The Middle of a Crossfire:

Drug Policies and Injection Drug Users During the HIV/AIDS Epidemic

by

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Submitted to the Department of Political Science
and the Faculty of the Graduate School of the University of Kansas
In partial fulfillment of the requirements for the degree of
Master’s of Arts

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Needle-exchange programs (NEPs) have been increasingly utilized in the fight against the spread of HIV/AIDS since the epidemic began in the early 1980s. Safe-injection facilities (SIF) have been established in six nations since the late 1980s as another means to combat HIV/AIDS while also seeking to counsel drug addicts so they can eventually break free from addiction. Both NEPs and SIFs are the products of health professionals and injecting-drug users (IDUs) mobilizing to lobby for policy change. The pattern of diffusion of government-supported or tolerated NEPs across nations was studied to analyze how structural and contextual characteristics of nations could have impeded the collective action that resulted in the establishment of NEPs in most nations and SIFs in six. I utilized a most different systems design and single-country analysis and analyzed data for the years between 1980 and 2006. Data on 18 nations are analyzed; sixteen nations currently have government-tolerated or supported NEPs while six nations have government-tolerated or supported safe-injection facilities. All nations that went as far as establishing SIFs also had previous experience with NEPs and other ‘harm reduction’ techniques, parliamentary systems of government, and no significant opposition to establishing facilities from the Catholic Church.
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Chapter One
Introduction

For over 20 years in the United States, a specific minority group has been a large contributor to the spread of infectious diseases, illnesses, and most of all, the HIV/AIDS epidemic, yet this group has been shunned in terms of government outreach. In comparison with other industrialized democracies, the U.S. has been hesitant and resistant to trying controversial techniques to reach injecting drug users (IDUs), a group of people that historically has been difficult to mobilize. IDUs could be considered the forgotten group in the U.S. because while many programs and services have worked to reach them around the world, they have not received the same attention in the U.S. The U.S. government, along with a majority of state governments, have consistently not funded programs and educational projects that target IDUs in spite of witnessing efforts to do so in other countries that the U.S. has extensive contacts with. Examples of this reluctance can be seen in the lack of maintenance prescription programs, safe-injection facilities (SIFs), and the absence of federal funding for needle-exchange programs (NEPs) – all drug policy techniques from the ‘harm reduction’ perspective that have been utilized throughout Western Europe and Australia. Beginning with the Harrison Narcotics Act in 1914, the U.S. began to follow a prohibitionist, ‘criminal’ model for its drug policies that viewed drug addiction as just another anti-social behavior popularized by criminals instead of viewing it as a disease (Inciardi & Harrison, 2000, 194 – 195). U.S. rates of HIV/AIDS among IDUs have remained much higher than those in Western Europe and Australia since the epidemic began in the early 1980s, and many argue that this is directly related to the U.S.’s long stance of opposing or not supporting maintenance prescription programs and NEPs (Inciardi & Harrison, 2000, 34).

Currently in the U.S., 185 NEPs exist in 36 states as well as Washington D.C., Puerto Rico, and on Native American lands, but their legality depends on a county-by-county
certification of a State of Emergency that has to be regularly renewed (Drug Policy Alliance, 2006). Likewise, there are no safe-injection facilities (SIFs) like those found in Australia, Canada, Germany, the Netherlands, Spain, and Switzerland. SIFs are legal places for IDUs to use intravenous drugs with sterile equipment, which also have medical doctors on hand for emergencies like overdoses and offer counseling services, meals, and a place for users to sleep during hours of operation. They open with the goals of improving the health of drug users, reducing the incidence of drug overdoses and disease transmission, reducing crime like discarded needles and public drug use, increasing IDU access to health and social services, and reducing the incarceration costs associated with drug use (City of Vancouver Four Pillars Drug Strategy, 2003; EMCDDA (European Report on Drug Consumption Rooms), 2004). In addition to offering safe rooms and/or safer ways to administer or consume drugs, NEPs and SIFs both target IDUs by offering educational counseling on reducing the harm associated with their choice of lifestyles by changing their drug-taking and sexual behaviors. In many places, SIFs encompass a variety of ‘harm reduction’ techniques that are available to IDUs in order to attract the hardest to reach clients. At least 19 SIFs in cities in Western Europe, Canada, and Australia offer needle and syringe exchange on site in addition to counseling. Many of those facilities also offer beds, showers, and job training to clients (Broadhead et al., 2002).

