

# Syringe Exchange Programmes – The Portuguese Experience

Carla Matos Torre



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Faculdade de Medicina da Universidade do Porto

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Esta dissertação teve como base duas Secções: I) "*The Portuguese syringe exchange programme – a 15 years experience*" e II) "*Process characterization by the syringe exchange programme providers*", sendo que colaborei activamente no desenho, recolha, armazenamento e análise da informação, tendo sido responsável pela análise dos dados que reportam, bem como pela versão inicial dos manuscritos correspondentes à Secção II:

- Carla Torre, Raquel Lucas, Henrique Barros. *Community pharmacies and the syringe exchange programme in Portugal – a 15 years experience*. [submetido para publicação]
- Carla Torre, Raquel Lucas, Henrique Barros. *A survey of syringe exchange programmes in Portugal*. [submetido para publicação]

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## **BACKGROUND**

**SYRINGE EXCHANGE PROGRAMMES IN THE  
CONTEXT OF HARM REDUCTION**



## The Rationale of Syringe Exchange Programmes

Injecting drug users (IDU) are particularly vulnerable to hepatitis C virus (HCV), human immunodeficiency virus (HIV), and other bloodborne infections as result of sharing (multi-person use) contaminated injecting equipment (1,2).

There are an estimated 16 million [11 to 21 million] injecting drug users worldwide (3) – 78 percent of whom live in developing or transitional countries (4).

Hepatitis C virus is a serious public health issue. Globally, HCV has one of the highest prevalence rates among all infectious diseases. The World Health Organization (WHO) estimates that about 180 million people are infected with HCV, 130 million of whom are chronic HCV carriers (5,6). By contrast, estimates show that 33 million [30 to 36 million] people are living with HIV/AIDS (PLWHA) worldwide (7).

Fewer sharing partners are necessary to sustain HCV transmission than are necessary for other bloodborne viruses (8). Indirect drug sharing and preparation practices, such as backloading or frontloading (front and/or backloading are defined as splitting drugs prepared in one recipient with subsequent transfer of prepared drug from one syringe to a second syringe, via the front of the recipient syringe – frontloading - or the back of the recipient syringe, after removing the plunger – backloading), sharing cotton, cooker, and water, have been associated with HCV transmission (9-14).

Injecting drugs has been the predominant mode of transmission of HCV during the past 40 years in countries such as the United States and Australia, and accounts for most newly acquired infections in many other countries, including those in Western, Northern, and Southern Europe (15). Antibody levels of over 60% among IDU samples tested in 2003–2004 were reported from Belgium, Denmark, Germany, Greece, Spain, Ireland, Italy, Poland, Portugal, United Kingdom, Romania and Norway. The highest prevalence (over 40%) among IDU under age 25 was found during 2003–2004 in samples from Belgium, Greece, Austria, Poland, Portugal, Slovakia and the United Kingdom (16).

More than 120 countries reported HIV transmission associated with sharing of contaminated injecting equipment and about 3 million [0.8 to 6.6 million] people who inject drugs worldwide are living with HIV/AIDS (3).

Injecting drug users have been initially driving the HIV epidemics in western Europe and North America (17). In 2008, the Joint United Nations Programme on HIV/AIDS (UNAIDS) reports HIV transmission due to injection drug use is advancing rapidly in many countries, mostly in Eastern Europe and Central (18), south and southeast Asia (3,7).

According to UNAIDS, by 2010, the global epicentre of HIV epidemic is expected to shift from sub-Saharan Africa, where injection drug use has made a negligible contribution, to Asia and Central and Eastern Europe. This region is the one of the fastest growing HIV epidemics in the world and has had a 20-fold increase of PLWHA in less than a decade (19,20).

The sexual behaviour of IDU should not be neglected (21). Cross-sectional studies from the nineties found a potential role for sexual risk behaviour in HIV transmission among drug

users (22) as did recent prospective studies (23-25). Catharina Lindenburg *et al* investigated trends in HIV incidence and both injecting and sexual behaviours among HIV-negative drug users of the Amsterdam Cohort study since 1985 up to 2004. A declining trend in HIV incidence accompanied a steep declining in injecting was observed despite continued risky sexual behaviour. In the later years of the study period, new HIV seroconversions were related mainly with unprotected heterosexual contacts (24).

In 2007 a total of 48 892 HIV cases were reported from 49 of the 53 countries in the WHO European Region (missing data for Austria, Italy, Monaco and Russia Federation). Of these, 13 538 cases were reported among IDU (26).

According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the number of newly diagnosed cases of HIV among IDU is estimated to be currently around 3500 *per annum* in the EU (27).

The response to HIV favoured the need for scaling up of prevention, treatment and care. In particular the world made an unprecedented commitment during the United Nations General assembly Special Session on HIV/AIDS in 2001 to halting and reversing the epidemic by 2015 (28). Countries face the challenge of translating these commitments into practical programmes, including a range of comprehensive interventions to address HIV transmission related to injection drug use (29). Later, Europe reaffirmed this commitment and set its own targets and goals in the Dublin Declaration (30).

Regardless of the effort to treat drug dependence effective HIV prevention for injecting drug users involves ready access to opiate substitution treatment (OST) and to syringe exchange programmes (SEP)<sup>1</sup>. In addition, prevention programmes should help injecting drug users to reduce the risks of sexual HIV transmission and link them to other health and social services, including confidential HIV testing, counselling, and antiretroviral therapy. Together, these programme components are commonly known as "harm reduction" (1,4,29,31).

Studies have consistently demonstrated that harm reduction prevents HIV infections and risk behaviours without contributing to increased drug use or increasing other harms in the communities in which such programmes operate (1,20,32-34).

A wide variety of measures have been developed to improve access to and utilization of sterile injecting equipment, including SEP at different settings, pharmacy-based distribution, sale or exchange-schemes, strategies for disinfecting needles and syringes where they are reused or shared, vending or distribution machines and other distribution programmes, policies and programmes for safe disposal of used syringes and needles and injecting paraphernalia legislation (29).

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<sup>1</sup> In this document the term SEP is used to refer to programs that provide IDU with access to sterile injection equipment, health education, referrals, counselling and other services. However, in other parts of the world, the term needle exchange program (NEP) is used as the label for these types of programs. The term needle and syringe programs (NSP) is growing in popularity and in response to the move of many programs away from 'exchange' of equipment to 'distribution' of equipment with or without a return of used equipment. Nevertheless, in Portugal, these programs have been known as SEP since their inception. Consequently, the term SEP is used throughout the document. The term 'Exchange' refers to needle/syringe exchange, distribution and disposal.

The WHO reported that in 2004, SEP operated officially in forty countries (29) and has increased to 60 in 2007 (35). In 2007, substitution therapy with methadone was available in only 52 countries, and with buprenorphine in only 32 countries (7).

To control an epidemic of the magnitude of HIV among IDU would require public health measures on a scale proportional to the expected harm. These programmes need to be implemented on a sufficiently large scale to ideally reach every IDU (36,37). Nevertheless, there are still considerable differences between countries in the nature and scale of their national drug problems and also in the range and configuration of response. Some measures – especially SEP and OST remain controversial in many parts of Eastern Europe and Asia, whilst the availability of sterile injecting equipment in most of these countries is clearly insufficient to slow the spread of HIV and other bloodborne infections among drug users (38,39).

WHO strongly recommends that prison and public health care be closely linked (40). Despite that, prisons and prison health in particular are not always high on the agenda of politicians, but the dynamic of transmission of infectious diseases in prisons and ultimately from prisons to the rest of the society makes obvious the importance of ensuring better access to health care and health promotion in prisons.

About 8 to 10 million people are imprisoned globally. In many countries, drug users are at high risk of being imprisoned, due to crimes related to drug production, possession, trafficking or use, or crimes committed to guarantee the resources to purchase drugs (7).

Obviously, injecting drug behaviour also occurs in prisons. Since it is illegal, it is more likely to occur with unsafe shared equipment. A large number of studies from countries in many regions of the world reported HIV and/or HCV and/or hepatitis B virus (HBV) seroconversion within prisons or, more often, showed that a history of imprisonment was associated with a higher prevalence or incidence of HIV and/or HCV and/or HBV infection among IDU. In Lithuania the use of non-sterile injecting equipment resulted in one of the largest documented HIV outbreaks in the Alytus prison (41).

Given the prevalence of injecting drug use among inmates in many countries and the resulting risk of HIV and HCV transmission, providing sterile needles and syringes to prisoners has been widely recommended (40,42). As of 2006 SEP were introduced in over 50 prisons in 12 countries in Western Europe, Eastern Europe and in Central Asia. In some countries, only a few prisons have a SEP, but in Kyrgyzstan and Spain SEP have been rapidly scaled up and operate in a large number of prisons (41,42).

### **Historical Context of Syringe Exchange Programmes**

Acquired immunodeficiency syndrome (AIDS) was identified among IDU in 1981. The first cases of AIDS among IDU were highly concentrated in the New York City, leading to a false impression that the problem clustered geographically in this area (43-45). The development of the HIV antibody tests in 1985 showed HIV infection among drug injectors in many other U.S. and European cities, although at widely varying prevalence levels. By the mid-80s, HIV infection

among IDU was seen as an important problem in many parts of North America and Western Europe (44).

The Edinburgh epidemic of injection drug use started around 1980 and peaked in 1983-84, though there were few medical provisions for dealing with this problem since, unlike many other UK cities, in the early 1980s Edinburgh had little in the way of specialist services for drug users (46). In the mid-80s UK drug treatment service had become largely focused on the achievement of abstinence.

The idea of distributing injecting equipment to drug users was first advanced by a pharmacist in Edinburgh, following an epidemic of hepatitis B and C related with injecting drug use. This decision was soon overruled by authorities. In 1982, in an attempt to restrict the IDU epidemic, the Royal Pharmaceutical Society of Great Britain advised its members to restrict needle and syringes sales to only those individuals requiring them for therapeutic reasons (29,46). Nonetheless, trading of limited numbers of syringes and needles remained in some areas of the UK. Drug users in Edinburgh reported that their equipment was commonly confiscated by the police, during searches, as a means of gathering evidence against the suppliers. This resulted in suppliers' enforcing the use of drugs on site – similar to shooting galleries. By late 1984, intense police activity had almost eliminated this "marketplace", considered at the time as illegal services (46).

In 1983, after an outbreak of hepatitis B among IDU, an Amsterdam drug users group (*Junkiebond*) required municipal health authorities to provide sterile injection equipment, but the request was initially rejected (29). Nevertheless, in 1984, after a large pharmacy in central Amsterdam stopped selling injection equipment to IDU, the decision was soon reversed, allowing for the establishment of the first official SEP in the world (47-49). The SEP-mobile van was also first introduced in Amsterdam, in 1986. It was, in fact, a methadone dispensing but also offered injecting equipment (50).

The Amsterdam SEP was originally developed to prevent the spread of hepatitis B, but its goal soon became to prevent HIV infection and it was expanded to other Dutch cities (47,48) and also to other countries.

In April 1987, the government of the United Kingdom launched a pilot intervention involving fifteen schemes, which included one pharmacy-based scheme, influenced by the Scottish evidence of increased transmission of HIV among IDU following shortage of syringes (the highest rates known of HIV were in Edinburgh, where between 1983 and 1985 half of 164 heroin users were infected). There was a fear that this could replicate elsewhere in Britain (51). After a one-year evaluation a national system of SEP was implemented and different models were developed; schemes based within hospitals, drug agencies and pharmacies (52). In 1987 the Royal Pharmaceutical Society revised its restrictive policy on sales of needles and syringes and issued guidelines for pharmacists taking part in SEP (53).

Therefore, when evidence on the effectiveness of SEP began to accumulate, most industrialised countries, in Western Europe, Australia, New Zealand, and Canada, openly supported SEP and governments rapidly decided to provide sterile syringes to IDU through a combination of different programmes and increased availability of sterile injection equipment through pharmacies (54).

In the European Union context, Portugal was the sixteenth country to implement an SEP (1993) and the twelfth country that financed those programmes with public resources (1994) (55).

Syringes dispensing machines were first introduced in Denmark, in June 1987, and followed a few months later by Norway (50).

Nevertheless SEP remains controversial in many parts of the world. Since 1988, US law banned the use of federal funds for SEP. Federal funding of SEP has been prohibited until "*the Surgeon General determines that such programmes are effective in preventing the spread of HIV and do not encourage the use of illegal drugs*" (56). Despite the results of many USA government-sponsored reviews of SEP, which concluded that such programmes reduced the incidence of HIV infection among IDU and do not lead to an increase in rates of drug use – the ban on federal funding for SEP was not lifted. In maintaining a ban on national funding for these programmes, the USA is unique in the world (54,57,58). Opposition to SEP arose from some drug-treatment providers, ethnic minority communities, law enforcement officials, politicians, local business people and residents (56,59,60).

Some of the initial SEP in USA were the initiative of activists and some later gained legitimacy and funding from local city governments and public health programmes (58).

In 1986, Jon Parker, a recovering IDU and student at Yale University School of Public Health, formed a group called the National AIDS Brigade and started the first "underground" SEP in USA. Parker started to distribute and exchange syringes on the streets of New Haven, Connecticut; actions that would lead him to be repeatedly arrested (45,58).

The first formal programme in USA was established in Tacoma, Washington, in 1988, and later in New York City, Portland, Oregon, and San Francisco, California, in 1989 (61). The New York City programme was started with severe restrictions – a single location near a police station with participant identification required and only one syringe per visit. The Tacoma program operated from a tray table from the trunk of an automobile (45).

Since then the number of SEP in USA has increased from 55 in 1994 (62) to 184 in 2007 (63).

Barbara Tempalski *et al* examined the effects of political, socioeconomic, and organizational characteristics, including need (measured by the prevalence of AIDS cases among IDU or the proportion of IDU in each US metropolitan area), resources and local opposition in 96 USA metropolitan areas on the presence of SEP. SEP were more likely to be located in areas with high proportion of men who have sex with men (MSM), with high proportion of college-educated individuals and with presence of grassroots activists and

organizations (e.g. AIDS Coalition to Unleash Power). Surprisingly, need was not a predictor (59).

It may be close to reality to say that sometimes politics is the basic science of public health (64), as shown by this statement made in the first presidential campaign of George W. Bush: *"(...) I do not favor needle exchange programs and other so-called "harm reduction" strategies to combat drug use. I support a comprehensive mix of prevention, education, treatment, law enforcement, and supply interdiction to curb drug use and promote a healthy, drug-free America, not misguided efforts to weaken drug laws. (...) America needs a President who will aim not just for risk reduction, but for risk elimination that offers people hope and recovery, not a dead-end approach that offers despair and addiction"* (65).

Another paradigmatic example is the implementation of SEP in prison settings; it is paradoxical from legal, public health and human rights perspectives that IDU inmates may be placed at higher risk of bloodborne infection compared to IDU within society at large.

Despite the existence of WHO Guidelines on HIV/AIDS Infection in Prisons, published in 1993, which recommends that *"in countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injection equipment during detention and on release"*, few countries implemented programmes (41).

The first SEP within a prison system was established in Switzerland in 1992. The initial program was started on an informal basis by a physician who, ignoring prison regulations, began distributing sterile syringes to patients who were known to inject drugs (42).

Despite the effectiveness of SEP within prison settings being well documented some interventions remain unpopular among some politicians. The decision on the part of several state governments in Germany to end prison SEP clearly illustrates the continuing controversial nature of such programmes, even within jurisdictions where they have a history of successful implementation. Since 2001 political decisions have forced the closure of six SEP (42,66).

In other countries, including Portugal, there has been a lack of political leadership and political will to implement these programmes. Only in 2007 the Portuguese Government launched a pilot experiment SEP in two prisons.

Consumption rooms were developed in cities where – despite the availability of a variety of harm reduction services such as SEP, as well as a range of treatment options, including OST – public drug use persisted and there remained serious concern about infectious diseases, drug-related deaths and/or public nuisance. Although evidence suggests that consumption rooms reduce overdose deaths, sharing and other risk behaviours, this intervention remains controversial largely because of concerns that provision of a legal place to inject drugs may encourage initiation into injection drug use (67).

The first consumption room was opened in Bern, Switzerland in 1986. In the early nineties, the Netherlands and Germany opened their first consumption rooms, and in 2000 Spain followed (68). As of 2006, there were consumption rooms operating in Switzerland, the Netherlands, Germany, Spain, Luxembourg, Norway, Australia and Canada (68, 69).

In Portugal the implementation of consumption rooms, is allowed by law, since 2001 (Decree-law no. 183/2001, of 21st June) (70). However, despite the existence of this law, its implementation remains to be accomplished.

### **Modes of Service Delivery and Spectrum of Services**

A variety of measures have been developed to improve access to and utilization of sterile injecting equipment and to increase users choice. These include several methods for distribution or sale of injecting equipment such as conventional SEP in fixed-sites, pharmacy-based distribution, dispensing machines (that either sell injecting equipment, provide it for free or in exchange for used equipment) and outreach programmes – often using a mobile van or bus and sometimes through home-visits (29).

#### Fixed-sites

Fixed-sites SEP are usually set up near places where drugs are bought and sold openly (“drug scene”) or with a large number of IDU. Determining optimal locations for fixed sites is crucial for SEP effectiveness. The location of fixed-sites determines, to a large extent, the likelihood that IDU will use the services.

At a fixed-site it is also easy to offer additional services (*on-site*) such as health care, testing and counselling for HIV and hepatitis, treatment (e.g. antiretroviral, TB, OST), vaccination (hepatitis A and B), etc. (35).

#### Outreach Programmes (mobile vans or through home-visits or on the streets)

Drug scenes change over time in terms of person, place, time and behaviour. Changes in the drug sellers, types of drugs available and/or sought, housing, police surveillance and arrest activities and other events can impact the drug scene (71).

This approach offers the potential to provide injecting equipment to hard-to-reach and high-risk individuals or IDU populations and in some cases act as a bridge to fixed-sites.

A mobile service can cover a larger geographic area, can more readily accommodate changes in local conditions and can offer a congenial environment that provides near anonymous access. Normally, a van generally follows a relatively consistent route, and parks at a predictable location at a predictable time, although it can change in response to immediate variations (e.g. police presence, neighbourhoods’ conditions). Mobile services are often easier for local residents to cope with and can overcome opposition focused on a fixed site. Depending on the van’s size and infrastructure, it can also provide some health-care services, testing and counselling for HIV and hepatitis, etc. (50).

At their simplest, outreach programmes through home-visits, involve a person going to a dwelling where there are IDU, ready to provide sterile injecting equipment, a sharps container for disposal of used needles and syringes and leaflets or other information. Often outreach programmes through home or street visits are set up to complement the work of fixed-site or mobile SEP when it is apparent that there is a number of injectors who are not making use of these services (35).

#### Community Pharmacies

Community pharmacies have many benefits as locations for public-health interventions. Their convenient locations, extended days and hours of operation (their opening hours are often more convenient than those of fixed-site SEP) make them available to many people. These characteristics make them good locations for IDU to obtain sterile injecting equipment.

Community pharmacies can distribute sterile injecting equipment, through exchange schemes or sale (72-74).

#### Dispensing Machines

Sale or exchange machines have been introduced as an attempt to provide a more convenient and available method of providing sterile injecting equipment to hidden and hard-to-reach IDU in an anonymous, private and non-stigmatized way. These machines are typically available 24 hours a day, seven days a week.

There are however criticisms of dispensing machines. One of the major concerns about sale or exchange dispensing machines is that they reduced staff-user contact, thus depriving IDU of information and education of safer injecting and linkage to other services.

Sale or exchange machines should be located in an area where injecting is known to occur and where IDU can access the machine without fear of police surveillance or other harassment (75).

The coexistence of different modes of injecting equipment delivery, as well as tailoring services offered at different venues addresses several barriers that IDU encounter. Studies have suggested that different types of IDU make use of different syringe distribution channels (71, 75-78) and have indicated that the additional services provided by many SEP are especially important in attempts to reduce bloodborne infections and risk behaviours (39,79,80). Different modalities for improving syringe availability are complementary and not competitive (78).

Some studies have attempted to evaluate whether different types of modalities of SEP attract different profiles of IDU. For example, Obadia *et al* surveyed 343 IDU at SEP, pharmacies and vending machines sites in Marseille, France, and found that that 21.3% reported vending machines as their primary source of syringes. Those IDU were significantly more likely to be younger than 30 years old, never have received maintenance treatment and



significantly less likely to report a positive HIV test. The authors concluded that vending machines might reach IDU who are less likely to attend SEP or pharmacies (76). These findings were corroborated by Moatti *et al* (77).

Also, in prisons several models for the distribution of sterile injecting equipment have been used, including dispensing machines, hand-to-hand distribution by prison health care staff or by external community health workers (e.g. Non-Governmental Organizations) and distribution by prisoners trained as peer outreach workers (41,42).

In a different way, consumption rooms should also be mentioned as a model for distribution of sterile injecting equipment. Consumption rooms are protected places for hygienic consumption of pre-obtained drugs, under the supervision of trained staff. They constitute a highly specialised drugs service within a wider network of services for drug users, embedded in comprehensive local strategies to reach and fulfil a diverse range of individual and community needs that arise from drug use (67,68).

