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Needle Exchange Programs and HIV/AIDS: A Comparison of the Use of Harm Reduction Methods in Switzerland and the United States of America

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Abstract:

This paper explores the connections between needle exchange programs and rates of HIV/AIDS in Switzerland and the United States of America. While these two countries are very similar in their general political philosophies, they have some key cultural and historical differences which has shaped their responses to HIV/AIDS and injection drug use. Switzerland's unique experience with a very open injection drug use scene in the 1980s guided this country to a more pragmatic, harm reduction-based response. By contrast, United States responded to the AIDS epidemic that struck violently in the 1980s with a mix of fear and denial. Though both generally conservative countries, Switzerland has a history of being independent and pragmatic. The U.S., on the other hand, has built an international identity on its Puritanical roots and seeks global influence through repressive drug measures. As such, needle exchange programs have been widely implemented in Switzerland but their growth is stunted in the United States. The unfortunate result is that the USA has not been able to contain injection drug use or the AIDS epidemic to anywhere near the same extent has Switzerland.

All the experts interviewed for this paper were speaking with regards to their own personal opinion. Their statements in no way reflect the official positions of the organizations for which they work.

List of Abbreviations

- AIDS: Acquired Immune Deficiency Syndrome
- CDC: Center for Disease control
- CHUV: Centre Hospitalier Universitaire Vaudois
- COROMA: Collège Romand de Médicine de l'Addiction
- HIV: Human Immunodeficiency Virus
- IDU: Injection Drug User
- NEP: Needle Exchange Program
- NHAS: National HIV/AIDS Strategy
- NSP: Needle and Syringe Program
- SAF: Swiss Aids Federation
- SEP: Syringe Exchange Program
- UNAIDS: Joint United Nations Programme on HIV/AIDS
- UNDP: United Nations Development Programme
- USA, US: United States of America
- WHO: World Health Organization
- WOD: War on Drugs

Introduction:

Literature Review

Needle Exchange Programs (NEPs) are an undoubtedly controversial component of the harm reduction framework. Many countries continue to outlaw these types of programs despite the fact that there exists a general consensus amongst most experts that these programs are effective and do not result in other, deleterious effects. Countries such as the U.S., which is very influential within the UN system, "Japan, Sweden, many ex-Soviet states and most Arab and African nations" feverishly support prohibitive approaches to global drug control.[1] However, sentiments are shifting in Europe where many countries are "increasingly at odds with some sectors of the UN drug control system" because of their support for harm reduction-based approaches.[2]

These controversies and global debates persist despite the fact that many organizations, including the WHO, support Needle and Syringe Programs as a "fundamental component of any comprehensive and effective HIV-prevention programme" because of their ability to significantly reduce the transmission of HIV associated with injection drug use.[3] According to a report by the Global Commission on Drug Policy, countries that have followed a harm reduction framework "have experienced consistently low rates of HIV transmission" among injection drug users (IDUs).[4] In 2004, the WHO released a report of their findings after a comprehensive study of existing literature on NEPs. Among their many conclusions, the WHO stated that NSPs are "cost-effective and cost-saving" programs and that they were able to find "no convincing evidence" of "unintended complications associated with NSPS" such as increased drug

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[1] Bewley-Taylor, "Getting High on the Policy Agenda."p.35
[2] Ibid. p.28
[3] Wodak and Cooney, "Effectivness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users." p.5
[4] "War on Drugs."p.6

consumption, maintenance of addiction, or higher numbers of discarded syringes in the communities surrounding NSPs.[5] Emmanuel Ducret, the Executive Director of Premiere Ligne, a NEP in Geneva, supported this information through the experiences of his own organization. Premiere Ligne is able to recover 98% of all syringes that it distributes, both through people returning them to the center and by teams that walk through the streets during the day to collect the needles.[6] Thus, the concerns surrounding needle exchanges seem to be founded in a fear of drugs and drug users rather than in the reality of the situation.

The implementation of NEPs in many countries and localities is fraught with political implications and is often met with resistance from the surrounding community. Political and social factors "can be more important than epidemiologic data" in influencing decisions around public health policies.[7] A study by Beletsky, Macalino, and Burris illustrated the resistance of police officers in Rhode Island, USA to support such programs. The perceptions of police officers are also quite important because they "exercise a great deal of discretion in their work" and can act in ways that are inconsistent with official policies.[8] Though officers in this study agreed that social factors contributed heavily to drug use and dependence they did not feel that social environment was enough to "absolve IDUs of responsibility for drug abuse and criminal behaviour."[9] Beletsky et. al. note that officers are "in a better position" than the rest of society

[5] Wodak and Cooney, "Effectivness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users." p.15 and p.16
[6] Ducret, Formal Interview with Premiere Ligne.
[7] Des Jarlais, "Research, Politics, and Needle Exchange." p.1392
[8] Beletsky, Macalino, and Burris, "Attitudes of Police Officers towards Syringe Access, Occupational Needle-Sticks, and Drug Use: A Qualitative Study of One City Police Department in the United States."p.268
[9] Ibid. p.271

"to see the complexities of drug use and control," especially with regards to the ways in which drug use affects individuals and communities.[10]

Some resistance to needle exchange programs originates from early experiments conducted in Vancouver and Montreal. The first papers published about these programs seemed to indicate an "apparent failure" of the NEP programs in Canada, some of the first in North America.[11] While these studies indicated that HIV rates in clients at these particular NEPs were increasing, they did not account for the fact that IDUs attending NEPs were among the most vulnerable populations in society and thus had drastically higher odds of contracting HIV. The detractors from these programs also often fail to account for the structural failings of the Vancouver and Montreal programs, such as limited operating hours and small geographic coverage which resulted in a "significant proportion" of clients experiencing "difficulty accessing sterile syringes" and thus severely hindered the ability of these programs to be efficacious.[12]

Dr. Roel A. Coutinho falls into a similar trap with his piece "Needle Exchange, Pragmatism, and Moralism." He cites the Vancouver and Montreal studies to support his findings that there is "no effect on seroconversion for HIV from needle exchange use" and that NEPs have "no protective effect" against HIV, hepatitis C, and hepatitis B.[13] He, like other detractors, fails to consider the contextual factors surrounding any needle exchange program. More intensive studies by the WHO and other organizations have found a preponderance of evidence that allows us to "reject the null hypothesis that attendance at NSP does not confer

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[10] Ibid. p.272
[11] Hyshka et al., "Needle Exchange and the HIV Epidemic in Vancouver: Lessons Learned from 15 Years of Research." p.263
[12] Ibid. p.264
[13] Work, "Needle Exchange, Pragmatism, and Moralism." P.1388

protection against HIV" for injection drug users.[14] Furthermore, a 2012 report by the La Commission Mondiale Pour la Politique Des Drogues (UNODC) claims that "la guerre contre la drogue ait favorisé la propagation du VIH dans de nombreuses régions" of the world. [15] Unfortunately, a 2011 report by the UNODC highlights that those targeted by the War on Drugs, such as users and low-level sellers or growers, "are themselves the victims of violence and intimidation" because they are typically in the lowest rungs of the drug-market hierarchy.[16] As such, the continued debate on the efficacy of these programs is not only misguided but actually quite harmful.

