Bill as Introduced

HB 427 - AS INTRODUCED

1999 SESSION

99-0606
01/09

HOUSE BILL ***427***

AN ACT relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

SPONSORS: Rep. Splaine, Rock 34; Rep. C. Kane, Rock 32; Rep. O'Keefe, Rock 21; Rep. Copenhaver, Graf 10; Rep. DeChane, Straf 6

COMMITTEE: Criminal Justice and Public Safety

ANALYSIS

This bill revises the laws that require a prescription to purchase a hypodermic needle to allow persons, except for persons under 18 years of age, to acquire such needles without a prescription. However, such needles are still to be sold only in registered pharmacies, except for public and nonpublic schools in certain cases. The bill also imposes certain informational requirements and other conditions before such needles can be sold.

This bill also modifies the drug paraphernalia laws applying to syringes.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

99-0606
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord One Thousand Nine Hundred and Ninety-Nine

AN ACT relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Prescription Not Required for Persons Over 18; Other Requirements. Amend RSA 318:52-c to read as follows:

318:52-c Sale of Hypodermic Syringe.

I.*(a)* Hypodermic syringes, needles or any instrument adapted for the administration of drugs by injection shall not be sold except in registered pharmacies. No person shall sell, furnish, or give to any person [~~or persons other than a duly licensed physician, dentist, veterinarian, nurse, podiatrist, pharmacist, or embalmer, or a hospital, sanitarium, clinical laboratory or any other medical institution or a state or governmental agency, or a regular dealer in medical, dental or surgical supplies, or a resident physician or intern or advanced registered nurse practitioner of a hospital, sanitarium or other medical institution~~], ***under 18 years of age,*** an instrument commonly known as a hypodermic syringe, hypodermic needle or any instrument adapted for the administration of drugs by injection without the written or oral prescription of a duly licensed physician, dentist, veterinarian, or advanced registered nurse practitioner. Such prescription shall contain the name and address of the patient, the date of the prescription, the description of the instrument prescribed, and the number of instruments prescribed.

(b) The following conditions shall apply to all purchases of hypodermic syringes or needles:

(1) Pharmacists shall provide to each purchaser at the time of purchase information regarding the safe disposal of hypodermic syringes or needles, including local disposal locations or a telephone number to call for such information, if appropriate.

(2) Pharmacists shall also provide purchasers with information on drug addiction treatment, including a local telephone number to get assistance, if appropriate.

(c) A purchaser shall not be sold more than 10 syringes or needles at any single purchase unless such purchaser has a prescription for a bulk purchase.

(d) The commissioner of health and human services shall adopt rules, under RSA 541-A, relative to:

(1) The content, format, and distribution of any materials required under this paragraph.

(2) Any other matter necessary to administer this paragraph.

II. Public and nonpublic schools, including institutions of higher learning, shall be exempt from the [~~provisions of~~] ***requirement under*** paragraph I ***that such needles be sold only in registered pharmacies*** when the school is purchasing the syringes and needles for use in school science laboratory activities and assignments.

2 Reference Added. Amend RSA 318:52-d to read as follows:

318:52-d Recording and Filing of Prescription. Every person who dispenses, sells, furnishes, or gives away a hypodermic syringe or hypodermic needle or an instrument adapted for the administration of drugs by injection, upon the written or oral prescription of a duly licensed practitioner ***under RSA 318:52-c***, shall record over [~~his~~] ***such person's*** signature the date of sale or furnishing of the instrument and the number of instruments sold. This prescription shall be retained on file for a period of 4 years and shall be open to inspection by any public officer or employee engaged in the enforcement of RSA 318 or 318-B. A prescription filled in accordance with this section shall be sufficient authority, without the necessity of a renewal or reissuance, to permit subsequent sales or the furnishing of hypodermic syringes or hypodermic needles or instruments adapted for the administration of drugs by injection to the person to whom the prescription was issued for a period of one year from the date of its original issuance.

3 Prescription Required For Minors. Amend RSA 318:52-e to read as follows:

318:52-e Control or Possession of Hypodermic or Like Instruments Without Prescription Prohibited ***for Minors***. No person ***under 18 years of age*** shall have under [~~his~~] ***such person's*** control or possess a hypodermic syringe, hypodermic needle, or any instrument adapted for the administration of drugs by injection, [~~except a duly licensed physician, dentist, nurse, pharmacist, podiatrist, veterinarian, embalmer, a manufacturer or dealer in embalming supplies, registered wholesale druggist, manufacturing pharmacist, manufacturer of surgical instruments, official of any government having possession of the articles covered by this section by reason of his official duties, paramedical personnel acting under the direction of a physician, dentist, or advanced registered nurse practitioner, employees of a hospital, sanitarium or other licensed medical institution acting under the direction of its superintendent or officer in immediate charge, a carrier or messenger engaged in the transportation of such articles during the official performance of his duties, or a~~] ***unless the*** person [~~who~~] has received a written or oral prescription issued under RSA 318:52-c. For the purpose of this subdivision, no such prescription shall be valid which has been outstanding for more than one year. [~~Provided, however, that the industrial use of hypodermic syringes, needles or instruments in any manufacturing process not utilizing drugs shall not be prohibited, so long as such use is under the proper supervision of a designated person or persons; and such hypodermic syringes, needles or instruments may be purchased for such use from a registered drug store without a written or oral prescription issued under RSA 318:52-c.~~]

4 Injecting Deleted. Amend the introductory paragraph of RSA 318-B:1, X-a to read as follows:

X-a. "Drug paraphernalia" means all equipment, products and materials of any kind which are used or intended for use or customarily intended for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, [~~injecting,~~] ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of this chapter. It includes, but is not limited to:

5 Inject Deleted. Amend RSA 318-B:2, II to read as follows:

II. It shall be unlawful for any person to deliver, possess with intent to deliver, or manufacture with intent to deliver, drug paraphernalia, knowing that it will be used or is customarily intended to be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, [~~inject,~~] ingest, inhale, or otherwise introduce into the human body a controlled substance.

6 Effective Date. This act shall take effect January 1, 2000.

Committee Minutes

REVISED

CRIMINAL JUSTICE & PUBLIC SAFETY COMMITTEE

1999 Re-Referred Bills

7/2/99

HB 202	legalizing the possession and cultivation of marijuana for medicinal purposes.	**Rep. Sargent, Chair** Rep. Flora Rep. MacDonald Rep. McCarthy Rep. O'Keefe Rep. Robertson
HB 359	establishing a committee to study the rights of a private citizen to pursue a criminal investigation if he or she believes it is not being pursued vigorously.	
HB 427	relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.	
SB 029	relative to the proper sheltering of dogs.	

HB 522	relative to the public's access to sex offender registry information.	**Rep. Christie, Chair** Rep. Andrews Rep. Callaghan Rep. Hansen Rep. Knowles Rep. Rodd Rep. Weare
HB 683	requiring teachers and school administrators to report incidents of disruptive behavior by students.	
HB 713	relative to penalties for multiple DWI offenses.	
SB 088	relative to penalties for third driving while intoxicated offenses.	
SB 143	relative to penalties for incest.	

HB 254	relative to restricting the fire marshal's authority in certain municipalities.	**Rep. Welch, Chair** Rep. Berube Rep. Doucette Rep. Mikowlski Rep. Pepino Rep. Schanda
HB 282	relative to bomb dogs and making an appropriation therefor.	
HB 312	restricting the carrying of firearms in courthouses.	
HB 478	prohibiting smoking in all areas of prisons.	
HB 631	authorizing the department of safety to issue photographic identification cards to persons required to have criminal background checks for employment or other lawful purposes.	

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 427 Date 3-2-99

Committee CJ + PS

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Rep. Tim McGough	Merrimack, NH		Hills-18		✓
Rep Trisha O'Keefe			Rock 21	✓	
FRANK G CASE	NOTTINGHAM			✓	
Rep. Geneva Rowe				✓	
Rep Carol Moore				✓	
Lisa K Carpenter	Concord	228-3322	NH Nurses' Assoc.	✓	
JEFFREY D. TOFFIC R.N.	ENFIELD	632-7608	SELF	✓	
PETE GIESE	NH Chief's Association				✓
Rep Margaret A. Case	Rock Dist II			✓	

Hearing Minutes

HOUSE COMMITTEE ON CRIMINAL JUSTICE AND PUBLIC SAFETY

PUBLIC HEARING ON HB427

BILL TITLE: relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

DATE: March 2, 1999

LOB ROOM: 204 **Time Public Hearing Called to Order:** 3:03 PM

Time Adjourned: 4:30 PM

(please circle if present)

Committee Members: Reps. Welch, Christie, Hansen, Dunham, Sargent, Pepino, Flora, Mikowlski, Fesh, MacDonald, Weare, Andrews, J. Johnson, Knowles, Doucette, Berube, Schanda, O'Keefe, McCarthy, Robertson, Callaghan and Rodd.