Whether or not these facilities will ever be established in the U.S. is a question that remains a topic of debate, and forms part of the foundation of this research. The purpose of this thesis is to explain why some countries have established needle-exchange programs and safe-injection facilities while others have not. Eighteen countries are compared to determine what structural and contextual characteristics of some countries have contributed to them establishing methadone programs, maintenance prescription programs, NEPs and SIFs.
Initially, this project began with a cross-sectional, time-series design but a most different systems design and single-country analysis was used for the final result because this approach allowed me to look at every nation in the data set on an individual basis which helped place the data on those countries into perspective. Data are taken from Australia, Brazil, Canada, China, France, Germany, India, Ireland, Italy, Malaysia, the Netherlands, Spain, Sweden, Switzerland, Thailand, Ukraine, the UK, and the U.S. These countries were chosen on the basis of being industrialized democracies with a history of HIV/AIDS.\(^1\) After analyzing this topic, I present evidence that there are specific characteristics of some countries that provided a more favorable environment for drug policy innovations. Indeed, I argue that if countries possess these specific characteristics, they will be more likely to see policy innovations like SIFs in the future than other countries that do not share those characteristics. These characteristics of countries can favor or impede policy adoption, and they are explained in detail in the body of this thesis.

My main question of interest is two-fold; I want to know what characteristics the countries that have NEPs and SIFs share and do not share with one another, as well as what makes the U.S. and other countries unique from those countries. This topic was important to me because the differences between U.S. drug policy and European and Western countries’ drug policies have resulted in consistently higher rates of HIV/AIDS among American IDUs since the early 1980s, meaning that for more than two decades, policy differences between the U.S. and other countries have resulted in more IDUs being mobilized and changing their behaviors outside of the U.S. In other words, it may be that in the last two decades, specific characteristics of the U.S. have contributed to more IDUs contracting and dying from HIV/AIDS than in other countries. NEPs and SIFs have been the result of collective action that was produced when

\(^1\) Earlier versions of this paper only featured countries with some form of NEPs, but other industrialized countries were subsequently included in the final analysis to clear up issues with the dependent variable. The countries added after the fact – China, India, Malaysia Thailand, and Ukraine – vary in their levels of industrialization, and not all may be truly comparable to the other countries included in the analysis.
health professionals and high-risk groups like IDUs mobilized to lobby for policy change (Rhodes & Hartnoll, 1996, 206 – 207). Once these coalitions formed in each nation, each one of them proceeded to act in different ways in their efforts to get new drug policies adopted because every nation had unique characteristics that constrained how coalitions could operate. Policy adoption could be influenced by characteristics like the type of government a nation has or whether rates of HIV/AIDS fluctuate or significantly change over time. Likewise, the level of mobilization of the Catholic Church leadership and the type of drug or drugs most widely injected among IDU populations can also affect it. These characteristics have the potential to affect coalitions at every stage of their efforts, including what they can use as the basis for their arguments, what policymakers or organizations can be targeted, and at what levels of government that policy innovations are feasible.