There is a large consensus that no single intervention will effectively prevent or control outbreaks or epidemics of blood borne infections related with injecting drug use, hence the need for a comprehensive package for prevention, treatment and care. HIV epidemics among injecting drug users can be averted, halted and reversed, if comprehensive HIV programmes targeting drug users are implemented (1,32).

A comprehensive package for prevention, treatment and care for injecting drug users, should include the following interventions: distribution of sterile injecting equipment, drug treatment maintenance (e.g. OST), voluntary HIV counselling and testing, anti-retroviral treatment, sexually transmitted infection (STI) prevention and treatment, condom programming for IDU and their sexual partners (including clients in the case of IDU sex workers), target information, education and communication (IEC) for IDU and partners, hepatitis diagnosis, treatment (hepatitis A, B and C) and vaccination (hepatitis A and B) and tuberculosis (TB) prevention, diagnosis and treatment (1,32,81-86).

IDU often have difficulty in accessing formal healthcare services, so that the "SEP environment" itself can be an important outlet for this comprehensive package. Of note, however many SEP clients failed to receive needed preventive services. For example, only 35% of California SEP clients in need of HIV testing had received it in the past six months, and only 17% of those in need of HCV testing had received it for the same period. Yet, the presence of preventive and health services will not result in improved community health if IDU in those communities do not receive in fact the needed services (80).

### **Coverage and Dispensation Policy of Syringe Exchange Programmes**

Scaling up and reaching high coverage on programmes targeting IDU has become a topic of global concern (87-89). However, the semantics of these terms, especially "coverage", has created confusion and there is no commonly accepted definition (90).

According to WHO, scaling up “refers either to the geographical expansion of existing interventions or to diversification of the range of services” and coverage is defined as “the probability of receiving a necessary health intervention conditional on the presence of a health care need” (91). In 2005, WHO further proposed five domains of coverage – availability, accessibility, affordability, acceptability and effective coverage (92).

Determinants of supply and demand of HIV/AIDS infection interventions defined by WHO are: availability (quality service delivery points established), accessibility (distance, time), affordability (monetary and other costs, opportunity costs), acceptability (gender, ethnicity, language), perceived needs (perception of a disease or health risk, belief that the intervention will make a difference) and perceived quality of care (diagnosis ability, choice of interventions, adherence) (92).

In recent years, researchers' questions have centred on “How should we?”, “How can we achieve adequate coverage?” and “How much is enough?”. In a report commissioned to investigate programmes and sites, in developing countries (37), UNAIDS defined “high coverage” as being “where more than 50% of IDU has been reached by one or more HIV-prevention programme”.

Coverage targets were addressed by Des Jarlais *et al* (93), using a modified Delphi process to ascertain what were the essential activities needed to prevent and stabilize a HIV epidemic and the levels of coverage required to be effective. Regarding SEP the majority of the coverage estimates were that 20% to 33% of injections should be made with a needle and a syringe obtained from a program source (for free), although there was considerable overall range in this estimates, and a common belief that a high local HIV seroprevalence level might require higher levels of coverage. In the latter, coverage was measured by the number of injections with syringes and needles obtain from a programme, while previous estimate of coverage (given by UNAIDS) focused on the percentage of IDU reached by preventions programmes.

A wide range of measures and definitions might be used. Coverage can be measured at the individual level (e.g. percentage of injections with a sterile needle and syringe), at population level (e.g. percentage of estimated population of IDU reached in a geographic area by a programme in a specific period), and regarding to services provided to an IDU population (addressing the fact that a spectrum of services is needed).

Another issue of coverage is the regularity with which IDU access services: reached vs. ever reached vs. reached on a regular basis by prevention programmes. Nonetheless, an IDU reached once in a year (or once in a lifetime) by a SEP is qualitatively different from an IDU reached every day for a year by the same SEP. Careful consideration is also necessary in the definitions of clients, e.g. the distinction between number of clients and number of contacts (32).

The definition of coverage measured at a population level requires several methodological considerations, the most important of which is related with the estimate of the drug injection population, although in many countries, the estimated denominator populations remains poor and primary data collection system for making such estimates are absent.

Quality and standards of those programmes are other topics that should be taken into account. Clearly it is not just the quantity but also the quality of programmes and services that impact on utilization of HIV prevention efforts (90).

Using the term "coverage" to represent all these aspects of individual and population utilization and access, mixed with the concepts of reach and the quality of services has led to understandable confusion on parts of governments, programmes and researchers.

There is a consensus that more work needs to be done in this area of research and that widely accepted, accurate definitions are needed to replace the global (and broadly misunderstood) single term "coverage" (93).

Several studies have found differences that in SEP operational characteristics are associated with health outcomes and risk behaviour patterns among IDU, such as client-level outcomes associated with injecting equipment dispensation policies (94-98).

The Centers for Diseases Control and Prevention (CDC) recommended that an IDU should use a sterile syringe for each injection and then safely dispose it (99), which emphasizes the need of 100% syringe coverage at individual level as a public health goal.

Bluthenthal and colleagues, using data acquired from a large cross-sectional sample of IDU (1577 IDU from 24 SEP in California), have calculated syringe coverage percentage for each client (coverage measured at individual level), where syringe coverage rates were calculated by the number of injections divided by the number of syringes retained by SEP clients over a 30-day period and multiplied by 100. Coverage of 100% was defined and classified as an SEP client receiving as many syringes from the SEP as self-reported injections in the last 30 days. The study grouped IDU into four categories: 150% coverage or more, 100-149%, 50-99%, and less than 50% coverage. In a multivariate logistic regression, SEP clients with less than 50% of coverage had significantly higher odds of reporting syringe re-use (AOR=2.64; 95%CI=1.76, 3.95) and receptive (AOR=2.29; 95%CI=1.44, 3.63) and distributive (AOR=1.63; 95%CI=1.07, 2.49) syringe sharing and those with 150% or more coverage had lower odds of reporting syringe re-use (AOR=0.49; 95%CI=0.33, 0.72) and receptive (AOR=0.47; 95%CI=0.28, 0.80) and distributive (AOR=0.46; 95%CI=0.29, 0.72) syringe sharing as compared to SEP clients with 100-149% coverage (97).

Using the same data acquired from 24 SEP in California, Bluthenthal *et al* in another study determined if client syringe coverage (defined in the same way as in the previous study) differed significantly by syringe dispensation policy (which were, ranging from the least to the most restrictive: unlimited needs-based distribution, unlimited one-for-one exchange plus a few additional syringes, limited one-for-one plus a few additional syringes, unlimited one-for-one exchange and limited one-for-one exchange) and found that SEP that provided less restrictive dispensation policies were associated with increased prevalence of adequate syringe coverage among clients (measured at a client-level) (98).

The dynamic between sterile syringes availability and the probability of infection through use of contaminated syringes depends also on the rate at which contaminated syringes are removed from the community. "Circulation theory" argues that SEP must balance the number of

syringes distributed with syringes returned. Facilitating the turnaround of syringes reduces circulation time, thereby reduces the time syringes availability for sharing (100,101) and unsafe syringe disposal (streets, parks, schoolyards, etc.) (102). On the one hand a strict exchange policy may minimize the number of abandoned and possibly infected needles and syringes. However, on the other hand, a strict "one-for-one" policy could increase the likelihood of re-use and sharing injecting equipment (97,98,103).

Beyond the rationale of exchange, the proponents of restrictive dispensation policies (limits on the number of syringes and strict "one-for-one" policy) have asserted that this approach is an ideal way to maintain direct contact to IDU and provide referrals to other services and information on safe injections practices (80,104).

It is argued that merely distributing syringes without personal contact is a missed opportunity for intervention. Though in an attempt to achieve direct contact with each IDU, some SEP have actively discouraged secondary exchange (SE) (SE of needles and syringes refers to the giving or receiving of new sterile syringes and needles to/from another individual that were originally obtain from formal SEP. It can include trading, purchasing or selling for money, commodities or services, or it can simply involve the giving or receiving of syringes outright) (105). However, opposition to SE inhibits the distribution of sterile equipment to IDU who do not frequently attend SEP, and consequently could limit SEP effectiveness (106,107). Capping the number of syringes provided to IDU per visit is counterproductive (94).

Californian data indicated that 75% of clients of SEP reported engaging in SE in the previous six months (108) and in USA 93% of SEP allowed SE (63). Ultimately, however, programmes that discourage SE cannot truly prevent it. For example, in a comparison of two Canadian SEP with opposing SE policies, rates of SE were virtually identical (109).

Overall, laws, operational protocols and policies for SEP which consider limiting the number of syringes that can be distributed, sold or exchanged have been developed without the benefit of empirical data or even strong theoretical perspective to guide police and protocol choices (98), although they are a common practice in many implemented SEP in the world (72,73,96,97,110-113).

### **Effectiveness of Syringe Exchange Programmes**

The effectiveness of SEP to prevent HIV among IDU has been discussed intensely for more than 20 years.

There is evidence that increasing the availability and utilization of sterile injecting equipment by IDU reduces HIV infection - effectively, safely and in a cost-effective way. The first international review of the evidence that SEP reduce HIV infection among IDU found that conservative interpretation of the published data fulfilled six of the nine Bradford-Hill criteria (strength of association, replication of findings, temporal sequence, biological plausibility, coherence of evidence and reasoning by analogy) and all six additional criteria (cost-

effectiveness, absence of consequences, feasibility of implementation, expansion and coverage, unanticipated benefits, and application to special populations) (20,29,34).

One could argue that the ideal study design to examine the SEP efficacy is a randomised clinical trial of IDU in a community that has or has not access to SEP. However, conducting a randomised clinical trial to evaluate SEP is almost impossible due to insuperable ethical and logistical problems.

In the absence of a randomisation other methodological problems arise including the accurate measures of needle and syringe sharing and injecting frequency. In addition, evaluations studies are generally conducted at different stages of epidemic (with wide variations in seroprevalence and seroincidence) (34), and with different confounding factors, internal or external to the programme, that influence the effectiveness of SEP: duration and sustainability, law enforcement, dispensation policies, location of the programme, etc. (61,98,114).

Surveillance data on HIV infections, as often limited to passive case reporting, is generally inadequate to the task of estimating the impact of preventive interventions such as SEP. Even if comprehensive surveillance data is available, it would rarely identify the moment when infection occurred (87). A notification scheme will thus not provide the actual incidence, but rather the cumulative incidence over several years (115). Even with surveillance data based on the year of diagnosis, estimates should be made with caution; for example increases in the number of IDU could be the result of better sentinel surveillance in this group. On the other hand, decreases could be the result of increased stigmatisation and reluctance of IDU to be tested (32). Due to these difficulties most attempts in this direction have involved mathematical modeling which estimate the incidence using a combination of behavioural, transmission and SEP data.

Selection (self-referral) bias has fuelled the debate concerning the possibility of SEP actually causing an increase in bloodborne virus infection. Canadian studies in Montreal and Vancouver showed increases in HIV incidence and prevalence among SEP participants relative to non participants or frequent vs infrequent attendees (79,116). Nonetheless, these results were due to selection factors that lead high risk IDU to be over-represented among SEP attendees.

Given the confusion created by these studies, the relationship between frequent syringe exchange attendance and HIV incidence was evaluated by the same authors in a Vancouver follow-up study. It was demonstrated that the number of HIV seroconversions observed among frequent vs. infrequent SEP attendees could be predicted solely on the basis of their higher baseline risk profile. Selection factors in that case could entirely explain the observed disparity in HIV incidence rates based on SEP attendance. Frequent SEP attendees were more likely than non-frequent SEP attendees to live in unstable housing, to inject frequently, inject cocaine, exchange sex for money, inject in "shooting galleries" and to have recently been incarcerated (117). This explanation was also corroborated by Evan Wood *et al* who demonstrated that differential HIV incidence rates between frequent vs. infrequent SEP attendees were due to the higher consumption of cocaine among daily attendees (118).

However, SEP were criticised for promoting unsafe injecting drug use behaviour, and at that time it was postulated by politicians and opponents that SEP could act as a focus for forming social networks conducive to the initiation into unsafe injecting practices. Actually, the results were misinterpreted and misused as an evidence of a casual link between SEP and HIV seroconversion, leading to continued ban on the use of USA federal funds to support SEP (64,116). United Nations Office on Drugs and Crime (UNODC) was for years barred from funding syringe exchange due to objections from the United States and only recently has begun offering limited support. UNAIDS and WHO, by contrast, have expressed consistent support for programmes providing sterile injection equipment to reduce HIV infections (119).

### **Barriers to Use Syringe Exchange Programmes**

Understanding barriers to SEP and preferences of IDU, including those who do not attend SEP, is essential to providing services which better meet the needs of IDU and in developing alternative programmes of distributions or modifying some operational characteristics of the existing SEP (120-122).

SEP are extremely diverse in their design, staffing, characteristics of participants, operation and program delivery policies, and legal, social, cultural and economic environments in the community (123-124). As such, the ability of any given SEP to reach its clientele will be dependent on these factors. Barriers to SEP access have been associated with lack of awareness (121), inconvenient location (studies suggested that the willingness of IDU to use a SEP declines significantly if SEP is more distant than a 10 minutes-walk) (125), limited hours of programme operation: *"drug use is not confined to a nine-to-five schedule"* (50,75), dispensation policies (96) and stigma associated with being identified as an IDU (126).

As above mentioned, legal factors, such as laws, regulations and policing practices represent other important structural factors on access to SEP. Laws and regulations controlling access to needles and syringes, intended to discourage injection drug use, have resulted in an artificial scarcity of sterile injection equipment for IDU (127) and further stigmatization of this group (44,128). The difficulty faced by IDU in the procurement of sterile injecting equipment and the fear of arrest has encouraged the multiperson use and reuse of syringes and needles (95,112,114,129,130).

Several interrelated laws and regulations restrict IDU's ability or willingness to obtain and possess injecting equipment, such as the following (131):

- Drug paraphernalia laws: laws which establish criminal penalties for the manufacture, sale, distribution, possession, or advertisement of any item used to produce and consume illegal drugs, including needles and syringes;
- Syringe prescription laws: laws which prohibit dispensing or possessing syringes without a medical prescription;
- Pharmacy regulations and practices guidelines: as part of their oversight responsibilities, state boards of pharmacy develop and enforce regulations and

guidelines that cover many aspects of syringe sales, such as: display, advertising, record keeping, limits on syringes that can be purchased, customer identification and assessments of client's probable use;

- Restrictions on SEP: existence of syringe prescription and drug laws paraphernalia effectively restrict the ability of SEP to operate unless they are specifically exempted from the laws.

In 2004, 43 states of USA and the District of Columbia had drug paraphernalia laws and five states had syringes prescription laws (94). Access to sterile equipment (including sales and carrying of drug injection equipment) has been illegal also in Sweden except for two SEP in low HIV prevalence areas (Lund and Malmo – SEP are operating on a trial basis since 1986 and 1987, respectively) (111).

In addition to legal and regulatory barriers, the individual attitudes and moral beliefs of SEP providers, including pharmacists, affect syringe sales and distribution, and must be addressed when designing interventions to improve injection drug user access to sterile injecting equipment (113,132-134).

Regarding pharmacy sales or distribution; unclear laws and pharmacists who are uncertain as to their interpretation may also constitute continuing barriers to injecting equipment access for IDU (113,135). In several countries, possessing syringes puts IDU at risk of police searches, arrest and criminal prosecution. Hence, IDU can be reluctant to participate in sterile injecting equipment access such as SEP or pharmacy sales. Legalizing over-the-counter syringe sales and SEP without legalizing possession of syringes for IDU is likely to impede the public health benefits of such policy changes.

In Portugal distribution (without medical prescription) and possession of injecting equipment (that includes not only needles and syringes, but the whole paraphernalia injection equipment) is legal.

The legal framework in place since July 2001 (Law no. 30/2000, of 29th November) (136), although decriminalising illicit drug use, maintains drug use as an illicit behaviour and also maintains the illegal status for all drugs included in the relevant United Nations Conventions. However, a person caught in possession of a quantity of drugs for personal use (up to a maximum amount of drug required to a consumption period of 10 days), without any suspicion of being involved in drug trafficking, will be evaluated by a local Commission for Drug Addiction Dissuasion composed of a lawyer, a doctor and a social worker. Sanctions can be applied, but the main objective is to explore the need for treatment and to promote healthy recovery (136,137).

### **Basis for the present dissertation**

In Portugal, a variety of measures have been developed to promote access to sterile injecting equipment for free to IDU, which have included conventional SEP in fixed-sites, outreach programmes and community pharmacy-based SEP.

As above mentioned, in the European Union context, Portugal was the sixteenth country to implement an SEP (1993) and the twelfth country and that financed those programmes with public resources (1994) (55).

However, despite the existence of the Portuguese SEP since 1993, the information available is scarce and there is a need to clarify the programme in terms of its extent and the nature of service provision. In addition, there is a need to examine the trends in terms of the distribution and collection of injecting equipment and also in terms of SEP providers.



**AIMS**

The present dissertation aims to investigate the extent and nature of the Portuguese Syringe Exchange Programme (SEP) provision, to identify barriers and difficulties to service delivery and areas of good practice in order to contribute to its improvement. These should be accomplished by means of the following sections, with the subsequent specific objectives:

### **Section I – The Portuguese syringe exchange programme - a 15 year experience**

- To describe the establishment of SEP in Portugal
- To describe the trends of the programme in terms of distribution and collection of injecting equipment and also in terms of the service providers during the period 1993-2008

### **Section II – Process characterization by the syringe exchange programme providers**

#### **Manuscript 1**

##### **“Community pharmacies and the syringe exchange programme in Portugal – a 15 years experience”**

- To assess the current injecting equipment dispensation policies, the level of SEP provision and the availability of other services provided to injecting drug users (regardless of SEP involvement)
- To identify problems faced by community pharmacies, training levels and needs and to look for improvements in service provision
- To examine reasons for pharmacies for withdrawing SEP

#### **Manuscript 2**

##### **“A survey of syringe exchange programmes in Portugal”**

- To assess the current non-pharmacy SEP injecting equipment dispensation policies, level and nature of service provision
- To identify problems faced by SEP, training levels and needs and to look for improvements in service provision
- To establish the availability of services provided to drug users and non-injecting equipment distributed

## **SECTION I**

**THE PORTUGUESE SYRINGE EXCHANGE  
PROGRAMME – A 15 YEARS EXPERIENCE**

## I. Frequency of injecting drug use in Portugal

In Portugal, heroin is still the main substance leading to a request for treatment, followed by cocaine. Smoking/inhaling is increasingly being referred as administration route whereas injection behaviours are becoming less frequent.

The proportion of IDU admitted to first treatment (defined as clients with intravenous use of any drug 30 days before admission to outpatient treatment) declined from 45% in 1999 to 18% in 2007 (137,138).

In Portugal, knowledge on the prevalence of injecting drug use (IDU) is scarce. From the relatively limited data available, a rate of IDU was estimate for 2000 and 2005, values proposed ranging between 2.3 and 4.7 and between 1.5 and 3.0, respectively, per 1 000 population aged 15-64 years (138,139).

## II. HIV/AIDS infection among injecting drug users

Between 1983 – when the first HIV/AIDS infection case was identified and diagnosed in a Portuguese citizen – and June 2008 there was a cumulative total of 33 815 reported cases of HIV infection, regardless of stage at diagnosis or reporting – asymptomatic, AIDS-related complex or AIDS –, of which 43% corresponded to injection drug use as the most probable mode of transmission (140).

However, its proportion decreased from 58% in the mid-nineties to less than 20% at present. The actual crude number also decreased from a maximum of 1526 in 1999 to 336 in 2007 (140). SEP as part of a set of harm reduction measures played an important role in those trends.

In 2007 a total of 48 892 HIV cases were reported from 49 of the 53 countries in the WHO European Region (missing data for Austria, Italy, Monaco and Russia Federation). Of these, 13 538 cases were reported among IDU. In 2007 Portugal presented the fourth highest rate of HIV cases (by year of diagnosis) in the European Union context, 84.3 cases per million population, just after Estonia (471.8), Latvia (148.5), and United Kingdom (126.8). However, as a result of Portuguese effort in promoting the notification of HIV infection, Portugal submitted 2 302 notifications of HIV cases in 2007 (of these 670 were among IDU), placing Portugal with the second highest rate of HIV cases (by year of notification), 217 cases per million population, in the European Union context (26).

According to the classification adopted by WHO/UNAIDS, the Portuguese HIV epidemic has a concentrated pattern, with a prevalence below 1% in the general population and above 5% among some specific vulnerable populations such as IDU and inmates (141).

### III. Establishing Portuguese Syringe Exchange Programme

In 1993 the Portuguese government launched a pilot pharmacy-based scheme, in an attempt to reduce the spread of HIV amongst IDU, by making a kit available to IDU. This kit comprised a sterile syringe, a disinfectant towel, a condom and a leaflet concerning injecting and sexual risk behaviours.

The government took this step because of high rates of HIV/AIDS infection reported amongst IDU. Since 1983, when the first HIV/AIDS infection case was identified and diagnosed in a Portuguese citizen, until 1993 about third of cases reported concerned IDU.

