

Health Departments Role in Expanding Syringe Access

INTRODUCTION

Sharing used syringes is the primary reason people who inject drugs become infected with HIV and hepatitis C. Use of sterile syringes greatly reduces the risk of infection for people who inject drugs. Unfortunately, sterile syringes are not readily available to many injection drug users (IDUs). Expanding access to sterile syringes was identified early in the HIV/AIDS epidemic as an important strategy to minimize transmission of HIV among active injection drug users. Subsequent research provided overwhelming evidence that access to sterile syringes is effective in reducing transmission of HIV, without increasing drug use. Furthermore, hepatitis C is much more prevalent among people who inject drugs, making access to sterile syringes to prevent HCV transmission even more critical.¹

Despite the scientific evidence of the effectiveness of expanding syringe access in preventing transmission, the federal government prohibited the use of federal funds for syringe exchange programs until late 2009. The 21-year-old ban on the use of federal funds for syringe exchange programs was lifted in December 2009 when President Obama signed the *Omnibus Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2010* into law without this restriction.

The science behind the approaches to syringe access prompted many states, cities and communities to develop syringe exchange programs and work with policymakers, local officials, law enforcement, pharmacies and others to expand access to syringes using other resources. These efforts to expand syringe

WHAT IS SYRINGE ACCESS?

Syringe access refers to the myriad of approaches geared towards ensuring that people who inject drugs have access to sterile syringes to prevent the transmission of HIV, viral hepatitis and other blood-borne pathogens. These approaches may include programs to exchange used syringes, but also include over-the-counter pharmacy sale of syringes without prescription and structural interventions to reduce barriers to syringe exchange and pharmacy sale of syringes. For more information, please see www.harmreduction.org

access have given U.S. domestic prevention one of its greatest success stories to date. Although at one point in time, CDC estimated that one-fifth of all HIV infections and virtually all hepatitis C infections as of 2004 were due to injection drug use, the latest data on HIV/AIDS indicates that from 2003 through 2007, among male adults and adolescents, the estimated number of newly diagnosed AIDS cases decreased among IDUs and MSM who were also IDUs.² Furthermore, there is data from New York City that shows that “sexual transmission may now be a more significant contributor to HIV prevalence among injectors in New York City than unsafe injection practices.”³

“In communities where syringe access programs have been locally supported, HIV infection rates have decreased dramatically among people who use injection drugs.”

NASTAD Prevention Blueprint, December 2007

PROFILES OF SYRINGE ACCESS PROGRAMS

As the profiles presented below demonstrate, state and local health department HIV/AIDS and viral hepatitis programs are already supporting diverse and effective strategies to expand syringe access to those who inject drugs. Furthermore, they have been able to institute the appropriate routine oversight and monitoring to demonstrate this effectiveness. The collective experience of state and local health departments, working with local providers of syringe access activities, has provided three important lessons:

1. **Flexibility is critical to the effectiveness of syringe access programs.** The tremendous diversity in syringe access programs and initiatives that has emerged over the past two decades reflects that there is no single, ideal “one size fits all” model for syringe access.
2. **Anonymity and the provision of low-threshold services are essential to the success of syringe access programs.** The overwhelming majority of syringe access programs operate on a low-threshold basis, balancing the value of data collection for monitoring and evaluation with the goals of streamlining procedures to maximize accessibility and responding to the privacy and confidentiality needs of a stigmatized and criminalized population.
3. **Engagement of law enforcement and community stakeholders must be supported and sustained.** Continued engagement with law enforcement is critical for the safety and security of both participants and program operations and issues regarding safe syringe disposal frequently constitute a priority for communities with significant levels of injection drug use.

NEW YORK STATE

Syringe access in New York State has its statutory basis in Public Health Law Section 3381, which states that the sale or furnishing of syringes may occur in one of three ways: 1) via prescription; 2) by persons specifically authorized by the Commissioner of Health; or 3) through a program which specifically authorizes the non-prescription sale of syringes by pharmacies, health care facilities and certain health care practitioners. The state's oldest program is its Syringe Exchange Program (SEP), which permits those who inject drugs to exchange used syringes for new, sterile ones. Participants enroll in programs, receive identification cards with unique identifiers, and are instructed to return used syringes. There are eighteen syringe exchange programs in New York State, five upstate and thirteen in the five boroughs of New York City. Syringe exchange may be conducted through storefronts, street-side, mobile van, single room occupancy hotel (SRO), walkabout and via peers. An array of ancillary services, such as case management, mental health, meals, behavioral interventions, HIV counseling and testing, hepatitis B and C screening, buprenorphine induction, and/or medical care may be offered on-site at the SEP.