Bill Sponsors: Rep. Splaine, Rock 34; Rep. C. Kane, Rock 32; Rep. O'Keefe, Rock 21; Rep. Copenhaver, Graf 10, Rep. DeChane, Straf 6

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

See Attachments

New Hampshire House of Representatives
Criminal Justice and Public Safety Committee
Committee Minutes

Bill Number - HB 427 **Date of meeting** - March 2, 1999
Presiding - Rep. David A. Welch, Chairman

Testifying:

*1. Rep. J. Splaine, Rockingham Dist. # 24, sponsor, in support. **(See written testimony.)** a) Dirty needles spread disease; best to have clean needles. Has had at least 45 friends die of AIDS. If one AIDS case is stopped by clean needles, this bill is worth it.

*2. Rep. M. Copenhaver, Grafton District # 10, co-sponsor, in support. **(See written testimony.)** Feels bill should have been heard in Health and Human Services. Has material put out by Center of Disease Control.

*3. Bill Kassler, Dept. of Health and Human Services, (271-4273), in support. **(See written testimony.)** In answer to question: Problem on recycled needles or needle stick injuries are unknown.

4. Peter Giese, Enfield Police Dept., and Police Chiefs Assn., (632-7501), in opposition. State is on the verge of a heroin epidemic. Have had some deaths in young people. This bill is trying to take care of one problem by accelerating another.

5. David Minnis, N.H. Pharmacists Assn. (228-8191), in support. Shouldn't be put into effect until rules are adopted and in effect. Pharmacist aren't going to sell needles to just anyone who walks in. Discussion between Rep. Andrews and Minnis re: selling or not selling.

*6. Gerry Scoppettuolo, President, Gay Men Fight AIDS, Inc, a Lifeguard Project, P.O. Box 4342, Portsmouth, NH, in support. **(See written testimony.)** Clean needles will help reduce HIV transmission.

*7. Georgia Tuttle, physician, N.H. Medical Society, 129 Mechanic St., Lebanon, NH (448-1071), in support. **(See written testimony.)** IV drug use is the 2nd leading cause of HIV transmission. Bill does not provide free needles; allows people to buy clean needles.

In answer to question from Rep. Welch: Addiction is a disease. Many bright people are caught in a trap of addiction.

Rep. Welch asked re: disposal of needles. Response: Give people information at the pharmacy; sharp boxes, etc. Proper disposal will be more likely.

In answer to question from Rep. Christie, Jr. Life of HIV virus on needle is about 6 hours; Hepatitis B – up to 1 week.

8. Frank Case, 44 Beacon Head Rd., Nottingham (895-2716), serves on Board Of Pharmacy; they are all in favor, though haven't formally voted. 10 syringes costs about $ 2 or 3. Taking syringes back takes special handling and can cost 4 or 5 times more than the syringes themselves. Diabetics use many; doesn't see disposal problem. Pharmacists don't necessarily want to dispose of them.

In answer to question: Disposal in sharps container would be better than throwing them on the ground.

Sub-committee appointed: Chair-Rep. Sargent; Reps. Christie, Jr., Rodd, O'Keefe

Maxwell D. Sargent

Rep. Maxwell D. Sargent - Clerk

Sub-Committee Actions

HOUSE COMMITTEE ON CRIMINAL JUSTICE AND PUBLIC SAFETY

SUBCOMMITTEE WORK SESSION ON HB 427

BILL TITLE: relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

DATE: March 24, 1999

Subcommittee Members: Reps. Sargent, Chair; Christie, Jr., O'Keefe, Rodd

Comments and Recommendations: Several important questions concerning needle disposal, participation by pharmacists; addicts crossing state lines to buy syringes, etc. were difficult to answer and to seek data for. So, the committee determined more time was needed for some in-depth research.

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, (Re-Refer,) Interim Study (Please circle one.)

Moved by Rep. Sargent

Seconded by Rep. O'Keefe

Vote: 4-0

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Maxwell D. Sargent
Subcommittee Chairman/Clerk

Criminal Justice and Public Safety Committee
Subcommittee Work Session
HB 427 9/29/99

Attending: Chair: Rep. Maxwell D. Sargent; Reps. Flora, McCarthy, Robertson
Others: Brook Dupee, Dept. of H.& H.S.; Frank Case, Board of Pharmacy

B. Dupee: Summarized in a letter the H & HS position; favors. Also responded in letter to questions from previous meeting.
F. Case: May run into problems with drug paraphenalia laws if we change the law in this area. Board of Pharmacy is not opposed to the bill; rather is neutral. In N.H. most pharmacy decisions will be made in larger corporations much higher up the ladder, re: whether or not to sell syringes. He doesn't believe that prescriptions should be necessary for purchase of needles. Pharmacists would not want to do the disposal. Syringe laws are very old, before drug use was a problem. This would be removing a legislative barrier. Drug use is not going down. Adding a sharps container requirement woud encumber what the legislature is trying to do.
Hepatitis is a very big problem. Suggests hand-out vs. counseling. Agrees with lines 18-27 of the bill.

Rep. Robertson moved Ought to Pass. Rep. McCarthy seconded.
Vote: 4-0

Notes by Rep. Flora.

Study Bill # HB 427 **Date** 9/29 **1999**

Motion by	OTP	OTP-A	ITL
Robertson	✓		

Members in attendance	Present	Aye	Nay
Rep. Sargent, Chair	✓	✓	
Rep. Flora	✓	✓	
Rep. MacDonald			
Rep. McCarthy	✓	✓	
Rep. O'Keefe			
Rep. Robertson	✓	✓	
TOTAL			

Report

The committee spent considerable time discussing the positive aspects of lifting the prescription requirement and also on the aspect of proper disposal of needles and syringes. Needle disposal is becoming a recognized issue, with disposal containers appearing in drug stores, etc. Removing the prescription requirement does not increase use of IV drugs, but may well reduce transmission of disease. This bill also mandates literature about proper disposal methods and information about illegal drug use, drug addiction and where to seek help.

Sub-Committee Minutes

New Hampshire House of Representatives
Criminal Justice and Public Safety Committee
Sub-Committee Minutes

Bill Number - HB 427 **Date of meeting** - March 10, 1999
Presiding - Rep. Maxwell D. Sargent, Sub-Committee Chairman

Attending: Chief Giese, Enfield Police Dept. (632-7501); Dr. Bill Kassler, N.H. Public Health (271-8560); Janet Monahan, N.H. Medical Society (spoke briefly in support of bill); Rep. Tim McGough; Rep. Jim Splaine, prime sponsor of bill; David Minnis, N.H. Pharmacists Assn.; Jeff Toffic, N.H. Nurse's Assn. (632-7608), in strong support with Ms. Carpenter from same assn.; Rep. Cecelia Kane; Rep. Marian Copenhaver dropped off written materials.

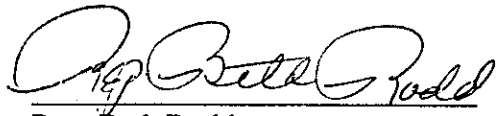
Sub-committee members attending: Reps. M. Sargent, B. Rodd, P. O'Keefe, A. Christie, Jr.

1. David Minnis, Pharmacist's Assn., no position. However, requires an amendment re: date of implementation until after rules have been adopted and materials made which are to be distributed. Estimates for a pharmacy to dispose of 45,00 needles, approx. $35. (Rep. Tim McGough says more like $30 – $50 per pound.
2. Jeff Toffic, RN, N.H. Nurse's Assn. Supports. Notes no problems in other states with disposal issues. Some hospitals provide disposal bins. Nurse's Assn. Would like to see an amendment related to disposal to reduce HIV/Contagious diseases. Rep. O'Keefe asked what Maine does re: disposal. Mr. Toffic will check.
3. Rep. Tim McGough, opposes because it puts more needles on the street. Supports removing prescription requirement for diabetics. He doesn't believe heroin addicts are responsible enough to attend to disposal.

