National HIV/AIDS Strategy Issue Brief

Access to Sterile Syringes for People Who Use Drugs

The National HIV/AIDS Strategy:

- Sets the goal of reducing new HIV infections by 25 percent by 2015 (p.5)
- States that "an important step we can take is to ensure that our laws and policies support our current understanding of best public health practices for prevention and treatment of HIV."(p. 36)
- Finds that access to sterile needles and syringes is a scientifically proven biomedical and behavioral approach that reduces the probability of HIV transmission, increases the probability that drug users will initiate treatment, and does not increase drug use (p. 16)
- Recommends that federal funds should support and local governments should be encouraged to expand access to effective prevention services with the greatest potential for population-level impact for high-risk populations (p.21).

The National HIV/AIDS Strategy does NOT:

- Acknowledge the dramatic gap between the drug users' need for access to sterile syringes in the United States and the extent of current coverage, which falls far short of the goal set by the World Health Organization of reaching 60 percent of drug users in order to contain the HIV epidemic.
- Identify state laws and policies, particularly drug paraphernalia laws, as primary obstacles to the expansion of sterile syringe distribution programs in the United States.
- Propose any plan for "encouraging local governments" to expand access to sterile syringe distribution programs to ensure implementation of the goals of the National HIV/AIDS Strategy to reduce new infections by 25 percent by 2015.

Summary

More than 30 years into the epidemic, we know that comprehensive harm reduction services, including access to sterile syringes, are critical to prevent HIV among people who inject drugs. But throughout the United States, people who inject drugs continue to face serious barriers to obtaining, carrying and using clean needles in order to prevent transmission of disease. A primary barrier is the prohibition of syringe possession and distribution by state drug paraphernalia laws that were enacted prior to the AIDS epidemic and never intended to bar, penalize or restrict necessary public health measures. The limited availability of clean needles to prevent disease is a public health failure on the part of federal and state government that must be addressed in order to ensure that basic public health services that are evidence-based, cost-effective and life-saving are available in our communities.

The evidence is clear that access to sterile syringes for drug users reduces HIV transmission, increases participation in drug treatment, and does not increase drug use. The lifting of the federal ban on funding syringe exchange is a necessary, but insufficient step on the issue of syringe access. Many states cannot implement syringe access programs due to criminal laws that prohibit possession and distribution of syringes. More must be done by the federal government and the states to address criminal laws that are largely responsible for the very limited implementation of syringe access programs in the United States. Reform of these laws is both a public health and human rights imperative.

Taking the steps recommended in this brief will signal that the Office of National AIDS Policy is no longer willing to accept an unacceptable status quo with regard to state laws and policies that permit preventable HIV and hepatitis transmission among drug users. These actions will move the United States closer to meeting its obligations under domestic and international law to protect the right to health and the right of minorities to be free from racial discrimination in public health. Most importantly, these actions will move the goals and vision of the National HIV/AIDS Strategy closer to becoming a reality.

The Importance of Access to Sterile Syringes

Sharing of needles during injection drug use is a major risk factor for the transmission of HIV, hepatitis C, and other blood-borne diseases. Nationally, injection drug users represent 12 percent of annual HIV infections and 19 percent of people living with HIV/AIDS.[1] In the U.S., 16 percent of

[1] CDC ,"HIV in the United States," Factsheet, http://www.cdc.gov/hiv/resources/factsheets/us.htm (accessed October 22, 2010.)

injection drug users are HIV-positive and more than 70 percent are infected with hepatitis C. [2] For drug users, the availability of drug dependence treatment and harm reduction services, including access to sterile syringes, is a key component of the right to health.[3] Access to sterile syringes, like other effective harm reduction measures, "meets people where they are" by acknowledging that they may not be ready or able to stop using drugs, but nevertheless places value on their health and their lives as well as that of their communities.

