to comment on our Ukrainian friend's question around, has there been any research around combining needle exchange and air—treatment as prevention? And, at the Dr. Peter Centre, we're part of the British Columbia Stop AIDs program, and at the Centre we have a combination of nursing care, supervised injection service, methadone, meals, a number of things.

With the Stop AIDs initiative some preliminary research that's been done at the Centre shows that the engagement in treatment as prevention, the adherence rate got up to 94-percent quite quickly, and it's a sustained engagement. The next step will be that the Canadian Institute of Health Research has just approved a three-year study in looking at the model of care, in terms of health outcomes and engagement. So, we look forward to three years from now in sharing that.

But, I can tell you from a very personal perspective. It's an incredible combination that individuals that need clean

needles, who need to have access to a supervised injection service, actually it's a very high engagement in treatment as prevention.

DANIEL WOLFE: Thanks. And just to add a little context to the Ukrainian colleagues question. There are some people—it's not about whether or not needle exchange can be combined with treatment to make it, as they have done in Vancouver.

But there are some people who are actually proposing that money be reprogrammed from needle exchange to treatment—taken away from one to the other. So, for those of us who were at a session on Friday when Julio Montaner, who is both involved in the Vancouver research, but also a great advocate for treatment as prevention, people put the question to him very bluntly, what do you think about this?

And as Maxine just said, he said that the evidence for treatment as prevention among drug users assumes a kind of comprehensive package, with access to harm-reduction, etc. It was not—there is not evidence, as yet, that treatment alone—and again, here we're talking about anti-retroviral treatment, not methadone treatment—that treatment alone, he would not see the evidence as justifying moving all the money away from needle exchange.

Okay, final words from the panelists? Anything that you would like people to know before we close? Or to think about?

ANYA SARANG: I just want to announce that we will have an excellent presentation of the work of photographer, Misha Friedman, who did a documentary on tuberculosis in Russia. The presentation will be at 6:30 at the Global Village Human Rights Zone. Anyone who is interested in [inaudible] Russia tuberculosis, please come and join our presentation.

STEFFANIE STRATHDEE: And all I want I do, as scientist who's also an activist, is tell you to march tomorrow and join hands to ensure that we can overturn this congressional ban on federal funds that deny access to needle exchange. And also to ask the IAS to have future conferences where drug users and sex workers are as welcome as anybody else. Thank you [applause].

DANIEL WOLFE: Okay. Thank you very much.