Question was asked if diabetics receive a disposal container automatically when they buy needles – No.

4. Dr. Bill Kassler, Public Health, supports. Annual HIV infection stats in N.H. are a guess – 100 to 150? This and Hepatitis B & C move into the whole community; to families and children. 25% of HIV cases result from dirty needles. Less of a surveillance system for Hepatitis – not a reportable disease.
5. Chief Gese, opposes. No stats on Aids related deaths in N.H. No deaths in Enfield from AIDS, but there are drug overdoses. Feels that proliferation of needles will encourage drug use. Agrees even diabetics should have disposal container.

Statistics of 1997. 47 persons died of aids in N.H. Which is 3.3 per thousand. Dr. Kassler feels that pharmacists would welcome opportunities to educate community members. Evidence in CT indicated very strongly that clean needles decreases multiple use of dirty needles. Public Safety (EMT's, Police, etc.) needle stick injuries decreased with program. This bill decriminalizes needles, but does not encourage drug use. Evidence strongly indicates that clean needle use does not serve to recruit new users. Self preservation instinct in drug users – if clean needles are available, they will buy them. Largest number of new AIDS patients are minorities, women, Afro-Americans. Pre-natal care has reduced inter-uterine transmission by 40 – 60%.



Rep. Beth Rodd

State of New Hampshire

HOUSE OF REPRESENTATIVES
Legislative Office Building, 33 North State Street
Concord, NH 03301-6328

TEL: (603) 271-3418
TDD Access: Relay NH 1-800-735-2964

COMMITTEE ON CRIMINAL JUSTICE AND PUBLIC SAFETY

MEMORANDUM

TO: **Re-referred HB 202, HB 359, HB 427, SB 29-L Subcommittee Members**
Rep. Kathleen M. Flora
Rep. Kenneth J. MacDonald
Rep. William J. McCarthy
Rep. Patricia M. O'Keefe
Rep. Timothy N. Robertson

FROM: **Rep. Maxwell D. Sargent, Subcommittee Chair**
PO Box 948, Hillsboro, NH 03244-0948
(603) 464-4073 / puddy42@yahoo.com

DATE: **August 27, 1999**

SUBJ: **Re-referred HB 202,** legalizing the possession and cultivation of marijuana for medicinal purposes.
Re-referred HB 359, establishing a committee to study the rights of a private citizen to pursue a criminal investigation if he/she believes it is not being pursued vigorously.
Re-referred HB 427, relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.
Re-referred SB 29-L, relative to the proper sheltering of dogs.

Enclosed please find materials as promised at our last subcommittee work session of August 25, 1999 on the above-referenced re-referred bills.

Please be reminded of the upcoming subcommittee work sessions that are scheduled for Wednesday, September 8, 1999 (10:00 a.m. in Room 202, LOB) and Wednesday, September 22, 1999 (10:00 a.m. in Room 205, LOB).

Also, please note that the full Criminal Justice and Public Safety Committee will meet on October 26 (and 27, if necessary) to act on all our re-referred bills.

Should you have any questions or unable to attend the work session, please do not hesitate to contact me.

MDS/laz
Enclosures
cc: Marie-Hélène Bailinson, Committee Researcher

Criminal Justice & Public Safety Committee
Re-referred bills
Meeting Notes

August 25, 1999

HB 202 -

Rep. D. Welch: will obtain web site address re: legalizing marijuana and other issues.

Rep. M. Sargent will give copies of public hearing minutes, and other material on this bill and the following 3 bills to M. Bailinson to copy and mail to all sub-committee members.

Rep. Flora: Stated that the problems some had with the bill were the issues of who is the primary care giver and the laundry list of diseases mentioned.

J. Monehan, N.H. Medical Society stated that Medical Society is still opposed in favor of merinol. Also, stated that marijuana for medical purposes is legal in Alaska, Oregon, Washington, California, Arizona and Nevada.

Brook Dupee, H.& H. S. - will scope out the department's stand, if any, etc.

Suggested that we should contact Peter Grasso, Board of Pharmacy, as he testified on this issue before the Health & Human Services Committee previously.

HB 359

Rep. D. Welch will try to locate newspaper clippings re: cases which have been brought back with new evidence. Suggests that we contact the Atty. General's office about: 1) How many cases are still pending, (active, not prosecuted); How many have been brought back after many years, and prosecuted. DNA evidence could help resurrect dormant cases.

M. Bailinson said Colorado has a statute, but relates to a special prosecutor, and N.H. doesn't have a special prosecutor statute. She will research how often they may have used it and the outcome.

HB 427

Discussion centered around needle disposal. How was it handled in CT; results? It was reported that 95% of pharmacists in Maine opted to sell needles without proof of medical need.
Maine and Vermont have no prescription requirement.
Suggested that we contact former police chief Nicolas Pastore in CT who favors this type of law, and for the same meeting, invite someone from the NH Chiefs of Police.
Also, contact Nashua Chief; Nashua was invited to be a needle exchange site. Also, Nashua is working on needle disposal protocol.

Rep. Sargent will fax Brook Dupee questions the committee has to pass on to Dr. Kessler.

Rep. Sargent received results of a N.H. Hospital Assn. survey of hospitals re: needle disposal, and will present a summary at next meeting.

SB 29-L

Rep. Phinizy and Russel Pope, (has prosecuted animal cruelty cases for 13 years), spoke to present RSA's and how they believed present law was sufficient. In fact, this bill weakened present law as in some areas, cruelty would be dropped from a misdemeanor to a violation. They agreed that the definition of shelter in this bill is good, and could be inserted into present law. Rep. Phinizy talked about the Illinois law which was quite specific, but which also required enforcers to be trained. Rep. Phinizy will speak with Sen. Cohen and the other bill sponsors too see if they agree with replacing the entire bill with just the shelter definition.

Criminal Justice & Public Safety Committee
Re-referred bills
Meeting Notes

August 25, 1999

HB 202 -

Rep. D. Welch: will obtain web site address re: legalizing marijuana and other issues.

Rep. M. Sargent will give copies of public hearing minutes, and other material on this bill and the following 3 bills to M. Bailinson to copy and mail to all sub-committee members.

Rep. Flora: Stated that the problems some had with the bill were the issues of who is the primary care giver and the laundry list of diseases mentioned.

J. Monehan, N.H. Medical Society stated that Medical Society is still opposed in favor of merinol. Also, stated that marijuana for medical purposes is legal in Alaska, Oregon, Washington, California, Arizona and Nevada.

Brook Dupee, H.& H. S. - will scope out the department's stand, if any, etc.

Suggested that we should contact Peter Grasso, Board of Pharmacy, as he testified on this issue before the Health & Human Services Committee previously.

HB 359

Rep. D. Welch will try to locate newspaper clippings re: cases which have been brought back with new evidence. Suggests that we contact the Atty. General's office about: 1) How many cases are still pending, (active, not prosecuted); How many have been brought back after many years, and prosecuted. DNA evidence could help resurrect dormant cases.

M. Bailinson said Colorado has a statute, but relates to a special prosecutor, and N.H. doesn't have a special prosecutor statute. She will research how often they may have used it and the outcome.

HB 427

Discussion centered around needle disposal. How was it handled in CT; results? It was reported that 95% of pharmacists in Maine opted to sell needles without proof of medical need.
Maine and Vermont have no prescription requirement.
Suggested that we contact former police chief Nicolas Pastore in CT who favors this type of law, and for the same meeting, invite someone from the NH Chiefs of Police.
Also, contact Nashua Chief; Nashua was invited to be a needle exchange site. Also, Nashua is working on needle disposal protocol.

Rep. Sargent will fax Brook Dupee questions the committee has to pass on to Dr. Kessler.

Rep. Sargent received results of a N.H. Hospital Assn. survey of hospitals re: needle disposal, and will present a summary at next meeting.

SB 29-L

Rep. Phinizy and Russell Pope, (has prosecuted animal cruelty cases for 13 years), spoke to present RSA's and how they believed present law was sufficient. In fact, this bill weakened present law as in some areas, cruelty would be dropped from a misdemeanor to a violation. They agreed that the definition of shelter in this bill is good, and could be inserted into present law. Rep. Phinizy talked about the Illinois law which was quite specific, but which also required enforcers to be trained. Rep. Phinizy will speak with Sen. Cohen and the other bill sponsors too see if they agree with replacing the entire bill with just the shelter definition.