In the United States, the racial disparities in rates of HIV transmission from drug use are alarming. Despite similar rates of injection drug use among whites,[4] African-Americans who inject drugs are ten times more likely to be diagnosed with HIV than their white counterparts.[5] HIV rates among Latino injectors are five times higher than that among whites.[6] Greater levels of poverty, poorer access to medical care and health insurance, and other indicators of social inequality contribute to this disparity.

Incarceration plays an important role as well. Human Rights Watch and others have documented that blacks and Latinos are imprisoned at grossly disproportionate rates for drug related crimes.[7] Incarceration of drug users has been linked to increased HIV risk, as incarceration disrupts stable networks that limit needle-sharing. [8] Police practices and fear of arrest have been shown to alter the behavior of injection drug users, from avoiding syringe exchange sites to hurried, less hygienic injection to disruption of stable user networks that reduce sharing of needles.[9] These behaviors in turn correlate with higher rates of HIV among injection drug users.[10]

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[2] Strathdee, S. and Stockman, J., "Epidemiology of HIV among injecting and non-injecting drug users: current trends and implications for interventions", Current HIV/AIDS Reports, 7: 2 (May 2010, pp. 99-106; Nelson, P. et al, "Global Epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews, Lancet, 378:9791 August 2011, pp. 571-83.

[3] Universal Declaration of Human Rights, UNGA Res. 217 (111) UN GAOR, 3d Session, Supp. No. 13, UN Doc. A/810 (1948) article 25; International Covenant on Economic, Social and Cultural Rights, adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 UN GAOR (no. 16) at 49, UN Doc. A/6316 (1966), 99 UNTS 3, entered into force January 3, 1976, signed by the United States on October 5, 1977, articles 2, 12. See, General comment No. 14, The Right to the Highest Attainable Standard of Health, Committee on Economic, Social and Cultural Rights, 22nd Session, 2000. For a discussion of syringe access in the context of international human rights law, see, Special Rapporteur for the Highest Attainable Standard of Health, Foreword, "Global State of Harm Reduction 2008: Mapping the Response to Drug-Related HIV and Hepatitis C Epidemics, International Harm Reduction Association, 2008.

[4] 0.18 percent of white and 0.14 of black Americans reported injection drug use between 2006 and 2008. Office of Applied Studies, US Department of Health and Human Services, "Injection Drug Use and Related Risk Behaviors 2009."

[5] US Centers for Disease Control and Prevention, "HIV Infection Among Injection Drug Users- 34 states, 2004-2007", MMWR 1291, 1293 (2009).

[6] Ibid.

[7] Human Rights Watch, Targeting Blacks New York May 2008. http://www.hrw.org/en/node/62236/section/3.

[8] Werb, D. et al, "HIV Rates Associated with Incarceration Among Injection Drug Users: Implications for Public Health- Based Strategies," Journal of Public Health 30: 126 (2008).

[9] Small. W. et al, "Impacts of Intensified Police Activity on Injection Drug Users: Evidence from an Ethnographic Investigation, 17 International Journal of Drug Policy, 85 (2009); Kerr, T., et al, "The Public Health and Social Impacts of Drug Market Enforcement: A Review of the Evidence" 16 International Journal of Drug Policy 210 (2005). Burris, S., et al, "Racial Disparities in Injection-Related HIV: A Case Study of Toxic Law," 82 Temple University Law Review 5: 1263 (2011).

[10] Friedman, S, et al, "Relationships of Deterrence and Law Enforcement to Drug Related Harms Among Drug Injectors in US Metropolitan Areas," 20 AIDS 93 (2006); Burris, S., "Racial Disparities," p. 1270.