The Portuguese SEP began as a partnership established in 1993, between the Ministry of Health, through the National Coordination for HIV/AIDS, and the National Association of Pharmacies with the collaboration of pharmaceutical wholesalers and local municipalities. This pilot scheme, initially announced to last for three months (October to December 1993), was run exclusively through community pharmacies.

To launch SEP, all the community pharmacies received written information about the programme and on the prevention of HIV among IDU, 20 kits, two containers for collecting used syringes and information and promotional material for IDU. Also, a telephone helpline, called the "green line", was created in order to support the pharmacists involved in SEP.

The initial goals and duration of the programme were publicised through television, radio and written press.

During the initial phase of implementation the programme was the object of some contention, as it was in other countries.

The union of pharmacy technicians and paramedics were against the implementation of the programme by the pharmacists, alleging that (at the time), the use of illicit drugs was a criminal act, punished by law and invoking that they were in the "front-line" services and that SEP participation could pose various risks for them, fears that were demonstrated early on to be unfounded.

One of the Portuguese television channels – which belonged at the time to the Catholic Church – was against the promotion of SEP because the kit contained a condom. There were also reports of diabetics criticising SEP, complaining that unlike IDU they had to buy their syringes, for insulin therapy, from pharmacies.

The high number of syringes collected, 277 095 in the period between October and December 1993, led the Ministry of Health, through the National Coordination for HIV/AIDS, to undertake its financing from the beginning of 1994, which it still does to this day.

Since the beginning of the programme, the participation of pharmacies has been voluntary and no remuneration is provided. As above mentioned, community pharmacies involved in SEP distribute free kits to IDU but also have the responsibility to ensure the safe disposal of used injecting equipment.

The pharmaceutical wholesalers realised the fundamental importance of the programme since they distribute, for free, the kits and containers for collection of used needles and syringes to the participating community pharmacies. The collection of the containers is done generally on a monthly basis, by a specialised private company or by the municipal services, after which they are incinerated.

Given the high prevalence of injection drug use, a mobile post was implemented, in late December 1993, in a neighbourhood in Lisbon that was known to have high numbers of IDU. The purpose of this mobile post was to support the local pharmacies in the dispensation of the injection equipment to IDU. The mobile post changed its location several times, taking into account gentrification of the neighbourhoods but currently maintains its operations in two different areas of Lisbon. The injection materials are made available individually, rather than as a kit.

Until 1998 the distribution of sterile injection equipment was exclusively through community pharmacies and the Lisbon mobile post. Only in 1999 were partnerships formalised between governmental (GO) and non governmental organisations (NGO) therefore allowing them too to take part in SEP as part of their activities.

Similarly to the mobile posts the injection material distributed by these partnerships is not made available in a kit but individually distributed in order to make better use of the material and to respond to the necessities presented.

Since the beginning of SEP the kit provided by the National Coordination for HIV/AIDS has changed. In 1999, one ampoule of double-distilled water, one filter, another syringe and needle and another disinfectant towel were included, and in 2007 two recipients for drug preparation (clean cups) and two citric sachets acid were added. In 2008, the kit comprised two sterile syringes and needles, one condom, one filter, two ampoules of double-distilled water, two recipients for drug preparation (clean cups), two citric acid sachets and two disinfectant towels (Figure 1).

Figure 1. Portuguese Kit distributed to IDU



The Portuguese SEP is managed centrally, including the acquisition of all the injection material and collection and destruction of the used syringes from the pharmacies, mobile post and NGO and GO involved in SEP. The financial duties of SEP have been supported by the

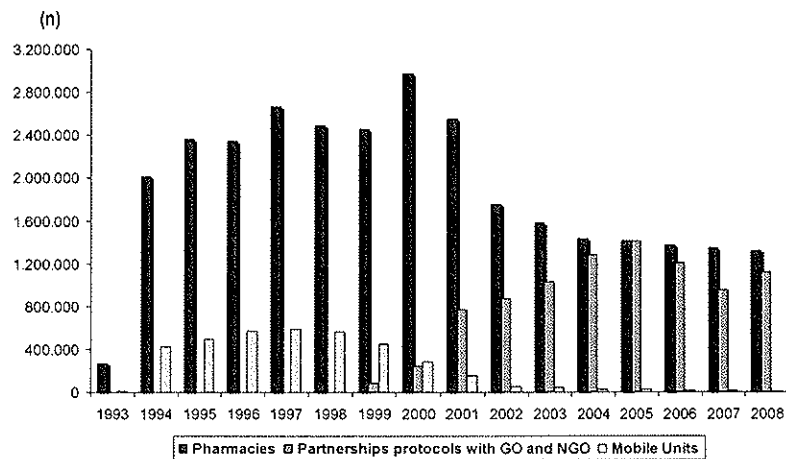
National Coordination for HIV/AIDS since 1994. This comprised the value of the sterile injection material distributed, the collection and destruction service for sharps waste generated by SEP, the functioning of the mobile posts and the operational management.

#### IV. Syringes distribution and collection

In the period 1993 to 2008, 43 043 495 syringes were collected in Portugal by pharmacies, mobile units and governmental and non governmental organizations (142).

The total number of syringes collected gradually increased until 1997, followed by a decrease until 1999. In the period between 2000 and 2001 there was a slight increase in the number of syringes collected, followed by a decrease until 2003. Since 2004 the number of syringes collected decreased and remained stable until 2007. In 2008 the total number of syringes collected slightly increased (Table 1 and Figure 2).

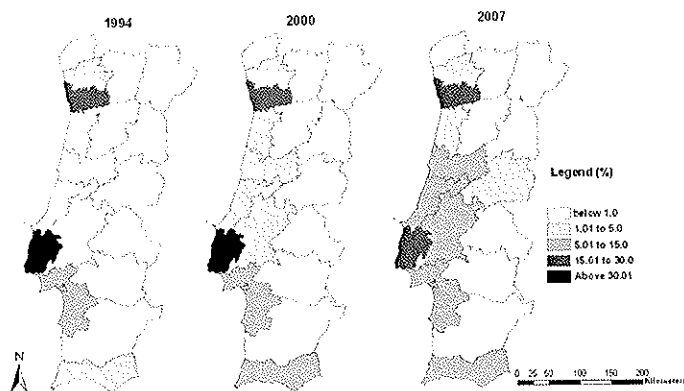
Figure 2. Syringes collected: 1993-2008



Since the beginning of the programme, the proportion of collected syringes was the highest in Portugal's two biggest districts: Lisboa and Porto, representing 44.3% and 20.7%, respectively, of the total number of collected syringes during this period (Figure 3).



Figure 3. Proportion of syringes collected by district level



Up to 2008, 70.4% of the total number of syringes was collected by pharmacies. However, since 1999, with the involvement of governmental entities and non governmental organizations in SEP, the proportion of syringes collected by pharmacies gradually decreased: 82% in 1999, 65% in 2002 and 53.8% in 2008.

The involvement of each pharmacy-based SEP, with regard to the number of syringes collected per year, has also decreased since 2000. More than 1000 syringes per year were collected by 41.5%, 25.5%, and 16.3% of pharmacies in 2000, 2003 and 2008, respectively.

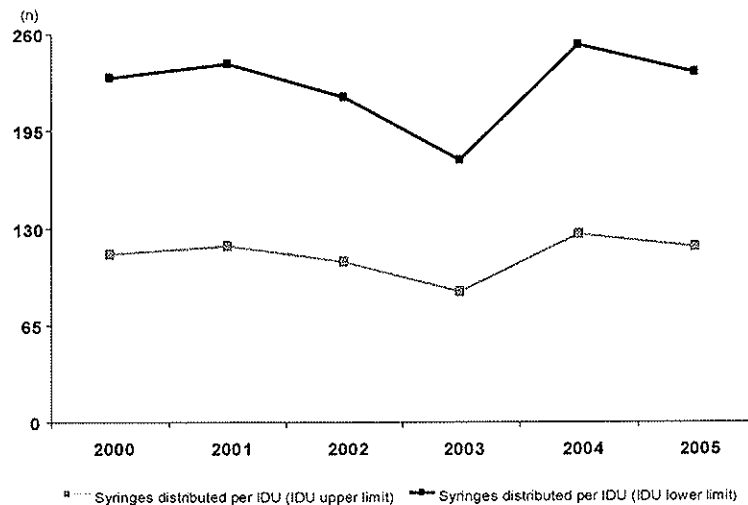
Between 2000 and 2008, the average of return rate of used syringes to all SEP facilities was 97.5%. However, it should be noted that in 2003, 2005 and in 2008, the number of syringes collected was higher than the number of syringes distributed.

These figures can only be considered as estimates. It is difficult to obtain accurate data on injecting equipment returns and on distribution, because sharp bins are not opened due to potential injury, and because distribution data refers to injection equipment distributed to SEP facilities, rather than directly to IDU.

Nevertheless, even taking into account questions about data quality, this finding echoes a strict “one-for-one” injecting equipment dispensation policy in Portuguese SEP.

Based on estimates of the number of IDU in Portugal above mentioned (138,139), the number of sterile syringes distributed per IDU (including those distributed by SEP, pharmacy-based SEP and mobile post) during the calendar year 2000-2005 is shown in Figure 4. Overall, the number of sterile syringes distributed per estimated IDU ranged between 113 and 231 in 2000, 108 and 218 in 2003 and 117 and 235 in 2005.

Figure 4. Syringes distributed per IDU (2000-2005)



These findings suggest that the number of syringes given out for free was not sufficient to ensure that IDU have a sterile syringe for every injection. It is to be noted, however, that according to WHO/UNDOC/UNAIDS (143) these figures place Portugal at medium level of SEP coverage (>100-≤200 syringes per IDU per year) or even at high level (>200 syringes per IDU per year), if considered the lower limit of the number of IDU taken from the national injecting prevalence studies mentioned above.

In Portugal, there is not data available with regard to the number of syringes sold to drug users at community pharmacies or outlets.

## V. Trends in the distribution of pharmacies, NGO and GO involved in SEP

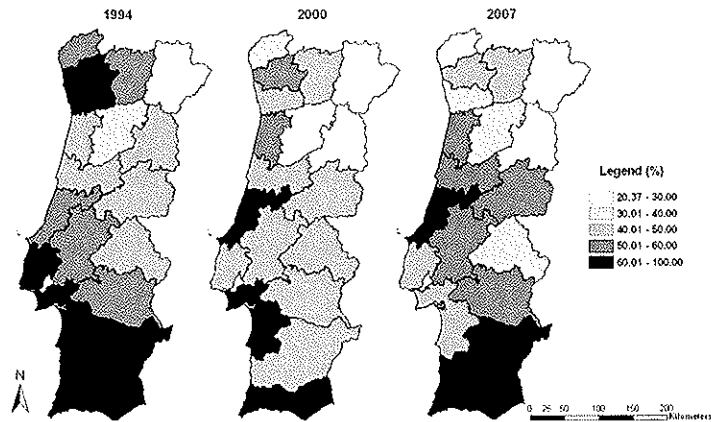
In 2008, syringe exchange facilities were available in all Portuguese districts. Although only 10 out of 18 districts had more than one measure to improve access to and utilization of sterile injecting equipment.

Since the beginning of SEP, there were pharmacy-based exchange schemes in all Portuguese districts. However, pharmacies' involvement in SEP had decreased since 1994. In 2007, 47% of pharmacies (1314 out of 2775) took part in SEP, compared with 50.4%, in 2001, and 66.9%, in 1994.

In the south region of Portugal the proportion of pharmacies involved in SEP was the highest during the period 1994-2007 (approximately above 70%) and in the two largest districts, Lisboa and Porto, where the highest HIV/AIDS infection rate and drug use prevalence is observed it decreased until 2000 and maintained up to 2007.

In Lisboa, the proportion of pharmacies involved in SEP decreased from 80.1% in 1994 to 48.7% in 2007. Porto also saw a decrease in this period from 83.5% to 38.6% (Figure 5).

**Figure 5. Trends in the distribution of pharmacies involved in Syringe Exchange Programme (district level)**



Non pharmacy-based SEP facilities were least accessible in the most remote and rural areas of Portugal. In those areas the number of NGO or GO involved in the SEP is low or even non-existent. Indeed, as of 2007, there were only 10 districts where the distribution of injecting equipment was also throughout NGO and GO, although in contrast to pharmacies, they were more likely to be located in Lisboa and Porto (Figure 6).

**Figure 6. Number of SEP points run by National Governmental Organizations and Governmental Organizations (district level)**

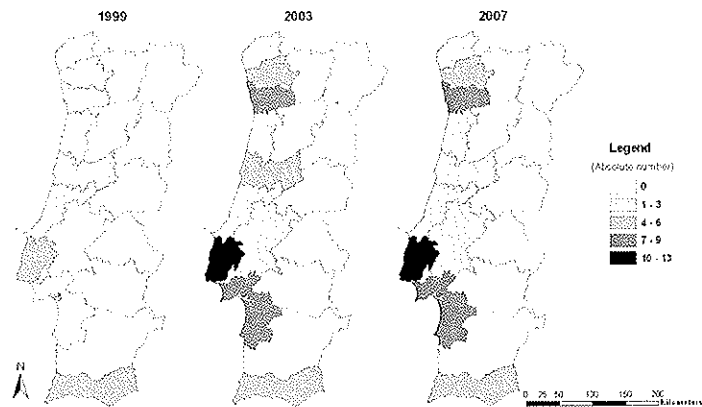


Table 1. Syringes collected and distributed, entities involved and total costs of SEP

Year	Syringes distributed (n)	Syringes collected (n)			Pharmacies involved in SEP (n)	NGO and GO involved in SEP (n)	Total cost <sup>‡</sup> of SEP (€)
		Pharmacies	NGO/GO	Mobile Post			
1993	NA	272 215	-	4 880	1 405	-	89 641
1994	NA	2 011 914	-	428 791	1 685	-	789 574
1995	NA	2 361 501	-	491 504	1 506	-	922 954
1996	NA	2 342 419	-	571 496	1 358	-	968 898
1997	NA	2 658 793	-	591 392	1 375	-	1 085 663
1998	NA	2 484 561	-	564 744	1 283	-	992 075
1999	NA	2 456 795	83 486	451 884	1 278	8	950 962
2000	3 680 000	2 972 468	241 757	288 212	1 212	10	1 078 963
2001	3 590 000	2 552 346	775 231	158 290	1 287	16	1 149 180
2002	3 037 000	1 749 362	875 277	49 474	1 238	29	971 743
2003	2 272 000	1 580 720	1 034 681	47 487	1 232	36	967 737
2004	2 990 000	1 434 234	1 283 474	27 193	1 270	34	975 365
2005	2 505 000	1 412 652	1 409 973	22 406	1 327	35	1 021 962
2006	2 845 000	1 368 322	1 204 716	18 112	1 341	35	1 166 369
2007	2 640 000	1 340 408	954 988	15 986	1 314	36	1 644 185
2008	2 350 000	1 318 682	1 121 086	9 583	1 384	36	1 591 411

‡ - The financial duties of SEP have been supported by the National Coordination for HIV/AIDS, except in 1993 – which were undertaken by the National Pharmacies Association. This comprised the value of the injection material distributed, the collection and destruction service for sharp waste generated by SEP, the functioning of the mobile posts and the operational management, by means of the payment of the programme staffing by the National Pharmacies Association. They do not include the operational costs related to the NGO or GO involved in SEP.

NA – Data not available

## **SECTION II**

**PROCESS CHARACTERIZATION BY THE SYRINGE  
EXCHANGE PROGRAMME PROVIDERS**

**Community Pharmacies and the Syringe Exchange  
Programme in Portugal – A 15 Years Experience**

## Abstract

**Objective:** The aim of this study is to assess the current dispensation policies with regards to pharmacy-based syringe exchange programme (SEP), to identify problems faced by pharmacies, look for improvements in service provision, to establish the availability of other services provided to IDU (regardless of SEP involvement) and to examine the reasons for pharmacies for withdrawing SEP.

**Study design and setting:** We conducted a cross-sectional survey of all Portuguese pharmacies (n= 2775). Descriptive data were collected on demography, services provided to IDU and SEP involvement. The latter comprised injecting equipment service delivery and activity, training levels and needs, barriers and conflicts with service provision and also difficulties faced by pharmacies with SEP clients.

**Results:** A 55.4% response rate was achieved. Overall, 59.4% of pharmacies were involved in SEP, 24.8% had been involved in the past and 15.7% had never been involved. With regard to dispensation policies implemented by current SEP providers, 64.3% followed a strict "one-for-one" policy and 21.6% established limits on the number of syringes distributed per visit. Problems associated with service provision, such as shoplifting and disturbing behaviour/nuisance were experienced by 12.8% of pharmacies over the 12 months prior to the survey, although more serious problems such as violent behaviour were rare.

Of all pharmacies, 76.2% had the policy of selling sterile syringes to IDU and 10.2% supervised methadone consumption. Pharmacies currently involved in SEP reported selling syringes to IDU less frequently (OR=0.57, 95%CI: 0.39-0.84) and were more likely to supervise methadone consumption (OR=1.36, 95%CI: 0.93-1.98).

For pharmacies involved in SEP in the past the probability of discontinuation in the first ten years of the programme was significantly higher among urban pharmacies (p<0.001) and in those that reported syringes sales in the previous month to the survey (p=0.013).

Training and improving referral pathways to specialist drug treatment services were identified as potential areas for further development.

**Conclusion:** Portuguese pharmacies, which are typically located throughout communities and have extended operating hours, play an important role in the "front line" services for IDU, although there is scope for increasing services and other harm reduction interventions. Written pharmacy-based SEP best practice recommendations, regarding injecting equipment dispensation policies, should be performed in the least restrictive approach, which should be accomplished with a proper training plan.

**Keywords:** syringe-exchange programme, community pharmacy, injection drug use.



## Introduction

Injecting drug use, because of sharing contaminated injecting equipment, has become a major infectious disease public health concern. It has played a critical role in the spread of HIV infection and other bloodborne infections such as hepatitis B and C (1-4).

Pharmacy-syringe exchange, syringe sales and other harm reduction initiatives (e.g. dispensing pharmacotherapies for the management of drug dependence) are developed as part of the overall wider approach to prevent the spread of bloodborne diseases and other drug-related harm (5-8).

The Portuguese Syringe Exchange Programme (SEP) began as a partnership, established in 1993, between the National Coordination for HIV/AIDS and the National Association of Pharmacies - whose members own of 98% of community pharmacies (9) – with the collaboration of wholesalers and local municipalities.

Portugal currently has 2775 community pharmacies (10) which were part of the net of services provided to drug users through the provision of sterile equipment, either by means of free pharmacy-syringe exchange or by sale. In Portugal, there are no legal restrictions on the sale and possession of injecting equipment but no pharmaceutical guidelines or standard procedures are available regarding the provision of this service.

Community pharmacies involved in SEP distribute free kits, which contain two sterile syringes and needles, two disinfectant towels, one condom, one filter, two ampoules of double-distilled water, two recipients (clean cups) for the preparation of drugs for injection and two citric acid sachets. The pharmacies also have the responsibility to ensure the safe disposal of the used injecting equipment returned. The participation of pharmacies is voluntary and no fee-for-service is provided.

The pharmaceutical wholesalers distribute, for free, kits and the containers for collection of used injection equipment to the community pharmacies involved in SEP. The National Coordination for HIV/AIDS funds all the production and distribution circuit of injecting equipment (kits) and the collection and destruction service for sharp waste generated by pharmacy-based SEP.

As of 2007, there were 1314 pharmacies and 37 governmental entities and non governmental organizations (which joined since 1999) involved in the SEP. However, by the end of 2007, only 47.3% of the Portuguese pharmacies took part in SEP, compared with 50.4%, in 2001, and 66.9%, in 1994 (11).

In Portugal, between 1993 and 2007, 40 594 144 syringes were collected. Since 1999, with the involvement of GO and NGO, the proportion of syringes collected by community pharmacies gradually decreased: 82.1% in 1999, 59.3% in 2003 and 57.9% in 2007 (11). The involvement of each pharmacy-based SEP, with regard to the number of syringes collected per year, has decreased since 2000. More than 1000 syringes per year were collected by 41.5%, 25.5%, and 21.7% of pharmacies in 2000, 2003 and 2007, respectively.

According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), formally organised pharmacy-based syringe exchange or distribution schemes are reported in

eight European countries (Belgium, Denmark, Spain, France, Netherlands, Portugal, Slovenia, United Kingdom) (12). After France, the Portuguese rate of community pharmacies' involvement in SEP is the highest. In 2003, in Portugal, 44.5% of pharmacies were involved in SEP, compared to 38.7% in Denmark, 13.3% in the United Kingdom and 4.7% in Spain (13). However, a wide variation across the countries in terms of the number of syringes distributed through pharmacies was found. For example, in Scotland, 1.7 million syringes were distributed through a network of 116 pharmacies in 2004, compared to about 1.4 million syringes distributed through 1270 Portuguese pharmacies (12).

In 2007, 431 pharmacies took part in the Portuguese methadone substitution programme, of which 176 (40.8%) served 3.6% (471 out of 13 175) of the number of total patients under methadone treatment (14).

However, despite the Portuguese community pharmacies' involvement in SEP and in other services provided to drug users, such as methadone programme or syringe sales, very little information exists about their operation modes, policies on service provision and major faced problems. Additionally, information has never been published on attitudes and practices of pharmacy's sales concerning injecting equipment to IDU.