Though some try to hide behind doubts about the efficacy of these programs as the main reason for their reluctance to accept these programs, the reality is that NEPs raise moralistic questions that divide the general public. In general, governments and individuals tend view needle exchanges as "condoning drug use" and letting drug users continue their morally unacceptable behaviors.[17] It is also important to note that harm reduction programs "have a critical moral component" to them.[18] Supporters of this philosophy of public health are taking a moral stance about the "sphere of individual autonomy" and human rights with regards to drug use.[19] As such, both supporters and detractors of needle exchange programs are not arguing solely on the level of scientific fact and accuracy. Rather, they are also debating moral and ethical questions about law, individual rights, and community responsibilities.

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[14] Wodak and Cooney, "Effectivness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users." p. 11

[15] "La Guerre Aux Drogues Face Au VIH/sida: Comment La Criminalisation de L'usage de Drogues Aggrave La Pandémie Mondiale." p.2

Courtesy translation by author: The war against drugs has favored the propagation of HIV in many regions of the world

[16] "War on Drugs." p.6

[17] Work, "Needle Exchange, Pragmatism, and Moralism." p. 1387

[18] Des Jarlais, "Research, Politics, and Needle Exchange." p.1394

[19] Buchanan et al., "Empirical Science Meets Moral Panic: An Analysis of the Politics of Needle Exchange." p.435

Research Questions

Though official sister nations, and quite similar in many regards, the United States of America and Switzerland have chosen significantly different tactics in order to address drug use within their countries. The primary purpose of this research project is to determine the ways in which these countries diverge from each other in respond to injection drug use and how these varying policies have resulted in different outcomes regarding HIV/AIDS in the two countries. However, perhaps more importantly, this paper is centered on the historical, cultural, and political differences between Switzerland and the USA in order to determine the root causes of their varying policies. In this paper, I argue that the repression-based policies of the US and the harm reduction-focused efforts of Switzerland can be linked to fundamental differences in the historical contexts of the two countries. These countries were presented with similarly severe situations, HIV/AIDS in the US and open drug use in Switzerland, but political and cultural legacies caused them drastically different responses.

Very few other papers have directly compared the fundamental cultural and political bases in the USA and Switzerland that shaped their responses to the growing pandemics of drug use and AIDS. While extensive work has been done in each country to monitor the situations of AIDS and drug use, there is a definite lack of research that seeks to identify the fundamental historical, cultural, and political structures that vary within each country and have had a direct impact on the present outcomes of these health crises. This paper features an analysis of historical contexts and how they caused these otherwise very similar countries to diverge in terms of drug policy.

Research Methodology

This paper features a combination of primary and secondary research. Primary research consisted of individual interviews with experts in the areas of harm reduction and HIV/AIDS. Those interviewed were primarily directors of programs or organizations who work directly in one of the following domains in Switzerland: Harm reduction, HIV/AIDS, injection drug use, or addiction. Experts were identified based on their affiliation with an organization or through the recommendation by another expert in the field. The major organizations working with AIDS and NEPs were identified through internet searches and through their own publicly-available advertising in organizations frequented by homosexual men (who are most at risk for contracting HIV in Switzerland at the current moment) and injection drug users. Experts were either contacted directly, if their information was available on line, or by first contacting the organization generally in the case that no one person was identified online. Formal interviews were scheduled over email with the interviewer being as flexible as possible to the interviewees' schedules. Interviews were conducted in both English and French, with the interviewee choosing their preferred language. The interviewer is fluent in English and proficient in French. Whenever possible, interviews were recorded to allow the interviewer to review what was said and to limit misunderstanding from language barriers. However, interviews were only recorded with the permission and consent of the participating expert. No outside translator was used.

Given that those interviewed often had a specific focus to their work (i.e. either AIDS or drug use, but usually not both), interview questions were tailored to the expertise of the interviewee. A master list of questions was created in both French and English. Questions that were most relevant to the expert's field of work were then selected before each interview. Clarifying and further questions were also asked during the interview as needed.

Secondary research provides a theoretical basis and historical context to this paper. Sources were primarily identified through online databases provided by Brown University. The key terms used in this literature review include: Needle Exchange Programs, Switzerland, Harm Reduction, United States, HIV and Harm Reduction, HIV and Needle Exchange Programs. Journal articles and reports were selected based on their relevancy to the topic and countries. Though some reports provide an important global context, most of the papers focus on either Switzerland or the USA. Though some papers were written before 2000, I focused my research on papers written after the year 2000 in order to ensure the currency and relevancy of the information provided.

Theoretical Framework

This paper explores interventions based on a harm reduction framework. According to Harm Reduction International, harm reduction works "primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs" through a variety of policies and programs.[20] It is a philosophy of public health that stands in direct contradiction to repression-based policies. Harm reduction focuses on a pragmatic approach to limiting the danger associated with certain behaviors by providing help rather than relying on punishment. This framework accepts incremental changes rather than immediate and total abstinence.[21] As Mireille Wehrli of Aspasie described, harm reduction often operates under the assumption that it is easier to control an activity or behavior if that behavior. When something like drug use or prostitution is criminalized within a country, people hide themselves to avoid law enforcement officials but also then restrict themselves from available resources. Public Health practitioners have a more difficult time gaining access to marginalized persons when they

[20] "What Is Harm Reduction? | Harm Reduction International."
[21] Ibid.

are afraid of being arrested.[22] Harm reduction is human-rights based approach to public health that recognizes that drug addiction is "a complex health condition that has a mixture of causes" and is not simply a moral defect on the part of users. [23]

Needle Exchange Programs, also known as Needle Syringe Programs (NSP) and Syringe-Exchange Programs (SEP), are key components to a harm reduction approach to drug use. Freddy Muller, the supervisor of Tremplin, an NEP in Fribourg, Switzerland describes that the primary function of these programs is to allow people to exchange a used, dirty needle for a clean, sterile one in order to limit the transmission of blood-borne diseases such as HIV and hepatitis C.[24] These programs exist globally and may operate legally or illegally, depending on the laws of the locality. They can be run by health departments, governments, or private/non-profit organizations.[25]Though the main function of NEPs is to provide injection drug users with clean syringes, they may also provide other services like counseling programs and access to harm reduction materials. Less common services include shower facilities, food and cafeterias for clients, and supervised drug-consumption rooms.