Criminal Justice and Public Safety Committee
Subcommittee Work Session
HB 427 9/8/99

Attending: Chair: Rep. Maxwell D. Sargent; Reps. Flora, McCarthy, Robertson
Others: David Ayotte, Dr. Kessler; Marie Bailinson, committee researcher

Dr. Kessler that there are approx. 6,000 IV drug users in N.H.
Question: In states that have lifted prescription requirements, is there a needle exchange/disposal program? Referred to extensive effects with change of law in CT. Submitted extensive written testimony.
Rep. Robertson: In the states listed, has there been any attempt to educate pharmacists regarding the need to make needles more accessible?
M. Bailinson: Connecticut found the need to educate pharmacist on these issues.
Rep. Sargent asked if Peter Grasso could come in to address this issue, too.
Question: When we made prescription a requirement, did it increase the cost of needles.
Did other states provide for disposing? If prescription requirement removed, does cost go down? Or if we put in a requirement for a disposal container, what's the cost?
Rep. Sargent passed out an article on the Salem needle stick at McDonalds, and a N.H.Hospital Assn. survey on what hospitals are doing now re: disposal. Of the 17 responses, 11 have disposal programs, 8 of which can be used by the community, anonymously.
Rep. Sargent: Attended a hearing on methadone bill in the House Health and Human Services Committee. There is presently a study going on re: heroin users in N.H. Susan Langley gave testimony. We could use info from this study. He will ask her to provide us with the info.
D.Ayotte: AIDS expert in state had no idea of number of heroin users in state.
Rep. Flora: suggest we also get data from drug treatment organizations in the state. She will contact someone from New Futures for the next meeting.
Rep. Sargent: Should ask Nicholas Pastore, ex police chief of New Haven, CT. to come in along with someone from the Police Chiefs Assn. of N.H.

Notes by Rep. Flora.

State of New Hampshire

HOUSE OF REPRESENTATIVES
Legislative Office Building, 33 North State Street
Concord, NH 03301-6328

TEL: (603) 271-3418
TDD Access: Relay NH 1-800-735-2964

COMMITTEE ON CRIMINAL JUSTICE AND PUBLIC SAFETY

MEMORANDUM

TO: **Re-referred HB 427 Subcommittee Members**
Rep. Kathleen M. Flora
Rep. Kenneth J. MacDonald
Rep. William J. McCarthy
Rep. Patricia M. O'Keefe
Rep. Timothy N. Robertson

FROM: **Rep. Maxwell D. Sargent, Subcommittee Chair**
PO Box 948, Hillsboro, NH 03244-0948
(603) 464-4073 / puddy42@yahoo.com

DATE: **September 13, 1999**

SUBJ: **Re-referred HB 427,** an act relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

The next subcommittee work session on re-referred HB 427 is scheduled for Wednesday, September 22, 1999 at 10:00 a.m. in Room 205 of the Legislative Office Building. Enclosed is some information relative to our study.

Should you have any questions or unable to attend the work session, please do not hesitate to contact me.

MDS/laz
Enclosure
cc: Marie-Hélène Bailinson, Committee Researcher

New Hampshire Hospital Association

June 18, 1999

The Honorable Maxwell Sargent
Criminal Justice & Public Safety Committee
House of Representatives
P.O. Box 948
Hillsboro, NH 03244-0948

Re: HB 427

Dear Representative Sargent:

Representative Cecelia Kane, the sponsor of HB 427, has asked the New Hampshire Hospital Association to conduct a survey of our member hospitals regarding the safe disposal of hypodermic syringes. Enclosed is the survey we sent out to 26 acute care hospitals throughout the State.

We received seventeen (17) responses. Of these, eleven (11) reported the existence of a needle disposal program in their community. The survey results are enclosed. I've also enclosed two excellent examples of publicizing a community disposal program and educating patients on the proper disposal of syringes.

The survey results demonstrate that safe needle and syringe disposal can be accomplished within communities. Legislation which permits over-the-counter purchase of needles and syringes is an important step toward reduced sharing of needles, making it the most effective practice for limiting the transmission of blood borne infections. Published studies have demonstrated that access to clean needles decreases HIV transmission and that legal access to clean needles does not increase drug use.

Finally, with effective community education on effective SHARPS disposal, coupled with accessible disposal sites, our communities can provide patients, who routinely use syringes for medical purposes, with more options for safe disposal.

125 Airport Road ❑ Concord, NH 03301-7300 ❑ 603.225.0900 ❑ Fax: 603.225.4346 ❑ http://www.nhha.org

Please call on us for any other information you need as you study this most important public health issue.

Sincerely,

Leslie K. Melby

Leslie Melby
Vice President
Strategic Alliances

Enclosures

cc. Representative Cecelia Kane
Dianne Luby, Director, Office of Community and Public Health, DHHS
William Kassler, MD, Medical Director, DHHS
Donald Messina, NH Pharmaceutical Association

K:\hb427letr.doc

New Hampshire Hospital Association

NEW HAMPSHIRE HOSPITAL ASSOCIATION
SYRINGE DISPOSAL SURVEY
HB 427

SHARPS Disposal Program

- The public may obtain free SHARPS containers from the hospital and return them when filled. (5 hospitals)
- The public may bring SHARPS to the hospital (no mention of providing a container) (4 hospitals)
- Physician office staff, VNA and school nurses deliver SHARPS they collect to the hospital (2 hospitals)

Publicity

- Health care personnel in the community are informed of the program (4 hospitals)
- Flyers, newspaper advertisements (3 hospitals)
- Not publicized (4 hospitals)

Accessibility of Drop Sites

- Can only be dropped off at the hospital (7)
- No response (4)

Anonymity of Drops

- Yes (3 hospitals)
- No (8 hospitals)

Self-Locking SHARPS Containers

- Yes (8)
- Sometimes (3)

Hospitals' SHARPS Container Disposal

- Shipped out through biohazard disposal company (6)
- Incinerator (5)

In the absence of a community disposal program, how do community members who routinely use syringes for medical purposes dispose of them?

- Use of a rigid plastic container (laundry detergent bottle) and place in household trash (4 hospitals)

Do area pharmacies provide SHARPS containers with syringe prescriptions?

- No (15 hospitals)

Would consider starting a SHARPS program if it doesn't currently exist at the hospital

- Yes (4 hospitals)
- No (2 hospitals). Issues: no space; legal concerns regarding accepting regulated waste from non-licensed sources.

New Hampshire Hospital Association

TO: CEOs
FR: Gina Balkus, VP Public Affairs
RE: Syringe Disposal Survey
DT: April 20 1999

The House Criminal Justice and Public Safety Committee is working on a bill which removes the prescription requirement for obtaining and purchasing hypodermic syringes. The bill will likely be sent to study, but in the meantime its sponsor, Rep. Cecelia Kane, an ardent advocate for needle exchange programs, has come to us for help in researching this issue.

This survey hopefully will resolve many of the unresolved issues or at least shed a little light on the subject for the subcommittee. We would greatly appreciate if you or the appropriate person in your facility could **respond to this survey by Friday, April 30 1999. Completed surveys may be faxed to Miriam Watson at (603) 225-4346.**

Please let me know if you have any questions. Thanks for your help!

Does your facility have a formal or informal SHARPs disposal program in your community?
_____ yes _____ no

If so, please describe:_____
_____
_____

How is it publicized in your community? _____
_____

How accessible are drop sites in your community? _____
_____

Are drops made anonymously? _____ yes _____ no

Are needles contained in a self-locking SHARPs containers? _____ yes _____ no

How are SHARPs containers disposed of in your facility? _____
_____

If you do not have a SHARPs disposal program, how do community members who routinely use syringes for medical purposes (i.e. diabetes and allergy shots) dispose of them?
_____
_____

Do pharmacists in your area provide SHARPs containers as syringe prescriptions are being filled?
_____ yes _____ no

If you do not have a SHARPs disposal program, would you consider starting one at your facility?
_____ yes _____ no

If not, why not? _____
_____
_____

125 Airport Road ❑ Concord, NH 03301-7300 ❑ 603.225.0900 ❑ Fax: 603.225.4346 ❑ http://www.nhha.org

Criminal Justice and Public Safety Committee
Subcommittee Work Session
HB 427 9/22/99

Attending: Chair: Rep. Maxwell D. Sargent; Reps. K. MacDonald, W. McCarthy, K. Flora, T. Robertson. Others: Janet Monahan, N.H. Medical Society; Brook Dupee, Health and Human Services; Marie Bailinson, committee researcher

Peter Grasso, Board of Pharmacy, was invited to attend, but wasn't there. Also, Susan Langley from H.H. S., Behavioral Health re: study on number of drug users.
Brook Dupee: Dept. supports needle exchange and the the prescription repeal bill.
Rep. Sargent: Dr. Kassler estimates 6,000 ID users in the state. If the bill passed, would pharmacies sell them?
Rep. Flora: Suggested that a requirement for sharps containers being sold in tandem with the syringes should be added to the bill.