The aim of this work was to assess the current policies and the level of provision with regard to pharmacy-syringe exchange, to identify problems faced by community pharmacies, training levels and needs and to look for improvements to service provision. Also, pharmacists' attitudes and practices towards syringe sales to IDU and reasons presented by community pharmacies for withdrawing services were assessed.

## **Materials and methods**

We conducted a cross-sectional survey of Portuguese pharmacies. Data were collected using an anonymous self-completion postal questionnaire. The questionnaire was piloted on a convenience sample of eight community pharmacies, selected regardless of SEP participation. The questionnaire was also piloted amongst a group of key informants who did not participate in the SEP, but had knowledge of the programme. Subsequently, necessary changes to the contents or form of the questionnaire were made to produce the final version.

The final version of the questionnaire was posted to all Portuguese community pharmacies (n=2775), together with a covering letter with instructions for completion and return and a prepaid return envelope.

The questionnaire was first mailed in March 2008 and a reminder letter and another copy of the questionnaire were sent after four weeks. To boost response, the survey was announced in advance by two Portuguese private organizations of community pharmacies, National Association of Pharmacies (ANF) and Pharmacies Association of Portugal (AFP).

### Core data collection

The questionnaire was designed to collect data from all community pharmacies, regardless of their involvement in SEP. Pharmacy characterization included setting (urban, suburban or rural), staff and characteristics of the respondent (gender, age and function of in the pharmacy).

SEP involvement was questioned and pharmacies were classified for data analysis as never or ever involved in the programme, the latter category being further subdivided in previously or currently involved. Regarding other harm reduction services, attitudes and practices towards selling injection equipment (including the number of syringes sold in the last month) and other services provided to IDU (including methadone treatment, as well as the number of IDU currently taking their methadone dose at the pharmacy) were asked. Respondents were invited to provide suggestions for SEP improvement.

### Data collection from pharmacies currently involved in SEP

For pharmacies involved in SEP, the questionnaire covered year of SEP implementation, respondents' opinions on the role of the pharmacies in relation to SEP, service delivery and activity (dispensation policies and procedures, levels of activity in the previous month – in terms of number of clients, number of syringes distributed and returned), services provided to SEP clients, staff involvement in the service provision at the pharmacy, participation in training and perceived further training needs, barriers and conflicts with service provision and also difficulties faced by pharmacists with SEP clients.

### Data collection from pharmacies previously involved in SEP

Regarding pharmacies that had been previously involved in SEP but had discontinued the programme, implementation and discontinuation dates were inquired. The reasons for these pharmacies to have abandoned the SEP were investigated.

### Data analysis

Data are described as absolute counts and proportions for categorical variables. For continuous variables medians (25<sup>th</sup> – 75<sup>th</sup> percentiles) are presented.

The magnitude of the associations between SEP involvement (ever vs. never and current vs. past) and pharmacy characteristics (setting and other harm reduction policies) was estimated using odds ratios (OR) and 95% confidence intervals (95%CI) calculated by unconditional logistic regression.

The rate of SEP discontinuation according to pharmacy setting (urban, suburban, rural), selling of syringes in the previous month (yes vs. no), and year of SEP implementation (1993-1994, 1995-1997 and 1998-2008) were plotted using the Kaplan-Meier method. Differences between classes were tested using the log-rank test.

## Results

### a) Response rate and demography

After two mailshots, a 55.4% response rate was achieved (n=1538, 1110 in the first and 428 in the second mail shot).

One thousand four hundred and fifty three questionnaires (95.5%) were filled in by pharmacists (of whom 964 were both pharmacists and pharmacy-owners and 153 were pharmacies' technical directors). Amongst these, the median (25<sup>th</sup> – 75<sup>th</sup> percentiles) length of experience in community pharmacies was 14 (7-23) years. Of all respondents, 1160 (75.2%) were female and 820 (53.3%) aged more than 40 years. More than half of all pharmacies (n=806, 52.4%) were urban, 375 (21.4%) were rural and 329 (24.4%) were suburban.

### b) Community pharmacies' involvement in service provision for drug users

At the time of the survey, 914 pharmacies (59.4%) were involved in SEP, 382 (24.8%) had been involved in SEP in the past and 242 pharmacies had never been involved in SEP.

Current SEP providers were asked to indicate the main motives for their involvement. The most commonly chosen options were: "to protect the community of needle-stick injuries" (n=713, 78.1%), the perception of a "community pharmacies' role in promoting public health programmes" (n=640, 70.0%) and "to reduce the number of new HIV infections among IDU" (n=446, 48.8%).

By contrast, amongst those which had been involved in SEP in the past, the main reasons for their dropping out were: aggressive behaviours from IDU (n=225, 58.9%), concerns about other customers' negative feelings regarding IDU (n=202, 52.8%), theft and shoplifting (n=116, 30.4%), and lack of demand (n=72, 18.8%).

The majority of the respondents were current SEP providers but this proportion was highest among suburban (69.1%) and lowest among urban pharmacies (52.4%). The proportion of pharmacies that had never been involved in SEP was slightly higher in rural than in urban or suburban respondents. Comparing ever- with never-involved pharmacies, there were no significant differences according to pharmacy setting. However, when considering only ever adherents, current (vs. past) involvement was more frequent in suburban (OR=2.68, 95%CI: 1.94-3.69) and urban (OR=2.49, 95%CI: 1.78-3.49), when compared to rural pharmacies.

Of all pharmacies, 157 (10.2%) were currently supervising methadone consumption of 148 patients and a further 24 were prepared to do so but reported no current demand.

Regarding sales of injecting equipment, 1172 (76.2%) of all respondents reported having the policy of selling sterile syringes to IDU. However, 794 (67.8%) had sold less than 20 sterile syringes in the previous month. Amongst these, 160 did not sell any sterile syringe in this period. It was noted that amongst the 72 pharmacies that had abandoned SEP claiming lack of demand, 27 (37.5%) had sold syringes in the previous month.

There was a significant overall difference in syringe-selling policy and in participation in methadone programme according to pharmacy-based SEP involvement (Table 2). Pharmacies that provided methadone treatment maintenance were involved in SEP more frequently, considering mainly ever (OR=2.21, 95%CI: 1.28-3.82) but also current (OR=1.36, 95%CI: 0.93-1.98) involvement. Although non-significantly, selling of syringes to IDU was more frequent among ever adherents (OR=1.38, 95%CI: 0.95-2.00). On the other hand, pharmacies currently involved in the programme reported selling syringes to IDU less frequently (OR=0.57, 95%CI: 0.39-0.84).

c) Community pharmacy-based SEP duration

Median (25<sup>th</sup>-75<sup>th</sup> percentiles) duration of pharmacies' involvement in SEP was 13 (8-15) years for those that were involved in SEP at the time of the survey and 4 (2-8) years for those that had been involved in SEP in the past.

The probability of discontinuation in the first ten years of SEP was significantly higher among urban pharmacies ( $p<0.001$ ) and in those that reported syringes sales in the previous month ( $p=0.013$ ) (Figures 1 and 2). Additionally, discontinuation was more frequent throughout the first ten years of SEP in pharmacies where the programme had started between 1995 and 1997, followed by those with more recent implementation date. Pharmacies where SEP was implemented earlier were less likely to abandon throughout the first ten years ( $p=0.004$ ) (Figure 3).

d) Community pharmacy-based SEP delivery and activity

Almost all pharmacies involved in SEP set no time restrictions for SEP during opening hours ( $n=894$ , 99.7%). Amongst pharmacies which were enrolled in local nightshift services ( $n=588$ ), 356 (60.5%) provided SEP in that schedule. Four-hundred and one pharmacies (43.9%) reported that they advertised their involvement in SEP by the use of logo (image of the kit), which is recognizable by IDU.

There was variation across pharmacies in syringes dispensation policies, either on the relationship between used syringes collected and sterile syringes distributed or on limits of the number of syringes distributed per transaction (Table 3). One hundred and ninety seven pharmacies (21.6%) had established limits on the number of kits they would give out to an IDU and 588 (64.3%) followed a strict "one-for-one" policy.

When asked what the pharmacy dispensation policy was regarding an IDU without a used syringe to exchange, 570 (62.4%) indicated that they provided at least one kit, 188 (20.6%) stated that they never provided a kit under those conditions and 85 (9.3%) affirmed that they provided a kit under certain circumstances (32 if the IDU was "known" to the pharmacy and 53 would strongly encourage the return). Nine respondents obliged IDU to buy two sterile syringes from the pharmacy to put in the container before they would be provided with a free kit.

According to the dispensation policy implemented at pharmacy, 666 (72.9%) allowed IDU to exchange or to get syringes for other IDU, i.e. secondary exchange (SE).

Respondents were asked to provide data on sterile injecting equipment distributed, used syringes returned and number of IDU using the service during the 30 days prior to the survey, and where data was not available, to provide the best estimate.

Two-hundred and seven (22.6%) and 204 (22.3%) pharmacies reported that they did not distribute any kit and did not collect any used syringes, respectively, for the study period. Almost half distributed at least one kit but less than 50 kits (n=434, 47.5%) and more than half of the pharmacies collected at least one used syringe but less than 100 used syringes (n=461, 50.4%). Nearly a quarter of pharmacies (n=215, 23.5%) reported no IDU contact in the previously month.

The distribution of respondents according to the relationship between the number of used syringes collected and the number of sterile syringes distributed per IDU is described in Table 4. In the majority of pharmacies (70.0%) the number of syringes collected equaled the number of sterile syringes distributed.

Respondents were asked about other interventions and additional services regarding IDU clients, such as advice on safer sex, safe drug use, HIV testing and referrals to drug centres. Amongst these, only less than 10% tended to offer these interventions proactively.

Three-hundred and sixty pharmacies (39.4%) had leaflets regarding specific issues addressed to IDU: 280 (77.8%) about HIV/AIDS and 191 (53.1%) about either hepatitis B or safer sex. Only 55 pharmacies (15.3%) had leaflets concerning HIV testing.

#### Problems and difficulties faced by community pharmacies involved in SEP

One-hundred ninety-one respondents (20.9%) had refused SEP provision at least once over the 12 month period prior to completing the questionnaire: 153 (80.1%) refused IDU who had no used equipment to return, 42 (22.0%) refused IDU who had displayed violent behaviour and 38 (13.6%) refused SEP provision due to logistical problems (e.g. lack of kits). Nine respondents refused IDU who were under treatment for drug dependence (e.g. methadone) and 4 refused to supply IDU under 16 year-old.

During the twelve month period, 117 pharmacies (12.8%) faced at least one problem regarding IDU. Disturbing behaviour and nuisance, shoplifting and thefts occurred at least "rarely" in 41 (4.5%) and 37 (4.0%) pharmacies, respectively (Table 5).

Since the beginning of SEP implementation, 18 pharmacies faced aggression from IDU with a syringe (a syringe was used as a weapon) and 12 pharmacies reported cases of accidental needle-stick injuries.

Regarding the effect that SEP had on other customers as well as changes noticed since the beginning of its implementation, 385 (42.1%) respondents did not perceive any change in other customers' attitudes towards SEP. In fact, 274 pharmacies (30.0%) reported that other customers seemed more positive about SEP and 117 (12.8%) declared that other customers

were not aware that this service was taking place.

#### Training of pharmacy staff involved in SEP

Over three-quarters of the respondents (n=698, 76.4%) indicated that all pharmacy staff conducted the SEP transactions. Only 133 (14.5%) answered that it would be pharmacists and staff who felt comfortable in the role.

Since the beginning of the programme, 321 pharmacies (35.1%) took part in some type of training sessions regarding SEP and 98 respondents (10.7%) had received training in the previous 12 months. More than half respondents (n=498, 54.5%) were interested in receiving training. Suggestions for areas for further training included: HIV/AIDS (n=374, 75.1%), HCV and HBV (n=369, 74.1%), security issues (n=303, 60.8%) and drug consumption (n=294, 59.0%).

#### e) Improving the pharmacy-based SEP

All respondents, independently of SEP involvement, were inquired to point out suggestions on how SEP provision could be improved. Overall, 971 (63.1%) referred "improving referral pathways to specialist drug treatment services and other harm reduction structures" and 383 (24.9%) "provision of training". Associations between SEP involvement and suggestions on how SEP could be improved are shown in Table 6. SEP discontinuation was positively associated with the opinion that SEP transactions should take place in locations other than pharmacies (OR=5.34; 95%CI 1.59-17.93), contrasting with pharmacies that were involved in SEP at the time of inquiry (OR=0.87; 95%CI 0.09-0.84).



## Discussion

This is the first study that provides information about current dispensation policies of injecting equipment implemented by Portuguese community pharmacies-based SEP and the availability of other services provided to IDU, independently of their involvement in SEP.

The overall response rate achieved (55.4%) was lower than observed in surveys carried out in other countries (15,16). However, if only the community pharmacies involved in SEP are considered and surveys which used a comparable methodology, i.e. mailed questionnaires, the response rate obtained in the present study (69.6%, 914 out of 1314 pharmacies-based SEP) was similar to (17) or even higher than (18) what was previously reported.

The findings of this survey are subject to limitations that should be considered in interpreting the results. This was a cross-sectional study, so causal inferences cannot be drawn. There is selection bias since community pharmacies involved in SEP were over-represented (the response rate of pharmacies currently involved in SEP was 69.6% compared to 42.7% of those which were not involved).

Most responders (59.4%) were involved in SEP, followed by pharmacies that had been involved in SEP in the past and then abandoned (24.8%) and by pharmacies that had never been involved in SEP (15.7%).

Amongst pharmacies currently involved in SEP, a variation in practices regarding syringes dispensation policies and level of provision was found.

One hundred and ninety seven respondents (21.6%) had established limits on the number of kits they would give out to an IDU, based merely on a subjective decision made by the pharmacy, and 64.3% followed a strict "one-for-one" policy. Additionally, it was found that 153 respondents refused SEP provision to IDU who had no used equipment to return, over the 12 month period prior to completing the questionnaire, which highlights the strict policy that exists regarding this issue.

An exchange with a cap meets far less of the need in terms of syringes and other sterile injection paraphernalia than an exchange which operates without one (19). Also, previous studies have demonstrated that syringe re-use (20-22) and sharing practices (either receptive or distributive syringe sharing) (23) are less frequent when SEP have less restrictive dispensation policies, either by establishing limits or existence of restrictive rules regarding strict policy "one-for-one".

These survey findings strongly favour the development of guidelines regarding injection paraphernalia distribution in Portugal so that standard procedures are in place. They should consider the least restrictive approach possible, and also compliance with the guidelines by National Coordination for HIV/AIDS should be ensured. Therefore, limits on the number of syringes distributed per visit and strict exchange policies "one-for-one" should be abandoned for purposes of HIV and other bloodborne infections prevention. Nonetheless, the return of used needles and syringes should not be neglected. Kaplan's circulation theory (24,25) argues that the rate of transmission of HIV among IDU was at least partially determined by the time a syringe was in circulation. Shortening circulation time was proposed as an effective strategy to reducing the transmission of HIV and other bloodborne infections.

According to the injecting equipment dispensation policy implemented at pharmacy, 72.9% allowed secondary exchange (SE) practice, contrasting with Scottish policy where this practice is discouraged (26). SE practice should be encouraged, since it increases accessibility of injecting equipment to a large number of IDU in terms of location, time, culture and age group (27,28).

As expected, the level of pharmacy-based SEP activity, in terms of the number of kits distributed or number of different SEP clients reached was low. Amongst pharmacy-based SEP respondents, more than one fifth reported that they did not distribute any kit or did not collect any used syringes, respectively, and nearly a quarter of pharmacies reported no IDU contact in the previous month. Additionally, it was found that in half of pharmacies the number of SEP clients was the same as the number of kits distributed, which represents one kit distributed per IDU per month. This suggests that the number of syringes distributed could not achieve a rate of a sterile syringe for every injection and/or probably, in those cases, IDU are irregular clients and had other sources of injecting equipment, such as NGO or even other pharmacies.

During the previous twelve month period, 12.8% of pharmacies currently involved in SEP faced at least one problem regarding IDU. Pharmacies did experience problems such as shoplifting and disturbing behaviour/nuisance, but more serious problems such as violent behaviour were rare, corroborating the results of an English study (18). In fact, 42 pharmacies had refused injecting equipment provision to IDU who had displayed violent behaviour for the same study period.

It should be stressed that 38 pharmacies refused SEP provision due to logistical problems (e.g. lack of kits). Efforts to improve SEP logistic procedures should be put into practice, especially those regarding the link between community pharmacies and pharmaceutical wholesalers. According to their needs, pharmacies involved in SEP should define an adequate stock of kits.

According to WHO, personal qualities and skills of the staff, are as important as supervision and training for SEP providers (29). In an English study, a significant association was found between participation in training on drug use and attitude, with those who had taken part in training having a more positive attitude towards the role of pharmacists in HIV prevention, the supply of injecting equipment and the supervision of drug consumption in the pharmacy (15).

Nonetheless, in Portugal there is no standard training for pharmacy staff who conducted SEP transactions, unlike pharmacists who supervised methadone consumption. In fact, pharmacy staff is not required to undertake any specific training before running SEP, contrasting with British practice (30). Moreover, there are several generations of practising community pharmacists who have had little or no undergraduate or postgraduate training in the management of drug use.

Only 35.1% of respondents had taken part in any training sessions regarding SEP related issues. By contrast, a higher proportion of training levels were found in Scotland (68.97%) (16) and in England (74.0%) (18). Given that the lack of, and demand for, training is high, ensuring that pharmacy staff receive appropriate training, particularly in relation to the purpose of the programme, injecting equipment dispensation policies, safer sex and injection

drug practices, should be a priority.

With regard to other services provided to IDU other than the availability of sterile injecting equipment or participation in the methadone programme, it was found that only less than 10% of respondents tended to offer services proactively, such as advice on safe drug use, referrals to HIV testing and to drug centres. As mentioned this could be probably due to the lack of training that was demonstrated by this study.

In addition to provision of additional training, the need to improve referral pathways to specialist drug treatment centres, and other harm reduction structures, between pharmacies and other local services was another area highlighted for SEP improvement.

The practice of syringe selling to IDU was overall very frequent, particularly in pharmacies that had discontinued SEP at the time of the survey. These pharmacies also reported highest numbers of syringes sold in the previous month.

On the other hand syringe selling to IDU was a common practice among pharmacies currently involved in SEP. Despite the fact that some IDU may prefer the anonymity of OTC purchases, efforts should be made in order to promote the participation of these clients in SEP, ensuring the provision of other injection equipment (e.g. clean cups, citric sachets, etc) and safe disposal.

Despite the high involvement of community pharmacies in SEP, the participation in the methadone programme is low. Of all community pharmacies, 10.2% were participating in the methadone substitution programme, compared to 79.1% (16) and 81% (31) reported by Scottish and Swiss (Swiss Canton of Vaud) pharmacies, respectively. Given the extended hours of operation, geographical availability and the possible multiple services provided to IDU, efforts to increase community pharmacies' involvement in the methadone programme should be considered.

Previous studies in other countries, involving community pharmacies, addressed concerns regarding safety (shoplifting and aggression, for example) and the impact of drug users discouraging other customers (6,15). In fact, these were the main reasons cited by pharmacies, for dropping out. However, with regard to the latter, previous studies supported that such concerns are based on pharmacists' personal opinion, since it was found that other customers were supportive to pharmacy-based SEP and understood the rationale behind of harm reduction (32).

Another reason that was mentioned for dropping out was lack of demand. However, it is not possible to ascertain whether this was a true lack of demand, i.e. no one was requesting the service, or whether a result of an awareness that the pharmacy did not like providing the service the drug users ceased to request it. In fact, it was noted that amongst the 72 pharmacies that had abandoned SEP claiming lack of demand, 27 had sold syringes in the previous month, therefore contradicting this claim.

The frequency of ever-involvement in SEP was similar across pharmacy demographic settings, rather than reflecting aggregation of IDU in urban settings. This finding indicates that the initial decision of SEP involvement was independent of the prevalence of IDU in the geographical area. However, continuity of the programme may reflect this distribution, since, among those ever involved in SEP, urban pharmacies had discontinued SEP more frequently.

Overall, pharmacies previously involved in SEP are categorized as urban pharmacies that are probably placed in regions with high drug use prevalence, since they reported highest number of syringes sold in the previous month. By contrast, pharmacies where SEP was implemented earlier were less likely to abandon throughout the first ten years.

The number of syringes sold and the level of SEP provision (number of SEP clients, syringes collected and kits distributed) in the last 30 days, or the number of patients under methadone maintenance treatment supervised in pharmacies, was self-reported. The quality of data may be variable according to the questions asked. Pharmacists keep precise records of methadone treatments, so data relating to the number of patients should be accurate. However, regarding level of SEP provision, it is unknown how community pharmacies arrive at these figures and whether all of them carry out the reporting in the same way, so figures should be considered rough estimates. Reports on the number of syringes sold over the 30 days period prior to completing the questionnaire were probably based on pharmacies' information systems. However, it is difficult to reliably estimate the extent of syringe sales in pharmacies just associated with injecting drug use.

