Needle Exchange Programs:
Making a Risky Behavior Safer

Kimberly Swan

Every year in the United States, 40,000 to 50,000 individuals become infected with the human immunodeficiency virus (HIV). Most become infected by participating in male-to-male sex and heterosexual sex; however, 25% of new HIV infections are through the use of intravenous drugs (Beshers, HLH 163 Lecture, 2008). While HIV is not a curable disease, it is certainly one that can be effectively prevented. Illicit intravenous (IV) drug use is a risky behavior, and HIV becomes part of this risk once drug users share their needles. In order to alleviate this issue, needle exchange programs have been designed to distribute clean needles to intravenous drug users (IDUs) in order to decrease needle sharing. As a result, the spread of the virus can potentially be reduced in this population. Just as condom use can help prevent the transmission of HIV during sexual activities, needle exchange programs can reduce the transmission of HIV in IV drug use.

Needle exchange programs (NEPs) attempt to make intravenous drug use safer by not only distributing clean needles to IDUs free of cost, but by also serving as a location where IDUs can discard their used syringes (Syringe Exchange Programs, 2005, ¶3). As its name implies, “exchange” programs require the drug user to return a used syringe in exchange for a new and sterile syringe (Needle Exchange Facts, 2001, ¶4). The premise underlying this exchange process is that by obtaining clean needles, one is less likely to share, and returning the needles removes the availability of such syringes for unsanitary second-hand use. The reason why IV drug users share needles in the first place is due to the fact that there are simply not enough needles easily accessible, and IDUs may not be able to afford syringes that are available (Does HIV Needle Exchange Work?, 1998, ¶5). Dirty needles are then collected and saved by the drug users, for this is all that is available to them. NEPs solve these problems by providing and exchanging free needles, and in doing so, they decrease the number of dirty needles in circulation (Murphy, Kelley & Lune, 2004). In addition to providing IDUs with sterile equipment, many programs go further and have HIV testing on-site, distribute condoms, as well as provide education and counseling about HIV/AIDS, and offer referrals to drug abuse treatments (Syringe Exchange Programs, 2005, ¶5). These are just a few of the many additional services needle exchange programs provide. One can see that NEPs do not solely act as a place from which to obtain needles; instead, they serve as a comprehensive program that provides education and testing, and helps individuals contact other medical services that they may need. By being an all-inclusive program, NEPs can potentially attack
the spread of HIV from a variety of fronts. They have the ability to physically provide clean needles for safer drug use, provide condoms for safer sex, and then educate these individuals about the risky behavior that they partake in. This multifaceted approach certainly appears as though it has the potential to be effective.

Researchers in the United States and abroad have performed copious studies investigating the effectiveness of needle exchange programs in the prevention of HIV in drug users (Needle Exchange Facts, 2001, ¶5). Many of these studies have yielded promising findings. In 1997, Hurley, Jolley and Kaldor investigated the efficiency of NEPs by comparing HIV seroprevalence in intravenous drug users in cities that had NEPs and cities that did not have such programs (Hurley et al., 1997). Seroprevalence refers to “the frequency of individuals in a population that have a particular element (as antibodies to HIV) in their blood serum” (Merriam-Webster Online Dictionary, 2008); thus, this particular study examined the change in the prevalence rate of HIV in the IV drug-user population in a number of cities. According to their analysis, cities without NEPs had an increase of 5-9% in HIV seroprevalence in IDUs, while seroprevalence decreased 5-8% per year in cities with NEPs (Hurley et al., 1997, p. 1799). As hinted above, the authors attribute this evidence of effectiveness to both direct and indirect factors. NEPs directly decreased the seroprevalence number by “lowering the rate of needle sharing and the prevalence of HIV in needles available for reuse” as well as indirectly by making “referrals to drug treatment centres” in addition to providing “condoms, and education about risk behavior” (Hurley et al., 1997, p. 1799). Another research study by Des Jaralai, Marmor and Paone (1996) supports the effectiveness of NEPs, for they found that the population of injecting drug users that used needle exchange programs were “three times less likely to contract HIV than those who do not” (as cited in Richard, Mosier, and Atkinson). This statistic demonstrates how access to sterile needles can efficiently reduce an individual’s risk of contracting this fatal disease. Injecting drug users that have access to sanitary needles are certainly benefitting from such programs, for their risky behavior suddenly becomes less hazardous. Although IV drug use is dangerous in numerous ways: physically, mentally, etc., NEPs are proving to make IV drug use safer. Using drugs will not go away, but what can disappear is the risk of contracting HIV.