Notes by Rep. O'Keefe

Testimony

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF COMMUNITY AND PUBLIC HEALTH

6 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4716 1-800-852-3345, Ext. 4716 TDD Access: 1-800-735-2964

Donald L. Shumway
Commissioner

Dianne Luby
Director

September 28, 1999

The Honorable Maxwell Sargent
Chairman
Subcommittee on HB 202 & HB 427
PO Box 948
Hillsboro, NH 03244

Post-it® Fax Note 7671	Date	# of pages ▶
To Rep Sargent	From Brok Duran	
Co./Dept.	Co.	
Phone #	Phone # 271-4716	
Fax #	Fax #	

Dear Representative Sargent:

The purpose of this letter is to provide responses to the questions raised at last week's subcommittee work session regarding HB 202 and HB 427.

HB 202

You asked that a DHHS representative attend the next subcommittee meeting to discuss the Department's response if the Legislature were to legalize the use of marijuana for medicinal purposes. I have relayed your request to our Division of Behavioral Health as they are the proper group within the Department to explain what impact, if any, such legalization would have on the Department's substance abuse programs. They know that the next study committee meeting is scheduled for 10:00 on 9/29 in room 202 of the LOB.

The other question had to do with the increased cost of Medicaid services if marijuana was to become a legally prescribed drug. While we can't say for certain, we believe that any cost increase would be minor given the few instances in which marijuana could be prescribed under HB 202.

HB 427

Question 1: How long can HIV survive in a needle/syringe?

Answer: Under the right conditions (large volumes of blood) several weeks. Under typical conditions (trace volumes), probably hours to days.

Question 2: Is there any prohibition to keep syringes from being sold at department stores or similar venues?

Answer: Other than the statute under consideration, possibly the drug paraphernalia law may have wording related to where syringes may be sold.

Question 3: What are the pro/cons of self-destroying or single use needles?

Answer: We have no actual experience here in New Hampshire, but the following abstract contains useful information:

Des Jarlais DC. "Single-use" needles and syringes for the prevention of HIV infection among injecting drug users. *J Acquir Immune Defic Syndr Hum Retrovirol* 1998;18(suppl 1):S52-56.

Providing single-use injection equipment to persons who inject illicit drugs would appear to be an effective method for reducing HIV transmission. However, interviews with manufacturers, syringe exchange program staff, and drug users revealed numerous difficulties with such a technologic solution. All designs for such equipment can be defeated and should probably be called difficult-to-reuse equipment. There are problems with consumer acceptance of difficult-to-reuse equipment and with safe disposal of large amounts of biohazardous waste. Despite these problems, it would be useful to conduct additional research, particularly on the potential for placing difficult-to-reuse equipment into shooting galleries.

Question 4: Where did DHHS get the estimate of 6,000 IDU in NH number?

Answer: Our Bureau of Substance Abuse Services reports that this number is based on a federal formula called the Marden Formula which is designed to estimate the number of users of various substances.

The only conclusive (although obviously an undercount) number I know of is that approximately 550 of the individuals seen in publicly funded treatment programs each year acknowledge a history of ID use.

I hope that this information is helpful to the subcommittee as you complete your deliberations. Please feel free to contact me if we can be of further assistance.

Sincerely,

Brook Dupee
Legislative Liaison
Office of Community &
Public Health

pc: William Kassler, MD, MPH
State Medical Director/DHHS

Carol Early, RN, Director
Medicaid Administration Bureau/OCPH/DHHS

Susan Langle, esq.
Division of Behavioral Health/OFS/DHHS



LAKES R

Hospital collects used medical needles tomorrow

Also: Free Jazz

Tomorrow from 3 to 7 p.m., Lakes Region General Hospital in Laconia will be holding a "drop-off" for needles used in medical treatment therapies.

Used needles should be brought to the front lobby of the hospital in a closed container like a bleach bottle, or in a hospital-provided "sharps container." The needles will be collected in a clearly marked red receptacle. New sharps' containers will be provided to replace old ones or doled out to anyone making a first-time visit to the drop-off.

The drop-off program began about a year ago.

"The Infection Control Department realized there was a need to provide more safe disposal of used needles in the region," said hospital spokeswoman Bridget Fontaine. "The danger is in the needles not being incinerated properly and the public gaining access to them somehow."

Diabetics and people with hepatitis B make up the majority of needle-users, according to Fontaine. Many have already embraced the program.

"In the last year the hospital received 20 'sharp boxes,' and there's about 30 needles in a box," Fontaine said.

The hospital has needle drop-offs four times a year – in March, June, September and December.

New Hampshire Hospital Association

NEW HAMPSHIRE HOSPITAL ASSOCIATION
SYRINGE DISPOSAL SURVEY
HB 427

SHARPS Disposal Program

- The public may obtain free SHARPS containers from the hospital and return them when filled. (5 hospitals)
- The public may bring SHARPS to the hospital (no mention of providing a container) (4 hospitals)
- Physician office staff, VNA and school nurses deliver SHARPS they collect to the hospital (2 hospitals)

Publicity

- Health care personnel in the community are informed of the program (4 hospitals)
- Flyers, newspaper advertisements (3 hospitals)
- Not publicized (4 hospitals)

Accessibility of Drop Sites

- Can only be dropped off at the hospital (7)
- No response (4)

Anonymity of Drops

- Yes (3 hospitals)
- No (8 hospitals)

Self-Locking SHARPS Containers

- Yes (8)
- Sometimes (3)

Hospitals' SHARPS Container Disposal

- Shipped out through biohazard disposal company (6)
- Incinerator (5)

125 Airport Road ❑ Concord, NH 03301-7300 ❑ 603.225.0900 ❑ Fax: 603.225.4346 ❑ http://www.nhha.org

In the absence of a community disposal program, how do community members who routinely use syringes for medical purposes dispose of them?

- Use of a rigid plastic container (laundry detergent bottle) and place in household trash (4 hospitals)

Do area pharmacies provide SHARPS containers with syringe prescriptions?

- No (15 hospitals) of 17 responses

Would consider starting a SHARPS program if it doesn't currently exist at the hospital

- Yes (4 hospitals)
- No (2 hospitals). Issues: no space; legal concerns regarding accepting regulated waste from non-licensed sources.

FRISBIE MEMORIAL HOSPITAL

FOR IMMEDIATE RELEASE
APRIL 12, 1999

CONTACT:
HILARY DOUGLASS
COMMUNITY RELATIONS
(603) 335-8129

FRISBIE MEMORIAL HOSPITAL TO PRESENT FREE PROGRAM ON SHARPS DISPOSAL

ROCHESTER - In an effort to educate the community on proper disposal of syringes to help protect everyone and the environment, Frisbie Memorial Hospital and BFI Waste Systems of North America are sponsoring a free SHARP (Store Household sharps And Return Properly) Program on Tuesday, April 20, 1999 anytime from 3 to 7p.m. at Frisbie Memorial Hospital.

Keeping our community safe and beautiful is important to us all. Through the SHARP program, everyone has an easy way to properly dispose of syringes and lancets used at home. Simply follow the directions provided by Frisbie Memorial Hospital. There is no cost and it's easy to get started. Working together, we can improve environmental safety which benefits our community.

By joining the program, participants can:

Safely store and properly dispose of used syringes and lancets
Help protect family members, waste collectors and others in your community from accidental needle sticks.
Help prevent your used syringes from falling into the wrong hands.

Bring your used syringes and lancets for disposal through BFI to the workshop. Receive a free home sharps container from manufacturers. The program is simple and easy to follow. All you need to do is:

Obtain your approved home sharps container available free, one time, when you bring your syringes and lancets for disposal.

Place used syringes and lancets in the container. Insert the syringe or lancet into the container, needle first.

(more)

Seal container firmly. When container is full, close lid and seal securely. When the container is full, snap the lid shut. Return filled container to disposal center. Dispose of the container according to local ordinances. Contact Frisbie for information and assistance. Please do not place container in a recycle bin.