Community pharmacies remain the largest provider of syringe exchange in Portugal. However, there is scope for increasing services and other harm reduction interventions, far more than supply and disposal of syringes and other injection paraphernalia. Written SEP best practice recommendations, regarding injecting equipment dispensation policies, should be performed and distributed to all pharmacies, which should be accomplished with a proper training plan.

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**Table 1. Association between pharmacies' involvement in SEP and setting**

		Pharmacies' involvement in SEP			
		Total n (%)	never n (%)	past n (%)	current n (%)
Setting	urban	806 (53.4)	122 (50.4)	262 (68.6)	422 (46.2)
	suburban	375 (24.8)	56 (23.1)	60 (15.7)	259 (28.3)
	rural	329 (21.8)	58 (24.0)	54 (14.1)	217 (23.7)
Methadone programme	No	1335 (88.1)	222 (93.7)	335 (89.3)	778 (86.1)
	Yes	181 (11.9)	15 (6.3)	40 (10.7)	126 (13.9)
Sale of syringes	No	222 (14.8)	42 (18.3)	37 (10.0)	143 (15.8)
	Yes	1172 (77.9)	170 (80.2)	313 (89.4)	689 (82.8)
	Does not know	111 (7.4)	18 (7.8)	20 (5.4)	73 (8.1)

**Table 2. Association between SEP involvement and other services for drug users**

Pharmacies' involvement in SEP	ever vs. never	current vs. past
Setting		
rural	1	1
suburban	1.02 (0.72-1.43)	2.68 (1.94-3.69)
urban	0.83 (0.59-1.17)	2.49 (1.78-3.49)
Methadone programme		
No	1	1
Yes	2.21 (1.28-3.82)	1.36 (0.93-1.98)
Sale of syringes		
No	1	1
Yes	1.38 (0.95-2.00)	0.57 (0.39-0.84)

OR – Odds Ratio; 95% CI – 95% Confidence Interval.

**Table 3. Syringe dispensation policy of pharmacies involved in SEP**

Syringe Dispensation Policy	n (%)
Unlimited number of kits* distributed without regard to the number of syringes returned for disposal	75 (8.2)
Unlimited number of kits distributed and return of at least one used syringe	187 (20.5)
Limited number of kits distributed following a strict one-for-one exchange	195 (21.3)
Limits on the number of kits distributed	
1 kit	16 (8.2)
2 kits	54 (27.7)
3-4 kits	62 (31.8)
≥5 kits	52 (26.7)
Unlimited number of kits distributed following a strict one-for-one exchange	393 (43.0)
Other	12 (1.2)

\* Each kit is composed by two sterile syringes and needles, two disinfectant towels, one condom, one filter, two ampoules of double-distilled water, two recipients (cleancups) and two citric acid sachets

**Table 4. Level of activity on syringes distributed, collected and IDU (during the 30 days prior to the survey)**

	n (%)
Sterile syringes distributed vs Used syringes collected	
number of used syringes collected > number of sterile syringes distributed	25 (3.1)
number of used syringes collected = number of sterile syringes distributed	568 (70.0)
number of used syringes collected < number of sterile syringes distributed	218 (26.9)
Kits distributed vs IDU	
number of IDU > number of kits distributed	8 (1.0)
number of IDU = number of kits distributed	406 (50.8)
number of IDU < number of kits distributed	385 (48.2)

**Table 5. Problems faced by pharmacies in SEP provision in the last 12 months**

	n (%)			
	Often	Sometimes	Rarely	Never
Violent behaviour	0 (0)	5 (4.27)	19 (16.24)	62 (52.99)
Disturbing behaviour/nuisance	2 (1.71)	61 (52.14)	41 (35.04)	2 (1.71)
Shoplifting/theft	0 (0)	27 (23.08)	37 (31.62)	37 (31.62)
Clients dealing in pharmacy	0 (0)	0 (0)	1 (0.85)	88 (75.21)
Clients using pharmacy as a meeting place	3 (2.56)	27 (23.08)	27 (23.08)	46 (39.32)

**Table 6. Association between SEP involvement and suggestions on how SEP could be improved**

	n (%)	OR (95% CI)
Provision of training		
never been involved	51 (21.07)	1
were involved in the past	62 (16.23)	0.73 (0.48-1.09)
currently involved	270 (29.54)	1.57 (1.11-2.20)
Improving interconnection between the pharmacies involved in SEP (e.g. through regular meetings)		
never been involved	35 (14.5)	1
were involved in the past	59 (15.4)	1.08 (0.69-1.70)
currently involved	135 (14.8)	1.02 (0.69-1.53)
Improving referral pathways to specialist drug treatment services and other harm reduction structures		
never been involved	126 (52.1)	1
were involved in the past	231 (60.5)	1.40 (1.01-1.94)
currently involved	614 (67.2)	1.88 (1.41-2.51)
Syringe exchange should take place in locations other than pharmacies (e.g. Health Centres)		
never been involved	3 (1.24)	1
were involved in the past	24 (6.28)	5.34 (1.59-17.93)
currently involved	1 (0.11)	0.09 (0.01-0.84)

OR – Odds Ratio; 95% CI – 95% Confidence Interval.

Figure 1.

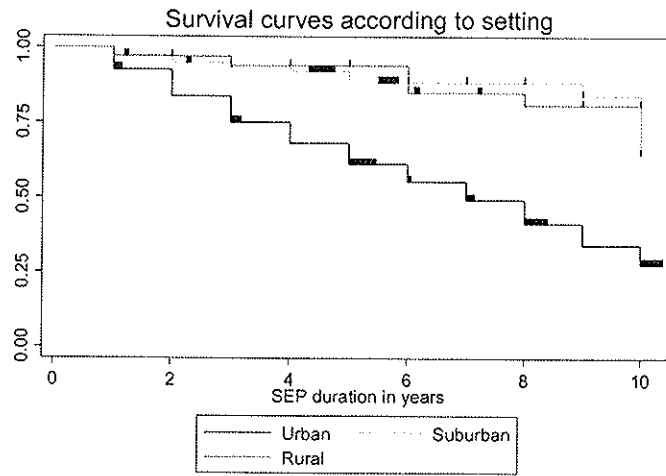


Figure 2.

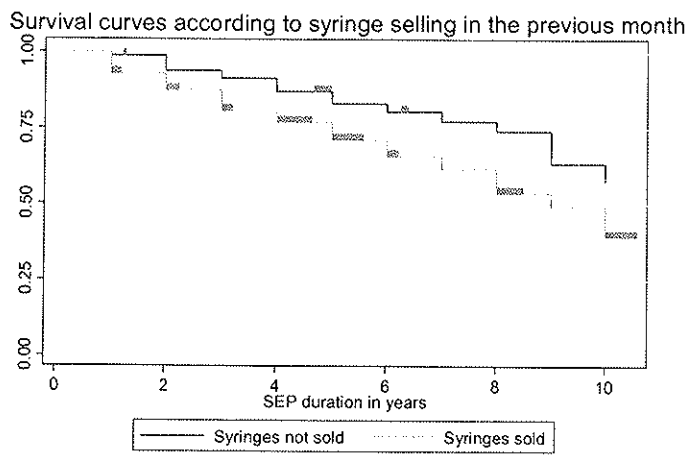
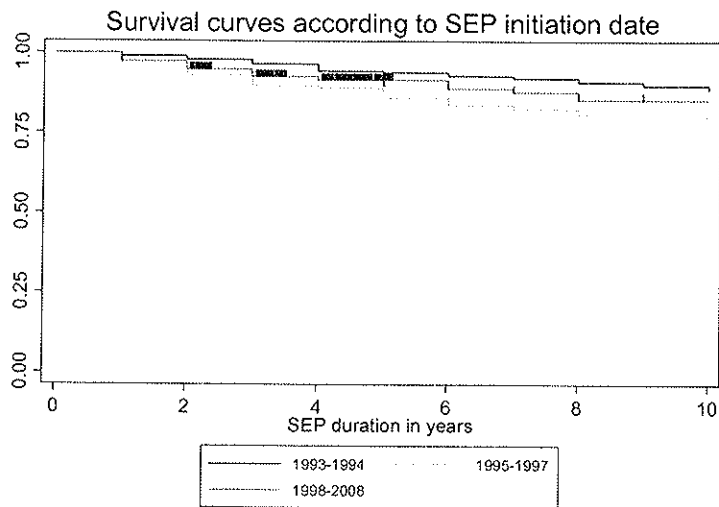


Figure 3.



**A Survey of Syringe Exchange Programmes  
in Portugal**

## Abstract

**Background:** Portugal has been offering syringe exchange programmes (SEP) since 1993. Up to 1998, the distribution of injection equipment was almost exclusively through pharmacy-based SEP. Only in 1999 governmental (GO) and non governmental organisations (NGO) took part in SEP. In Portugal, knowledge about the extent and type of service provision by SEP is scarce. This study aimed to assess the current injecting equipment dispensation policies, the nature of delivery models, the availability of services provided, to identify problems faced by SEP and to look for improvements to service provision.

**Study design and setting:** We conducted a cross-sectional survey of all SEP run by governmental (GO) and non governmental organisations (NGO). Descriptive data were collected on demography, SEP operational characteristics, injecting equipment service delivery and activity, services provided to IDU, barriers and conflicts in service provision, sources of SEP funding and forms of evaluation.

**Results:** A 80.6% (n=25) response rate was achieved. Almost half of SEP had more than one mode of service delivery. Almost all SEP (96%) received public funds and 3 SEP directors reported that their programme had an external evaluation.

With regard to dispensation policies implemented, 68.0% followed a strict "one-for-one" policy, 32.0% established limits on the number of syringes distributed per visit and 68.0% allowed secondary exchange (SE). Half of SEP provided some form of on-site testing related to bloodborne viruses and only 32.0% provided hepatitis B vaccination.

Over the 12 month prior to the survey, 36% of SEP reported opposition from the local community and 13 % had been raided by the police.

Training and financial stability were identified as potential areas for further improvement by respondents.

**Conclusion:** SEP are often the only source of health care for IDU. Hence, interventions to provide a comprehensive package of services beyond the availability of injecting equipment are needed. Written SEP best practice recommendations, regarding injecting equipment dispensation policies, should be performed in the least restrictive manner possible, which should be accomplished with a proper training plan. Ongoing evaluation should be put in place in order to determine if the programme meets the needs of IDU and where further improvements are warranted.

**Keywords:** injecting drug use, syringe exchange programme, harm reduction.

## Introduction

The Portuguese HIV epidemic has a concentrated pattern, according to the classification adopted by WHO/UNAIDS, with prevalence below 1% in general population and above 5% amongst injection drug users (IDU) and inmates (1). IDU accounts for 43% of the 33 815 cases of HIV/AIDS infection reported in Portugal from 1983 until 2007. However, its proportion decreased from 58% in the mid-nineties to less than 20% at present. The actual crude number also decreased from a maximum of 1526 in 1999 to 336 in 2007 (2).

Portuguese Syringe Exchange Programme (SEP), along with other harm reduction measures, played an important role in those trends. In Portugal, a variety of measures have been developed to improve access to and utilization of sterile injecting equipment and to increase choice for drug users.

The coexistence of different modes of injecting equipment delivery, as well as tailoring services offered at different venues addresses several barriers that IDU encounter. International studies have suggested that different types of IDU make use of different syringe distribution channels (3-5) and have indicated that the additional services provided by SEP are especially important in attempts to reduce bloodborne infections and risk behaviours (6-8).

However, in Portugal this process took place later than desirable. Up to 1998, the distribution of injection equipment was almost exclusively through community pharmacies (which participated in the programme since 1993) and therefore Portuguese SEP probably did not reach different types of IDU as desirable. Only in 1999, partnerships were formalised with governmental (GO) and non governmental organisations (NGO) therefore allowing them to take part in SEP as part of their activities.

Between 1993 and 2007, 40 594 144 syringes were collected in Portugal. As of 2007, there were 1314 pharmacies and 36 GO and NGO involved in the SEP (9).

The Portuguese SEP is managed centrally. The National Coordination for HIV/AIDS distribute for free to all pharmacies, GO and NGO involved in SEP sterile syringes and needles, disinfectant towels, filters, ampoules of double-distilled water, recipients (cleancups) for the preparation of drugs for injection, citric acid sachets and condoms and also funds the collection and destruction service for sharp waste generated by SEP.

In Portugal, there are no written protocols, guidelines or state laws defined by government entities regarding dispensation policies of injecting equipment.

With regard to non-pharmacy SEP facilities, very little information is given about SEP operation, syringe dispensation policies and availability of other services beyond the distribution of injecting equipment.

The aim of this work is to assess the current non-pharmacy SEP dispensation of injecting equipment policies, nature of service provision, availability of services provided and non-injecting equipment distributed, and to identify problems faced by SEP and to look for improvements to service provision.

## Materials and methods

We conducted a cross sectional survey design of Portuguese non-pharmacy SEP facilities. Data were collected using an anonymous self-completion postal questionnaire.

The questionnaire was designed to collect data on demographic of the SEP coordinator, operational characteristics (modes of service delivery, times of operation – day of week, time of day), injecting equipment service delivery and activity (dispensation policies and procedures and levels of activity in the previous month – in terms of number of clients, number of syringes distributed and returned), staffing, participation in training and further training needs, barriers and conflicts with service provision and also difficulties faced by staff with SEP clients. Respondents were invited to provide suggestions for SEP improvement.

Services provided to SEP clients were also covered in this questionnaire. The availability - either on site or through referrals - of voluntary and testing counselling for HIV, sexually transmitted infections (STI), hepatitis A, hepatitis B and hepatitis C was asked. The on site availability of methadone maintenance treatment, anti-retroviral treatment, TB treatment, vaccination (hepatitis A and B), primary care, safer injection education, overdose and abscesses prevention education, social services were also included, as was the provision of non-injection material equipment. The questionnaire also comprised questions regarding sources of SEP funding and the forms of evaluation that were undertaken either by entities that specifically finance SEP or through external entities.

The questionnaire was piloted amongst a group of key informants who did not participate in the SEP, but had knowledge of the programme and/or prior experience. Subsequently, minor amendments were made to the questionnaire in order to produce the final version.

Using the National Coordination for HIV/AIDS database the final version of the questionnaire was posted to all SEP directors of all GO and NGO that were involved in the programme (n=35) at the time of the survey, together with a covering letter with instructions for completion and return and a prepaid return envelope.

The questionnaire was first mailed in October 2008 and after four weeks all SEP Directors were reminded by telephone to complete it.

Data are described as absolute counts and proportions for categorical variables. For continuous variables medians (25<sup>th</sup> - 75<sup>th</sup> percentiles) are presented.

## Results

After one mailshot and a telephone contact, 25 SEP directors (from 24 NGO and 1 GO) responded to the self-completion questionnaire. During the telephone contact period, 3 NGO reported that they had their SEP activity suspended due to lack of funds and one GO reported that it was no longer participating in SEP. Overall, a 80.6% response rate was achieved.

Of all SEP directors, 15 (60.0%) were female and 19 (76.0%) aged less than 41 years.

More than three quarters of all respondents (n=19, 76.0%) were urban SEP, 4 (16.0%) and 1 (4.0%) were suburban and rural SEP, respectively. The median (25<sup>th</sup> - 75<sup>th</sup> percentiles) time of GO and NGO's involvement in provision of injection equipment through SEP was 6.0 (5-7) years.

Median (25<sup>th</sup> - 75<sup>th</sup> percentiles) number of SEP workers was 8 (4-9.5). Ten SEP (40%) had a combination of paid staff and volunteers. Amongst all 157 SEP workers reported, 84 (53.5%) were volunteers. Five SEP staff (20%) included a current or ex-IDU.

The different SEP modes of service delivery existents are shown in Table 1. Eleven SEP (44%) had at least two different models of SEP delivery.

The majority of SEP was open Monday to Friday, mornings and afternoons, although services were more likely to be open in the afternoon than in the morning and almost a half of SEP were available at night on weekdays. Sixteen SEP (64%) were open on Saturday or Sunday, although less than a third were available in each period of the day (Figure 1). Regarding the number of weekly hours, 9 (36.0%) SEP facilities were available less than 30 hours and 8 (32%) at least 50 hours.

There was variation across SEP in syringes dispensation policies, in either the existence of a maximum number of syringes given out or in returning used syringes. Eight SEP (32.0%) had established limits on the number of sterile syringes they would give out to an IDU and 17 (68.0%) followed a strict "one-for-one" policy (Table 2).

When asked what the SEP dispensation policy was regarding an IDU without a used syringe to exchange, 11 (44.0%) directors indicated that they provide at least one syringe, 12 (48.0%) answered that they would provide the necessary number of syringes for a day of consumption, according to IDU pattern of drug use, and 2 (2.8%) stated that they never provide a kit under those conditions.

According to the SEP dispensation policy implemented, 17 (68.0%) allowed secondary exchange (SE) (i.e. giving or receiving new sterile syringes and needles to/from another individual that were originally obtain from formal SEP).

SEP directors were asked to provide data on sterile injecting equipment distributed, used syringes returned and the number of IDU using the service during the 30 days prior to the survey. Five (20.0%) and 18 (62.0%) SEP directors reported that they distributed and collected more than 5000 and less than 1500 syringes, respectively.

A difference within SEP regarding the relationship between the number of syringes distributed and the number of IDU contacted is shown in Table 3, for the study period.



Eight respondents (32.0%) refused SEP provision over the 12 month period prior to completing the questionnaire: 8 refused IDU who had no used equipment to return, 2 refused IDU who were under 16 years old and 1 refused to supply IDU who was under treatment for drug dependence (e.g. methadone).

During the twelve month period 9 SEP (36.0%) faced at least one problem regarding IDU. Disturbing behaviour/nuisance and thefts occurred at least "rarely" in 6 and 4 SEP, respectively.

Since the beginning of SEP implementation, one SEP (4%) faced an aggression from IDU with a syringe (a syringe was used as a weapon) and 6 SEP (24.0%) reported cases of accidental needle-stick injuries, of which 5 had occurred in the last 12 months.

For the same period, 9 SEP (36.0%) reported opposition from the local community and 13 (52.0%) had been raided by the police.

Besides the distribution of injection equipment all SEP provided other services and distributed other material.

Of note, however, there were differences between services in the types of interventions that they offered to their clients on-site. Only about half of SEP provided any form of on-site testing related to bloodborne viruses. The interventions most commonly provided were HIV and hepatitis B testing (Table 4).

In terms of non-injecting equipment, 22 (88.0%) distributed male condoms and 7 (28.0%) distributed female condoms. It was found that other material needed to practice safer sex, such as dental dam, latex gloves and finger cots was not distributed by any SEP (Table 5).

Twenty-three SEP directors (92.0%) reported that their staff had taken part in training sessions regarding harm reduction. Amongst these, 21 (84.0%) indicated that their staff had received training in the last 12 months. All respondents (n=25) were interested in receiving training. Suggestions of areas for further training included: safer injection practice (n=22, 88.0%), conflict management (n=19, 76.0%), HCV and HBV (n=17, 68.0%), STI (n=17, 68.0%), security issues (n=17, 68.0%) and HIV/AIDS (n=14, 56.0%).

SEP directors were inquired to point out suggestions on how SEP provision could be improved. Overall, 15 (60.0%) stated "provision of training", 13 (52.0%) "more financial stability", and 11 (44.0%) "greater links and communication between SEP in the same area in order to provide a coordination of services, for example through regular meetings".

Twenty SEP (80%) were funded by National Health System institutions (13 by Institute on Drugs and Drug Addiction, 4 by National HIV/AIDS Coordination, 2 by Regional Health Administration and 1 by Institute on Drugs and Drug Addiction and National HIV/AIDS Coordination, simultaneously), 2 by Ministry of Labour and Social Solidarity, 1 by a local municipality and 1 by Ministry of Labour and Social Solidarity and by Institute on Drugs and Drug Addiction, simultaneously.

Twenty-three SEP directors (92%) reported that their programme was evaluated by funded entities. Amongst these, 10 reported that the evaluation was by means of reports submitted by SEP and 13 indicated that the evaluation was by means of reports submitted by

SEP and also by periodical visits from their funders.

Only 3 respondents reported their programme was evaluated by an external entity other than the entity that funded them.

## Discussion

This study reports on the findings from the first Portuguese survey of SEP.

With regard to SEP dispensation of injecting equipment policies, lack of uniformity in syringe distribution and exchange practices was found. Almost one third of SEP had established limits on the number of sterile syringes they would give out to an IDU, based merely on a subjective decision made by SEP director, and that those SEP had simultaneously a strict "one-for-one-policy". Amongst these, 75% only provided up to 10 syringes per IDU. Overall, more than two thirds of SEP surveyed had a strict "one-for-one" policy.

Syringe disposal is an important element of the syringe dispensation approach. In Portugal this aspect has been stressed since the beginning of SEP implementation. On the one hand a strict exchange programme may minimize the number of abandoned and possibly infected needles and syringes (10,11). But, on the other hand, a strict policy, based on strict "one-for-one", could increase the likelihood of re-use and sharing injecting equipment. Previous studies have demonstrated that syringe re-use (12-14) and sharing practices (either receptive or distributive syringe sharing) (15) are lower when SEP have less restrictive dispensation policies, either on establishing limits or existence of restrictive rules regarding strict policy "one-for-one".