This topic is worthy of academic research because understanding the characteristics of countries that assist or impede the mobilization of health professionals and IDUs can contribute to literature on both the theories of collective action and the diffusion of innovations. These two theories are used to understand the collective action process that leads to policy adoption in countries and to explore the relationship between certain characteristics of countries and the timing of policy innovations. If Mancur Olson were to analyze this problem today, he would likely say that high levels of collective action in countries could produce NEPs and SIFs under certain conditions since the general population in each nation could benefit from programs and facilities that target high-risk groups and works to limit them from spreading illnesses and diseases. In the 1980s, the onset of HIV/AIDS presented a public health crisis around the world. In 1983, a virus was discovered that appeared to be linked to HIV/AIDS and evidence began to suggest that the disease was blood-borne like hepatitis or syphilis. Scientists and researchers
then focused on the homosexual lifestyle as the cause of it (Berridge, 1996, 28 – 29). This caused the press start covering it as a ‘gay disease,’ with one Sun article in the UK titled “U.S. Gay Blood Plague Kills Three in Britain” and a People article in the U.S. titled “What the Gay Plague Did to Handsome Kenny” going to print that year (Berridge, 1996, 62). In both the UK and in the U.S. in 1984 and 1985, HIV/AIDS became prominent in the public’s conscious amid the deaths of some high profile people, and a sense of panic began to sweep through health professionals due to the implications for the heterosexual population (Berridge, 1996, 56).

In response to this growing epidemic, advocacy groups and governments around the world had to come up with ways to lessen the impact that other high-risk groups besides gay men were having on the epidemic. IDUs, along with sex workers, and prisoners, account for the other three most high-risk populations for spreading HIV/AIDS (2006 Report on the Global AIDS Epidemic, 104). Besides the typical unprotected heterosexual and homosexual sexual contract that now accounts for the majority of the new infections of the disease in the world, these high-risk groups are also still contributing to the epidemic in significant ways. In many parts of the world, some or all of these groups are linked with one another. Drug users often use sex to pay for their habits, while sex workers use drugs to escape the realities of their lifestyles. It has been found that sex workers who use drugs are usually much less likely to use contraceptive protection like condoms to limit the spread of diseases than non-drug using sex workers (2006 Report on the Global AIDS Epidemic, 107). Incarcerated IDUs also rapidly spread diseases and illnesses through the widespread sharing of limited numbers of needles and homosexual contact while they are incarcerated. After they are released from prison, they can then further spread these diseases to their sexual partners and sex workers, completing a deadly cycle (Strang & Stimson, 1990, 201; Sorensen et al., 1991, 4). IDUs most often share needles with sexual
partners, friends, and family members, and a lack of access to sterile equipment influences their decisions to share needles (McKeganey & Barnard, 1992, 51).

There are economic reasons for countries to establish these programs and facilities. Countries save more money over time when they successfully reach and treat IDUs because it is more cost-effective to prevent the spread of HIV/AIDS than to treat a large population that contracted the disease through preventable ways like intravenous drug use or unsafe sexual practices (Conley et al., 1996). Evidence collected on 27 cities with SIFs around the world have so far demonstrated a significant reduction in drug overdose deaths and the spread of diseases like HIV/AIDS and hepatitis C, as well as a dramatic reduction in the “open drug scenes” – essentially, tolerance areas for IDUs to freely inject and congregate – in those cities (City of Vancouver Four Pillars Drug Strategy, 2003). Once HIV/AIDS enters the IDU community, spread of the virus can become rapid since the social and legal status of IDUs prevent them from being reached by many interventions. In many countries, IDUs are either unable to access NEPs or are unwilling to do so for fear of harassment and prosecution by law enforcement officials, and this contributes to them continuing to engage in risky behaviors (2006 Report on the Global AIDS Epidemic, 114 – 115). Thus, intravenous drug use by a small population of drug addicts presents a collective action problem with implications for the entire population of a nation.

Following the outbreak and spread of HIV/AIDS in the early 1980s, governments had to decide how to reach IDUs in order to educate them about how to change their lifestyles and limit their contribution to the epidemic. However, these countries varied not only in the speed in which they acknowledged HIV/AIDS was a growing problem, but also in how far they have been willing to go to get at some of the root causes of the problem.
The theories of collective action and diffusion of innovations are appropriate in this context. Collective action is defined here as any action taken by coalitions that is meant to lead to policy adoption. IDUs, health professionals, and social workers in particular can produce this by forming groups and coalitions that work to change policies that have the potential to lessen the spread of HIV/AIDS among high-risk populations. Collective action is possible as long as the members of these groups and coalitions stand to gain more than they lose by making an effort to participate. For all members, as long as there is the potential to reduce spread of HIV/AIDS in the IDU community and the broader public by means of modifying the behaviors of IDUs, the benefits for all members will outweigh the costs of participation (Marwell & Oliver, 1993, 101).