Whatever the causes of these dramatic racial disparities, the remedies are clear. The effectiveness of syringe services programs (SSP) in reducing HIV transmission and transmission of hepatitis C has been well documented, globally and in the United States and has been identified as a proven prevention method in the National HIV/AIDS Strategy.[11] Indeed, syringe exchange and other effective harm reduction measures have made injection drug use the *only* mode of HIV transmission that has shown long-term, consistent decline in adults and adolescents since the epidemic began.[12] The presence of syringe exchange programs in a community is correlated with reduction of behavior associated with HIV risk, including needle sharing and use of "shooting galleries" and other locations where needle sharing is high.[13] The presence of exchanges in a community has been correlated with lower rates of HIV transmission, with studies in New York City showing that as the number of syringes available increased, the number of new cases of HIV among injection drug users declined significantly.[14]

SSPs are compatible with the United States' drug control policy. The United States National Drug Control Strategy endorses syringe exchange both domestically as a means to increase linkage to drug treatment and internationally as part of the PEPFAR program's comprehensive package of HIV prevention services for injection drug users.[15]. The US Surgeon General has determined that there is "ample evidence" that syringe exchanges promote entry into drug dependence treatment. [16] Prevention is also extremely cost-effective. In the United States a sterile syringe costs approximately $0.97, while the average lifetime cost of treatment for HIV ranges from $150,000 to $300,000 and treatment for hepatitis C ranges from $100,000 to $300,000 for each person undergoing care.[17]

Syringe Services Programs and the Law

The National HIV/AIDS Strategy endorses access to sterile needles and syringes as a "scientifically proven" method for reducing HIV transmission. The Strategy recognizes the increased risk of HIV among black and Latino drug users and calls for targeting the most effective prevention programs to the populations who need them the most.[18] The Strategy fails to acknowledge, however, that in the

[11] National HIV/AIDS Strategy for the United States, pp. 6,16.
[12] National HIV/AIDS Strategy, p. 6.
[13] Burris, S. et al., "Addressing the Risk Environment for Injection Drug Users: The Mysterious Case of the Missing Cop," 82 Milbank Quarterly, No.1, 125 (2004).
[14] Gibson, D. et al, "Effectiveness of Syringe Exchange Programs in Reducing HIV Risk Behavior and HIV Seroconversion Among Injecting Drug Users", 15 AIDS 1329 (2001); Des Jarlais, D. et al, "HIV Incidence Among Injection Drug Users in New York City 1990 to 2002: Use of Serologic Test Algorithm to Assess Expansion of HIV Prevention Services, " 95 American Journal of Public Health 1439 (2005).
[15] Office of National Drug Control Policy, 2011 National Drug Control Strategy for the United States , pp. 37.74.
[16] Federal Register Notice February 23, 2011, Vol. 76, No. 36. See, e.g. Guydish, J. et al, "Evaluating Needle Exchange: Are there Negative Effects?" 7 AIDS 871 (1993); Hagan, H. et al, "Reduced Injection Frequency and Increased Entry and Retention in Drug Treatment Associated with Needle-Exchange Participation in Seattle Drug Injectors," 19 Journal of Substance Abuse Treatment 247 (2000).
[17] Sansom S., et al., "Cost-effectiveness of newborn circumcision in reducing lifetime HIV risk among US males" PLos ONE 5(1) e8723 (2010); The C. Everett Koop Institute of Dartmouth Medical School, "Hepatitis C: Associated Health Costs - United States," 2011, http://www.epidemic.org/thefacts/theEpidemic/USHealthCareCosts/ (accessed July 22, 2011).
[18] National HIV/AIDS Strategy, pp. 16, 21.

United States, syringe exchange programs only provide sterile equipment for 3 percent of the estimated one billion drug injections each year, and that, in the words of public health experts, "access to sterile syringes through syringe exchange programs and pharmacies remains the undernourished stepchild of HIV prevention."[19]

A recent study of racially-based disparities in injection-related HIV stated:

> The World Health Organization recommends that syringe exchange programs reach at least sixty percent of injection drug users to effectively control HIV. Today, the United States is not close to reaching this level of coverage in *any* major city (emphasis in original). [20]

There are approximately 220 syringe services programs (SSPs) operating in 33 states and the District of Columbia. [21] SSPs are authorized by state law in only 15 states, leaving the remainder to operate under local permission or without an explicit claim to legality.[22]

Legal limitations on access to sterile syringes exist on both the federal and state levels. Between 1988 and 2009, the federal government banned the use of federal funding for syringe exchange programs.[23] Most importantly, federal funding is expressly conditioned on authorization under state and local law.[24] Federal support may now be available, but it is still out of reach in many localities due to state and local laws that present significant obstacles to increasing access to sterile syringes for drug users.