Even when NSPs are present within a community, they may not be fully utilized for a variety of reasons. Clients of these sites often report that "location, adequate space and hours of operation" are the biggest barriers to access the services.[26] There is often conflict about where NEPs are located because the programs try to find areas of the city that are easily accessible to IDUs, but the general population does not want to have an NEP located in that area. NEPs must also work to be respectful of the humanity of their clients. Many patients report that they avoid the programs until emergency situations because they have had "humiliating, degrading, [and]

[22] Wehrli, Formal Interview with Aspasie.
[23] "War on Drugs." p. 6
[24] Muller, Formal Interview with Tremplin.
[25] DeSimone, "Needle Exchange Programs and Drug Injection Behavior."
[26] Strike et al., "Needle Exchange Programs: Delivery and Access Issues." P.340

unhelpful" experiences with past NSPs.[27] According to Strike et al., needle exchange programs are constructed in a variety of ways in order to fit the needs of the population they are serving. Practitioners may locate at fixed sites or create mobile programs within a city. In some rarer cases, needle exchanges are even offered through home visits.[28]

Though other STIs and diseases can be transmitted through the sharing of injection materials, this paper will focus on HIV and AIDS.

Analysis

Historical, Cultural, and Political forces in Switzerland

Although all of Europe experienced increased drug use during the 1960s and the 1970s as the counter-culture movement proliferated globally, "the increase was more dramatic in Switzerland" compared to neighboring countries for unknown reasons.[29] Despite a strict drug law enacted in 1975 that declared "possession and use of drug to be illegal", thus centering Swiss law on repression over harm reduction, the amount of IV drug use in the country continued to grow uncontrollably.[30] The number of people using drugs injection drugs in Switzerland grew by 20,000 in just seven years, from around 10,000 people in 1985 to over 30,000S in 1992.[31] Injection drug use was starkly prominent in Zurich's Platzspitz Park, which was also referred to as the "needle park" and often had over 2000 people gathering there daily to inject drugs.[32] Unable to control this illegal drug use, the government decided that it "would tolerate IV drug

[27] Ibid. p.340
[28] Ibid.
[29] Csete and Grob, "Switzerland, HIV and the Power of Pragmatism: Lessons for Drug Policy Development." p. 83
[30] Somaini and Grob, "Commentary: How and Why AIDS Changed Drug Policy in Switzerland." p.328
[31] Csete and Grob, "Switzerland, HIV and the Power of Pragmatism: Lessons for Drug Policy Development."p. 83
[32] Somaini and Grob, "Commentary: How and Why AIDS Changed Drug Policy in Switzerland."

users" within Platzspitz Park, a definite sign of their struggling ability to enforce a repression-based policy.[33]

During the 1980s, Switzerland was forced to simultaneously with the rapidly increasing use of injection drugs and the emerging AIDS epidemic. The first case of AIDS in Switzerland was diagnosed in 1982 and Switzerland "had the highest rate of newly diagnosed HIV infections in Europe" by the late 1980s.[34] Andreas Lehner, an Executive Director of the Swiss AIDS Federation (SAF) attributes this higher prevalence to Switzerland's wealth and "historical" legacy of non-repressive policies. According to Mr. Lehner, there were not many "other cities in Europe where there were so many rich people who [could] pay to visit America."[35] By 1985, 39 cases had been reported, mainly among men who had "a history of sexual contact" with men from the United States.[36]

In this same year, the first case of AIDS was reported in an injection drug user. After serologic tests were developed, it was found that drug users had around a 40% infection rate for HIV. [37] HIV and other blood borne infections were being transmitted at alarmingly high rates because of injection drug use. The sharing of used needles between IDUs "was the most significant pathway for transmitting HIV, HBV, and hepatitis C" for Switzerland.[38] Recognizing the severity of the situation and the possibility for increasing rates of transmission, private and public actors sprang into action across Switzerland. Working in direct violation of federal law "300 medical doctors in Zurich declared their commitment" to creating and maintaining NEPs so

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[33] Ibid. p.319
[34] Dubois-Arber et al., "Trends in Drug Consumption and Risk of Transmission of HIV and Hepatitis C Virus among Injecting Drug Users in Switzerland, 1993-2006." p.1
[35] Lehner, Formal Interview with Swiss Aids Federation.
[36] Somaini and Grob p.318
[37] Ibid. p.318
[38] Ibid. p.319

that IDUs would have increased access to sterile syringes.[39] Additional needle exchange programs were supported in Zurich by universities, the Swiss Red cross, and the governmental health unit of the city. Again, in direct violation of federal law, "local police stopped confiscating needles and syringes" from injection drug users. [40] Finally, a pilot program call ZIPP-AIDS (Zurich Intervention Pilot Project against AIDS) was introduced in the late 1980s. According to Somaini and Grob ZIPP-AIDS "profoundly influenced the future of Swiss drug policy" by promoting the understanding of injection drug users by community members and policy makers.[41] Needle exchange programs and the harm reduction framework spread around Switzerland through the help of NGOs and city governments.

In fact, though legally Switzerland only recognized a punitive approach to drugs, by 1994 the country was implementing, in practice, a four-pillar approach based on "repression, prevention, harm reduction and treatment."[42] According to Somaini and Grob, it is imperative to "understand the Swiss government structure" and the "extent of decentralization" within Switzerland in particular, in order to be able to fully contextualize the Swiss response to the AIDS epidemic.[43] Switzerland is a direct democracy which allows "national policy decisions" to be brought to a popular vote through national referendums.[44] Mr. Simon of CHUV and COROMA, like many of the experts interviewed for this paper, emphasized that the Swiss system of enacting laws moves very slowly but the final results are typically quite good and

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[39] Csete and Grob, "Switzerland, HIV and the Power of Pragmatism: Lessons for Drug Policy Development." p.83
[40] Somaini and Grob, "Commentary: How and Why AIDS Changed Drug Policy in Switzerland." p.320
[41] Ibid. p.321
[42] Ibid. p.321
[43] Ibid. p.318
[44] Csete and Grob, "Switzerland, HIV and the Power of Pragmatism: Lessons for Drug Policy Development." p.84

supported by the Swiss people. The process of direct democracy gives Switzerland the opportunity to carefully craft its legislation and to garner public support.[45]

Multiple national referendums regarding drug use and harm reduction programs have been brought up in the past 25 years in Switzerland. The first referendum was about a policy called "Youth Without Drugs" which was purely abstinence-focused and would have criminalized all drug use and possession. The second referendum, called "Droleg", was a complete reversal from Youth Without Drugs. This referendum asked the Swiss to legalize all drug use. Youth Without Drugs was rejected in 1997 by more than 70% of Swiss voters and Droleg was rejected in 1998 by more than 74% of voters. As a result, the unique Swiss referendum process showed popular support for a moderate and "pragmatic approach to drug policy."[46]

Though not officially enacted into law until 2008, the Swiss people have been in support of a more comprehensive and moderate system since the 1990s. For example. According to Mr. Ducret, Premiere Ligne has been in operation for the past 20 years. However, their existence only became legal with the 2008 vote. As such, Premiere Ligne existed illegally for over a decade with no interference from the government. This organization is located in a prominent building next to the busy train station in Geneva. Police officers often refer people caught using drugs to Premiere Ligne. Thus, we can see that the Swiss system has room for much flexibility. Though it takes time for laws to be decided upon, they are fully supported when they are voted in. [47]

Historical, Cultural, and Political forces in the United States of America

[45] Simon, Formal Interview with COROMA.
[46] Somaini and Grob, "Commentary: How and Why AIDS Changed Drug Policy in Switzerland." p.322
[47] Ducret, Formal Interview with Premiere Ligne.