Classic diffusion of innovation models incorporate four main elements – the innovation, the communication channels, time, and the members of a social system. The innovation is the new idea, practice, or object perceived as new by the government. Communication channels are how messages and debate about the idea or policy proposal are transmitted between the members of a social system, who can be individuals, informal groups, or organizations (Merritt & Merritt, 1985, 87 – 90). For my purposes, policy innovations are considered to be the adoption of government-tolerated or supported NEPs and SIFs. The members of a social system are IDUs and health professionals, social workers, or anybody else sympathetic to the problem of HIV/AIDS in the IDU community that works to change government policy. Communication channels encompass any of the ways in which governments can be engaged in debate, scientific study, or any other means of considering policy proposals that are not currently supported.

**International Drug Policies in the 20th Century**

To understand how some countries could end up establishing these programs and facilities while others did not, one must first know how drug policies around the world changed
from the beginning of the 20th century to its final quarter, as well as how the HIV/AIDS epidemic influenced this process. This century marked a time when drug policies around the world were repressive. From North America to Europe, drug policy followed a prohibition model, as more and more drugs became illegal to distribute and consume while maintenance prescription programs – prescriptions for addicts that gave them controlled amounts of illegal drugs – were increasingly shut down over the first half of the century (Frey, 1997; Kübler, 2001; Lindberg & Haynes, 2000). Early during the 20th century, there was a global trend to regulate drugs to varying degrees in different countries. Most countries reformed their drug policies between 1890 and 1920 to better safeguard foods, ensure that medicinal drugs were of high quality, and to regulate access to addictive drugs. However, some drug policies changed for reasons of race and/or social class. For example, drug policies changed in the Netherlands and the United Kingdom to outlaw opium use after those governments came under pressure from religious missionary groups. These groups blamed the effects of opium on being the reason why so many Chinese would not convert to Christianity (Erlen & Spillane, 2004, 178 – 179).

This negative link between specific drugs and racial groups and social classes was also common in the U.S., and thus opium was looked down upon for its association with the Chinese much like cocaine was looked down on due to its association with African Americans (Meier, 1994, 21; Sharp, 1994, 21). Following the implementation of the Harrison Narcotics Act and the conclusion of World War I, the U.S. even began making attempts to sway other countries’ policies; pressure from American diplomats resulted in the Netherlands signing on to the 1919 Opium act despite there being no substantial opium problem among citizens (Inciardi & Harrison, 2000, 117).
U.S. drug policy throughout most of the 20th century remained repressive with only a few exceptions to the contrary. From 1914 to 1923, the U.S. gave limited support to maintenance prescription programs but American programs never received the same amount of support as European ones did (Inciardi & Harrison, 2000, 34). In 1919, in the case of Webb et al. v. United States, the Supreme Court ruled against maintenance programs, saying that Mr. Webb, a pharmacist, subverted the meaning of a physician’s prescription when he gave morphine to an addict without it intending to be a cure (Sharp, 1994, 20 – 21). Despite the fact that 40 drug clinics with maintenance programs had opened by the end of that year (1919), nearly all of them were shut down by 1921 due to changes to federal drug policies and shifts in medical opinion following the Webb decision (Erlen & Spillane, 2004, 27).

