Infectious Diseases Society of America and HIV Medicine Association Policy Statement on Syringe Exchange, Prescribing and Paraphernalia Laws

The HIV Medicine Association and Infectious Diseases Society of America (IDSA) are strongly committed to public health intervention that decreases transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HCV). Intravenous (IVD) use is a major route of transmission for all three infectious agents. Even for IVD users who desire treatment to diminish their addiction, it often is not available or requires a prolonged wait that may lead to additional exposures to other IVD users, and in turn, to their sexual partners and/or children. Because HIV, HBV and HCV transmission occurs through the sharing or re-use of infected paraphernalia, access to uninfected injection equipment is a key part of infection prevention programs.

The U.S. Public Health Service specifically recommended in 1997 to “ensure” sterile syringes for each injection in IVD users who cannot or will not cease to inject.

Based on a thorough review of the efficacy and epidemiological evidence and in the context of the HIV public health emergency, IDSA strongly supports efforts to:

1. Increase IVD users’ access to clean injection equipment.
2. Reform and decriminalize syringe possession and paraphernalia laws.
3. Legalize over-the-counter (OTC) syringe access.
4. Legalize physician prescribing of sterile syringes to injection drug users.
5. Allow federal and other funding for syringe exchange programs.

All of these activities must be coupled with increased provision and access to drug treatment.

[The American Medical Association has supported, through policy statements that it issued in 1997 and 2000, increased pharmacy access to syringes, physician prescribing of syringes and modification of drug paraphernalia laws so that IVD users can purchase and possess needles and syringes without a prescription. Similar statements have been issued by the American Pharmaceutical Association (1999), the Association of State and Territorial Health Officers (1995) and the National Alliance of State and Territorial AIDS Directors (1997).]
Supporting Document for IDSA’s Policy Statement on Syringe Exchange, Prescribing and Paraphernalia Laws
[Also endorsed by the HIV Medicine Association, Oct. 25, 2001]

In the United States, federal funding for syringe exchange programs (SEPs) is prohibited; state and local governments or private sources provide SEP funding. There is variability on syringe prescribing statutes and drug paraphernalia laws by state; within the United States, however, there is a progressive movement toward deregulation of syringe paraphernalia and prescribing prohibitions. SEPs are widely available in Western Europe and increasingly available in developing countries.

There are potentially three approaches for providing sterile paraphernalia to IVD users.

1. **Existing Syringe Exchange Paradigm.** The current approach is dependent upon a patchwork of funding structures. Generally, individuals are required to possess a syringe to enter an SEP. This approach does not adequately meet the demand and is a temporary measure for high-risk injectors. In addition, some IVD users have no access to SEPs or choose not to enroll in them.

2. **Physician prescription of sterile syringes specifically for the purpose of injecting illicit drugs.** The medical community has generally accepted this approach as a viable option. It is inadequate on its own, however, because it requires IVD users, many of whom do not have access to adequate health care, to see a physician to obtain a prescription to purchase a syringe.

3. **Deregulation of pharmacy laws to allow syringes to be purchased over-the-counter in pharmacies.** This approach has been adopted in many states. Many localities in these states, however, have retained drug paraphernalia laws that make the possession of syringes illegal once the individual steps outside the pharmacy. Modifying these secondary laws is an important adjunct to successfully advancing this approach.

**Efficacy**

The effectiveness/efficacy of SEPs is difficult to assess because of the following reasons:

1. Methodological shortcomings compromise the causal inference capability from observational studies. By necessity, SEPs have to be assessed through observational studies since randomized control trials are not ethical or practical in the vast majority of settings. The National Institute on Drug Abuse currently is funding a randomized community-based trial. Resulting data from that study will not be available for several years.

2. Methodological problems include selection bias issues. For example, data strongly suggest that persons enrolling in SEPs are more likely to be high-risk
injectors and more likely to seroconvert (develop human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HCV) infection), which results in a paradoxical higher seroconversion rate. This was recently observed in studies of SEPs in Montreal and Vancouver.

3. There are contextual issues of the influence of the person’s drug using network on potential risk for seroconversion including other drug practices and syringe sharing. There also are overall contextual issues as well in terms of drug availability, drug practices, and law enforcement in a particular city or drug using area.

4. New sophisticated molecular techniques permit the identification of HBV, HCV and HIV in discarded or exchanged syringes. However, on a community basis, the differentiation between prevalent and incident infection is still quite difficult.

5. The risk of seroconversion is dependent on a number of issues including:
   
   A. The background HIV prevalence of the at-risk population;
   B. Specific drug using practices, such as sharing and use of auxiliary paraphernalia;
   C. Frequency of injecting; and
   D. Prevalence of HIV in the injecting paraphernalia.

**Conclusions From Studies**

The data from observational studies conducted in a large number of venues in the United States and Western Europe, and more recently in developing countries, strongly suggest that SEPs are associated with decreased HIV seroincidence, despite methodological shortcomings. This relationship is biologically plausible. SEPs reduce the amount of syringe sharing, they reduce the circulation time of syringes in a particular drug-using network and they reduce the amount of reuse of syringes within a particular drug-using network.

SEPs have been proposed to have potential indirect effects (collateral impact). These include increased opportunities to:

- reduce sexual risk exposures,
- provide condoms and instruction on condom use,
- initiate HIV counseling and testing,
- initiate HBV/HCV testing,
- initiate drug abuse treatment, and
- provide healthcare services to a population that desperately needs it.

In addition, SEPs have been associated with:

- reducing the length of time until IVD users enter drug treatment (akin to stages of change model in behavioral science); and
- diffusing innovation by providing positive benefits to IVD users in the SEP enrollee’s social network (i.e., SEPs benefit persons who are not directly exchanging syringes, but are exchanging syringes through a third party).
Concerns have been raised that SEPs:

1. **Increase level of drug use.** The General Accounting Office and Institute of Medicine have studied this issue, and the data strongly suggest that SEPs do not increase drug use nor do they increase the number of new IVD users. (See *U.S. General Accounting Office* and *Normand* below.)

2. **Increase criminal activity.** Syringe exchange does not increase criminal activity in the areas where the exchange is taking place. (See *Marx* below.)

3. **Are opposed by communities.** Community acceptance for SEPs has been studied in a number of locales, and generally this has not been found to be an issue. A Baltimore household study found that 65% of individuals in a highly impacted neighborhood supported SEPs. (See *Keyl* below)

4. **Increase risk of communities’ exposure to discarded syringes.** SEPs have not been found to result in problems of syringe disposal. Using specialized containers as an adjunct to SEPs has been found to be useful. Also, there is good evidence that SEPs actually decrease the prevalence of discarded syringes since exchange means exactly that – you must exchange a syringe in order to receive a new clean one. (See *Doherty* below)

References