To learn more about the SHARP Program, please contact Cindy Cunningham, Frisbie's infection control coordinator at (603) 332-3100, ext. 8119.

-30-

Comm. T

Hospitals without SHARPS Disposal Programs

The Cheshire Medical Center, Keene

- SHARPS are incinerated at the hospital.
- The attached *Disposal Recommendations Memo* is provided to community members.
- Area pharmacists do not provide SHARPS containers when syringe prescriptions are being filled.
- The hospital would consider implementing a SHARPS disposal program.

Concord Hospital, Concord

- SHARPS are incinerated at the hospital.
- Community members put their syringes in hard plastic containers such as Clorox or laundry detergent containers and placed in their trash when full. As part of their diabetic instruction, patients are taught to use BD needle clips which use holds a 2-year supply of needles.
- Area pharmacists do not provide SHARPS containers when syringe prescriptions are being filled.
- The hospital would not consider starting a SHARPS disposal program because there is no space available at the facility.

Exeter Hospital

- Area pharmacists do not provide SHARPS containers when syringe prescriptions are being filled.
- The hospital would consider implementing a SHARPS disposal program as the disposal restrictions become more stringent.

Mary Hitchcock Memorial Hospital, Lebanon

- Community members dispose of their syringes in rigid containers that are put out for trash pick-up for disposal in the landfill.
- Area pharmacists do not provide SHARPS containers when syringe prescriptions are being filled.
- The hospital would consider implementing a SHARPS disposal program, but would need more information before doing so. At the moment, they are unaware of problems related to disposal in their community.

Huggins Hospital, Wolfeboro

- BFI Waste Management disposes of SHARPS for the hospital.
- The hospital does not know how community members dispose of their syringes. Additionally they do now know when area pharmacists provide SHARPS containers as prescriptions are being filled.
- The hospital would not consider creating a SHARPS disposal program.

DRAFT

Lahey Hitchcock Clinic

DRAFT

Lahey Hitchcock Clinic • Keene

To Our Patients Who Use Needles and Syringes at Home,

Please do not bring your used needles and syringes to the Clinic for disposal. Federal OSHA regulations prohibit our being able to accept them.

Over a billion syringes and lancets are used in the United States each year. Improper disposal presents the risk of infection with blood-borne disease such as HIV and Hepatitis. The following guidelines, outlined by the City of Keene (landfill phone # 352-5739) will help you to dispose of used hypodermic syringes and lancets properly:

- Immediately after use, place the lancet and syringe into a rigid plastic container such as a bleach bottle or laundry detergent bottle. The small opening helps to prevent spills and the plastic is hard enough so that needles don't pierce through it.
- Keep the container close to the place where injections and blood glucose tests are done. **Remember: Always keep materials away from the reach of children.**
- When the container is full, replace the cap or lid to seal tightly.
- Mark the container" Medical Waste" (so that it won't be mistaken for plastic to be recycled).
- Dispose of the sealed, labeled container with regular trash.

If you live outside of Keene you should check with your local landfill department for any special guidelines or information.

DRAFT

Committed to caring for the community!

590 Court Street • Keene, New Hampshire 03431-1798 • 603 357-3411 • Fax 603 355-3999

1996

04/26/1999 10:01 6033552090 TCMC MATERIALS MNGMT PAGE 03

Hospitals with SHARPS disposal program

Androscoggin Valley Hospital, Berlin

- Informal program in which members of the public may obtain self-locking SHARPS Containers from the hospital and return them when filled.
- The program is publicized through word of mouth and referrals from local physician offices.
- Drops are made only at the hospital and are not made anonymously.
- SHARPS containers are disposed on via the facility's incinerators.
- Area pharmacists do not provide SHARPS containers when syringe prescriptions are being filled.

Frisbie Memorial Hospital, Rochester

- Formal program in which four times a year community members bring their SHARPS to the hospital only for disposal and exchange for a new syringe box.
- The program is publicized through the newspaper and brochures at the local pharmacy. (Please see attached news release.)
- Drops are made anonymously and are typically contained in a self-locking SHARPS container or the occasional coffee can.
- BFI removes the syringes from the hospital along with the facility's other hazardous waste for disposal.
- Area pharmacists do not provide SHARPS containers when syringe prescriptions are being filled.

Lakes Region General Hospital, Laconia

- Formal program in which four times a year community members bring their "contained" needles and syringes to the hospital only for disposal and receive a free SHARPS container.
- Notification of upcoming drop-offs is provided in area newspapers and through radio spots.
- Drops are not made anonymously.
- SHARPS are "red bagged" at the hospital and shipped to BFI for disposal.
- Area pharmacists do not provide SHARPS containers when syringe prescriptions are being filled.

DRAFT

DRAFT

Southern New Hampshire Medical Center, Nashua

- Formal program in which eight times a year patients can bring syringes to the hospital lobby drop-off area only. Needles must be contained in either SHARPS containers or liquid laundry detergent bottles with the caps on.
- The program is publicized through word of mouth and flyers distributed at a variety of locations, including the hospital, physician offices and pharmacies.
- Drops are made anonymously.
- Syringes are sent to BFI Waste Management for incineration.
- Even with the hospital's SHARPS program, many community members dispose of syringes in their household trash. SNHMC is working with the City of Nashua to decrease this method of disposal since there have been some needle sticks that have occurred during curbside collection.
- SHARPS containers are available for purchase at most pharmacies in the city. The cost for a small container is approximately $3.00; this size is appropriate for more users.
- SNHMC's program is run by the Diabetes Education Center in conjunction with an infection control nurse. They ask for volunteered information from those who drop-off their needles. In addition to persons with diabetes, they have patients on epogen shots, fertility medicine and even people with diabetic animals that use their program. Please call Maryann Krutsick, RN, BSN, CDE at 577-2547 for more information.

Upper Connecticut Valley Hospital, Colebrook

- Informal program in which community members with SHARPS boxes are allowed to bring their full boxes in for disposal at the hospital and exchange for new containers.
- The program is not formally publicized through advertising, but rather through home health agencies and local physician practices.
- Drops are not made anonymously and occur only at the hospital, which is centrally located to the community.
- SHARPS are then picked up by BFI Waste Management from their biohazard room.
- Area pharmacists do not provide SHARPS containers when syringe prescriptions are being filled.
- The hospital would consider formalizing the program they presently have.

Weeks Memorial Hospital, Lancaster, NH

- Program for diabetics in which SHARPS containers are provided and brought to the hospital in exchange for new boxes.
- The program is publicized by physicians and/or health care personnel caring for diabetics.
- Drops are not made anonymously and occur only at the hospital.
- SHARPS are incinerated in the hospital's incinerators.
- Area pharmacists do not provide SHARPS containers when syringe prescriptions are being filled; they are instead made available by health care providers.

DRAFT

FRISBIE MEMORIAL HOSPITAL

DRAFT

FOR IMMEDIATE RELEASE
APRIL 12, 1999

CONTACT:
HILARY DOUGLASS
COMMUNITY RELATIONS
(603) 335-8129

FRISBIE MEMORIAL HOSPITAL TO PRESENT FREE PROGRAM ON SHARPS DISPOSAL

ROCHESTER - In an effort to educate the community on proper disposal of syringes to help protect everyone and the environment, Frisbie Memorial Hospital and BFI Waste Systems of North America are sponsoring a free SHARP (Store Household sharps And Return Properly) Program on Tuesday, April 20, 1999 anytime from 3 to 7p.m. at Frisbie Memorial Hospital.

Keeping our community safe and beautiful is important to us all. Through the SHARP program, everyone has an easy way to properly dispose of syringes and lancets used at home. Simply follow the directions provided by Frisbie Memorial Hospital. There is no cost and it's easy to get started. Working together, we can improve environmental safety which benefits our community.

By joining the program, participants can:

Safely store and properly dispose of used syringes and lancets
Help protect family members, waste collectors and others in your community from accidental needle sticks.
Help prevent your used syringes from falling into the wrong hands.

Bring your used syringes and lancets for disposal through BFI to the workshop. Receive a free home sharps container from manufacturers. The program is simple and easy to follow. All you need to do is:

Obtain your approved home sharps container available free, one time, when you bring your syringes and lancets for disposal.

Place used syringes and lancets in the container. Insert the syringe or lancet into the container, needle first.

(more)

DRAFT

DRAFT

Seal container firmly. When container is full, close lid and seal securely. When the container is full, snap the lid shut. Return filled container to disposal center. Dispose of the container according to local ordinances. Contact Frisbie for information and assistance. Please do not place container in a recycle bin.