Whereas Switzerland had a dramatic and undeniable problem with injection drug use, the United States of America was blindsided by the AIDS epidemic and its perilous trajectory. Yet, despite the fact that AIDS has killed "more Americans than every conflict from World War II through Iraq," and thus is comparable to the drastic open drug scenes which forced Switzerland to adopt harm reduction policies, the American reaction to this epidemic has been markedly different from that of Switzerland.[48] AIDS first emerged in the USA over thirty years ago in 1981. [49] However, this devastating disease remained largely ignored by the government and general population. Seen as "a disease that killed gay men and drug addicts," AIDS was not an easy disease for the average American to sympathize with.[50]

Unlike in Switzerland, where efforts at Platzspits Park attempted to bridge the divide between the general community and the affected populations, in this case IDUs, Americans were reluctant to interact with people living with AIDS. Ronald Reagan, the president during the outbreak of the epidemic, waited until 1985, four years into the epidemic, to "discuss AIDS in a public forum" and did not actually use the word "AIDS" in public until 1987.[51] The "fiscally and socially conservative climate" permeating American culture at this time certainly played a role in the detrimentally delayed reaction to the emerging epidemic.[52]

Eventually, in 1987, President Reagan created the Presidential Commission on the HIV Epidemic in order to respond to the crisis. This commission provided a set of comprehensive recommendations including treating substance abuse, promoting HIV testing, and protecting the rights of those who were identified to be HIV-positive. However, the President's "lukewarm commitment to ensuring implementation" of these recommendations meant that they were

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[48] Jefferson, "How AIDS Changed America." p.36
[49] Yehia and Frank, "Battling AIDS in America: An Evaluation of the National HIV/AIDS Strategy." p.e4
[50] Jefferson, "How AIDS Changed America." p.36
[51] Ibid. p.36
[52] Ibid. p.37

"largely ignored" and little work was done to advance the situation of people affected by HIV/AIDS.[53] Since then, only two other presidents, President Clinton and President Obama, have released strategies for combatting the AIDS epidemic.

There has historically been a definite lack of vocal federal support for measures to support people living with HIV/AIDS.[54] The conservative and puritanical foundations of American society have made it so that politicians are "loath to fund research into a new pathogen" that kills the undesirable populations of "gay men and intravenous drug users."[55]These populations have typically been viewed as an affront to American moral norms and are thus seen as less deserving of funding and attention. While these sentiments clearly exist in Switzerland, as demonstrated by Andrea Verwohlt from UNAIDS' comment that Swiss "people living with HIV may experience sometimes discrimination at work and in social relationships," the Swiss federal government has intervened to create base levels of support for all citizens.[56]

The United States also has a history of focusing on punitive and abstinence-based measures that shame affected people and portray them as being morally defective. There is a "longstanding emphasis on drug law enforcement" and supply-side measures as the primary reactions for illegal drug use in the United States, strategies that can be traced back to Prohibition.[57] The Eighteenth Amendment, ratified in 1920 and repealed in 1933, made alcohol, its sale, consumption, and manufacture, completely illegal within the borders to the United

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[53] Yehia and Frank, "Battling AIDS in America: An Evaluation of the National HIV/AIDS Strategy."p.e4
[54] Ibid. p.34
[55] Jefferson, "How AIDS Changed America." p.37
[56] Verwohlt, Formal Interview with UNAIDS.
[57] Hyshka et al., "Needle Exchange and the HIV Epidemic in Vancouver: Lessons Learned from 15 Years of Research." p.262

States.[58] Though the Eighteenth Amendment was only in place for 13 years, the issues of temperance and abstinence from any sort of drug use still continue today. This amendment signified a federal-level commitment to the practices of repression, creating a powerful historical legacy engrained in American culture.

Prohibition can largely be seen as a reaction against changing American society at the time which was becoming "more urban, more secular, and more Catholic", much to the distaste of the rural, deeply religious, Protestant groups who felt a claim over America's moral authority.[59] The movement pitted "urban, immigrant, lower class" Americans against the white, middle-class temperance advocates.[60] Issues of class, race, religion, and citizen-ship status are deeply bred within the United States. Political and religious leaders such as Brent, Wright, Tenney and Hobson decried the moral scourge of drug and alcohol use and framed the debate in terms of racial and class differences. Newspapers during the Prohibition period were filled "with xenophobic headlines against ethnic minority groups" linking alcohol use to marginalized and less desirable populations.[61] Attempts to control and limit drug use can be directly linked to white, financially secure, Anglo-Saxon Americans attempting to maintain their control over the American populous.

The United States of America has also constructed itself to be the moral leader of the world. Starting in the early 1900s, the US has attempted to maintain control over the global drug response. For example, in 1909 the US organized the first meeting of the International Opium commission "where 13 nations discussed the problems of the opium trade" globally.[62] The US

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[58] Frendreis and Tatalovich, "A Hundred Miles of Dry."
[59] Ibid. p. 304
[60] Ibid. p. 306
[61] Blackman, "Drug War Politics: Governing Culture Through Prohibition, Intoxicants as Customary Practice and the Challenge of Drug Normalisation." p.846
[62] Ibid. p.846

had an explicit interest in the global opium trade due to the fact that the Philippines was one of their colonies and had very "high levels of opium addiction" amongst the population.[63] While the Prohibition movement was in full motion in the internal politics of the United States, politicians and religious leaders were working to extend this abstinence-based philosophy globally, such as through the Harrison Act of 1914 which is considered by experts to be "the cornerstone of global drug prohibition."[64]