A second syringe access program – the Expanded Syringe Access Program (ESAP) – was initiated in 2001. Through ESAP, licensed pharmacies, health care facilities and health care practitioners may register with the New York State Department of Health to sell or furnish up to ten syringes per transaction without a prescription to persons 18 years of age or older. There are currently approximately 3,200 ESAP-registered providers, 40 percent of whom are in New York City. Ninety-seven percent of the principal ESAP providers are pharmacies. Many of these programs have creatively integrated

PROFILES OF SYRINGE ACCESS PROGRAMS

prevention and access to other services into their activities. Special collaborations have been established among community based organizations, pharmacies and health care providers that are registered in ESAP to reach a larger number of individuals in the community, to expand the utilization of the program and to provide easy access to services. Community based organizations may collaborate with ESAPs to deliver ESAP services, including syringe collection/disposal sites using kiosks provided by the AIDS Institute and a syringe voucher program. An important component of the ESAP is the promotion of safe sharps disposal. In New York, all hospitals and nursing homes (930) are required by law to accept household sharps. The New York State Sharps Collection Program provides opportunities for implementing alternative sites for disposal. There are approximately 140 agencies, including mobile vans, hosting kiosks or wall mounted units, for safe disposal in 20 counties. Venues for disposal include pharmacies, community-based organizations, housing projects, community colleges, a bus depot, an airport, a police station, landfills, waste transfer stations, and substance abuse treatment programs.

BALTIMORE, MARYLAND

Syringe access in Baltimore has focused on reducing stigma by providing access through a mobile medical unit that allows clients to access support services such as vaccinations, Medicaid and Food Stamps enrollment, identification services, and reproductive health services, along with access to sterile syringes. To reduce stigma, access to services provided by the mobile medical unit is not limited to persons who inject drugs. Baltimore's syringe program is confidential, rather than anonymous, and Baltimore has developed specialized syringe access for specific populations of those who use drugs. For example, they support a Trans

Needle Exchange project for transgendered persons and The Block Project for sex workers.

MAINE

In 1993, Maine Public Law 394 removed the prescription requirement for syringe sales, making it legal for individuals over the age of 18 to buy syringes without a prescription. In 1997, legislation was passed legalizing syringe exchange and in 1999, the Maine Pharmacy Association clarified its support for full implementation of the syringe laws. In 2007, the operating requirements of syringe exchange programs were amended through legislation to remove the 10-syringe limit for a single visit. Maine requires a one-for-one exchange, and consumers must enroll in the needle exchange program in order to receive needle exchange services. In order to operate a syringe exchange program in the state of Maine, the person or other entity wishing to operate the Program must be certified by the Maine CDC, HIV, STD, and Viral Hepatitis Program as a "Hypodermic Apparatus Exchange Program."

HAWAII

In 1990 the Hawaii State legislature passed a law establishing the Hawai'i Syringe Exchange Program (SEP). In recent years, the program has exchanged 400,000-450,000 syringes annually. Its purpose is to prevent the transmission of HIV, hepatitis B virus (HBV), and hepatitis C virus (HCV) by providing access to sterile syringes, supplies and appropriate health and social services to those who inject drugs.

Using state general funds, the Department of Health contracts with a community based agency called the Community Health Outreach Worker (CHOW) program, which operates anonymous syringe exchange using six mobile vans in sites on four islands across the state. The program provides HIV and HCV counseling,

PROFILES OF SYRINGE ACCESS PROGRAMS

testing, and referral services to their clients and refers clients for hepatitis A/B vaccinations. For many years, CHOW has provided education and information on syringe access and harm reduction concepts to local law enforcement through training sessions for new recruits. This has significantly improved understanding and relations with law enforcement officials who frequently voice their support and commitment to the SEP in public settings and are appreciated as a strong, informed ally of the program.

NEW JERSEY

New Jersey Syringe Exchange Programs (SEPs) have evolved considerably since their inception, moving from a fragmented approach to a comprehensive system of care and referrals. The SEPs maintain their uniqueness as drop-in centers, mobile vans, and/or fixed sites while offering the same compliment of services, in order to match the needs of participants. A new dimension to SEP has been fueled by in-depth training of nurses on HIV, hepatitis, harm reduction, STDs, adult immunizations, reducing perinatal HIV transmission, improving pregnancy outcomes for women and reducing the risk of HIV and STD transmission for injection drug users. The syringe exchange programs have become the gateway to treatment for injection drug users. This is evidenced by the more than 50 percent of SEP enrollees entering drug treatment: methadone, suboxone or residential. New Jersey works to wrap services around SEP in order to meet clients where they are.