To learn more about the SHARP Program, please contact Cindy Cunningham, Frisbie's infection control coordinator at (603) 332-3100, ext. 8119.

-30-

DRAFT

New Hampshire Hospital Association

VIA BROADCAST FAX

TO: CEOs
FR: Gina Balkus, VP Public Affairs
RE: Syringe Disposal Survey
DT: April 20, 1999

The House Criminal Justice and Public Safety Committee is working on a bill which removes the prescription requirement for obtaining and purchasing hypodermic syringes. The bill will likely be sent to study, but in the meantime its sponsor, Rep. Cecelia Kane, an ardent advocate for needle exchange programs, has come to us for help in researching this issue.

This survey hopefully will resolve many of the unresolved issues or at least shed a little light on the subject for the subcommittee. We would greatly appreciate if you or the appropriate person in your facility could **respond to this survey by Friday, April 30, 1999. Completed surveys may be faxed to Miriam Watson at (603) 225-4346.**

Please let me know if you have any questions. Thanks for your help!

Does your facility have a formal or informal SHARPs disposal program in your community?
_____ yes _____ no

If so, please describe:_____
_____
_____

How is it publicized in your community? _____
_____

How accessible are drop sites in your community? _____
_____

Are drops made anonymously? _____ yes _____ no

Are needles contained in a self-locking SHARPs containers? _____ yes _____ no

How are SHARPs containers disposed of in your facility? _____
_____

If you do not have a SHARPs disposal program, how do community members who routinely use syringes for medical purposes (i.e. diabetes and allergy shots) dispose of them?
_____
_____

Do pharmacists in your area provide SHARPs containers as syringe prescriptions are being filled?
_____ yes _____ no

If you do not have a SHARPs disposal program, would you consider starting one at your facility?
_____ yes _____ no

If not, why not? _____
_____
_____

125 Airport Road ⊣ Concord, NH 03301-7300 ⊣ 603.225.0900 ⊣ Fax: 603.225.4346 ⊣ http://www.nhha.org

to substantially increase the use of sterile syringes by IDUs. To do so sends mixed messages to both IDUs and pharmacists when sales are permitted but possession is severely punished. Second, efforts by HIV prevention advocates to address sterile syringe issues should involve education, communication, and coalition-building with pharmacy, substance abuse treatment, and law enforcement professionals, who are directly affected by these issues. The arguments of prevention of transmission of HIV and other blood-borne infections through increased sterile syringe access are intrinsically powerful and will generate the support of these groups and others who may not have been historical allies in HIV prevention efforts.

*Geoffrey A. Beckett
†Richard Galena
*Deborah Shields
*Dora Anne Mills
*Maine Bureau of Health
†Maine HIV Advisory Committee
Augusta, Maine

REFERENCES

1. *AIDS surveillance data.* Augusta, ME: Maine Bureau of Health, 1996.
2. *Viral hepatitis surveillance data.* Augusta, ME: Maine Bureau of Health, 1996.
3. Case P, Beckett GA, Jones TS. Access to sterile syringes in Maine: pharmacy practice after the 1993 repeal of the syringe prescription law. *J Acquir Immune Defic Syndr Hum Retrovirol* 1998;18(Suppl 1):S94–101.

Peer Education of Pharmacists and Supplying Pharmacies With IDU Packets to Increase Injection Drug Users' Access to Sterile Syringes in Connecticut

To the Editor: We report two initiatives to increase the access of injection drug users (IDUs) to sterile syringes through pharmacies: peer education of pharmacists and a pilot program of sale and distribution by pharmacists of "IDU packets" containing two syringes (and needles) and two condoms. The IDU packets were modeled after similar ones sold or distributed in France, Spain, and other countries.

In 1992, the Connecticut General Assembly passed a partial repeal of the state's prescription and paraphernalia laws, which allowed the sale of up to 10 syringes in pharmacies without a prescription and legalized the possession of up to 10 clean syringes without a medical purpose (1,2). In 1994, the Centers for Disease Control and Prevention and the Connecticut Department of Public Health surveyed pharmacy managers regarding their sales policies and the manner in which they sold syringes (3).

The survey found that pharmacists routinely stock wrapped packages of 10 syringes, but few carry single syringes. For most pharmacists, selling <10 syringes (referred to as "single syringes") requires the pharmacist to break open a sealed pack of 10 syringes. Only 44% of pharmacists in the five cities and 54% in the other cities and towns reported selling syringes in quantities of <10. This finding concerned public health officials, because IDUs had expressed the desire to purchase <10 syringes to avoid carrying 10 syringes at one time and being at the risk for harassment by police for possession of paraphernalia (4).

In 1995, the Connecticut Department of Public Health contracted with the University of Connecticut School of Pharmacy (UCSP) to work with local health departments and pharmacists. The goals of this effort were to encourage pharmacists to sell sterile syringes without prescriptions to persons who may be IDUs, to reinforce the behaviors of pharmacists who were selling syringes, to encourage sales of small quantities of single syringes, and to inform pharmacists about the study (2) showing a decrease in syringe sharing after adoption of the new laws.

A UCSP faculty pharmacist worked with the local health department AIDS coordinators in cities A and B. The pharmacist surveyed pharmacists by mail in city A in the fall and winter of 1995 and 1996 and in city B in the spring of 1996 to assess current syringe sales policies, to determine attitudes toward sale of syringes, and to assess the willingness of the pharmacists to sell or provide free of charge the IDU packets, each containing two syringes and two condoms supplied by the local health department, to customers who wanted to buy a small number of syringes. These packets are thought to be the first offered in the United States and are much like packets used in other countries, such as the Steribox sold in pharmacies in France (5).

In city A, 17 of 21 pharmacists responded to an initial survey, with 14 reporting that they sold syringes over the counter. Nine of the 14 pharmacies reported selling small numbers of single syringes. In city B, 14 of 23 pharmacists responded to the initial survey, with all reporting that they sold syringes over the counter. Eight of those 14 pharmacies reported selling single syringes.

Each of the 44 pharmacies included in the survey in the two cities was visited by a team of the local health department AIDS coordinator and the UCSP faculty pharmacist. Each visit lasted between 20 and 30 minutes. Concerns raised by pharmacists (e.g., used syringes found in the store and in the parking lot, the possibility that sale of syringes would promote drug use, the potential for disruptive behavior by IDUs seeking to buy syringes) were discussed with the AIDS coordinator.

The pharmacists were then asked whether they would be willing to provide, without charge or at a price of up to $1, IDU packets containing two syringes and two condoms, which would be provided to them by the local health department free of charge. The pharmacies that agreed (16 in city A and 19 in city B) were given 5 to 10 packets and told to contact the local health department when more packets were needed.

Sixteen pharmacies in city A and 19 in city B completed the pilot program by distributing or selling the packets to customers over a 3-month period. A follow-up postal survey was carried out in May 1996 in city A and in July 1996 in city B to determine whether the pharmacists had encountered any problems and they would be willing to sell small numbers of single syringes from that point on without the packets being provided to them.

Of 22 pharmacists completing the follow-up survey, 10 said that they had sold the packets provided to them; 10 said they had given them away; 1 said that he had sold and given away the packets, depending on the customer's ability to pay; and 1 did not respond to the question. No problems related to sale or distribution of the IDU packets were reported. There

was no increase in the willingness of pharmacists who sold the packets to sell single syringes from store stock to IDUs who wished to purchase them. However, pharmacists were willing to continue to sell or distribute the packets given to them by the local health departments. Their lack of willingness to sell small numbers of single syringes on their own appears to be related to the fact that they do not stock single syringes and that they did not wish to open packets of 10 syringes to sell small numbers of single syringes. Several pharmacists reported that a low volume of syringe sales and of requests for single syringes made such a sales policy impractical.

City A has a needle exchange program operated by the local health department, and pharmacists were encouraged to refer IDUs to the needle exchange program. Several new needle exchange clients reported being referred to needle exchange by pharmacists during this period.

Other effects of the program were documented. Five pharmacists in city A and two pharmacists in city B informed the local health department representative that some customers purchased 3-ml insulin syringes instead of the 1-ml insulin syringes purchased by most IDUs. These customers were thought to be steroid users. This information prompted the local health department to stock 3-ml syringes for the needle exchange program to provide steroid users with sterile syringes.