State and local laws limit syringe access by prohibiting possession and/or distribution of syringes for the purpose of injecting illegal drugs under drug paraphernalia laws and they restrict sale of syringes at pharmacies. In 1979, as part of the federal "war on drugs," the Drug Enforcement Administration of the US Department of Justice drafted model drug paraphernalia laws that criminalized syringe possession and were adopted in virtually every US state. [25] Over time, thirty-three states have amended their paraphernalia laws to exempt syringes in response to public health concerns, by excluding syringes themselves or by exempting health-care related sellers of syringes

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[19] Burris, S., "Racial Disparities," p. 1267.
[20] Burris, S., et al, "Racial Disparities," p. 1281.
[21] Kaiser State Health Facts, Sterile Syringe Programs 2011, http://www.statehealthfacts.org/comparetable.jsp?ind=566&cat=11 (accessed September 26, 2011); Harm Reduction Coalition , Local Resources Map, http://www.harmreduction.org/article.php?id=530 (accessed September 26, 2011). Note that these sources both warn that information about syringe access programs changes frequently.
[22] Kaiser State Health Facts, Sterile Syringe Programs 2011; Burris, S., "Racial Disparities."
[23] Health Omnibus Programs Extension of 1988, Pub.L. No. 100-607, section 256.
[24] US Department of Health and Human Services, "Implementation Guidance for Syringe Services Programs," July 2010.
[25] "Drug Enforcement Administration 1975-1980", available on the US Department of Justice website, http://searchjustice.usdoj.gov/search?q=Model+drug+Paraphernalia+Act+site%3Awww.justice.gov%2Fdea&btnG=Search&sort=date%3AD%3AL%3Ad1&output=xml_no_dtd&ie=iso-8859-1&oe=UTF-8&client=default_frontend&proxystylesheet=default_frontend&entqr=0&ud=1&site=default_collection (accessed September 26, 2011). Regnier 2011, "Civilizing" Drug Paraphernalia Policy: Preserving Our Free Speech and Due Process Rights While Protecting Children (http://law.nyu.edu/ecm_dlv1/groups/public/@nyu_law_website__journals__journal_of_legislation_and_public_policy/documents/documents/ecm_pro_068492.pdf)

such as pharmacists and health care institutions.[26] These amendments reflect the evidence that syringe exchange programs do not increase drug use or drug-related crime.

In many states, however, syringes remain criminalized, and pharmacy laws often impose restrictions that reduce drug users' access to clean syringes. In North Carolina, for example, pharmacists retain discretion to reject attempted syringe purchases, and drug users told Human Rights Watch that they were turned away at pharmacies.[27] In North Carolina, a 2009 study revealed that African-Americans are the group least likely to access sterile syringes through pharmacy sales. [28]

Public health officials often support syringe exchange but are reluctant to take action that they fear may conflict with drug control regulations or other restrictions relating to injection equipment. Jeffrey McDowell, Executive Director of the Atlanta Harm Reduction Center, confirmed the need for clarification of laws surrounding syringe exchange. The center's clean syringe program has been operating openly for 16 years with the support of local police, who "see the benefits of the program" not only for drug users but for police officers as SEPs reduce injuries from hidden and discarded syringes.[29] Georgia law specifically prohibits the exchange of syringes and other "drug-related objects."[30] Georgia 's drug paraphernalia laws exempt the sale of syringes by pharmacists[31], but according to Mr. McDowell, "nobody knows that, so people avoid buying clean needles. The laws need to be clear and people need to be educated as to what the law really means."[32]

