

Sterile Syringe Access

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Introduction

Injection drug use is associated with a high risk of infection by blood-borne diseases such as HIV and hepatitis C. Sterile syringe access programs help lower these risks by limiting syringe sharing and providing safe disposal options. These programs also provide people who inject drugs with referrals to treatment, detoxification, social services, and primary health care.

Increasing access to sterile syringes through syringe exchange programs and non-prescription pharmacy sales is essential to reducing syringe sharing among people who inject drugs. Throughout the world, research has consistently shown that syringe access programs decrease rates of HIV/AIDS and hepatitis C transmission. Syringe access programs have also been shown to increase the safe disposal of used syringes, protecting police officers and the public from accidental exposure to blood-borne diseases.

Despite the benefits of these life-saving programs, legal and bureaucratic barriers still prevent people who inject drugs from accessing clean syringes. The U.S. Congress recently reinstated the federal ban on funding of sterile syringe programs, after finally lifting the two-decade-long ban just two years ago. The federal ban is estimated to have cost thousands of lives and hundreds of millions of dollars.¹

Drug Injection and HIV/AIDS

Globally, injection drug use accounts for approximately one in three new cases of HIV outside of sub-Saharan Africa.² In the U.S., estimated HIV prevalence among people who inject drugs is roughly 16 percent. Rates in countries that have comprehensively and consistently funded syringe access programs are far lower – in some cases, close to zero.³

The U.S. Centers for Disease Control and Prevention

(CDC) estimates that more than one-third (36 percent) of AIDS cases in the U.S. since the beginning of the epidemic are directly or indirectly attributable to injection drug use,⁴ and that people who inject drugs represented 9 percent of all new HIV infections in 2009.⁵ Sharing syringes not only puts people who use drugs at risk, but also their sexual partners.

Obstacles to sterile syringe access perpetuate the escalating racial disparities in HIV infection rates. Among people who inject drugs in the U.S., blacks and Latinos have considerably higher rates of HIV compared to whites. In 2009, black men and women accounted for almost half (48 percent) of new HIV infections among injection-drug using people.⁶

Injection drug-related HIV/AIDS also affects women disproportionately. Since the beginning of the epidemic, “57 percent of all AIDS cases among women have been attributed to injection drug use or sex with partners who inject drugs, compared with 31 percent of cases among men.”⁷

“For injection drug users who cannot or will not stop injecting drugs, using sterile needles and syringes only once remains the safest, most effective approach for limiting HIV transmission.”

– *Center for Disease Control and Prevention (CDC), March 2007*

Syringe Access Saves Lives

Decades of research have conclusively shown that syringe access programs reduce the spread of HIV and viral hepatitis, without increasing drug use, crime, or unsafe discarding of syringes.⁸

In some U.S. cities and states, advocates have overcome drug war hostility to implement syringe access programs that have saved thousands of lives with no negative impacts to their communities. Syringe

access has helped reduce HIV incidence among people who inject drugs in the U.S. by 80 percent in the past decade.⁹

Most syringe access programs not only provide disease prevention education and materials, but also provide referral to drug treatment and other vital health services, including screenings for HIV, hepatitis and sexually transmitted infections.

“Needle exchange programs have been proven to reduce the transmission of blood-borne diseases...[and] do not increase drug use..”

– Gil Kerlikowske, Director of the White House Office of National Drug Control Policy, April 2009

Syringe Access is Cost Effective

Restricting access to sterile syringes is not only bad public health policy – it’s also bad economic policy. Research has consistently shown that not only does syringe access save lives – it saves money.

A sterile syringe costs roughly \$0.97, and the cost of averting a new HIV infection by providing syringe access ranges from \$3,000-50,000.¹⁰ Yet the lifetime cost of treating someone with HIV can be as high as \$618,000, and the lifetime cost of treating someone with hepatitis C is estimated to cost between \$100,000 and \$300,000.¹¹ The U.S. can save billions of dollars by increasing access to sterile syringes to prevent injection-related HIV and viral hepatitis infections.

Support for Expanded Syringe Access

Syringe access programs are supported by every major medical and public health organization in the U.S. and the world, including the American Medical Association, National Academy of Sciences, CDC, World Health Organization, American Academy of Pediatrics, American Bar Association, U.S. Conference of Mayors, UNICEF, the World Bank, and International Red Cross-Red Crescent Society.

Recommendations

The Drug Policy Alliance is working to ensure wider access to sterile syringes throughout the country.

End the criminalization of syringe possession. DPA supports ending policies that criminalize syringe possession and limit sterile syringe distribution. DPA supports state efforts to exempt syringes from paraphernalia laws and broaden the legal definition of medical necessity as it relates to syringe access.

Lift the ban on federal funding for syringe access programs. DPA is also committed to permanently eliminating the federal ban on syringe access funding.

Expand syringe exchange services. DPA has led successful efforts to launch syringe exchange programs in several states, most recently New Jersey.

Permit over-the-counter sales of syringes. DPA backs the non-prescription, over-the-counter sale of syringes, which is now permitted in all but one U.S. state, but which is still unduly restricted in others. DPA also favors allowing doctors to prescribe syringes to their patients, a practice few states currently permit.

¹ Peter Lurie and Ernest Drucker, “An opportunity lost: HIV infections associated with lack of a national needle-exchange programme in the USA,” *Lancet* 349, no. 9052 (1997):604–608.

² UNAIDS report on the global AIDS epidemic 2010. http://www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf.

³ Bradley M. Mathers et al., “Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review,” *Lancet*, 372, no. 9651 (2008): 1733-1745.

⁴ Center for Disease Control and Prevention (CDC), “Drug-Associated HIV Transmission Continues in the United States,” (2007), <http://www.cdc.gov/hiv/resources/factsheets/idu.htm>

⁵ CDC, *Estimates of New HIV Infections in the United States, 2006–2009*, (2011), <http://www.cdc.gov/nchstp/newsroom/docs/HIV-Infections-2006-2009.pdf>.

⁶ Ibid.

⁷ Ibid.

⁸ Institute of Medicine (IOM), *Preventing HIV Infection among Injecting Drug Users in High-Risk Countries: An Assessment of the Evidence* (2006); World Health Organization (WHO), *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users* (2004), http://www.who.int/hiv/pub/prev_care/effectivenesssterileneedle.pdf;

CDC, *Syringe Exchange Programs* (2005) http://www.cdc.gov/IDU/facts/AED_IDU_SYR.pdf; National Institute on Drug Abuse, *Principles of HIV prevention in drug-using populations: a research based guide* (2002); and Melissa Marx et al., “Trends in Crime and the Introduction of a Needle Exchange Program,” *American Journal of Public Health*, 90 no. 12 (2000):1933–6.

⁹ H. Irene Hall et al., “Estimation of HIV incidence in the United States,” *JAMA* 300, no. 5 (2008): 520-9.

¹⁰ CDC (2005); Institute of Medicine, *No Time to Lose: Getting More from HIV Prevention* (2001).

¹¹ Peter Lurie et al., “An economic analysis of needle exchange and pharmacy-based programs to increase sterile syringe availability for injection drug users,” *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* 18 (1998): S126-S132; and Barry Schackman et al., “The lifetime cost of current human immunodeficiency virus care in the United States,” *Medical Care* 44 (2006): 990–997.