American foreign policy has only continued to rely on drug prohibition as a "means to transform other countries' economics to promote the interests of US capital" through the modern age.[65] The US uses the war on drugs as an excuse to "provide economic aid, training and security services"[66], which thus allows the US to enter other states and assert its interests "through the notion of global self defence rather than interference."[67] According to Blackman, examples of the USA using drug prohibition as a means to enter and control a country can be seen in Afghanistan, Pakistan, Laos, Thailand, and Iran. America has dominated global conversations regarding drugs to the point where "the United Nations has adopted US style anti-drug policies on a global basis" [68]

Clearly the international prominence of the United States' prohibition-focused drug rhetoric requires that the country maintain strict drug policies domestically. Despite "conclusive scientific evidence" supporting needle exchange programs as an effective measure to reduce the harms associated with injection drug use, the US maintains federal opposition towards these

[63] Ibid. p.846
[64] Ibid. p.846
[65] Ibid. p.842
[66] Ibid. p.841
[67] Ibid. p.847-848
[68] Ibid. p.851

programs.[69] The studies in Canada were "repeatedly cited as rationale for opposing NEPs" by US officials.[70] In 2005, the paper regarding NEPs in Vancouver was cited by a congressional representative in an effort to limit US funding to international organizations that implement NEPs. As recently as 2011 "the US Congress reinstated a ban on federal needle exchange program funding."[71] However, even the authors of these studies in Vancouver have publicly stated that the United States is egregiously misinterpreting the results of their work. By continuing to cling onto these misinterpretations of on select study, and ignoring a large body of empirical evidence supporting the benefits of NEPs, the federal government is illustrating that is clearly "does not support the distribution of sterile syringes" as a viable policy. [72]

According to McLean, the lack of federal support for these programs stunts their implementation nationwide and has resulted in a "patchy and precarious" system of programs which are not sufficient for the entire affected population.[73] By the end of 2002, NEPs were operating in only 36 states across the US. However, these programs were only legal in 12 of the states. Undoubtedly "like the earlier campaigns for temperance and prohibition", drug prohibition has become a "symbolic crusade" against supposed moral defects.[74] According to Buchanan, since the beginning of the founding of America, the people of America have felt like they are "God's Chosen People" and "must live up to higher moral standards as a beacon to the

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[69] Buchanan et al., "Empirical Science Meets Moral Panic: An Analysis of the Politics of Needle Exchange." p.427
[70] Hyshka et al., "Needle Exchange and the HIV Epidemic in Vancouver: Lessons Learned from 15 Years of Research."p.262
[71] Ibid. p.262
[72] Buchanan et al., "Empirical Science Meets Moral Panic: An Analysis of the Politics of Needle Exchange."p.430
[73] McLean, "The Biopolitics of Needle Exchange in the United States."p.72
[74] Buchanan et al., "Empirical Science Meets Moral Panic: An Analysis of the Politics of Needle Exchange." p.437

rest of the world."[75]Such imperially moralistic viewpoints have created the US into a rigid supporter of drug prohibition, "despite international guidelines recommending NEPs as an essential HIV prevention program" and an overwhelming body of evidence supporting their efficacy. Despite hiding behind concerns of the results of these programs, it is clear that US opposition to these harm reduction strategies stems from a deeper cultural and political legacy within the US that seeks a global cultural domination.

Current Situation regarding IDU and HIV/AIDS in Switzerland and USA

Similarly to Switzerland, needle and syringe programs began in the US as "a fragmented and illegal practice" created by individuals who were willing to partake in acts of civil disobedience in order to protect the health and wellbeing of others.[76] It is thought that one of the first needle exchange programs in the United States was created by Jon Stuen-Parker in 1983. Stuen-Parker, a student at Yale University and "former heroin user" started to distribute "sterile needles to intravenous drug users in New Haven, CT" despite the fact that this practice was illegal. [77] He, like many others practicing harm reduction methods around this time, was arrested multiple times for his efforts. Yet, Stuen-Parker and others across the country continued their work because they realized that not only do IDUs have an increased risk of being infected by a blood borne disease like HIV or hepatitis, they "can transmit these diseases to needle-sharing or sexual partners and their own children."[78] Thus, the public health implications of injection drug use are vast. Diseases can spread quickly through the population of IDUs and their social networks.

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[75] Ibid. p.436
[76] McLean, "The Biopolitics of Needle Exchange in the United States." P.71
[77] Ibid. p.73
[78] DeSimone, "Needle Exchange Programs and Drug Injection Behavior." p.559

However, as noted by Freddy Muller of Tremplin, the Swiss system of needle exchanges grew into a reliable network of programs that has largely been successful in targeting the most vulnerable populations despite their illegal status. Whereas early activists were arrested in the United States for their work with needle exchange programs, the local governments of Zurich supported the programs once they realized the public health implications of failing to do so.[79] Andreas Lehner of SAF stressed that while the Swiss may be conservative, they are also very pragmatic. Ideological concerns reigned supreme in the United States and actually worsened the AIDS epidemic.[80]

The Swiss government has steadily moved towards acceptance of these harm reduction. Yet, despite the fact that comprehensive studies have found "no evidence that NEPs increase drug use by clients or in communities" and huge benefits for the health of communities due to NEPs, the federal government of the United States continues to reinstate a ban on the use of federal funds for needle exchange programs.[81] This ban has inhibited the creation of needle and syringe programs for injection drug users across the United States. Two years after the ban was instated in 1989, NEPs could only be found in the following US cities: "Portland, Tacoma, San Francisco, and occasionally, New York, New Haven, Philadelphia, and Boston."[82]These operations were very small, often just one or two volunteers working at a curbside table.

Though the situation has improved and NEPs can now be found in 36 states, they are still not widely accepted. Many NEPs must rely solely on local or private funding and are either "operating secretly" or "in tacit agreement with local law enforcement agencies."[83] The programs also remain limited in their ability to gain institutional legitimacy and as such many

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[79] Muller, Formal Interview with Tremplin.
[80] Lehner, Formal Interview with Swiss Aids Federation.
[81] DeSimone, "Needle Exchange Programs and Drug Injection Behavior."p.561
[82] McLean, "The Biopolitics of Needle Exchange in the United States." P.73
[83] DeSimone, "Needle Exchange Programs and Drug Injection Behavior." P. 560

continue to "operate at health van stops, sidewalk tables, cars, storefronts and health clinics" and hold limited hours, often only 20 hours per week. [84] These constraints prevent the NEPs from being as effective as they possibly can by limiting the ability of vulnerable populations to access their resources. As such, NEPs may seem less effective and then continue to lose support from surrounding communities.