Mr. McDowell told Human Rights Watch:

> State health officials privately support syringe exchange, but tell me they can't support it publicly due to the criminal laws. The new prevention funds under the 12-city project can't go to needle exchange. The federal ban may have been lifted, but it hasn't meant a thing to us here on the ground.[33]

Florida is a state with an estimated 96,300 injection drug users, 20 percent of whom are HIV-positive.[34] In Florida, however, the syringe distribution program consists of two lone individuals

[26] Burris, S. "Racial Disparities."
[27] North Carolina Administrative Code Title 21, Pharmacy, Section 1800; Human Rights Watch interviews with Linda L., and Stan D. (pseudonyms used to protect confidentiality),Greensboro N.C. , April 11, 2011.
[28] Costenbader, et al, "Racial Difference in Acquisition of Syringes from Pharmacies Under Condition of Legal but Restricted Sales", International Journal of Drug Policy, doi;10.1016/j.drugpo.2009.12.006 (accessed October 22, 2010.)
[29] Human Rights Watch telephone interview with Jeffrey McDowell, Atlanta Harm Reduction Center, November 11, 2010.
[30] Georgia Code Annotated, Section 16-13-32 (c).
[31] Ibid.
[32] Human Rights Watch telephone interview with Jeffrey McDowell, Atlanta Harm Reduction Center, November 11, 2010.
[33] Human Rights Watch telephone interview with Jeffrey McDowell, Atlanta Harm Reduction Center, August 26, 2011.
[34] State of Florida HIV/AIDS Patient Care Comprehensive Plan and Statewide Coordinated Statement of Need 2009-2012.

struggling to avoid arrest while working in impoverished neighborhoods to provide sterile syringes to drug users.[35]

Advocates argue that express authorization for SSPs is not strictly necessary, as these laws predated the AIDS epidemic, were not intended to impede public health efforts to reduce disease transmission and do not, in fact, apply to distribution of clean needles for health purposes. Some courts have agreed with this interpretation of the drug paraphernalia laws. [36] But as long as these laws exist, they create fear of arrest among people who inject drugs, and create apprehension among public health officials in states like Florida, where officials supportive of SSP have asked the state legislature to pass a specific exemption from the drug control laws.[37]

The experience of the North Carolina Harm Reduction Coalition provides another example of the need for legal clarification surrounding access to clean syringes. An estimated 50,000 injection drug users live in North Carolina.[38] Over the thirty-year course of the HIV/AIDS epidemic, North Carolina has had one of the nation's highest rates of AIDS diagnoses attributable to injection drug use. [39] Mecklenberg County, home to the urban area of Charlotte, has the state's highest rate of new HIV infections, the highest number of deaths from AIDS, and the highest number of deaths from viral hepatitis. [40] Yet there are no syringe exchange programs operating in Mecklenberg County.

North Carolina law permits syringe purchase at pharmacies, but it is a class A misdemeanor to possess or distribute syringes or other paraphernalia that may be used for injection of illegal substances.[41] There were nearly 2000 arrests for illegal possession of drug paraphernalia in 2008. Though not all of these involved syringes, a recent study found that fear of arrest was a likely factor in reducing purchase of syringes in pharmacies, particularly among African-Americans.[42]

