

Needle Exchange – A Matter of Public Health

So why is the government playing politics with this ticking time bomb?

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The American Medical Association (AMA), the American Nurses Association, the American Public Health Association (APHA), the American Society of Addiction Medicine, the American Bar Association, and the Society of Christian Ethics, to name a few, all endorse needle exchange programs. So why has it not been possible to achieve federal funding for such programs from 1988 to the present?

Needle exchange programs, which increase the availability of sterile syringes, are an important means of reducing the transmission of HIV infection and other blood-borne diseases such as hepatitis B and C among injection drug users and their often unsuspecting sexual partners and children – the most rapidly growing population of people with HIV. Most needle exchange programs operate on a one-for-one basis, so they also reduce the presence of infected needles in playgrounds, streets, and trash receptacles, thus protecting children, sanitation workers, and others from accidental needle sticks.

The use of federal funds to support needle exchange programs has been prohibited by Congress since 1988. The original intent was that the ban on federal support would remain in effect until the U.S. Secretary of Health and Human Services determined that such programs were effective in preventing the spread of HIV and did not encourage the use of illegal drugs. In the years since the funding ban was put instituted, an impressive number of researchers and medical organizations have carefully examined the issue and concluded that needle exchange programs are effective, necessary, and did not increase injection drug use.

In April 1998, then Secretary of Health and Human Services Donna Shalala publicly announced that the scientific evidence was in: needle exchange programs were effective in preventing the spread of HIV and did not encourage illegal drug use. But after Secretary Shalala made this determination, she nonetheless continued the federal ban on needle exchange funding. The decision was criticized by Mohammed Akhter, MD, MPH, executive director of the APHA, the oldest and largest organization of public health professionals representing more than 50,000 members from over 50 organizations. “The administration today has recognized that needle exchange programs work to protect the health of the American people,” said Dr. Akhter. “In the face of such overwhelming scientific evidence, not releasing federal funds gives the impression that politics takes precedence over saving lives”.

The scientific evidence is so overwhelming that the AMA encourages needle exchange programs and supports legislation revoking the 1988 federal funding ban. Additionally, the AMA encourages state medical associations to initiate state legislation to modify drug paraphernalia laws so that injection drug users may legally purchase and possess needles and syringes without a prescription. In 2002 former President Bill Clinton said he had made a mistake in not supporting needle exchange programs to prevent the spread of HIV and other diseases among injection drug users

As a presidential candidate, George W. Bush opposed needle exchange programs. That policy continues to the present day. Bush’s Secretary of Health and Human Services, Tommy Thompson, has said that the administration has no plans to permit federal funding of needle exchange. In an administration known for demanding loyalty, Bush’s “AIDS Czar” Scott Evertz nonetheless once let it be known that in his own view,

needle exchange saves lives and the evidence in its favor is conclusive.

In July 2002 the Bush administration announced that Joseph O'Neill, MD, would replace Evertz as director of the White House Office of National AIDS Policy. Dr. O'Neill is a career civil servant who has been acting director of the Department of Health and Human Services' Office of HIV/AIDS Policy. With the Bush administration, the terms of the debate on AIDS have changed. Needle exchange, although recommended by a majority of medical authorities, is not even up for discussion. Instead, questions are being raised about the effectiveness of condoms and –despite the increasing number of people living with HIV/AIDS – AIDS funding is leveling off.

The harm reduction paradigm is simple and approaches addictive behavior on the basis of three fundamental principles. First, excessive behaviors occur along a continuum of risk ranging from minimal to extreme. Addictive behavior is not an all-or-nothing phenomenon. Second, changing addictive behavior is a stepwise process, with complete abstinence as the final step. Those who embrace the harm reduction model believe that any movement in the direction of reduced harm, no matter how small, is positive. Third, sobriety simply isn't for everyone. This principle requires acceptance of the fact that many people live under horrible conditions. Some are able to cope without the use of drugs, while others use drugs as a primary means of coping. Until we as a society are able to offer an alternative means of survival to these people, we are in no position to cast moral judgment. Harm reduction holds that the health and well-being of the individual is of primary concern; if individuals are unwilling or unable to change addictive behaviors at this time, they should not be denied services. Attempts should be made to reduce the harm of their habits as much as possible. This approach to addiction is viewed by some as compassionate and pragmatic; by others as selfish and dangerous.

State laws prohibiting syringe sales without a prescription or possession of syringes for the purpose of injecting illegal drugs have made sterile needles hard to obtain and have led to substantial needle sharing, resulting in the spread of incurable diseases. In minority populations that are subject to considerable police presence, injection drug users avoid carrying syringes in order to avoid arrest, thereby increasing the frequency of needle sharing. An African American injection drug user is almost five times more likely, and a Latino more than three times more likely, to be diagnosed with HIV than a white drug injector.