The government of the United States has "actively stigmatized drug users and criminalized outreach efforts" for years with disastrous results.[85] The results of these restrictive policies are not decreased drug use or healthier communities. Rather, AIDS and HIV continue to present severe health concerns in many parts of the United States. While Switzerland has been able to essentially eliminate the transmission of HIV among injection drug users, the CDC "attributes 42 percent of U.S. cumulative nonpediatric AIDS cases through 2003" with injection drug use.[86] Approximately three-quarters of these cases are directly linked to IDUs sharing needle. The remaining quarter of these cases are likely the result of unprotected sex with an IDU partner.[87]

A global study of 81 cities, most of them American cities, "found that HIV infection rates among injectors decreased by 5.8 percent annually" in cities with needle exchange programs.[88] Cities without these programs saw a 5.9% average annual increase in the rate of HIV infection. There is also evidence to suggest that needle and syringe programs decrease the demand for drugs within a community by connecting clients with treatment and rehabilitative services. As such, the US has shown a callous disregard for the lives of injection drug users. NEPs are a tangible effort to improve a community's health as well as symbolic commitment to the health

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[84] Ibid. p.560
[85] McLean, "The Biopolitics of Needle Exchange in the United States." p.71
[86] DeSimone, "Needle Exchange Programs and Drug Injection Behavior." p.559
[87] Ibid.
[88] Ibid. p.561

and wellbeing of injection drug users. DeSimone notes that the creation of needle exchange programs in a community "often reflects a broader commitment to HIV prevention among the users of injectable drugs" and can thus stand as a symbol of a government's willingness to help its most marginalized populations. [89]

In Switzerland, excellent and astounding progress has been to drastically contain the AIDS epidemic and open drug use. Platzspits Park, which 25 years ago was considered a scourge upon the city, has been transformed into a popular family-friendly park with playgrounds and even a small café. Furthermore, this transition was able to happen not at the expense of injection drug users, who are typically just moved from place to place rather than being actually helped, but to their benefit. Needle exchanges are open across Switzerland and are fairly easy to access. None of the interviewed experts believed that the exchanges were difficult to access due to their location predominantly in larger cities. Mr. Lehner of the Swiss AIDS Federation stated that they "don't have AIDS anymore in Switzerland" due to all of the work that is done to prevent people from contracting HIV and the supports in place for people who are HIV positive.[90] Pierre, a volunteer at Checkpoint Geneva recalled that the situation was completely different 30 years ago, when you commonly saw people dying from AIDS in the community. He described the horror of seeing these people who looked like "corpses" and were clearly suffering.[91] The sources from Asile LGBT noted that while HIV is still affecting key populations, especially gay men, the changes over the past 30 years have been drastic.[92] Mr. Ducret of Premiere Ligne reports that there was no seroconversion of any injection drug user in Geneva in the last year.[93] Through campaigns like "Break the Chains", which offer reduced-prices for HIV testing at the end of

[89] Ibid. p.572
[90] Lehner, Formal Interview with Swiss Aids Federation.
[91] Pierre, Formal Interview with Checkpoint 2.
[92] Anonymous, Informal Interview with Asile LGBT Geneve.
[93] Ducret, Formal Interview with Premiere Ligne.

May, groups like Asile LGBT Genève and the Swiss AIDS Federation are hoping to target the most vulnerable populations and have them be aware of their HIV status. [94]

However, the situation in Switzerland is clearly not perfect. The experts seemed to have varying opinions about access to health care in general. Ms. Wehrli, a nurse with Aspasie, an organization that works with sex workers in Geneva, was very clear that her clients have insurance, pay their taxes, but they "n'ont pas d'accès aux soins."[95]The base insurance plan that all people in Switzerland must have at a minimum has a deductible of 300 francs. However, consumers can decrease their premiums by accepting a deductible of up to 2000 francs. Mr. Olivier Simon believes that this base insurance is sufficient for his clients. He rarely has a patient who is unable to afford services, and in general the services covered for addiction medicine are comprehensive.[96] Andrea Verwohlt also confirmed that "HIV/AIDS care is covered by Swiss health insurers" and assistance is available to those of lower economic means.[97]

However, according the Ms. Wehrli, the poorest members of society must have that 2000 francs available, because they need to choose the option with the lowest premiums, if they want to access medical care. Such a cost is too high for her clients and, as a result, they forego care despite the fact that they have insurance.[98] Mr. Lehrer, Mr. Ducret, and Mr. Husert all agreed that gay men were now the demographic group most affected by HIV. Mr. Husert of Checkpoint, a clinic specializing in providing testing and treatment for LGBTQ persons, also provided evidence that seems to contradict the opinions of Mr. Simon and Ms. Verwohlt. According to Mr. Huster, that the cost of an HIV test in Switzerland is 60 francs and PREP, a medication taken

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[94] Anonymous, Informal Interview with Asile LGBT Geneve.
[95] Wehrli, Formal Interview with Aspasie.
Courtesy translation by author: they do not have access to care
[96] Simon, Formal Interview with COROMA.
[97] Wehrli, Formal Interview with Aspasie.
[98] Ibid.

before exposure to HIV in order to lessen the likelihood of seroconversion, costs around 900 francs a month. These costs are not covered by insurance.[99] Checkpoint is able to provide some free testing to sex workers and lower-income populations. Mr. Lehner stated that that getting people tested is "not a problem of the money" because of public funding that exists to care for these populations.[100] However, access to PREP is more complicated and controversial.

There seems to be a large discrepancy in the opinions of the experts interviewed on the accessibility of services in Switzerland. While the system of obligatory insurance may succeed in adequately covering a large proportion of the Swiss population, there are clearly certain vulnerable populations that need additional support. Ms. Wehrli's comments about the needs of her clients suggest that these low-income women are covered in theory but not in practice. More work may be needed in Switzerland to assure that all people have access to care in practice.

Switzerland does have an advantage being such a small country. Whereas the AIDS epidemic is spread out across the US, "70% of new HIV diagnosis among gay men is in Zurich," a large city in Switzerland[101] Within the United States HIV and AIDS can be found at its highest prevalence in "certain discrete geographic," such as "urban areas of the Northeast and West Coast and cities and small towns in the South," as well as within certain demographic groups.[102] The US currently has 1.1 million HIV positive people living within its borders and 21% of these people do not know that they are infected with HIV. [103]

In 2006, the Center for Disease Control released new guidelines for HIV testing which states that all patients between the ages of 13 and 64 should be screened for HIV. However, despite the semblance of a cohesive national policy regarding HIV and AIDS, "conflicting state

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[99] Husert, Formal Interview with Checkpoint 1.
[100] Lehner, Formal Interview with Swiss Aids Federation.
[101] Ibid. p.e4
[102] El-Sadr, Mayer, and Hodder, "AIDS in America — Forgotten but Not Gone." p.967
[103] Yehia and Frank, "Battling AIDS in America: An Evaluation of the National HIV/AIDS Strategy."

laws" and "limited federal funding for testing programs" continue to prevent full implementation.[104] The Obama administration has attempted to improve access to care through the implementation of the Affordable Care Act (ACA) which extends government health insurance to all people less than 65 years of age (people older than 65 are covered through Medicare) "with incomes up to 133% of the federal poverty level" through the Medicaid program. [105] However, though the NHAS has predicted that the amount of funding needed for HIV/AIDS programming is $15 billion, the "Obama administration has only dedicated $30 million of the ACA Prevention and Public Health Fund" to HIV/AIDS prevention and programming.[106] As such, these agencies are simply playing lip service to these crises and not actually providing enough support to end the epidemic. Like the Swiss insurance system, this expansion will theoretically extend coverage to all US citizens. However, high out-of-pocket costs still prevent access to care.