NEW MEXICO

From 1994 to 1997, the New Mexico Department of Health conducted a statewide street-based seroprevalance study that showed that less than one percent of IDUs were infected with HIV and 82 percent had been infected with hepatitis C. These findings helped win legislative support

for a statewide harm reduction program – the Harm Reduction Act, passed in 1997. Today, New Mexico has diverse syringe access strategies, including: fixed-site street outreach, roving street outreaches, and walking street outreaches. One important aspect of the program, New Mexico has been working closely with law enforcement, including trainings for law enforcement regarding harm reduction, and outreach with law enforcement to help access participants and build relationships among participants, providers and law enforcement. The program has law enforcement trainers train other law enforcement officers about harm reduction and the principals of the harm reduction philosophy. In addition, the health department and the Albuquerque Health Care for the Homeless program worked with the Albuquerque police department to help transport participants needing services rather than giving citations or arresting participants.

MASSACHUSETTS

Access to sterile syringes in the Commonwealth of Massachusetts occurs via over-the-counter sales of syringes at pharmacies and/or enrollment in state-funded needle exchange programs. Massachusetts General Law [Chapter 172 of the Act of 2006, amended c.94C](#), was enacted to decriminalize distribution and possession of hypodermic needles, regardless of any involvement with a needle exchange program or issuance of a prescription. As of September 18, 2006, anyone over the age of 18 in Massachusetts can purchase needles from a pharmacy without a prescription and without fear of criminal prosecution. Wide-reaching communication to all licensed pharmacists from the Massachusetts Department of Public Health (MDPH) explains the legislation and the importance of community pharmacies participating in the sale of sterile syringes. In addition, MDPH, through the Office of

HIV/AIDS and the Bureau of Environmental Health, has established community sharps disposal programs across the state. Disposal sites are located at agencies funded to serve injection-drug users, pharmacies, hospitals, community health centers and local boards of health. The MDPH also funds four needle exchange programs, most of which have been in existence since 1993. All four sites are also Opioid Overdose Prevention Programs. In addition, as part of an upcoming procurement of HIV prevention and screening services, the Office of HIV/AIDS will endorse the addition of sterile syringe equipment to HIV prevention program supplies.

MICHIGAN

Syringe exchange programs first began operating in Michigan in 1995 in various communities in the southern portion of the lower peninsula of Michigan (Benton Harbor, Kalamazoo, Grand Rapids, Ann Arbor/Ypsilanti, Pontiac, and Detroit). The experience in these sites suggests that successful programs have been predicated upon being able to assess both the needs of those who inject drugs, as well as community receptivity to initiating syringe exchange programs. The sites that provide syringe exchange also provide related services including: wound care, triage/medical assessments, HIV counseling, testing, and referral; food in pre-packaged units, personal hygiene kits, referral for shelter, referral to soup kitchens, financial aid, legal assistance, and distribution of bus passes and/or other incentives. In addition, many sites in Michigan are increasing their services for viral hepatitis by providing testing for hepatitis C virus (HCV) and vaccinations for hepatitis A and B.

BEST PRACTICES FOR EXPANDING SYRINGE ACCESS AT THE STATE OR CITY LEVEL

- Seek the endorsement of state or city officials;
- Ensure that paraphernalia laws exempt possession of syringes;
- Involve and educate law enforcement;
- Include the affected population in the delivery of syringe access efforts, including peer-to-peer recruitment;
- Provide other health services such as HIV, STD and hepatitis testing, hepatitis A and B vaccination, Ryan White case management, diabetes testing, wound-care kits, counseling, female safety kits, and job and home referral services;
- Make regulations appropriate to allow pharmacy sales of syringes; and
- Ensure there are appropriate and accessible disposal systems.

These practices provide examples from only a few of the jurisdictions that have expanded syringe access as a strategy to reduce transmission of HIV and viral hepatitis among those who inject drugs. **NASTAD strongly cautions against any government actions which would increase the bureaucratic, regulatory, and reporting requirements on syringe access beyond those already in place at the state and local level.** It is our collective belief that public health and community leaders committed to expanding syringe access must adhere to a shared understanding of and commitment to these key principles.

ENDNOTES

¹ T. Stephen Jones and Phillip O. Coffin, "Preventing Blood-Borne Infections Through Pharmacy Syringe Sales and Safe Community Syringe Disposal" in *JAPhA*, November-December 2002, Vol. 42, No. 6, Supplement 2 -accessed [online](#) 2/9/2010

² CDC *HIV/AIDS Surveillance Report*, 2007, vol. 19/2009, accessed [online](#) on 2/9/10

³ "Using hepatitis C virus and herpes simplex virus-2 to track HIV among injecting drug users in New York City," by Don C. Des Jarlais, Kamyar Arasteh, Courtney McKnight, Holly Hagan, David Perlman and Samuel R. Friedman in *Drug and Alcohol Dependence*, vol. 101 (2009) 88-91