As a result, the findings of this survey emphasize the need to develop guidelines regarding paraphernalia distribution in Portugal in the least restrictive approach possible. Therefore, limits on the number of syringes distributed per visit and strict exchange policies "one-for-one" should be abandoned for purposes of HIV and other bloodborne infections prevention.

It was also worth noting that in SEP which provided a higher number of syringes per IDU, an increase of unsafe discarding syringes was not demonstrated, corroborating the results of a Californian study (15).

Regarding SEP dispensation policy to an IDU without a used syringe to exchange, 2 (2.8%) SEP directors stated that they would never provide a kit. Nonetheless, it was observed that 8 respondents (32.0%) refused SEP provision to an IDU who had no used equipment to return during the 12 months prior to the survey.

According to the SEP dispensation policy implemented, only 68.0% SEP allowed Secondary Exchange (SE), in comparison with 87% and 93% of California (16) and USA (17) SEP, respectively.

However, it has been demonstrated that regardless of the SEP operational characteristics (location, mode of service delivery) and even the distribution policy, most SEP clients engage in some form of SE (16,18). Overall, SE practices extend the benefits of formal SEP, making available sterile injecting equipment to IDU who probably do not use formal SEP. Thus, it should be accepted and incorporated in dispensation policy of SEP and strategies to enhance the provision and preventive messages to known distributors should be designed (e.g. peer-based interventions) (19,20).

Besides the sterile injecting equipment, male and female condoms are distributed for free with no restrictions by the National Coordination for HIV/AIDS. However, only 88% of SEP distributed male condoms. It was also found that only 28% of SEP distributed female condom, compared to 97% and 83% of USA SEP, respectively (17). Urgent efforts should be made in order to promote the presence of all prevention materials in all SEP.

IDU often have difficulty in accessing formal healthcare services, so the "SEP environment" itself can be an important outlet for services which should address multiple sources of risk and provide a comprehensive package of prevention services beyond the availability of sterile injecting equipment, including testing services, drug treatment/counselling, vaccination, etc. (6,8,21,22).

Despite that, it was found that only 44% and 16% of SEP provided on-site HIV and HCV testing and counselling, respectively. By contrast, in USA the availability of on-site HIV testing was 81% and 56% for HCV (17). Conversely, the availability of HIV testing on-site was 39% in England (23) and 29% in Scotland (24).

An increase in the availability of services amongst Portuguese SEP is needed, including vaccination (hepatitis A and B) and counselling and testing for HIV, HVB, HCV and STI. Nevertheless, regarding drug treatment and testing services, it should be ensured that an established referral mechanism is in place.

Offering SEP from different models of delivery is likely to improve accessibility of injecting equipment and therefore to increase choice for IDU. However, only 11 (44%) programmes had more than one different approach to IDU, compared to 55% of USA SEP which had multiple types of exchange sites (25).

It was reported that more than half of SEP workers were volunteers, compared to 31.2% in a Brazilian study (26). In practical terms, people with no other means of support are unlikely to be willing or able to keep working without some payment for a long time. Additionally, previous results from a Portuguese study (27) regarding the nature of professional affiliations of harm reduction programmes run by NGO, including SEP, showed that the majority of workers had no job security. Therefore, the combination of a higher proportion of volunteer SEP workers with workers who had little or no job security leads necessarily to a constant rotation of these professionals, which probably jeopardizes programme activities (28,29).

More than half of SEP had been raided by the police and more than a third reported opposition from the local community. Several studies have previously found that police presence has been associated with an increase in drug-related harms, including rushed injection and syringe sharing, which could place IDU at a greater risk of contracting bloodborne infections, such as HIV or HCV (30-32). A community's support or opposition to establishment of any SEP may depend on its' residents perceptions of drug users and the local context in which they live and use drugs (33). It has been shown that, community level dynamics "not in my backyard" opposition, may affect availability of SEP services and syringe coverage (34).

The establishment of a working relationship between SEP directors and health departments with the police (at local and a national level) and communities where SEP are

implemented should be done. Training regarding the role of SEP in preventing HIV and other infections can assist in reducing local residents' and police officers' stigmatization of injecting drug users, and can lead to decreased interference with SEP activities (29).

Twenty-three SEP directors reported that their programme was evaluated by funded entities, by means of reports submitted by SEP and/or by periodical visits from their funders. However, this sort of evaluation is based merely on financial reports, services provided and material given out to IDU.

There is not a national monitoring and evaluation of SEP. Nevertheless SEP monitoring and evaluation are crucial in order to measure its effect in the bloodborne viruses epidemic and to adjust the various actions to expected results. Ongoing evaluation should be put in place in order to determine if the programme meets the needs of IDU and where further improvements are warranted.

Assessing the quality of services, including the distribution of injecting equipment, was beyond the scope of this study. Future studies should begin to assess not only the availability but also use according to needs and important domains of service quality. These should include particularly SEP client satisfaction with services and barriers faced, SEP structural characteristics associated with delivery of higher quality services, and outcomes resulting from services such as change in risk behaviour or infectious disease incidence.

The findings of this survey are subject to limitations that should be considered in interpreting the results. Data is limited to 25 of 31 SEP effectively operating in Portugal. Despite this, data collected was based on programme director self-reports and were not verified independently.

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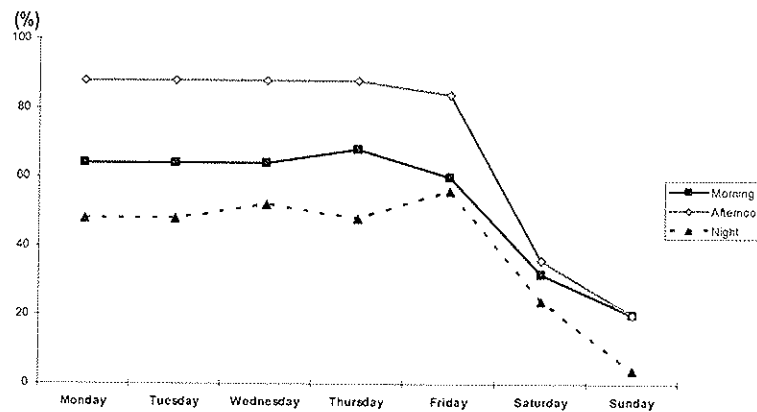
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**Table 1. Modes of SEP service delivery**

Modes of SEP service delivery	n (%)
Fixed-site	4 (16.0)
Mobile van or bus	9 (36.0)
Outreach†	1 (4.0)
Fixed-site + mobile van or bus	6 (24.0)
Fixed-site + outreach†	1 (4.0)
Mobile van or bus + outreach†	3 (12.0)
Fixed-site + mobile van or bus + outreach†	1 (4.0)

† through home-visits or on the streets

**Figure 1 – SEP opening times (%)**



**Table 2. Syringe dispensation policy**

Syringe Dispensation Policy	n (%)
Unlimited number of syringes distributed without regard to the number of syringes returned for disposal	7 (28.0)
Unlimited number of syringes distributed and return of at least one used syringe	1 (4.0)
Limited number of syringes distributed following a strict one-for-one exchange	8 (32.0)
Limits on the number of syringes distributed	
8 syringes	5 (62.5)
10 syringes	1 (12.5)
20 syringes	1 (12.5)
Unlimited number of syringes distributed following a strict one-for-one exchange	9 (36.0)

**Table 3. Level of activity on syringes distributed and IDU contacted  
(during the 30 days prior to the survey)**

Number of IDU contacted	Number of syringes distributed				
	0-500	501-1499	1500-4999	5000-7499	≥7500
0-49	8	8	1	0	1
50-99	2	3	1	1	0
100-299	0	0	0	1	1
≥300	0	1	0	0	1

**Table 4. Other services provided by SEP**

Services	n (%)
<b>Counselling and testing on-site</b>	
HIV	11 (44.0)
Hepatitis B	5 (20.0)
Hepatitis C	4 (16.0)
Hepatitis A	4 (16.0)
Other sexually transmitted infections (STI)	3 (12.0)
<b>Referrals for counselling and testing</b>	
HIV	20 (80.0)
Hepatitis B	22 (88.0)
Hepatitis C	22 (88.0)
Hepatitis A	21 (84.0)
Other sexually transmitted infections (STI)	18 (72.0)
Hepatitis B vaccination	8 (32.0)
Hepatitis A vaccination	2 (8.0)
<b>Education</b>	
Safer injection practice	21 (84.0)
Safer sex	21 (84.0)
HIV prevention	23 (92.0)
Hepatitis A, B and C prevention	19 (76.0)
Overdose prevention	20 (80.0)
Abscess prevention	20 (80.0)
Primary care/nursing care	22 (88.0)
Methadone maintenance treatment	11 (44.0)
ARV, TB and methadone treatment	11 (44.0)
Referrals to drug treatment centres and health and social services	25 (100.0)
Personal hygiene	18 (72.0)
Food	16 (66.7)

**Table 5. Non-injecting material provided by SEP**

	n (%)
Condom	
Male	22 (88.0)
Kit (male condom + lubricant)	5 (20.0)
Female	7 (28.0)
Lubricant	6 (24.0)
Tie	0 (0.0)
Dental dam	0 (0.0)
Latex gloves and finger cots	0 (0.0)
Foil	8 (32.0)
Kit for cocaine consumption	1 (4.0)
Leaflets to IDU	
HIV/AIDS	19 (76.0)
Hepatitis B	9 (36.0)
Hepatitis C	9 (36.0)
Safer injection	14 (56.0)
Safer sex	17 (68.0)
Testing (HIV, HBV, HCV and STI)	14 (25.0)

## GENERAL DISCUSSION

Twenty-five years after the implementation of the first official syringe exchange programme (SEP) in the world, providing injecting drug users (IDU) with access to sterile syringes remains a serious challenge in both developed and developing countries.

IDU are diverse populations with different languages, cultures, sexual preferences, life circumstances, behaviours, and requirements for services. The potential impact of SEP in reducing injecting related-harms is limited by the extent to which the programmes provide effective access to sterile injecting equipment and other services, and are therefore able to attract their potential clients either directly to the programmes or indirectly to secondary exchange (121).

Some efforts to identify structural, individual and environmental barriers to optimal sterile injecting equipment programmes have been done. Several studies have found differences that in SEP operational characteristics are associated with health outcomes and risk behaviours patterns amongst IDU. More specifically, SEP client individual outcomes have been associated with injection dispensation policies (94,96,98), locations and hours of operation (50,75,125), types of venues (71,144), availability of services (80) and attitudes and beliefs of SEP staff (78,126).

However, the challenge of implementing effective strategies to address these concerns remains a priority. Therefore we aimed to investigate the extent and nature of the Portuguese SEP provision, to identify barriers and difficulties in service delivery and areas of good practice in order to contribute to the programmes' improvement.

In Portugal, SEP was first established in 1993. Since then, a variety of measures have been developed to improve access to, and utilization of, sterile injecting equipment and to increase users' choice, which have included conventional fixed-site SEP, outreach programmes, community pharmacy-based SEP and pharmacy sales. However, this process took place later than desirable. Up to 1998, the distribution of injection equipment was almost exclusively through community pharmacies and therefore Portuguese SEP probably did not reach different types of IDU as warranted and had offered limited additional services beyond the distribution of sterile injecting equipment and condoms. Only in 1999, partnerships were formalised with governmental (GO) and non governmental organisations (NGO) therefore allowing them to take part in SEP.

The Portuguese SEP is managed centrally, including the acquisition of all the injection material and collection and destruction of the used syringes from the pharmacies, mobile post and NGO and GO involved in SEP. All SEP facilities, regardless their mode of service delivery, provide the same injection paraphernalia to IDU.

In Portugal, the proportion of HIV/cases corresponded to IDU decreased from 58% in the mid-nineties to less than 20% at present. The actual crude number also decreased from a maximum of 1526 in 1999 to 336 in 2007 (140). SEP, as part of a set of harm reduction measures, played an important role in those trends. Of note however, is that the programme was probably less successful in reducing HCV amongst IDU. Due to the high infectivity of the virus, HCV can be transmitted not only from sharing needles and syringes but also from sharing other injecting equipment, such as filter and recipients for drug preparation (13,14). Despite this,

only in 1999 were filters provided for free for IDU, followed in 2007 by recipients for drug preparation.

At the end of 2008, syringe exchange facilities were available in all Portuguese districts. Although, only 10 of 18 districts had more than one measure to provide access for free of injecting equipment to IDU. In the most remote and rural areas of Portugal, pharmacy-based SEP was the only option for access to sterile injecting equipment. A possible further alternative to increase injecting equipment access in those areas could be the provision of dispensing machines, which already exist in several other countries (50,75). In fact, due to small populations in rural and suburban settings the confidentiality of IDU can be a particular concern. This emphasizes the need for their availability as a complementary service, beyond the existence of pharmacy-SEP, in an attempt to increase geographical and also temporal accessibility and to provide more anonymous access.

Pharmacies' involvement in SEP had decreased since 1994, especially in the two Portuguese largest districts, Lisboa and Porto, where the highest HIV/AIDS infection rate and drug use prevalence is observed. However, we found that the initial decision of pharmacy-SEP involvement was independent of the prevalence of IDU in the geographical area. Nonetheless, continuity of the programme may reflect this distribution, since, among all pharmacies that had been involved in SEP at some point, urban pharmacies had discontinued SEP more frequently.

The level of syringe distribution in Portugal is likely to be inadequate and therefore the one sterile syringe for each injection goal is unlikely to be met.

It is of concern that the actual policies implemented by SEP providers have been developed without the benefit of empirical data or even a strong theoretical perspective to guide policy and protocol choices. We found that 64.3% of pharmacies and 68.0% of GO and NGO involved in SEP followed a strict "one-for-one" policy and 21.6% of pharmacies and 32.0% of non-pharmacy SEP established limits on the number of syringes distributed per visit. These findings strongly favour the development of guidelines regarding injection paraphernalia distribution in Portugal so that standard procedures are in place. They should consider the least restrictive approach possible. Therefore, limits on the number of syringes distributed per visit and strict exchange policies "one-for-one" should be abandoned for purposes of HIV and other bloodborne infections prevention. Nonetheless, the return of used needles and syringes should not be neglected.

We found a low level of availability of other service provision, in addition to the distribution of injecting equipment, especially in pharmacy-based SEP. Considering that SEP are often the only source of health care for IDU, increasing services and other harm reduction interventions in all SEP providers should be a primary developmental aim. In addition, our findings emphasize that training should be also a priority, especially for pharmacy based SEP providers, where levels of training were very low compared to other countries (110,145).

A possible maxim for Portuguese SEP could be the three S's strategy defined by Des Jarlais & Braine (120): "1) *Size*: more clean syringes are better than fewer clean syringes; 2) *Smiles*: exchanges should be "user friendly" and create a welcoming environment; 3) *Services*:

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## SUMMARY

## **Syringe Exchange Programmes – The Portuguese Experience**

Injecting drug users (IDU) are particularly vulnerable to hepatitis C virus (HCV), human immunodeficiency virus (HIV), and other bloodborne infections as result of sharing contaminated injecting equipment. Providing access and encouraging utilization of all sterile injection paraphernalia for IDU is considered a fundamental component of an effective HIV and HCV prevention programme. A Syringe exchange programme (SEP) was first established in Portugal in 1993, with its primary aim being the prevention of HIV transmission. Since then, a variety of measures have been developed to promote free access to sterile injecting equipment for IDU, which have included conventional SEP in fixed-sites, outreach programmes and community pharmacy-based SEP.

### **Objectives**

This study aimed to investigate the extent and nature of the Portuguese SEP provision, to identify barriers and difficulties to service delivery and areas of good practice in order to contribute to its improvement, through the accomplishment of the following objectives:

- to describe the trends of the programme in terms of distribution and collection of injecting equipment and also in terms of the service providers during the period 1993-2008 (*Section I*);
- to assess the current injecting equipment dispensation policies, the level of SEP provision and the availability of other services provided to IDU by pharmacies (regardless of SEP involvement) and by governmental (GO) and non governmental organisations (NGO) involved in SEP (*Section II*);
- to identify problems faced by SEP providers, training levels and needs and to look for improvements in service provision (*Section II*);
- to examine reasons for pharmacies withdrawing from SEP (*Section II*).

### **Section I – The Portuguese syringe exchange programme – A 15 year experience**

The Portuguese SEP began as a partnership established in 1993, between the Ministry of Health, through the National Coordination for HIV/AIDS, and the National Association of Pharmacies with the collaboration of pharmaceutical wholesalers and local municipalities.

Up to 1998, the distribution of injection equipment was almost exclusively through pharmacy-based SEP. Only in 1999 were partnerships formalised between GO and NGO therefore allowing them too to take part in SEP.

The Portuguese SEP is managed centrally. The National Coordination for HIV/AIDS distribute, for free, to all pharmacies, GO and NGO involved in SEP sterile syringes and needles, disinfectant towels, filters, ampoules of double-distilled water, recipients (cleancups) for the preparation of drugs for injection, citric acid sachets and condoms and also funds the collection and destruction service for sharp waste generated by SEP.

In the period 1993 to 2008, 43 043 495 syringes were collected in Portugal by all SEP providers. The total number of syringes collected gradually increased until 1997, followed by a decrease until 1999. In the period between 2000 and 2001 there was a slight increase in the number of syringes collected, followed by a decrease until 2003. Since 2004 the number of syringes collected decreased and remained stable until 2007. In 2008 the total number of syringes collected slightly increased.

Based on the existent estimates of the number of IDU in Portugal, the number of sterile syringes distributed per IDU ranged between 113 and 231 in 2000 and 117 and 235 in 2005, which suggests that the number of syringes distributed was insufficient and the one sterile syringe for each injection policy was not accomplished.

In 2008, syringe exchange facilities were available in all Portuguese districts. Although only 10 of 18 districts had more than one measure to improve access to, and utilization of, sterile injecting equipment. In the most remote and rural areas of Portugal, pharmacy-based SEP was the only option for access to sterile injecting equipment. To increase choice for users other modalities for distribution of injecting equipment should be considered in those areas.

Since 1994, pharmacies' involvement in the programme had decreased. In 2007, 47% of pharmacies (1314 out of 2775) took part in SEP, compared with 50.4%, in 2001, and 66.9%, in 1994.

At the end of 2008, 1384 pharmacies, 36 GO and NGO and one mobile post were part of the system.

## **Section II – Process characterization by the syringe exchange programme providers**

We conducted a cross-sectional survey of all Portuguese pharmacies (regardless of SEP involvement) – manuscript 1: "Community pharmacies and the syringe exchange programme in Portugal – a 15 years experience" – and a cross-sectional survey of all SEP run by GO and NGO - manuscript 2: "A survey of syringe exchange programmes in Portugal". Descriptive data were collected on demography, injecting equipment service delivery and activity, services provided to IDU, barriers and conflicts in service provision and training levels and needs. Furthermore, reasons for pharmacies for withdrawing SEP were examined and with regard to SEP run by GO and NGO, operational characteristics, sources of funding and forms of evaluation were assessed.

Of all respondent pharmacies, 59.4% were involved in SEP, 24.8% had been involved in the past and 15.7% had never been involved. With regard to SEP run by GO and NGO, almost half of SEP had more than one mode of service delivery and 96% received public funds.

Regarding dispensation policies implemented by SEP providers, 64.3% of pharmacies and 68.0% of SEP run by GO and NGO followed a strict "one-for-one" policy and 21.6% of pharmacies and 32.0% of SEP run by GO and NGO established limits on the number of syringes distributed per visit.

Of all pharmacies, 76.2% had the policy of selling sterile syringes to IDU and 10.2% supervised methadone consumption. Pharmacies currently involved in SEP reported selling syringes to IDU less frequently (OR=0.57, 95%CI: 0.39-0.84) and were more likely to supervise

methadone consumption (OR=1.36, 95%CI: 0.93-1.98).

Half of non-pharmacy SEP facilities provided some form of on-site testing related to bloodborne viruses and only 32.0% provided hepatitis B vaccination.

Problems associated with service provision, such as shoplifting and disturbing behaviour/nuisance were experienced by 12.8% of pharmacies over the 12 months prior to the survey, although more serious problems such as violent behaviour were rare. For the same period, more than one third of non-pharmacy SEP directors reported opposition from the local community and 13 % had been raided by the police.

For pharmacies involved in SEP in the past the probability of discontinuation in the first ten years of the programme was significantly higher among urban pharmacies ( $p<0.001$ ) and in those that reported syringes sales in the previous month to the survey ( $p=0.013$ ).

Only 10.7% of pharmacy providers had taken part in any training sessions regarding SEP related issues in the last 12 month period. By contrast, a higher proportion of training levels were found amongst non-pharmacy SEP (84.0%).

Training and improving referral pathways to specialist drug treatment services were identified as potential areas for further development by pharmacy SEP providers. Financial stability was mentioned as another area for improvement by GO and NGO SEP directors.

External evaluation of the programme was only reported by 3 non-pharmacy SEP directors.

The findings of the two surveys strongly suggest the need to develop written SEP best practice recommendations, regarding injecting equipment dispensation policies, in the least restrictive approach, which should be accomplished with a proper training plan for all SEP providers. Furthermore, the results highlight the demand for an increase in the availability of other services provided to IDU amongst SEP providers beyond the delivery of injecting equipment.