The unequal burden of AIDS and HIV in the US is appalling. While "the prevalence of HIV infection within some U.S. populations now rivals that in some sub-Saharan African countries", the average rates of HIV are low for the general population. [107] Thus, HIV and AIDS are disproportionately affecting "the disenfranchised and socially marginalized" populations of America. [108] Recent studies have shown that the "rate of new AIDS cases is 9.7 times higher for Blacks and 3.3 times higher for Hispanics than for Whites", indicating deep racial implications.[109]

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[104] Ibid. p.e6
[105] Ibid. p.e
[106] Ibid. p.e6
[107] El-Sadr, Mayer, and Hodder, "AIDS in America — Forgotten but Not Gone."p.967
[108] Ibid. p.968
[109] Yehia and Frank, "Battling AIDS in America: An Evaluation of the National HIV/AIDS Strategy." P.e6

In New York City, one geographic hotspot for AIDS, "1 in 8 injection-drug users are HIV-infected." [110]The low social mobility of the affected populations makes it easier for politicians to ignore their needs. HIV and AIDS in America "has historically been framed as not only a matter of individual pathology, but also one of the national security and economic growth" because the most affected populations are viewed as dangerous to the innocence and purity of women and children. [111]

It seems that this unequal burden of disease is not as prevalent in Switzerland, perhaps because the population is more homogenous or because HIV transmission has really been limited to within the gay community. None of the experts interviewed indicated racial disparities in the burden of HIV/AIDS in Switzerland. However, Mr. Lehner did note that because HIV is concentrated within the gay male population, little funding is given to support the health needs of gay women in Switzerland.

Conclusion

After a study of the cultural, historical, and political forces at work in Switzerland and the USA, it has become quite clear that the responses that these countries have had to drug use and HIV/AIDS have been generated by their unique cultural and historical contexts. Though both countries are typically conservative with regards to drug use and sexuality, their responses to public health crises in the 1980s diverged from each other's in such a way that has greatly impacted the current situation with regards to HIV and AIDS in each country.

Switzerland has made significant progress in controlling the public health crises of AIDS and injection drug use by employing a series of harm reduction methods. This country has essentially eliminated the transmission of HIV among injection drug users by reducing the rate of the sharing of injection materials. The main population still affected by HIV in Switzerland is

[110] El-Sadr, Mayer, and Hodder, "AIDS in America — Forgotten but Not Gone."p.967
[111] McLean, "The Biopolitics of Needle Exchange in the United States."p.75

gay men. However, by focusing resources on gay men, Switzerland has limited the amount of resources that are available to women who are vulnerable to HIV. Ms. Wehrli's comments regarding her work with sex workers indicate that further work needs to be done to ensure that the needs of marginalized women are met.

Milena Prvulovic from the UNDP indicated that though the Swiss are generally very accepting, programs about stigma and discrimination against people who have HIV and AIDS should "focus on service providers" and primarily medical providers.[112] Her comments are supported by Mr. Husert of Checkpoint who noted that many gay men are uncomfortable going to their primary care physicians in Switzerland for sexual health-related matters for fear of being discriminated against.[113]Thus, as Mr. Ducret from Premiere Ligne stressed, the biggest task that Switzerland now faces is not forgetting the severity of the past drug and HIV epidemics. Now that open drug use and AIDS have been controlled within the country, people may forget the huge impacts that they had on Swiss citizens.[114] Continued training of services providers, medical practitioners, and police officers is a critical component to maintaining the institutional memory surrounding injection drug use and HIV/AIDS.

Many experts interviewed stressed that the availability of resources can vary greatly from canton to canton in Switzerland. Though cantonal independence is an important feature of the Swiss political landscape, and matters of public health have traditionally fallen within the jurisdiction of the individual cantons, increased federal involvement in this arena would certainly improve equality in access to care. Residents of cantons that are historically more liberal, such as Vaud and Geneva, have a wider variety of options available to them, from needle exchange

[112] Prvulovic, Formal Interview with UNDP.
[113] Husert, Formal Interview with Checkpoint 1.
[114] Ducret, Formal Interview with Premiere Ligne.

programs, to methadone replacement therapy, to drug consumption rooms. People in more rural or conservative areas are not only more likely to face societal stigma as a barrier to accessing care, but also often have fewer options of programs because their canton refuses to create needle exchanges. In order to ensure equal access to all Swiss citizens, it seems as the federal government will need to take a larger role in the creation of these types of facilities. Further work should be done to measure cantonal differences to document all potential inequalities.

The USA has decided to maintain a strict War on Drugs which focuses on punitive measures for a public health problem. By responding to injection drug use with "moral indignation," the US has actually set itself up for failure.[115] This country has not been able to eliminate drug use or HIV transmission through its repressive policies, and has actually increased transmission of HIV between IDUs in areas where needle exchange programs are illegal. The United States cannot even begin to work on the discrepancies between states before it develops a comprehensive federal policy which accepts harm reduction as a legitimate and beneficial manner with which to target drug use. The first step of such a program would be to revoke the ban on federal funding of needle exchange programs. Without this federal support of NEPs, the country cannot feasibly reduce the transmission of HIV/AIDS within its geographic and demographic hotspots.

Perhaps most critically, the United States has used its global influence and power to mandate that other countries follow its destructive path of repression-based drug policy. While the UN and organizations like the WHO have started to accept and support harm reduction-based approaches, the US has had a significant role in slowing this acceptance. For example, because of the United States' influence in the UN and their strict drug policies, the "Un World Drugs

[115] Blackman, "Drug War Politics: Governing Culture Through Prohibition, Intoxicants as Customary Practice and the Challenge of Drug Normalisation." p.842

Report 2009 makes no reference to 'spirit', 'reform' or 'harm reduction'", whereas these terms are all referenced by the UN in a report they released in 2008. [116] Further work needs to be done to understand the impact that the US has had on other countries by directing global drug policies. The Swiss government has felt some pressure from the United States to reverse its drug policies but has been able to resist due to its high world position. However, Swiss neutrality has limited its role in protecting other countries, which receive aid from the US, from being cowed to the repressive philosophies of the U.S. Switzerland has greatly improved the health of its citizens by retaining a harm reduction framework. It now needs to support other countries to create these types of programs and to direct global narratives about drug use away from purely repression based approaches.