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[35] Human Rights Watch interview with John L., (pseudonym used to protect confidentiality) , Raleigh, North Carolina, September 8, 2011; Robin Williams Adams, "Proven Effective, Needle Exchange Banned in Florida," The Ledger, January 16, 2010.
[36] In *Spokane Health District v Brockett*, 120 Wash.2d 140, 839 P.2d 324 (1992) the Washington Supreme Court found syringe exchange programs not prohibited by the state's drug paraphernalia laws. See also Burris et al, "The Legal Strategies Used in Operating Syringe Exchange in the US," 86 American Journal of Public Health 1161 (1996); for analysis of the legality of SEPs in all 50 states, see "Project on Harm Reduction in the Health Care System," Temple University School of Law, http://www.temple.edu/lawschool/aidspolicy/, accessed November 11, 2010.
[37] Robin Williams Adams, "Proven Effective, Needle Exchange Banned in Florida," The Ledger, January 16, 2010.
[38] Friedman, S.F. et al. "Estimating Numbers of Injecting Drug Users in Metropolitan Areas for Structural Analyses of Community Vulnerability and for Assessing Relative Degrees of Service Provision for Injecting Drug Users*," Journal of Urban Health: Bulletin of the New York Academy of Medicine*, vol. 81, no. 3, 2004, p.377-400. Friedman et al. estimate that there are approximately 25,000 injection drug users in urban areas in North Carolina. The North Carolina Harm Reduction Coalition estimates there are an additional 25,000 injection drug users in rural and suburban areas in the state.
[39] Kaiser Family Foundation, State Health Facts, "50 State Comparisons: Estimated Numbers of AIDS Diagnoses Among Adults and Adolescents, By Transmission Category, through 2009."
[40] North Carolina Department of Health and Human Services, Epidemiologic Profile for HIV/STD Prevention and Care Planning, December 2010 and Detailed Mortality Statistics 2009.
[41] North Carolina General Statutes 90-113.22.
[42] Costenbader, et al, "Racial Difference in Acquisition of Syringes from Pharmacies Under Condition of Legal but Restricted Sales", International Journal of Drug Policy, doi;10.1016/j.drugpo.2009.12.006 (accessed August 22, 2011.)

It is important to remember that injection drug users are not just statistics but human beings with real lives and families. Stan is a former drug user now doing harm reduction outreach in Greensboro, North Carolina.[43] Stan knows too well the profound health consequences for those who struggle to find clean injection equipment. Stan has been HIV-positive for 25 years, and also has hepatitis C. Stan's wife has HIV, and is experiencing serious health complications from the disease. "Denying access to materials that can save lives is criminal," he said. "I lost my cousins, my sister-in-law, and my first wife to AIDS because of contaminated syringes," Stan told Human Rights Watch. "Drug users have just been forgotten."[44]

Stan goes into crack houses, "shooting galleries," and other places where drug users are found to deliver clean needles, rubbing alcohol, bleach, safer smoking equipment[45] and other harm reduction materials. He told Human Rights Watch that if the drug laws were changed, he "would set up shop on the corner. I would do this work in the open. I could reach many more people who really need it. And people would be able to have a [clean] needle on them when they needed it." [46] Stan is correct to fear arrest if he expands his activities. In June 2011, Linda, one of North Carolina's leading harm reduction advocates, was arrested and faces multiple charges related to syringe possession and distribution.[47]

In South Carolina, 16 percent of people living with HIV acquired it through injection drug use.[48] Advocates have attempted to establish a dialogue with police concerning the need for clean syringe access. Carmen Julious, Executive Director of Palmetto AIDS Life Support Services in Columbia, South Carolina, told Human Rights Watch that she once explored the possibility of needle exchange with local law enforcement. "It was a very short meeting," she said. "They said 'we'll arrest you' and that was that."[49]

The US Government Should Act Urgently to Challenge Harmful State Laws and Policies

All persons have the right to adequate means to protect their health and well being, and governments must protect these rights without discrimination. These fundamental principles are enshrined in the Universal Declaration of Human Rights.[50] Other international instruments address the meaning and scope of the right to health, and international bodies have specifically recognized harm reduction practices as a vital element of the right to maintain one's health and prevent disease. Under