In the 1920s, the U.S. began losing its leadership status in the international community in regards to international drug control (Meier, 1994, 31). Yet on the domestic front, laws became more specific and more widely enforced. Drug-enforcement responsibilities in the U.S. became institutionalized with the establishment of the Federal Bureau of Narcotics in 1930. When Harry J. Anslinger took control of this agency, tolerance for drug use diminished even further while the number of anti-drug legislation increased (Sharp, 1994, 21). As he worked to expand his bureau’s authority, he also got a few significant pieces of legislation passed, including the Marihuana Tax Act in 1937 which essentially outlawed drug use, the Boggs Act in 1951 which made penalties for marijuana equal to those for narcotics, and the Narcotics Control Act of 1956, which was the most repressive drug-control policy ever enacted by Congress to that point (Erlen & Spillane, 2004, 111; Sharp, 1994, 22).

Beginning in the 1960s, the U.S. began supporting methadone programs, which were essentially maintenance prescription programs that substituted methadone for heroin. Over the
next four decades, government support for methadone would increase substantially, and they are still considered to be the most successful way to treat heroin addiction and withdrawal (Inciardi & Harrison, 2000, 34 - 37). Methadone is usually dispensed in outpatient clinics but is occasionally given out in multiple day supplies, allowing drug users more freedom in their daily lives. This gives drug users the ability to live normal lives instead of constantly thinking about getting their next fix and potentially committing crimes in order to obtain it (Sharp, 1994, 71). Studies have demonstrated that the programs have also led to reductions in illnesses and overdoses among IDUs, reductions in the amount of crimes committed by IDUs, and they have limited the spread of HIV/AIDS (McKim, 2003, 252 – 253).

In the 1970s, health professionals in the U.S. began illegally giving out needles to IDUs to prevent medical problems like skin abscesses that were caused by the reusing of dirty needles (O’Neill et al., 2004). By the end of the decade, other countries saw that this had positive effects in the IDU population and they started reevaluating their national drug policies to include other measures aimed to protect the health of drug users. In spite of historically having prohibitionist drug policies that treated drug use as a crime, many countries began to shift the focus of their drug policies to view drug use as more of an illness (Boekhout Van Solinge, 1999). The Netherlands was a pioneer in doing this, and the focus of their drug policy shifted when they reorganized and reclassified drugs to differentiate between those that were ‘soft’ and those that were ‘hard,’ allowing police to refocus their resources on a growing ‘hard’ drug problem (Scheerer, 1978). The United Kingdom also saw changes in the 1970s, and those changes were initiated by the rebellion of people in the medical profession after it became apparent that policies like “competitive prescribing” and the recommendations of the Brain Committee that were recently implemented were not working (Bennett, 1988).
This rebellion of health professionals in various countries was further energized by the HIV/AIDS epidemic in the 1980s, and eventually the illegal practices that they had been advocating for years were organized into a perspective on drug policies that also advocated other policy techniques that sought to reduce the harms associated with drug use. Due to the rapid spread of HIV/AIDS and the increase of drug-related deaths around the globe during this decade, ‘harm reduction’ began to receive widespread attention and gained popularity amid frightening statistics like several European cities having over 50% of the IDU population infected with the disease (Strang & Stimson, 1990, 18; McKeganey & Barnard, 1992, 3; Inciardi & Harrison, 2000, 2).

To combat this growing epidemic, some countries began to specifically implement ‘harm reduction’ techniques in their drug policies to reduce the impact that IDUs were having on the spread of the disease. Among these countries were Australia, Switzerland, and the United Kingdom (Inciardi & Harrison, 2000, ix). ‘Harm reduction’ considered drug addiction to be more of an illness in need of medical attention than a crime that deserved punishment, and sought to educate IDUs about how to reduce the harms associated with drug abuse while providing them with opportunities to begin recovering from their addictions. Early methods and techniques to target IDUs were somewhat limited, and they included increasing IDU access to social services, methadone programs, maintenance prescription programs, needle-exchange programs, and safer-sex counseling (Pearson, 1991). Methadone has been consistently used in many countries for much of the last half of the 20th century, but maintenance prescription programs have not been widely implemented. Needle-exchange programs first arose in the Netherlands in 1984, and they quickly spread to other countries in the region within a few years.
While ‘harm reduction’ was expanding in Europe, in the U.S., HIV/AIDS was beginning to be cemented into public consciousness amid hysterical media headlines singling out IDUs and sex workers (McKeganey & Barnard, 1992, 70). This attention to the epidemic grew as the decade progressed. In 1987, the Centers for Disease Control began reporting that 40% of black and Hispanic men living with the disease were IDUs (Sharp, 1994, 54). U.S. NEPs were first established in 1988 and often began illegally amid great controversy in cities such as Tacoma, Washington, New Haven, Connecticut, San Francisco, California, and New York City, New York (Inciardi & Harrison, 2000, 51 – 52). Federal funding for the programs was banned in Congress the same year the first NEP was established, and this has forced the majority of American programs to operate with only limited amounts of support in comparison to European ones ever since (O’Neill et al., 2004).