Bibliography

Anonymous. Informal Interview with Asile LGBT Geneve. In Person, April 4, 2016.

Beletsky, Leo, Grace E. Macalino, and Scott Burris. "Attitudes of Police Officers towards Syringe Access, Occupational Needle-Sticks, and Drug Use: A Qualitative Study of One City Police Department in the United States." *International Journal of Drug Policy* 16, no. 4 (August 2005): 267–74. doi:10.1016/j.drugpo.2005.01.009.

[116] Ibid. p.850

Bewley-Taylor, David. "Getting High on the Policy Agenda: Europe, the Us and the Future of the Global Drug Prohibition Regime." *Journal of Transatlantic Studies (Edinburgh University Press)* 4, no. 1 (Spring 2006): 27–53.

Blackman, Shane. "Drug War Politics: Governing Culture Through Prohibition, Intoxicants as Customary Practice and the Challenge of Drug Normalisation." *Sociology Compass* 4, no. 10 (October 1, 2010): 841–55. doi:10.1111/j.1751-9020.2010.00324.x.

Buchanan, David, Susan Shaw, Amy Ford, and Merrill Singer. "Empirical Science Meets Moral Panic: An Analysis of the Politics of Needle Exchange." *Journal of Public Health Policy* 24, no. 3/4 (2003): 427–44. doi:10.2307/3343386.

Csete, Joanne, and Peter J. Grob. "Switzerland, HIV and the Power of Pragmatism: Lessons for Drug Policy Development." *International Journal of Drug Policy* 23, no. 1 (January 2012): 82–86. doi:10.1016/j.drugpo.2011.07.011.

Des Jarlais, D C. "Research, Politics, and Needle Exchange." *American Journal of Public Health* 90, no. 9 (September 2000): 1392–94.

DeSimone, Jeff. "Needle Exchange Programs and Drug Injection Behavior." *Journal of Policy Analysis and Management* 24, no. 3 (2005): 559–77.

Dubois-Arber, F, H Balthasar, T Huissoud, F Zobel, S Arnaud, S Samitca, A Jeannin, D Schnoz, and JP Gervasoni. "Trends in Drug Consumption and Risk of Transmission of HIV and Hepatitis C Virus among Injecting Drug Users in Switzerland, 1993-2006." *Euro Surveillance* 2008, 13, no. 21 (n.d.).

Ducret, Emmanuel. Formal Interview with Premiere Ligne. In Person, April 4, 2016.

El-Sadr, Wafaa M., Kenneth H. Mayer, and Sally L. Hodder. "AIDS in America — Forgotten but Not Gone." *New England Journal of Medicine* 362, no. 11 (March 18, 2010): 967–70. doi:10.1056/NEJMp1000069.

Frendreis, John, and Raymond Tatalovich. "'A Hundred Miles of Dry': Religion and the Persistence of Prohibition in the U.S. States." *State Politics & Policy Quarterly* 10, no. 3 (2010): 302–19.

Husert. Formal Interview with Checkpoint 1. In Person, April 4, 2016.

Hyshka, Elaine, Steffanie Strathdee, Evan Wood, and Thomas Kerr. "Needle Exchange and the HIV Epidemic in Vancouver: Lessons Learned from 15 Years of Research." *International Journal of Drug Policy* 23, no. 4 (July 2012): 261–70. doi:10.1016/j.drugpo.2012.03.006.

Institute of Medicine (U.S.), and National Academies Press (U.S.). *Preventing HIV Infection Among Injecting Drug Users in High-Risk Countries : An Assessment of the Evidence*. Washington, D.C.: National Academies Press, 2007.

"International Journal of Drug Policy, January 2012, Volume 23, Issue 1, Pages 1-90." Accessed April 4, 2016. http://www.ijdp.org/issue/S0955-3959(11)X0008-7.

Jefferson, David. "How AIDS Changed America." *Newsweek* 147, no. 20 (2006): 36–41.

"La Guerre Aux Drogues Face Au VIH/sida: Comment La Criminalisation de L'usage de Drogues Aggrave La Pandémie Mondiale." Commission Mondiale Pour la Politique des Drogues, Juin 2012.

Lehner, Andreas. Formal Interview with Swiss Aids Federation. In Person, April 12, 2016.

McLean, Katherine. "The Biopolitics of Needle Exchange in the United States." *Critical Public Health* 21, no. 1 (March 2011): 71–79.

Muller, Freddy. Formal Interview with Tremplin. In Person, April 19, 2016.

"National HIV/AIDS Strategy Implementation Progress Report 2011." U.S. Department of Health and Human Services, May 2012.

Pierre. Formal Interview with Checkpoint 2. In Person, April 4, 2016.

Prvulovic, Milena. Formal Interview with UNDP. In Person, March 29, 2016.

Senthilingam, Meera. "Sex in the UK: How Culture and Society Can Define Your Sexual Health| London School of Hygiene and Tropical Medicine." *Features | London School of Hygiene and Tropical Medicine*. Accessed April 24, 2016. http://features.lshtm.ac.uk/project/sex-culture-society-define-sexual-health.

Simon, Olivier. Formal Interview with COROMA. In Person, April 19, 2016.

Somaini, Bertino, and Peter Grob. "Commentary: How and Why AIDS Changed Drug Policy in Switzerland." *Journal of Public Health Policy* 33, no. 3 (2012): 317–24.

Strike, Carol J., Laurel Challacombe, Ted Myers, and Margaret Millson. "Needle Exchange Programs: Delivery and Access Issues." *Canadian Journal of Public Health / Revue Canadienne de Santee Publique* 93, no. 5 (2002): 339–43.

Tyrrell, Ian. "The US Prohibition Experiment: Myths, History and Implications." *Addiction* 92, no. 11 (November 1997): 1405–9.

Verwohlt, Andrea. Formal Interview with UNAIDS. E-mail, April 4, 2016.

"War on Drugs." Geneva Switzerland: Global Commission on Drug Policy, June 2011.

Wehrli, Mireille. Formal Interview with Aspasie. In Person, April 4, 2016.

"What Is Harm Reduction? | Harm Reduction International." Accessed April 5, 2016. http://www.ihra.net/what-is-harm-reduction.

Wodak, Alex, and Annie Cooney. "Effectivness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users." Geneva: World Health Organization, 2004.

Work. “Needle Exchange, Pragmatism, and Moralism.” *American Journal of Epidemiology* 149 (1999): 203–13.

Yehia, Baligh, and Ian Frank. “Battling AIDS in America: An Evaluation of the National HIV/AIDS Strategy.” *American Journal of Public Health* 101, no. 9 (September 2011): e4–8. doi:10.2105/AJPH.2011.300259.