[43] Stan is a pseudonym used to protect confidentiality.
[44] Human Rights Watch Interview with Stan D., Greensboro, North Carolina, April 11, 2011.
[45] E.g. Pyrex pipes, screens, rubber mouthpieces and other equipment designed to enhance sterility and reduce open sores, burns or cuts that can transmit blood to or from a pipe, thereby increasing the risk of viral transmission.
[46] Human Rights Watch Interview with Stan D., Greensboro, North Carolina, April 11, 2011.
[47] Human Rights Watch telephone interview with Linda L., (pseudonym used to protect confidentiality), August 1, 2011.
[48] South Carolina HIV Planning Council, "South Carolina HIV Prevention Plan 2010-14" (October 5, 2009.)
[49] Human Rights Watch interview with Carmen Julious, Executive Director of Palmetto AIDS Life Support Services, Columbia South Carolina, June 15, 2010.
[50] Universal Declaration of Human Rights, UNGA Res. 217 (111) UN GAOR, 3d Session, Supp. No. 13, UN Doc. A/810 (1948) article 25.

international human rights law, everyone has the right to appropriate health care, including people who use drugs and people living with HIV/AIDS and hepatitis.[51] Under other international instruments, the US is also obligated to address racial disparities in the public health and to ensure that minority communities have equal access to HIV prevention, care, and treatment.[52]

> *"Too often, drug users suffer discrimination, are forced to accept treatment, marginalized, and often harmed by approaches which over-emphasize criminalization and punishment while under-emphasizing harm reduction and respect for human rights. This is despite the longstanding evidence that a harm reduction approach is the most effective way of protecting rights, limiting personal suffering, and reducing the incidence of HIV."*
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> Navanethem Pillay, UN High Commissioner for Human Rights, March 10, 2009[53]

The barriers to remedial action are not scientific, but rather legal and political. Thus it is governments, both federal and state, that are accountable for failing to deliver an effective, low-cost method of disease prevention to a primarily minority population.

Every HIV infection among people who use drugs is preventable. Thirty years into the AIDS epidemic, the continued refusal on the part of states to implement proven HIV reduction methods is simply not acceptable. Strong federal leadership is needed here. Modifying the federal ban on funding for syringe exchange programs is a necessary, but insufficient, step when state and local laws continue to limit the ability of public health departments and harm reduction advocates to implement programs. Moreover, the HHS "Interim Guidance" for states on federal funding for syringe exchange conditions federal funding on the compliance with local law and even requires the express approval of local law enforcement. [54]

This is a far cry from the "encouragement" of local governments to implement effective prevention methods that is called for in the National HIV/AIDS Strategy. Syringe services programs are included in the HHS Operational Plans for implementing the Strategy, as the Plan requires HHS, CDC and other health agencies to "develop technical guidance for best practices" for syringe services

[51] ICESCR, articles 2, 12. See also General comment No. 14, The Right to the Highest Attainable Standard of Health, Committee on Economic, Social and Cultural Rights, 22nd Session, 2000.
[52] International Convention on the elimination of all forms of Racial Discrimination, adopted December 21, 1965, G.A. Res. 2106 (XX), annex, 20 UN GAOR Supp. (Npo. 14) at 47, UN Doc A/6014 (1966), 660 UNTS 195, entered into force January 4, 1969, ratified by the United States on November 20, 1994, article 5.
[53] United Nations Office of the High Commissioner for Human Rights (UN OHCHR), "High Commissioner calls for focus on human rights and harm reduction in international drug policy," UN OHCHR Press Release, March 10, 2009, http://www.unhchr.ch/huricane/huricane.nsf/view01/3A5B668A4EE1BBC2C12575750055262E?opendocument (accessed June 6, 2011).
[54] US Department of Health and Human Services, "Implementation Guidance for Syringe Services Programs," July 2010.

programs during fiscal year 2011. [55] However, syringe services programs are *not* part of the Department of Justice's (DOJ) Operational Plan for the implementation of the National HIV/AIDS Strategy, an omission that fails to recognize the barriers posed by state and local laws to expansion of this proven prevention measure. In contrast, the federal implementation plan for DOJ does include a review of state laws concerning HIV criminalization laws and the charge for the Department of Justice to "develop appropriate strategies and guidance" on how to ensure that these laws are aligned with public health objectives. [56] A similar recognition by the DOJ that action is needed to address problematic state syringe access laws is essential as part of a much more pro-active approach to changing the legal landscape surrounding SSPs in the United States.