The late 1980s also marked a time when international pressures once again began to influence approaches to national drug policies like they had near the beginning of the century. In 1988, a UN-sponsored conference created the Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control, which placed treatment and rehabilitation on equal footing with reducing and preventing demand, controlling supply, and disrupting trafficking as areas of focus in policies. In another signal of more widespread international cooperation on this issue, an anti-trafficking treaty received unprecedented support and cooperation from UN members that same year, unlike an earlier attempt to do in 1936. (Erlen & Spillane, 2004, 200 – 201).

As more countries began to use ‘harm reduction’ techniques in the early 1990s, the framework would expand with more techniques, approaches, and goals by the middle of the decade. These included more access to drug education programs that informed drug users about
the dangers associated with overdosing and why they should not mix drugs and share needles. Other controversial techniques like maintenance prescriptions and ‘tolerance’ areas like shooting galleries – where drug use is permissible and not prosecuted – were implemented and expanded in some countries (Conley et al., 1996). In many countries, law enforcement became more lax towards IDUs, and police policies softened the penalties for drug addicts while they simultaneously increased the penalties against drug traffickers (DEA, 2002). But despite the growth of ‘harm reduction’ techniques in drug policies through the 1990s, most countries continued to have repressive drug policies near the end of the century (Frey, 1997).

What follows in the next sections of this thesis are analyses centered on NEPs, SIFs, and the characteristics of countries that may explain why some countries successfully implement programs and facilities while others do not. Detailed histories of the 20th century drug policies of each nation in the data set are first discussed alongside the ‘harm reduction’ techniques instituted in most of these countries to combat the HIV/AIDS epidemic. Using data on characteristics of each nation, I run analyses to determine what characteristics are associated with countries that established and supported NEPs and SIFs early on during the HIV/AIDS epidemic and how they differ from countries that did this later on.
Chapter Two

Literature Review

Introduction

Before going any further, it should be noted that the differences across the following countries are distinct and plentiful, which presents problems for later data analysis. Although NEPs can be found in the majority of countries, most of them are not nationally or federally funded and have never been made legal through legislation. The U.S. is characteristic, as programs are tolerated in a majority of states even though they have never received federal funding (Broadhead et al., 1999). In contrast, the vast majority of safe-injection facilities that currently exist are sanctioned and supervised by the government (Broadhead et al., 2002).

Originally, my goal was to use the year in which NEPs and SIFs first received national funding as the determinant of whether or not they were supported or approved by the government, but this ended up being unfeasible since many NEPs are not directly dealt with by legislation or laws. Some countries could be falsely interpreted as having very repressive drug policies because NEPs have not been widely established, when in actuality they are not used because needles and syringes have been legally sold in pharmacies for decades and it is argued that there is little need for IDUs to share them. Other countries consider programs to be legal but because of issues related to national funding, a slow legislative process has resulted in limited government support. Thus, government-supported or tolerated NEP and SIF establishment is defined very broadly as any government agency or organization either approving a pilot program or not actively working to shut an existing unofficial program down. The drawback of having such a broad definition is that it can potentially bias my results later so that I interpret government ambivalence as government support; to counter this problem, I denote when a nation nationally funds and/or operates programs to clarify this issue.
Nation Profiles

Listed below are discussions concerning 18 countries. In each nation, the history of drugs and drug policy throughout the 20th century, what the type of government is, what countries are regionally close and share contiguous borders, as well as summaries of each nation’s first experience with NEPs and SIFs (if applicable) are presented. More expanded profiles of countries are included below to provide context for hypotheses regarding what is typical of early policy innovators and the ones that implement the most controversial of drug policy approaches.