Ongoing evaluation should be put in place in order to determine if the programme meets the needs of IDU and where further improvements might be made.

**Keywords:** syringe exchange programme, injecting drug use, community-pharmacy, harm reduction, Portugal.



## SUMÁRIO

## Programa de Troca de Seringas – A Experiência Portuguesa

Os utilizadores de drogas injectáveis (UDI) são particularmente vulneráveis à infecção por vírus da hepatite C (VHC), por vírus da imunodeficiência humana (VIH) e a outras infecções de transmissão sanguínea, como resultado da partilha de material de injeção contaminado. Proporcionar o acesso e promover a utilização de toda a parafernália de injeção aos utilizadores de drogas injectáveis é considerada uma componente fundamental nos programas de prevenção da infecção por VIH ou VHC. O Programa de troca de seringas (PTS) português foi implementado em 1993, tendo como primeiro objectivo a prevenção da transmissão da infecção por VIH. Desde então, várias medidas têm sido desenvolvidas para promover o acesso gratuito ao equipamento de injeção estéril aos UDI, que incluíram os convencionais PTS em locais fixos, programas de *outreach* e PTS implementados nas farmácias comunitárias.

### **Objectivos**

Este estudo teve como objectivo investigar a extensão e a natureza da provisão do PTS português, identificar barreiras e dificuldades relacionadas com a prestação do serviço e áreas de boas práticas, com o intuito de contribuir para a sua melhoria, através dos seguintes objectivos:

- descrever as tendências no que respeita à distribuição e recolha do equipamento de injeção, e das entidades envolvidas no PTS, durante o período 1993-2008 (Secção I);
- avaliar as políticas de dispensa do material de injeção implementadas, o nível de provisão do PTS e a existência de outros serviços disponibilizados pelas farmácias (independentemente do seu envolvimento no PTS), organizações governamentais (OG) e organizações não governamentais (ONG) envolvidas no programa (Secção II);
- identificar os problemas que as entidades envolvidas no PTS enfrentam, os níveis e necessidades de formação, com a finalidade de melhorar a provisão do serviço (Secção II);
- examinar as razões que conduziram à desistência das farmácias do PTS (Secção II).

### **Secção I – O programa de troca de seringas português – uma experiência de 15 anos**

O PTS português resultou de uma parceria estabelecida em 1993, entre o Ministério da Saúde, através da Coordenação Nacional para a Infecção VIH/sida, e a Associação Nacional das Farmácias, com a colaboração das cooperativas de distribuição de medicamentos e as Câmaras Municipais.

Até 1998, a distribuição do material de injeção foi realizada quase exclusivamente através das farmácias comunitárias. Apenas em 1999, foram formalizadas parcerias com as OG e as ONG, permitindo que estas fizessem parte do PTS.

O PTS português é gerido centralmente. A Coordenação Nacional para a Infecção

VIH/sida distribuí gratuitamente para todas as farmácias, OG e ONG envolvidas no programa, seringas e agulhas estéreis, toalhetes desinfetantes, filtros, ampolas de água bi-destilada, recipientes para a preparação da droga, carteiras de ácido cítrico e preservativos, e financia igualmente a recolha e a destruição do material utilizado.

Entre 1993 e 2008, em Portugal, foram recolhidas 43 043 495 seringas por todas as entidades envolvidas no PTS. O número de seringas recolhidas aumentou progressivamente até 1997 e decresceu até 1999. No período compreendido entre 2000 e 2001, verificou-se um ligeiro aumento no número de seringas recolhidas, voltando a decrescer até 2003. Desde 2004, o número de seringas recolhidas diminuiu e permaneceu estável até 2007. Em 2008, o número de seringas recolhidas aumentou ligeiramente.

Com base nas estimativas existentes do número de UDI em Portugal, o número de seringas estéreis distribuídas por UDI variou entre 113 e 231 em 2000 e 117 e 235 em 2005, o que indica que o número de seringas distribuídas foi insuficiente e que a política de 1 seringa estéril por cada injeção possivelmente não foi alcançada.

Em 2008, existiam em todos os distritos portugueses, entidades envolvidas no PTS. No entanto, apenas 10 dos 18 distritos apresentavam mais do que uma modalidade para promover o acesso e a utilização do equipamento estéril de injeção. Nas áreas mais remotas e rurais de Portugal, as farmácias foram a única opção para o acesso ao equipamento estéril de injeção.

Outras modalidades de disponibilização de material de injeção deverão ser consideradas para aumentar a opção de escolha por parte dos utilizadores.

Desde 1994, o envolvimento das farmácias no PTS tem vindo a decrescer. Em 2007, 47% das farmácias (1314 de 2775) participavam no PTS, comparativamente a 50.4% em 2001 e 66.9% em 1994.

No final de 2008, participavam no PTS 1384 farmácias, 36 OG e ONG e um posto móvel.

## **Secção II – Caracterização de processo das entidades envolvidas no programa de troca de seringas**

Foi realizado um estudo transversal, através de um inquérito a todas farmácias portuguesas (independentemente do seu envolvimento no PTS) – manuscrito 1 "Community pharmacies and the syringe exchange programme in Portugal – a 15 years experience" e a todos os PTS implementados pelas OG e ONG – manuscrito 2: "A survey of syringe exchange programmes in Portugal".

Foram recolhidos dados demográficos, dados referentes à prestação e actividade do serviço de distribuição do material de injeção, outros serviços prestados aos UDI, barreiras e conflitos na provisão do serviço, níveis e necessidades de formação. As razões que conduziram à desistência das farmácias do PTS foram investigadas e no que respeita aos PTS implementados pelas OG e ONG, as características operacionais, as fontes de financiamento e as formas de avaliação foram inquiridos.

Da totalidade das farmácias respondentes, 59.4% encontravam-se envolvidas no PTS, 24.9% tinham estado envolvidas no passado e 15.7% nunca tinham participado no programa.

No que respeita aos PTS implementados pelas GO e ONG, quase metade apresentava mais do que uma modalidade de serviço operacional e 96% recebia financiamento público para o seu funcionamento.

Relativamente às políticas de dispensa implementadas pelas entidades envolvidas no PTS, 64.3% das farmácias e 68.0% dos PTS das GO e ONG seguiam uma política rígida de “uma seringa usada por uma seringa estéril” e 21.6% das farmácias e 32.0% dos PTS das GO e ONG estabeleciam limites no número de seringas distribuídas por visita.

Da totalidade das farmácias respondentes, 76.2% afirmaram vender seringas aos UDI e 10.2% supervisionar o consumo de metadona. As farmácias que participavam no PTS eram as que vendiam seringas menos frequentemente (OR=0.57, IC95%: 0.39-0.84) e as que mais supervisionavam o consumo de metadona (OR=1.36, IC95%: 0.93-1.98).

Cerca de metade dos PTS das GO e ONG disponibilizavam testes de identificação de alguns dos vírus de transmissão sanguínea no próprio local de funcionamento e apenas 32% dispunha do serviço de vacinação contra a hepatite B.

Problemas associados com a provisão do serviço, como roubos e comportamentos perturbadores/incómodos foram experienciados por 12.8% das farmácias nos 12 meses anteriores ao preenchimento do inquérito. Problemas mais graves, como comportamentos violentos, foram reportados raramente. Para o mesmo período, mais de um terço dos directores dos PTS das GO e ONG referiram oposição da comunidade local e 13% mencionaram a existência de rusgas policiais.

Para as farmácias que já tinham participado no PTS no passado, a probabilidade de abandono do programa foi significativamente maior nas farmácias urbanas ( $p < 0.001$ ) e nas farmácias que reportaram a venda de seringas no mês anterior à realização do inquérito ( $p = 0.013$ ).

Apenas 10.7% das farmácias envolvidas no PTS participaram numa sessão de formação relacionada com o PTS nos 12 meses anteriores ao inquérito, comparativamente a 84.0% dos PTS das GO e ONG (84,0%).

Formação e melhor agilização dos mecanismos de referência para os serviços de tratamento da toxicod dependência foram áreas identificadas pelas farmácias como áreas necessárias de melhoria. Estabilidade financeira foi mencionada como sendo outra área necessária de melhoria pelos directores dos PTS das OG e ONG.

A avaliação externa do programa foi reportada apenas por 3 directores dos PTS das OG e ONG.

Os resultados dos dois inquéritos sugerem fortemente a necessidade de elaborar recomendações de boas práticas do PTS, nomeadamente em relação às políticas de dispensa do material de injeção, numa abordagem menos restritiva, cuja implementação deve ser acompanhada com um plano de formação adequado para todas as entidades que participam no programa.

Adicionalmente, os resultados deste estudo sublinham a necessidade da existência de um maior número de serviços prestados aos UDI, para além da disponibilização do material de injeção.

A avaliação contínua deve ser posta em prática com o intuito de determinar se o

programa responde às necessidades dos UDI e de identificar outras áreas alvo de melhoria.

**Palavras-chave:** programa de troca de seringas, uso de drogas injectáveis, farmácias comunitárias, redução de danos, Portugal.

## **ANNEXES**



Coordenação Nacional para a  
Infecção VIH/sida

## Programa de Troca de Seringas "Diz Não a Uma Seringa Em Segunda mão" Questionário - Farmácias Comunitárias Portuguesas

### Instruções de Preenchimento:

- Este questionário é totalmente **anónimo**, pelo que não é solicitado o seu nome ou outra informação que o possa identificar a si ou à Farmácia Comunitária.
- As questões que se seguem pedem-lhe a **opinião e a disponibilização de alguns dados** relacionados com o programa de troca de seringas (PTS) "Diz não a uma seringa em segunda mão" – implementado em Portugal desde Outubro de 1993.
- Este questionário é dirigido à **totalidade das Farmácias Comunitárias Portuguesas**: às participantes, às que participaram e desistiram posteriormente e às nunca participantes no programa de troca de seringas.
- **Leia com atenção** cada questão e **preencha o círculo** que representa a sua resposta.

Se necessitar de algum esclarecimento ou informação adicional por favor contacte:

Carla Torre (Farmacêutica)  
[ctorre@sida.acs.min-saude.pt](mailto:ctorre@sida.acs.min-saude.pt)

#### Coordenação Nacional para a Infecção VIH/sida

Palácio Bensaúde, Estrada da Luz, n.º 153  
1600-153 Lisboa  
Telefone: 217 210 360  
Fax: 217 220 822 / 217 210 365

#### Serviço de Higiene e Epidemiologia Faculdade de Medicina da Universidade do Porto

Alameda Prof. Hernâni Monteiro  
4200-319 Porto  
Telefone: 225 513 652  
Fax: 225 513 653



Data de preenchimento:   -   - 2 0 0 8

1. **Actualmente**, a Farmácia participa no **Programa de Troca de Seringas** "Diz não a uma seringa em segunda mão"?

Não  Sim  Não Sabe

1.1. **Se Sim, indique o mês e ano** em que a Farmácia implementou o Programa de Troca de Seringas:

mês     ano

1.2. **Se Não**, indique se a Farmácia **participou alguma vez** no Programa de Troca de Seringas?

Não  Sim  Não Sabe

Se **Sim**, por favor indique:

1.2.1. Data de início:   mês     ano

Data de desistência:   mês     ano

1.2.2. O(s) **principal (ais) motivo (s) de desistência do Programa de Troca de Seringas** (Selecione uma ou mais opções de resposta)

- Agressividade dos utilizadores de drogas injectáveis
- Roubos aos utentes da Farmácia e/ou à Farmácia
- Reacções negativas dos restantes utentes da Farmácia ao Programa de Troca de Seringas
- Inexistência de profissionais habilitados na Farmácia para participar no Programa de Troca de Seringas
- Agressão com uma seringa (utilização de uma seringa como uma arma) a um utente ou a um colaborador da Farmácia
- Ocorrência de uma picada acidental com uma agulha de uma seringa a um utente ou a um colaborador da Farmácia
- Outra. Especifique:

**Se Não participa actualmente no Programa de Troca de Seringas por favor passe para a questão 24.**

2. Qual a (s) principal (ais) **razão (ões) que motiva (m) a Farmácia a participar** no Programa de Troca de Seringas? (Selecione uma ou mais opções de respostas)

- Proteger a comunidade de seringas e agulhas potencialmente contaminadas com os Vírus da Imunodeficiência Humana (VIH) e das Hepatites B e C abandonadas
- A Farmácia tem como missão a promoção de programas de saúde pública
- Contribuir para a redução do número de utilizadores de drogas infectados por VIH
- Contribuir para a redução das despesas de saúde alocadas ao custo das pessoas infectadas por VIH/sida
- Outras. Especifique:

3. A Farmácia possui alguma  **sinalização** (cartaz, autocolante, etc.) que informe os utilizadores de drogas injectáveis sobre a sua participação no Programa de Troca de Seringas?

Não  Sim  Não Sabe





4. A Farmácia estabelece algum horário específico para a realização do Programa de Troca de Seringas?

Não  Sim. Especifique:   Não Sabe

5. A Farmácia faz serviço nocturno?

Não  Sim  Não Sabe

5.1. Se Sim, por favor indique se existe disponibilização de kits "Prevenção sida" aos utilizadores de drogas injectáveis durante o serviço nocturno:

Não  Sim  Não Sabe

6. Qual é a política de disponibilização de kits aos utilizadores de drogas injectáveis instituída na Farmácia? (Seleccione apenas a opção que melhor a descreve)

- Os kits são disponibilizados sem que seja necessária a entrega de pelo menos uma seringa utilizada, não existindo um limite máximo
- Os kits são disponibilizados, mas pelo menos uma seringa utilizada é entregue, não existindo um limite máximo
- Os kits são disponibilizados mediante o princípio da troca de 1 seringa estéril por 1 seringa usada, até ao máximo de   kits
- Os kits são disponibilizados mediante o princípio da troca de 1 seringa estéril por 1 seringa utilizada, não existindo um limite máximo
- Outras. Especifique:

7. Se o utilizador de drogas injectáveis solicitar um ou mais kits para outro (s) utilizador (es) de drogas, qual é a política instituída pela Farmácia? (Seleccione apenas uma opção de resposta)

- Na situação descrita nunca são disponibilizados kits
- São disponibilizados kits para outros utilizadores de drogas de acordo com a política de disponibilização de kits instituída na Farmácia (seleccionada na questão anterior)
- Outra. Especifique:

8. Se o utilizador de drogas injectáveis não possuir uma seringa usada e solicitar um kit ao Farmacêutico/ Ajudante Técnico de Farmácia, qual é a política instituída pela Farmácia?

- Na situação descrita nunca é disponibilizado um kit
- É disponibilizado pelo menos um kit ao utilizador de drogas injectáveis
- Outra. Especifique:

9. Quantos kits foram distribuídos aos utilizadores de drogas injectáveis nos últimos 30 dias? (Se não souber o número exacto - recorrendo por exemplo ao sistema informático da Farmácia, indique a melhor estimativa)?

- Nenhum  1 a 10  11 a 19  20 a 49  50 a 99  100 a 249  Mais de 250
- Não Sabe

10. Quantas seringas foram recolhidas nos últimos 30 dias? (Se não souber o número exacto, indique a melhor estimativa)?

- Nenhuma  1 a 19  20 a 39  40 a 99  100 a 199  200 a 499  Mais de 500
- Não Sabe



**11. Nos últimos 30 dias, quantos utilizadores de drogas injectáveis diferentes** recorreram à Farmácia e participaram no Programa de Troca de Seringas? (Se não souber o número exacto, indique a melhor estimativa)

- Nenhum  
 1 a 9  
 10 a 19  
 20 a 50  
 Mais de 50  
 Não Sabe

**12. Nos últimos 12 meses, alguma vez foi recusada a disponibilização de kits** aos utilizadores de drogas injectáveis?

- Não  
 Sim  
 Não Sabe

Motivos de Recusa			
Utilizadores de drogas injectáveis com menos de 16 anos	<input type="radio"/> Sim <u>Se Sim:</u> <input type="radio"/> Sempre <input type="radio"/> Às vezes <input type="radio"/> Raramente	<input type="radio"/> Não	<input type="radio"/> Nunca existiram solicitações
Utilizadores de drogas injectáveis que não entregaram as seringas usadas	<input type="radio"/> Sim <u>Se Sim:</u> <input type="radio"/> Sempre <input type="radio"/> Às vezes <input type="radio"/> Raramente	<input type="radio"/> Não	<input type="radio"/> Nunca existiram solicitações
Utilizadores de drogas injectáveis que apresentaram comportamentos agressivos	<input type="radio"/> Sim <u>Se Sim:</u> <input type="radio"/> Sempre <input type="radio"/> Às vezes <input type="radio"/> Raramente	<input type="radio"/> Não	<input type="radio"/> Nunca existiram solicitações
Utilizadores de drogas injectáveis que se encontravam em programas de substituição (exemplo: metadona)	<input type="radio"/> Sim <u>Se Sim:</u> <input type="radio"/> Sempre <input type="radio"/> Às vezes <input type="radio"/> Raramente	<input type="radio"/> Não	<input type="radio"/> Nunca existiram solicitações
Outros motivos de recusa:			

**13. Desde o início da implementação do Programa de Troca de Seringas, como avalia as mudanças relativas ao comportamento dos utilizadores de drogas injectáveis que recorrem aos serviços da Farmácia?**

**13.1. No que diz respeito à ansiedade:**

- Muito mais ansiosos  
 Mais ansiosos  
 Nem menos nem mais ansiosos  
 Menos ansiosos  
 Muito menos ansiosos  
 Não Sabe



13.2. No que diz respeito à **agressividade**:

- Muito mais agressivos
- Mais agressivos
- Nem menos nem mais agressivos
- Menos agressivos
- Muito menos agressivos
- Não Sabe

14. Nos **últimos 12 meses**, ocorreram **incidentes** na Farmácia que **implicassem os utilizadores de drogas injectáveis**?

- Não
- Sim
- Não Sabe

14.1. Se **Sim**, indique a frequência e as causas de dos incidentes ocorridos:

14.1.1. **Agressões violentas** aos utentes e aos colaboradores da Farmácia:

- Sempre
- Algumas vezes
- Raramente
- Nunca

14.1.2. **Actos perturbadores e incómodos** aos utentes e aos colaboradores da Farmácia:

- Sempre
- Algumas vezes
- Raramente
- Nunca

14.1.3. **Roubos** aos utentes e à Farmácia:

- Sempre
- Algumas vezes
- Raramente
- Nunca

14.1.4. **Tráfico de droga** nas instalações da Farmácia:

- Sempre
- Algumas vezes
- Raramente
- Nunca

14.1.5. **Utilização da área circundante** da Farmácia como "**ponto de encontro**" de **utilizadores de drogas e/ou realização de tráfico de droga**:

- Sempre
- Algumas vezes
- Raramente
- Nunca

15. Desde o início da implementação do Programa de Troca de Seringas, **alguma vez** ocorreu um **acidente com uma seringa (picada acidental)**, que tivesse envolvido um utente ou um colaborador da Farmácia?

- Não
- Sim
- Não Sabe

16. Desde o início da implementação do Programa de Troca de Seringas, **alguma vez** ocorreu **uma agressão com uma seringa** (utilização de uma seringa como uma arma) a um utente ou a um colaborador da Farmácia?

- Não
- Sim
- Não Sabe

17. Desde o início da implementação do Programa de Troca de Seringas, como avalia as **mudanças relativas à aceitação do programa** pelos **restantes utentes da Farmácia**?

- Muito Melhor
- Melhor
- Igual
- Pior
- Muito Pior
- Os restantes utentes da Farmácia nunca se aperceberam da implementação do Programa de Troca de Seringas
- Não Sabe



23. Os **colaboradores da Farmácia** estão interessados em receber algum tipo de formação relacionada com o Programa de Troca de Seringas?