In developing federal strategy and guidance for addressing state syringe law and policy, there is no need to for a "one size fits all" remedy, as there are numerous options for improving access to sterile syringes that can be evaluated in light of local conditions. Federal government agencies should coordinate an effort targeted to state attorneys general, state public health officials, and harm reduction advocates at the state level that will increase their capacity to reform laws and policies that are denying access to sterile syringes. Removing "syringes" from a state's drug paraphernalia law, as does proposed House Bill 601 in North Carolina, is the most direct and most effective approach. As syringe possession is against the law, other reforms may be rendered impossible or hindered by a cloud of uncertain legality.

There are numerous other actions that states can be encouraged to take to improve the legal environment for syringe access. These include a public health exception to the drug paraphernalia laws, such as the law passed last year in Colorado[57], and state laws that defer approval of SSPs to local jurisdictions, though this approach is problematic as it results in uneven access for state residents. (In October 2011, California modified its local deferral approach to one that permits the state, as well, to authorize syringe exchange in areas deemed high risk for HIV transmission through injection drug use.)[58] Innovative approaches might include the US Department of Justice working with states attorney general to issue opinions confirming that the drug paraphernalia laws are not intended to prevent public health measures such as SSPs. This would heighten awareness of the issue among state law enforcement officials and permit the local health departments to implement SSPs without fear of arrest.

Initial recommendations are set forth below.

[55] US Department of Health and Human Services Operational Plan: Achieving the Vision of the National HIV/AIDS Strategy, February 2011, p. 29.
[56] Memorandum from the U.S. Department of Justice to the Office of National HIV/AIDS Strategy, "Department of Justice Implementation of the National HIV/AIDS Strategy" March 15, 2011, p. 4.
[57] SB 189, signed by Governor Bill Ritter on May 27, 2010.
[58] Diana Marcum, "Governor Jerry Brown Signs Bills Expanding Drug User Access to Syringes," Los Angeles Times, October 11, 2011, http://articles.latimes.com/2011/oct/11/local/la-me-needles-20111011.

Recommendations

To the Office of National HIV/AIDS Policy and the relevant agencies charged with implementing the National HIV/AIDS Strategy, we respectfully submit the following recommendations:

- As a first step, ONAP, SAMHSA, the Department of Justice, CDC and other relevant agencies , should meet to consider options for a proactive approach to increasing syringe access, including considering the formation of a Syringe Access Task Force;
- The Task Force/Department of Justice should review of state laws and policies that are blocking implementation of proven HIV prevention methods for drug users. The Task Force/Department of Justice should draft a revised Model Drug Paraphernalia Law that provides for the decriminalization of syringe possession, distribution and sale, and draft a model State Attorney General's Opinion authorizing sterile syringe distribution for public health purposes. These actions are consistent with the National Drug Control Strategy's "balanced" approach to drug control that prioritizes public health, and should be endorsed by the Office of National Drug Control Policy.
- The Task Force/CDC should work closely with the National Association of State and Territorial AIDS Directors (NASTAD), an organization on record in support of syringe services programs, to increase their capacity to achieve reform of local laws and policies that block expansion of these programs.

These initial steps will signal that the Office of National AIDS Policy is no longer willing to accept an unacceptable status quo with regard to state laws and policies that permit preventable HIV and hepatitis transmission among people who use injection drugs. These actions will move the United States closer to meeting its obligations under domestic and international law to protect the right to health and the right of minorities to be free from racial discrimination in public health. Most importantly, these actions will move the goals and vision of the National HIV/AIDS Strategy closer to becoming a reality.