While most studies have analyzed the effectiveness of NEPs, another study sought to indirectly seek the difference between IV drugs users that had access to sterile needles through prescriptions, and those who had no access at all. This was done by comparing diabetic IV drug users to non-diabetic IV drug users. In this study, performed by Nelson and colleagues, as cited in Richard, Mosier, and Atkinson, a lower rate of HIV was found in diabetic IDUs. Diabetics, who have a deficiency in insulin production, use syringes for medicinal reasons. Consequently, they have prescriptions
for the needles, and are able to obtain them as needed. Therefore, these diabetic IDUs are at an advantage, for they have a supply of sterile needles that they can use for their illicit drug use. The difference in prevalence between non-diabetic IDUs and diabetic IDUs is astounding: 24.3% and 9.8% respectively (Richard, Mosier & Atkinson, 2002, p. 325). The difference in behavioral pattern between these two groups may be that diabetics are more careful in their injection use, for they have the luxury of obtaining sterile syringes (Richard et al., 2002, p. 325). The diabetics are obtaining needles from a location that guarantees sterility: a pharmacy. This study yielded interesting results, for it demonstrates how just access to clean needles, without additional education, makes a significant impact on the proportion of individuals that contract HIV.

The evidence of the effectiveness of NEPs is striking. This has caused researchers such as Lurie and Drucker (1997) to investigate what would have happened had the United States established a national needle exchange programs in the infancy of the HIV/AIDS crisis. According to the researchers, during the eight year span from 1987-1995, a range of 4,394 to 9,666 HIV cases could have been thwarted (Lurie & Drucker, 1997, p. 606). Lurie and Drucker believe that it would have been entirely possible for the United States to establish a national needle-exchange program, for in 1987 the United Kingdom took measures to start a needle exchange program, and in the same year, France changed its prescription policies (Lurie & Drucker, 1997, p. 607). Therefore, the United States was not blind to these reforms or establishments, and could have performed similar measures in the United States. Had the United States done so, a significant number of individuals would not have contracted this disease, and countless families, friends, and children would not have had to suffer. Adding insult to injury, the researchers also set out to determine the monetary cost of these unnecessary and preventable infections. The amount of money is enormous, ranging from $244 million to $538 million (Lurie & Drucker, 1997, p. 606). Had a national needle exchange been established, this money could have been put to better use. Perhaps this money could have been allotted toward the establishment of NEPs. The researchers estimated that the cost listed above could have operated 161 to 354 NEPs (Lurie & Drucker, 1997, p. 606). With these programs, the health of scores of individuals could have been protected. Instead, this money did not go toward NEPs; rather, it went toward treating preventable HIV infections. This “what-if?” study is demonstrative of the fact that NEPs can in fact save the United States a large amount of money. Therefore, NEPs are not only effective in reducing infections, but they are also cost-effective.

As one can see, NEPs truly have the potential to decrease the prevalence of infection in IDUs. The evidence of their effectiveness has been documented; therefore, one would assume that all of the fifty states would have such programs available. This, however, is not the case. In
2005, there were only 118 NEPs in twenty-seven states. California alone accounted for 22 of these sites, while New York had 9 programs. One barrier to the establishment of such institutions may be cost. The yearly costs are $169,000 to run such a program (Needle Exchange Facts, 2001, ¶9). However, as seen from the above, this is a small price to pay for the countless number of lives that do not have to be touched by this destructive virus.

While the price of such an establishment is certainly a complicated barrier to overcome, another obstacle is states’ paraphernalia laws. These legal issues are much more difficult to conquer, for laws are reflective of beliefs. As of 2001, 49 states, and Washington D.C. had drug paraphernalia laws (State Approaches to Expanded Access to Sterile Syringes, 2001, ¶3). These laws “assign criminal penalties to individuals possessing drug paraphernalia” (Richard et al., 2002, p. 325), and in some states needles fall under this category. NEPs are affected, for most drug paraphernalia laws prohibit the distribution and possession of drug paraphernalia (State Approaches to Expanded Access to Sterile Syringes, 2001, ¶3). This means that needle exchange programs cannot legally distribute needles, nor can drug users be caught in possession with the said syringes. This then increases the amount of needle sharing that occurs. IDUs who believe that they are likely to be searched for violations of drug laws are “more likely to share syringes than those who do not believe themselves to be vulnerable” (Richard et al., 2002, p.324). Drug laws intend to decrease drug use; however, in doing so, such laws only serve to precipitate the spread of HIV by making it difficult for IDUs to obtain needles. To overcome this obstacle to NEPs, sixteen out of the 49 states with paraphernalia laws have created certain stipulations within their drug laws that facilitate a drug user’s access to syringes. For example, there are four states that do not even include syringes within their paraphernalia laws (State Approaches to Expanded Access to Sterile Syringes, 2001, ¶3). These stipulations and exceptions can help needle exchange programs take off.