Australia

Australia has a parliamentary system of government and does not share contiguous borders with any other nation. Opium and cocaine were as accessible as tobacco and alcohol at the beginning of the 20th century, but this changed following federation in 1901. Opium was outlawed by various states at the turn of the century over racist concerns about the Chinese. Maintenance prescribing was practiced by general practitioners and continued into the early 1950s (Inciardi & Harrison, 2000, 171). Heroin was prescribed in hospitals until the 1960s when the federal government banned the importation and manufacture of the drug under pressure from the international community (Inciardi & Harrison, 2000, 182). This trend continued throughout the next few decades, and drug policies during the 1960s and 1970s became more severe until HIV/AIDS arrived in the early 1980s (Inciardi & Harrison, 2000, 172).

Although methadone programs were in place before NEPs were established, admission to them was liberalized in 1985. The following year, the first pilot NEP was implemented by a group of alcohol and drug workers based in Sydney, New South Wales. This NEP was established in breach of newly passed legislation outlawing such programs, but police did not
prosecute offenders (Strang & Stimson, 1990, 135). Toleration and support for NEPs increased, and by 1988, 40 programs had already been approved in the state of New South Wales (Strang & Stimson, 1990, 135).

Like the first NEP established in Australia, the first SIF was established in New South Wales. The proposal to establish a facility was initiated in 1997 during a Royal Commission into the NSW Police Service, but the facilities were recommended to not be trialed over concerns about safety, increasing crime, and questions about resources and funding. An unsanctioned facility began operating in a church in 1998, but it was shut down after only a few weeks. In 1999, a drug summit sponsored by the New South Wales Government recommended an 18-month trial of a SIF, however, securing a facility that met all law requirements proved to be difficult. The Vatican vetoed the idea of the Sisters of Charity operating the facility, but this was overcome when the Uniting Church obtained a license to operate it. In order to operate, the facility had to employ qualified health professionals and at least one employee had to be qualified in youth support or child protection. It also had to provide drug and alcohol counseling, detoxification, health and well-being education, methadone treatment, testing for STDs and blood-borne diseases, and needle exchange services. Upon meeting these requirements, a facility was finally established and functional by 2000 (Elliot et al., 2002).

Brazil

Brazil has a presidential system of government and shares contiguous borders with French Guiana, Suriname, Guyana, Venezuela, Columbia, Peru, Bolivia, Paraguay, Argentina, and Uruguay. None of these countries had experience with ‘harm reduction’ techniques prior to Brazil’s experience. The first cases of opiate dependence arose in Brazil in the 1930s (Baltieri, 2004). Purchasing and possessing syringes in Brazil is legal, but current drug laws are vague and
open to interpretation, and this has contributed to a problem of unsuccessful implementation of NEPs. The possession, manufacture, sale, and distribution of drugs are prohibited, and assisting or providing the means to ingest drugs is illegal as well. It is this language in Brazil’s drug policy that specifically creates barriers to NEP implementation (Inciardi & Harrison, 2000, 140 – 141).

Brazil has never had maintenance prescription programs or methadone programs, but government-tolerated or supported NEPs began operating in 1994. The first Brazilian NEP started in 1989 in Santos but was quickly shut down under pressure from the Federal Narcotics Council (Inciardi & Harrison, 2000, 140). The Municipal Government of Santos in Sao Paulo State worked to establish others but they were prevented from opening due to the Brazilian Legislation on Psychoactive Drugs (Andrade, 2001). The government finally started discussing the programs in 1992, and by 1994, the Ministry of Health proposed a pilot program for six cities that had approval from the Federal Narcotics Council. As support for these programs grew at the state level, the Secretary of Health required that these programs also include safer sex education, counseling on STD and HIV transmission, and evaluation of IDUs for future measures like bleach and condom distribution initiatives. The National Program on STD/AIDS of the Ministry of Health sent researchers to the U.S. in 1994 to study NEPs, and in 1995 the programs began being implemented based what was learned from the American experience. In September 1997, the Sao Paulo State Government became the first Brazilian state to pass a law that permits NEPs (Andrade, 2001). SIFs have never been considered to be a viable drug policy option by the Brazilian government, and have never been trialed or seriously discussed.