Needle exchanges have been operating legally and illegally in the United States since at least the late 1980s. The first needle exchange program was developed in 1984 in Amsterdam in the Netherlands by a drug users' advocacy group called the Junkie Union. The goal was to avoid an epidemic of hepatitis B when an inner-city pharmacist intended to put an end to the sale of syringes to injection drug users. The first person to hand out drug injection equipment openly in the U.S. was Jon Parker in New Haven, CT, and Boston, MA, in 1986. The first U.S. needle exchange program to provide all-inclusive services was established in Tacoma, WA, in 1988. Much has changed in the past decade. From its beginnings with a few lone individuals exchanging syringes on the streets, there are now over 100 needle exchange programs in some 80 cities and 30 states around the country and over 17 million syringes were exchanged in 1997 (the year of the last official survey). While the debate in Washington has been fairly inactive in recent years, steps forward have been made on the state level in many areas. In fact, 68 out of 113 of the needle exchanges participating in the 1997 survey were either legal or illegal but tolerated by local officials.

The Canadian experience with needle exchange programs has been quite different from that of the U.S. As early as 1989, the Canadian federal government offered to co-fund comprehensive pilot HIV prevention programs for injection drug users that included needle exchange. By 1993, nearly 30 Canadian cities had active needle exchange programs. While some Canadian community and neighborhood groups have opposed needle exchange, the debate has generally been less politically charged than in the U.S. The fact that the pilot needle exchange programs were part of a comprehensive approach to drug use that combines education, counseling, law enforcement, and linkages to other services, including drug treatment, helped diminish community resistance. In Britain, pharmacies and more than 250 agencies distribute clean needles. Before 1987, 60 percent of injection drug users regularly shared needles; today the figure in Britain is about 10 percent. Australia has also been a pioneer in the area of harm reduction. Three Catholic agencies

sponsor needle exchanges in that country. According to David Waterford of the Adelaide Diocesan AIDS Council, Southern Australia (with 55 exchange programs for a population of 1.2 million) has reported no new HIV infections resulting from needle sharing over the past three years.

So what is the religious view of the morality of needle exchange? There are some extremes, from a Jesuit doctor who called on Catholic leaders to support such programs because “needle exchange saves lives,” to a Catholic priest and member of the New Jersey Governor’s Advisory Council on AIDS who stated that needle exchange undermines society.

An excerpt from Dawn Day’s article on moral issues related to the spread of HIV/AIDS among injection drug users puts this issue in perspective for those struggling with the morality of supporting needle exchange. “With the best of intentions, our legislators passed laws prohibiting people from gaining access to sterile needles – the legislators were trying to protect people from the harm that comes from injecting drugs,” wrote Day. “Medical science now tells us that these laws are not effective in stopping drug use and are causing the further spread of HIV/AIDS. It is a tragic irony that the laws prohibiting access to sterile needles, laws meant to protect people, are now the cause of people dying with AIDS. As a religious person, I feel I have an obligation to work to correct this deadly situation”. Relating to medical care for all she wrote, “[I]f a women has a life-threatening hemorrhage after giving birth, we want the doctor to provide medical treatment at once. We do not want the doctor to first inquire about the circumstances under which the woman became pregnant. Or when an ambulance goes to the scene of an accident, we want all those who need help to be treated, even the person that caused the accident.”

Day continues with the following analogy: “There is a dangerous curve in the road. One speeding driver dies. Then another. Then another. They should not be speeding. They are responsible. But we know the curve is dangerous. Don’t we have an obligation to post a warning sign? Put in a stop light? Change the traffic pattern? Perhaps even straighten the road? And the driver is not always alone. Sometimes a wife or husband is along. Sometimes a newborn child. And so it is with injecting drugs in the age of AIDS. People who inject drugs know they are taking a risk. *But we know too.* I believe we have an obligation to permit people who inject drugs to have access to sterile needles so they can protect their health. Injection drug users are also God’s children. And, like the reckless driver in the example above, people who inject drugs have wives, husbands, and babies. When we abandon the person who injects drugs to HIV/AIDS, we are abandoning their non-drug injecting partners and babies as well. God has given us knowledge with which to slow the spread of HIV/AIDS to all these people. Let us use it.”

With over a 100 people in the United States becoming infected with HIV, HCV, or HBV every day as a result of injection drug use, it is clear that we must do more. We must continue to educate people about the harms of drug use, particularly injection drug use. We must pay attention to the expertise and knowledge of public health officials and scientists who urge that sterile syringes be made legally available to people who inject drugs. This can be accomplished by permitting and funding needle exchange programs wherever they are needed, permitting possession of sterile syringes, permitting pharmacies to sell syringes without a prescription. In addition, drug treatment programs must be made available to everyone who seeks their services. As a humane society, we must reach the point where injection drug users in every state can legally protect themselves from hepatitis C, hepatitis B, HIV, and other blood-borne diseases, and where needle exchange workers in every state are treated not as criminals but as the public health workers they are.

Contact one of the following organizations for more information about needle exchange:

- ◆ Harm Reduction Coalition – 212-213-6376 – www.harmreduction.org
- ◆ North American Needle Exchange Network – 253-272-4857 – www.nasen.org