Não  Sim  Não Sabe

23.1. Se respondeu **Sim** à questão anterior, indique qual ou quais os principais conteúdos de interesse: (Seleccione uma ou mais opções de resposta)

Objectivos e funcionamento do Programa de Troca de Seringas

Infecção VIH/sida

Hepatite B e Hepatite C

Consumo de Drogas

Segurança

Gestão de conflitos

Outra. Especifique:

24. A Farmácia **vende seringas estéreis** aos utilizadores de drogas injectáveis?

Não  Sim  Não Sabe

24.1. Se **Sim**, quantas seringas estéreis foram vendidas aos utilizadores de drogas injectáveis nos **últimos 30 dias**? (Se não souber o número exacto - recorrendo por exemplo ao sistema informático da farmácia, indique a melhor estimativa)

Nenhuma  1 a 9  10 a 19  20 a 49  50 a 99  100 a 249  Mais de 250

Não Sabe

25. A Farmácia participa no **Programa de Substituição com Metadona**?

Não  Sim   (número de utentes do programa)  Não Sabe

26. Na sua opinião, em que **medida o Programa de Troca de Seringas poderia ser melhorado**? (Seleccione uma ou mais opções de resposta)

Mais formação aos colaboradores da Farmácia

Maior interligação entre as farmácias participantes no Programa de Troca de Seringas da zona, através da realização de encontros de discussão periódicos

Maior articulação com outras entidades (ex. Centro de Atendimento a Toxicodependentes (CAT) e/ou a outras estruturas de minimização de danos)

Outra (s). Especifique :

27. A sua Farmácia encontra-se instalada numa **Freguesia**:

Urbana (Freguesia que possui uma densidade populacional superior a 500 hab. /Km<sup>2</sup> ou que integre um Lugar com população residente superior ou igual a 5000 habitantes)

Semi-urbana (Freguesia não urbana que possui uma densidade populacional superior a 100 hab. /Km<sup>2</sup> e inferior ou igual a 500 hab. /Km<sup>2</sup> ou que integre um Lugar com população residente superior ou igual a 2000 habitantes e inferior a 5000 habitantes)

Rural (Freguesia não classificada nem como urbana nem como semi-urbanas)

28. Há **quantos anos** a Farmácia funciona **sob a orientação do actual proprietário**?   anos



29. Qual o **número total de colaboradores** da Farmácia?

- 1 a 3    4 a 6    7 a 9    10 a 12    Mais de 12

30. Qual o **número de Farmacêuticos** da Farmácia?

- 1    2 a 4    5 a 7    Mais de 7

31. Este **questionário** foi **preenchido por**:

**31.1. Função desempenhada:**

- Proprietário da Farmácia  
 Proprietário e Director Técnico da Farmácia  
 Director Técnico da Farmácia  
 Farmacêutico Adjunto  
 Farmacêutico  
 Ajudante Técnico de Farmácia  
 Outro. Especifique:

31.2. Há **quantos anos** trabalha em **Farmácia Comunitária**?  anos

31.3. **Sexo:**

- Feminino    Masculino

31.4. **Idade:**

- 24 a 30 anos    31 a 40 anos    41 a 59 anos    60 a 65 anos    Mais de 65 anos

**Muito obrigado pela colaboração prestada.**



## Programa de Troca de Seringas “Diz Não a Uma Seringa Em Segunda Mão” Questionário – Organizações Governamentais (Parcerias)

### **Instruções de Preenchimento:**

- Este questionário é absolutamente confidencial, não sendo sequer solicitado o seu nome ou outra informação que o possa identificar a si ou à Instituição que na sua actividade procede à disponibilização e recolha de material de injeção, designada como Parceria pelo Programa de Troca de Seringas (PTS).
- Este questionário deverá ser preenchido pelo responsável/coordenador da Instituição, com a colaboração da equipa.
- As questões que se seguem pedem-lhe a opinião e a disponibilização de alguns dados relacionados com o PTS.
- **Leia com atenção** cada questão e **assinale com uma cruz** cada opção resposta.

Após preenchimento, solicitamos que remeta o questionário à Coordenação Nacional para a Infecção VIH/sida, utilizando para o efeito o envelope RSF, até ao próximo dia 7 de Novembro do corrente ano.

Se necessitar de algum esclarecimento ou informação adicional por favor contacte:

Carla Torre  
[ctorre@sida.acs.min-saude.pt](mailto:ctorre@sida.acs.min-saude.pt)  
Coordenação Nacional para a Infecção VIH/sida  
Palácio Bensaúde, Estrada da Luz, n.º 153  
1600-153 Lisboa  
Telefone: 217 210 360  
Fax: 217 220 822 / 217 210 365

1 – **Indique o ano** em que a Instituição implementou o **Programa de Troca de Seringas** “Diz não a uma seringa em segunda mão”: \_\_\_\_\_

2 – Qual(ais) o(s) **local(ais) em que ocorre a disponibilização e a recolha de material de injeção** aos utilizadores de drogas? (Selecione **uma ou mais opções** de resposta)

- Sede fixa/Gabinete fixo da Instituição
- Unidade Móvel
- Outro. Especifique: \_\_\_\_\_

3 – A Instituição possui alguma  **sinalização** (cartaz, autocolante, etc.) que informe os utilizadores de drogas injectáveis sobre a sua participação no Programa de Troca de Seringas?

- Não
- Sim

4 – Qual o **horário normal de funcionamento** (2<sup>a</sup> a 6<sup>a</sup> feira) para a realização do Programa de Troca de Seringas?

	Horário Realizado
2 <sup>a</sup> feira	
3 <sup>a</sup> feira	
4 <sup>a</sup> feira	
5 <sup>a</sup> feira	
6 <sup>a</sup> feira	

5 – O Programa de Troca de Seringas funciona durante o **período de fim-de-semana**?

- Não
- Sim. Se sim, especifique o horário realizado:

	Horário Realizado
Sábado	
Domingo	

6 – Qual o **número médio de horas semanais** (de 2<sup>a</sup> a 6<sup>a</sup> feira ou de 2<sup>a</sup> feira a domingo, se aplicável) de funcionamento do Programa de Troca de Seringas?

1 a 10 horas	11 a 19 horas	20 a 29 horas	30 a 49 horas	50 a 69 horas	Mais de 70 horas
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7 – Qual é a **política de disponibilização de seringas** aos utilizadores de drogas injectáveis instituída pela Instituição? (Selecione **apenas uma opção** de resposta)

- As seringas são disponibilizadas sem que seja necessária a entrega de pelo menos uma seringa utilizada, não existindo um limite máximo
- As seringas são disponibilizadas, mas pelo menos uma seringa utilizada é entregue, não existindo um limite máximo
- As seringas são disponibilizadas mediante o princípio da troca de 1 seringa estéril por 1 seringa usada, até ao limite máximo de \_\_\_\_ seringas/dia.
- As seringas são disponibilizadas mediante o princípio da troca de 1 seringa estéril por 1 seringa usada, não existindo um limite máximo
- Outra: \_\_\_\_\_

8 – Se o utilizador de drogas injectáveis solicitar uma ou mais seringas para outro (s) utilizador (es) de drogas, qual é a política estabelecida pela Instituição? (Selecione **apenas uma opção** de resposta)

- Na situação descrita nunca são disponibilizadas seringas
- São disponibilizadas seringas para outros utilizadores de drogas de acordo com a política de disponibilização de seringas instituída pela Instituição (seleccionada na questão anterior)
- Outra: \_\_\_\_\_

9 – Se o utilizador de drogas injectáveis não possuir uma seringa usada e solicitar uma seringa ao colaborador da Instituição, qual é a política estabelecida? (Selecione **apenas uma opção** de resposta)

- Na situação descrita nunca é disponibilizada uma seringa
- É disponibilizada pelo menos uma seringa ao utilizador de drogas injectáveis
- É disponibilizado ao utilizador de drogas injectáveis o número de seringas necessário para um dia de consumo (de acordo com o seu padrão de consumo de drogas)
- Outra: \_\_\_\_\_

10 - **Quantas seringas foram distribuídas** aos utilizadores de drogas injectáveis nos **últimos 30 dias**? (Se não souber o número exacto, indique a melhor estimativa)

0 a 500	501 a 1499	1500 a 2999	3000 a 4999	5000 a 7499	7500 a 9999	Mais de 10000
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11 - **Quantas seringas foram recolhidas** nos **últimos 30 dias**? (Se não souber o número exacto, indique a melhor estimativa)

0 a 500	501 a 1499	1500 a 2999	3000 a 4999	5000 a 7499	7500 a 9999	Mais de 10000
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



12 - Nos últimos 30 dias, quantos utilizadores de drogas injectáveis diferentes recorreram à Instituição e participaram no Programa de Troca de Seringas? (Se não souber o número exacto, indique a melhor estimativa)

0 a 49	50 a 99	100 a 199	200 a 299	300 a 499	Mais de 500
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13 - Nos últimos 12 meses, alguma vez foi recusada a disponibilização de seringas aos utilizadores de drogas injectáveis?

- Não  
 Sim

13.1 - Se Sim, indique a frequência e as causas de recusa da disponibilização das seringas, através do preenchimento do quadro abaixo indicado:

Motivos de Recusa			
Utilizadores de drogas injectáveis com menos de 16 anos	<input type="checkbox"/> Sim  <u>Se Sim:</u> <input type="checkbox"/> Sempre <input type="checkbox"/> Às vezes <input type="checkbox"/> Raramente	<input type="checkbox"/> Não	<input type="checkbox"/> Nunca existiram solicitações
Utilizadores de drogas injectáveis que não entregaram as seringas usadas	<input type="checkbox"/> Sim  <u>Se Sim:</u> <input type="checkbox"/> Sempre <input type="checkbox"/> Às vezes <input type="checkbox"/> Raramente	<input type="checkbox"/> Não	<input type="checkbox"/> Nunca existiram solicitações
Utilizadores de drogas injectáveis que apresentaram comportamentos agressivos	<input type="checkbox"/> Sim  <u>Se Sim:</u> <input type="checkbox"/> Sempre <input type="checkbox"/> Às vezes <input type="checkbox"/> Raramente	<input type="checkbox"/> Não	<input type="checkbox"/> Nunca existiram solicitações
Utilizadores de drogas injectáveis que se encontravam em programas de substituição (exemplo: metadona)	<input type="checkbox"/> Sim  <u>Se Sim:</u> <input type="checkbox"/> Sempre <input type="checkbox"/> Às vezes <input type="checkbox"/> Raramente	<input type="checkbox"/> Não	<input type="checkbox"/> Nunca existiram solicitações
Outros motivos de recusa:	<hr/> <hr/>		

14 – Como avalia as mudanças relativas ao comportamento dos utilizadores de drogas injectáveis que passaram a recorrer aos serviços da Instituição?

14.1 – No que diz respeito à ansiedade:

Muito mais ansiosos	Mais ansiosos	Nem menos nem mais ansiosos	Menos ansiosos	Muito menos ansiosos
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14.2 – No que diz respeito à agressividade:

Muito mais agressivos	Mais agressivos	Nem menos nem mais agressivos	Menos agressivos	Muito menos agressivos
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15 – Nos últimos 12 meses, ocorreram incidentes que implicaram os utilizadores de drogas injectáveis?

- Não
- Sim

15.1 - Se Sim, indique a frequência e as causas dos incidentes ocorridos:

15.1.1 – Agressões aos utentes e/ou colaboradores:

Sempre	Algumas vezes	Raramente	Nunca
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15.1.2 – Actos perturbadores e incómodos aos utentes e/ou colaboradores:

Sempre	Algumas vezes	Raramente	Nunca
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15.1.3 – Roubos aos utentes e/ou colaboradores:

Sempre	Algumas vezes	Raramente	Nunca
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15.1.4 – Tráfico de droga nas instalações da Instituição:

Sempre	Algumas vezes	Raramente	Nunca
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15.1.5 – Utilização da área circundante da Instituição como “ponto de encontro” de utilizadores de drogas e/ou realização de tráfico de droga:

Sempre	Algumas vezes	Raramente	Nunca
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16 – É do seu conhecimento ter ocorrido, desde o início da implementação do Programa de Troca de Seringas, algum acidente com uma seringa (picada acidental), que tivesse envolvido um utente ou um colaborador da Instituição?

- Não
- Sim

16.1 - Se **Sim**, foi há menos de 12 meses?

- Não
- Sim

17 – Desde o início da implementação do Programa de Troca de Seringas, alguma vez ocorreu uma agressão com uma seringa (utilização de uma seringa como uma arma) a um utente ou a um colaborador da Instituição?

- Não
- Sim

17.1 - Se **Sim**, foi há menos de 12 meses?

- Não
- Sim

18 – Nos últimos 12 meses, o Programa de Troca de Seringas foi alvo de oposição da comunidade local onde a Instituição exerce esta actividade?

- Não
- Sim

19 – Nos últimos 12 meses, a área local de intervenção do Programa de Troca de Seringas foi alvo de uma rusga policial?

- Não
- Sim

20 – Adicionalmente à disponibilização do material de injeção, existe(m) outro(s) serviço(s) dirigidos aos utilizadores de drogas prestado(s) pela Instituição?

- Não
- Sim

20.1 - Se **Sim**, indique qual (ais) o(s) serviço(s) prestados:

Realização do teste de identificação:

- Vírus de Imunodeficiência Humana (VIH)
- Vírus da Hepatite B (VHB)
- Vírus da Hepatite C (VHC)
- Vírus da Hepatite A (VHA)
- Outras infecções de transmissão sexual

Encaminhamento para as estruturas que realizam o teste de identificação:

- Vírus de Imunodeficiência Humana (VIH)
  - Vírus da Hepatite B (VHB)
  - Vírus da Hepatite C (VHC)
  - Vírus da Hepatite A (VHA)
  - Outras infecções de transmissão sexual
  - Vacinação Hepatite B
  - Vacinação Hepatite A
  - Educação para práticas seguras de injeção
  - Educação para práticas de relações sexuais seguras
  - Educação para a prevenção do VIH
  - Educação para a prevenção do VHA, VHB e VHC
  - Educação para a prevenção de overdoses
  - Educação para a prevenção de abscessos
  - Cuidados médicos e/ou de enfermagem
  - Participação no programa de metadona de baixo limiar de exigência
  - Participação em programas de terapêutica combinada (dispensa de metadona, antibióticos e terapêutica antirretrovírica)
  - Encaminhamento para respostas sociais e de saúde, nomeadamente estruturas de tratamento da toxicod dependência
  - Cuidados de higiene
  - Alimentação
  - Outro(s): \_\_\_\_\_
- 

21 – Adicionalmente à disponibilização do material de injeção (seringa, filtro, carga, ácido cítrico, ampola de água destilada e toalhete) existe a **distribuição de outro (s) tipo(s) de material (ais)** pela Instituição?

- Não
- Sim

21.1 - Se **Sim**, indique qual (ais) o(s) material (ais) distribuído(s):

- Preservativo masculino
- Preservativo feminino
- Kit *sexy* (preservativo masculino e lubrificante)
- Lubrificante
- Garrote
- Quadrados de látex
- Luvas e dedeiras de látex
- Prata
- Kit para o consumo de cocaína

Folheto(s) dirigido(s) aos utilizadores de drogas sobre a(s) temática(s):

- VIH/sida
  - Hepatite B
  - Hepatite C
  - Estratégias para um consumo menos danoso
  - Práticas de relações sexuais seguras
  - Locais onde é possível realizar o teste de identificação do VIH, VHA, VHB, VHC e outras infecções de transmissão sexual
  - Outra(s) temática (s): \_\_\_\_\_
-

Outro(s): \_\_\_\_\_  
\_\_\_\_\_

22 – Qual o **número total de colaboradores** (incluindo colaboradores a trabalho a tempo parcial e dedicação exclusiva e elementos de coordenação) da Instituição afectos ao Programa de Troca de Seringas? \_\_\_\_\_

Destes, indique:

22.1 – Número de colaboradores remunerados: \_\_\_\_\_

22.2 – Número de colaboradores não remunerados: \_\_\_\_\_

23 – A Instituição tem **colaboradores** afectos ao Programa de Troca de Seringas que **são ou já foram consumidores de drogas**?

Não

Sim

24 – Os **colaboradores da Instituição** receberam, **alguma vez**, **formação** relacionada com a Minimização de Danos e Redução de Riscos?

Não

Sim

25 – Nos **últimos 12 meses**, algum dos colaboradores participou nalguma **acção de formação** (presencial ou à distância) sobre temáticas relacionadas com a utilização de drogas ou com doenças infecciosas (infecção VIH/sida, Hepatite B, Hepatite C, infecções de transmissão sexual)?

Não

Sim

26 – Os **colaboradores da Instituição** estão **interessados em receber** algum tipo de **formação** relacionada com a utilização de drogas ou com doenças infecciosas (infecção VIH/sida, Hepatite B, Hepatite C, infecções de transmissão sexual)?

Não

Sim

26.1 - Se respondeu **Sim** à questão anterior, indique qual ou quais os principais conteúdos de interesse: (Seleccione **uma ou mais opções** de resposta)

Infecção VIH/sida

Hepatite B e Hepatite C

Infecções de transmissão sexual

Objectivos e funcionamento do Programa de Troca de Seringas (Modelos de Boas Práticas a implementar)

Estratégias para um consumo menos danoso de drogas

Segurança

Gestão de conflitos

Outra. Especifique: \_\_\_\_\_

27 – Na sua opinião, em que medida o Programa de Troca de Seringas poderia ser melhorado? (Selecione uma ou mais opções de resposta)

- Mais formação aos colaboradores da Instituição
  - Maior interligação entre as Instituições participantes no Programa de Troca de Seringas da zona, através da realização de encontros de discussão periódicos
  - Maior articulação com outras entidades (ex. Centro de Atendimento a Toxicodependentes (CAT), Serviços de Apoio Social, Farmácias Comunitárias que participam no PTS, etc.)
  - Maior acompanhamento por parte da entidade financiadora da OG ou ONG que implementa o Programa de Troca de Seringas
  - Maior estabilidade de financiamento da Instituição que implementa o Programa de Troca de Seringas
  - Outra (s): Especifique \_\_\_\_\_
- 

28 – Qual a principal Entidade Financiadora do Projecto/Serviço no âmbito do qual é implementado o Programa de Troca de Seringas?

- Administração Regional de Saúde
- Autarquia Local
- Coordenação Nacional para a Infecção VIH/sida
- Governo Civil
- Instituto da Droga e da Toxicodependência, IP
- Instituto da Segurança Social, IP
- Outra: \_\_\_\_\_

29 – A Entidade Financiadora avalia o Projecto/Serviço no âmbito do qual é implementado o Programa de Troca de Seringas?

- Não
- Sim

29.1 - Se respondeu Sim à questão anterior, indique de que forma: (Selecione apenas uma opção de resposta)

- Através da apresentação de Relatórios Semestrais ou Anuais elaborados pela Instituição
- Através da realização de visitas periódicas  
Se assinalou com uma cruz a opção de resposta anterior, a visita foi realizada no último ano?
  - Não
  - Sim
- Através da apresentação de Relatórios Semestrais ou Anuais elaborados pela Instituição e da realização de vistas periódicas  
Se assinalou com uma cruz a opção de resposta anterior, a visita foi realizada no último ano?
  - Não
  - Sim
- Outra: \_\_\_\_\_

30 – O Projecto/Serviço no âmbito do qual é implementado o Programa de Troca de Seringas é avaliado por alguma entidade externa (exclui-se a(s) entidade(s) financiadora(s))?

- Não
- Sim

30.1 - Se respondeu Sim à questão anterior, indique qual:

- Universidade
- Administração Regional de Saúde
- Autarquia
- Outra: \_\_\_\_\_

31– A Instituição encontra-se instalada numa Freguesia:

- Urbana (Freguesia que possui uma densidade populacional superior a 500 hab. /Km<sup>2</sup> ou que integre um Lugar com população residente superior ou igual a 5000 habitantes)
- Semi-urbana (Freguesia não urbana que possui uma densidade populacional superior a 100 hab. /Km<sup>2</sup> e inferior ou igual a 500 hab. /Km<sup>2</sup> ou que integre um Lugar com população residente superior ou igual a 2000 habitantes e inferior a 5000 habitantes)
- Rural (Freguesia não classificada nem como urbana nem como semi-urbanas)

32 – A pessoa que preencheu este questionário:

32.1 Sexo:

Feminino	Masculino
<input type="checkbox"/>	<input type="checkbox"/>

32.2 Idade:

18 a 23 anos	24 a 30 anos	31 a 40 anos	41 a 59 anos	60 a 65 anos
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Muito obrigado pela colaboração prestada.



Coordenação Nacional para a  
Infecção VIH/sida

## Programa de Troca de Seringas “Diz Não a Uma Seringa Em Segunda Mão” Questionário – Organizações Não Governamentais<sup>1</sup> (Parcerias)

### **Instruções de Preenchimento:**

- Este questionário é absolutamente confidencial, não sendo sequer solicitado o seu nome ou outra informação que o possa identificar a si ou à Instituição que na sua actividade procede à disponibilização e recolha de material de injeção, designada como Parceria pelo Programa de Troca de Seringas (PTS).
- Este questionário deverá ser preenchido pelo responsável/coordenador da Instituição, com a colaboração da equipa.
- As questões que se seguem pedem-lhe a opinião e a disponibilização de alguns dados relacionados com o PTS.
- **Leia com atenção** cada questão e **assinale com uma cruz** cada opção resposta.

Após preenchimento, solicitamos que **remeta o questionário à Coordenação Nacional para a Infecção VIH/sida, utilizando para o efeito o envelope RSF, até ao próximo dia 7 de Novembro** do corrente ano.

Se necessitar de algum esclarecimento ou informação adicional por favor contacte:

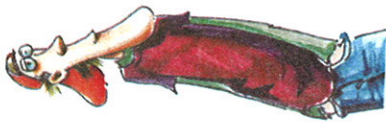
Carla Torre  
[ctorre@sida.acs.min-saude.pt](mailto:ctorre@sida.acs.min-saude.pt)

Coordenação Nacional para a Infecção VIH/sida

Palácio Bensaúde, Estrada da Luz, n.º 153  
1600-153 Lisboa  
Telefone: 217 210 360  
Fax: 217 220 822 / 217 210 365

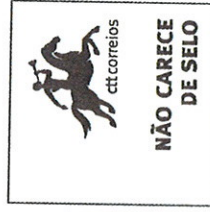
1) O questionário aplicado às Organizações Não Governamentais foi igual ao questionário aplicado às Organizações Governamentais





## Programa

Diz não a uma seringa  
em segunda mão



COORDENAÇÃO NACIONAL PARA A INFECÇÃO VIH/SIDA

ESTR DA LUZ 153  
1649-970 LISBOA