Canada
Canada has a parliamentary system of government and shares contiguous borders with only the U.S. The U.S. did not have experience with ‘harm reduction’ techniques prior to Canada’s experience. Methadone programs began operating in Canada in the 1950s. The Controlled Drugs and Substances Act was enacted in 1996 and prohibits the import and export of illegal drugs, possession and trafficking. It also prohibits possession of used injection equipment as well as the promotion, sale, and free distribution of “instruments for illicit drug use” (Elliot et al., 2002). Recently, heroin has been used on an experimental basis in Canada, similar to how it can be prescribed under certain conditions in the UK (McKim, 2003, 237).

NEPs were first established without government support in Toronto in 1987 and with government support in Vancouver in 1989 (BC Partners for Mental Health and Addictions Information). On September 22, 2003, the first pilot SIF opened in Vancouver. The federal government approved a three-year pilot study to determine the usefulness of the facilities, and in the last two years, two other Canadian cities have started to consider whether facilities should be opened. The Vancouver SIF was approved in part because of the city’s “open drug scene” and also due to the fact that rates of HIV/AIDS and Hepatitis C started to reach epidemic proportions by the late 1990s (City of Vancouver Four Pillars Drug Strategy, 2003).

China

China has a communist system of government and shares contiguous borders with Afghanistan, Bhutan, India, Kazakhstan, Kyrgyzstan, Tajikistan, Laos, Mongolia, Myanmar (Burma), Nepal, North Korea, Pakistan, Russia, and Vietnam. At least six of those countries had experience with ‘harm reduction’ techniques before China did. Historically, the Chinese government has “cracked down” on drug use many times and even eradicated it for a short time in the 1950s. Since then, there has been an epidemic of intravenous heroin use since the 1980s.
that resulted in new laws requiring IDUs to attend mandatory treatment, such as the “Regulations on Prohibition Against Narcotics” that was enacted in 1990 (Qian et al., 2006). This mandatory drug treatment has a very low success rate (Beyrer, 1998, 152). Although needles are legal and affordable in China, IDUs are often harassed and roughed up by police when they are caught carrying them (Burris & Villena, 2004).

The first NEP that was tolerated by the government began in 2004. By the end of that year, 30 cities in Guangxi began operating NEPs that were able to reach over 6,100 IDUs (Yan, 2006). The following year, the Chinese Health Ministry would not only acknowledge the failure of the 20-year long drug war that the government had been waging, but it would also begin a campaign to encourage the government to support NEPs, methadone programs, and promote the distribution of condoms to high risk groups like IDUs, gay men, sex workers, and migrants (Join Together, 2005; Stop the Drug War, 2005). By the end of 2005, over 91 programs had been established (Agence France-Presse, September 29, 2006).

France

France has a semi-presidential system of government and shares contiguous borders with Andorra, Belgium, Germany, Italy, Luxembourg, Spain, and Switzerland. Germany, Luxembourg, Spain, and Switzerland all had experience with ‘harm reduction’ techniques prior to France’s experience. In the 1980s, legislation existed that could force convicted IDUs into mandatory treatment programs (Strang & Stimson, 1990, 71). This legislation is no longer in effect and syringes and needles are now freely sold in pharmacies, in dispensing machines, in NEPs, or in community drop-in centers (EMCCDA (France), 2004).

‘Harm reduction’ techniques began being used in 1987 in France and the first NEP was established in 1989. By 2001, there were 118 programs in operation and 40 drop-in centers for