While needle exchange programs certainly have the potential to make dramatic changes, one of the most difficult battles that needs to be conquered is the controversy behind the issue. Drugs are illegal, and therefore many strongly believe that drug use is wrong (Navarro-Rivera, 2007). Opposition to needle exchange is due to the fact that people see it as breaking their moral beliefs and the distribution of needles gives society an incorrect impression that drug use is ethical. This is an understandable argument; however, drug use is not going to end. Therefore necessary measures should be taken in order to help this unsafe practice become a bit safer. It is not going against moral beliefs, for it is not condoning drug use. Instead, NEPs are trying to educate IDUs as well as help them make connections with drug-abuse facilities. NEPs are trying to be moral by
giving IDUs a chance; if anything, opposition to such programs is the unethical approach.

Other opponents of NEPs believe that providing IV drug users with needles is analogous to giving a box of matches to a pyromaniac (Murphy & Knowles, 2000, ¶4). This argument is convincing, for it relies on human nature: if you have access to something, you may be more willing to partake in certain behaviors. For example, if you are given money, theoretically you are more willing to spend. While this seems as though it would be the case for access to needles, the more needles one has, the more drugs one will do, numerous studies have shown just the opposite. A longitudinal study performed in San Francisco showed a lower rate of new drug users from when the study began to its conclusion (Needle Exchange Facts, 2001, ¶8). Several other studies have shown that such programs do not encourage drug use in the drug-using and non-drug-using populations (Needle Exchange Facts, 2001, ¶8). Furthermore, despite having access to needles, IDUs reported a decrease in the number of times they injected themselves per day, and some days they did not do it at all (Needle Exchange Facts, 2001, ¶8). This may be attributed to the fact that NEPs also serve to connect IDUs with facilities to help them with their addiction. This shows the importance of such sites. From these studies, it certainly can be said that the argument of promoting drug use is unfounded.

Negative opinions against intravenous drug users are also an obstacle for the establishment of NEPs. The argument is that using drugs is an irrational and nonsensical behavior, and therefore it is wrong to assume that such individuals will make sensible choices (Roques, 1997, ¶1). These critics believe that it is absurd to believe that someone who partakes in such a destructive behavior will take the time to consider a healthy choice when they are craving their drug of choice. This argument is certainly heartless: these individuals are humans. While IDUs have made poor decisions in their past, it is not fair to say that they would not consider their health. No one wants an incurable disease, and this truly could serve as a motivation to obtain clean needles. It is wrong to classify IDUs into one category. Everyone has different motivations. The individuals who care about their health will be the individuals that make use of these programs. Those who do not have a high regard for themselves can make the choice to not go. The important fact is those who want to be safe are trying to protect themselves. Even if there is only a handful in a population that wish to seek out clean needles, at least they will have the luxury of doing so if there are NEPs in their area.

While the United States failed to create a national needle exchange program in the 1980s, it is not too late to make a change. Our country has certainly made progress, for there are twenty-seven states that have chosen to establish NEPs. Despite these efforts, it is absolutely imperative that
more sites be created in all fifty states. What is most trying is the fact that
many states that do have NEPs, only have one. While this is better than
none, it is important to realize how this will only help a select population:
those who are close to the site. It is obvious that more programs need to be
founded. States are huge, and one NEP 1,000 miles away from
individuals who need it is simply not helpful. According to the
organization, *AIDS Action*, one needle exchange program can serve just
over 100 clients on a given day (Needle Exchange Facts, 2001, ¶8). Thus,
it is imperative to establish more programs in order for more individuals to
be serviced on a given day. One hundred people in one state is a good
start; however, 1,000 people in one state is even better. These programs
are a window of opportunity for drug addicts. They are not simply there
to distribute needles; instead, NEPs are made to educate individuals and
may even get them into contact with drug rehabilitation programs.
Education can help IDUs in other risk-taking behaviors they may
participate in, such as unprotected sex. NEPs can tackle the spread of HIV
from a variety of fronts. Failure to establish these sites is a lost
opportunity in the battle against the spread of this incurable, devastating
disease.
References


http://www.caps.ucsf.edu/pubs/FS/NEPrev.php