This intervention in two cities in Connecticut confirms that pharmacists can become active participants in AIDS prevention activities. It also demonstrates that pharmacies and local health departments can work together to carry out HIV prevention activities for IDUs and that IDUs want to purchase the packets. It offers an example of effective peer professional education, in this case by a university faculty pharmacist to community pharmacists, and demonstrates that such linkages can expand prevention services to IDUs.

*Beth Weinstein
†Patricia Toce
‡Debra Katz
§Lizabeth Love Ryan
*AIDS Programs
Connecticut Department of Public Health
Hartford, Connecticut
†University of Connecticut School of Pharmacy
‡Stamford Health Department
Stamford, Connecticut
§New London Health Department
New London, Connecticut

REFERENCES

1. Valleroy LA, Weinstein B, Jones TS, et al. Impact of increased legal access to needles and syringes on community pharmacies' needle and syringe sales—Connecticut 1992–1993. *J Acquir Immune Defic Syndr Hum Retrovirol* 1995;10:73–81.
2. Groseclose SL, Weinstein B, Jones TS, et al. Impact of increased legal access to needles and syringes on practices of injecting drug users and police officers—Connecticut 1992–1993. *J Acquir Immune Defic Syndr Hum Retrovirol* 1995;10:73–81.
3. Wright-DeAguero L, Weinstein B, Jones TS, Miles J. Impact of the change in Connecticut prescription laws on pharmacy sales and pharmacy managers' practices. *J Acquir Immune Defic Syndr Hum Retrovirol* 1998;18(Suppl 1):S102–10.
4. Grund JPC, Heckathorn DD, Broadhead RS, et al. In eastern Connecticut, IDUs purchase syringes from pharmacies but don't carry syringes. *J Acquir Immune Defic Syndr Hum Retrovirol* 1995;10:73–81.
5. Rioufol JF, Taboada MJ, Deybach F. The Steribox [abstract We.C.3540]. Proceedings of the XI International Conference on AIDS, vol 2. Vancouver, Canada, 1996:151.

Needle Hygiene and Sources of Needles for Injection Drug Users: Data From a National Survey

To the Editor: The injection of illegal drugs was associated with 35% of new AIDS cases reported in 1995 (1). National public health agencies recommend that persons who are unable to stop injecting drugs use new, sterile needles and syringes for each injection to avoid HIV transmission (2). In some states injection drug users (IDUs) can purchase new sterile syringes in pharmacies (3–4). Another approach to providing IDUs with sterile syringes is to implement syringe exchange programs (SEPs) (5–8). The American Medical Association has recently adopted new policies encouraging the use of SEPs and urging changes in laws and regulations governing the sale and possession of injection equipment (9). Although these strategies for making it easier for IDUs to use sterile syringes have been evaluated on local levels, their potential effect on a national level is not known. The addition of a number of questions on the National Household Survey on Drug Abuse (NHSDA) in 1995 and 1996 enable us to look at needle sharing and source of needles for a national sample of IDUs.

The NHSDA is an annual, household-based probability sample of the U.S. population ≥12 years of age (10). Total sample size was 17,747 in 1995 and 18,269 in 1996. Response rates for selected respondents have been approximately 79%. Questions on the sharing, cleaning, and source of needles (needles refers to needles and syringes) were added to a special self-administered questionnaire in those 2 years. We have combined the 1995 and 1996 samples to obtain a total of 379 respondents who had ever injected illegal drugs. Averaged over the 2 survey years, these respondents represent 2.6 million persons nationally (95% confidence interval, 2.2–3.0 million). We present estimates with confidence intervals adjusted for the effects of the sample design (11).

Substantial needle sharing is implied in the responses to the survey (Table 1). For example, 21.9% of persons who had ever injected drugs stated that the last time they injected someone had used the needle before; this represents 573,000 of the 2.6 million persons who had ever injected in the United States. Similarly, 22.4% (587,000 IDUs) reported passing a used needle on to someone else. The most frequent source of needles mentioned by IDUs was pharmacies: 38.4%, representing 1 million IDUs. A small proportion (2.5%) of IDUs reported getting their last needle at a SEP. The remainder obtained needles on the street or from other unsafe sources.

The NHSDA data provide us with information on needle sharing and source of needles that is generalizable to the national population of IDUs, but it must be interpreted in light of a number of limitations. In common with all large-scale sample surveys, the NHSDA uses a household-based sampling frame, which does not include IDUs who were incarcerated, otherwise institutionalized, or homeless at the time of the survey. Although the questions on sharing and source of needles were part of a self-administered section designed to minimize the underreporting of sensitive behaviors, drug injection still may have been underreported by respondents. Also, we have looked at

Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology
18(Suppl 1):S102–S110 © 1998 Lippincott Raven Publishers, Philadelphia

Impact of the Change in Connecticut Syringe Prescription Laws on Pharmacy Sales and Pharmacy Managers' Practices

*Linda Wright-De Agüero, ‡Beth Weinstein, *T. Stephen Jones, and †John Miles

**Division of HIV/AIDS Prevention, and †Office of the Director, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention, Atlanta, Georgia; ‡AIDS Division, Connecticut Department of Public Health, Hartford, Connecticut, U.S.A.*

Summary: We assessed the impact of the 1992 change in Connecticut syringe prescription laws on pharmacy sales and pharmacy managers' sales practices. A mail survey was conducted in 1994 of all current pharmacy managers in the five largest cities in Connecticut (Hartford, New Haven, Waterbury, Bridgeport, and Stamford) and a random sample of those practicing in all other areas. Of these, 89.3% of the pharmacies in the five largest cities and 85.1% in the other areas had ever sold syringes without a prescription since the July 1992 law went into effect. Most pharmacists identified safety issues as very important in their personal decision about the sale of syringes without a prescription. Although the purpose of the change in the prescription law was to provide expanded access to sterile syringes by injection drug users (IDUs), only 31.4% of the managers who were allowed to sell in all instances and 18.1% of those who sold at their discretion were very willing to sell syringes to IDUs. In the logistic regression model of pharmacies with a sell-in-all-instances policy, the perceived benefit of the sale of syringes on health and community well-being was the only influence independently associated with managers support for nonprescription sales. Overall, managers reported they did not know what other pharmacists thought (40.4%) or did (42.9%) regarding the sale of syringes. When pharmacists had discretion over syringe sales, managers' beliefs about what other Connecticut pharmacists thought and did about the nonprescription sale of syringes remained a significant influence on the degree of support for sales. Most pharmacies implemented and maintained policies permitting the sale of syringes without a prescription. Several issues, including risk of discarded contaminated syringes around pharmacies and in the community and reluctance to sell to IDUs, reduced pharmacists willingness to sell syringes. Efforts to incorporate pharmacists as active partners in HIV prevention in IDUs should promote the sale of syringes without a prescription to IDUs as acceptable public health practice.
Key Words: HIV—AIDS—Substance abuse—Injection drug use—HIV/AIDS prevention—Sterile syringes—Syringe prescription laws—Pharmacists.

Injection drug use involving the multiperson use of contaminated injection equipment is an important source of infection with HIV and other blood-borne pathogens (1). AIDS cases through June 1995 directly or indirectly associated with the injection of illicit drugs accounted for 36% of cumulative cases in the United States (2). Although injection drug users (IDUs) have reduced their risk behaviors (3–7), this group still accounts for most new HIV infections in the United States (8). In addition to parenteral transmission, the sexual transmission of HIV among IDUs is a growing concern, accounting for more than half of the heterosexual and perinatal transmission of HIV in 1995 (9,10).

The U.S. Preventive Services Task Force (11) and the American Medical Association (12) recommend that per-

Address correspondence and reprint requests to Linda Wright-De Agüero, Division of HIV/AIDS Prevention (E-59), Centers for Disease Control and Prevention, 1600 Clifton Road, Atlanta, GA 30333, U.S.A.

The views expressed in this paper are those of the authors and do not necessarily reflect the official policy of the Centers for Disease Control and Prevention or the Connecticut Department of Public Health.

sons who inject illicit drugs use a new sterile syringe* each time they inject. However, two kinds of laws constrain the availability of sterile injection equipment in many areas of the United States—syringe prescription laws that prohibit the sale, distribution, or possession of syringes without a prescription, and drug paraphernalia laws that make the possession or the distribution of syringes to inject illicit drugs illegal. Although designed to decrease the prevalence of injection drug use by limiting ease of access and supply and by penalizing users and suppliers, these laws are often viewed as inconsistent with public health efforts to reduce the risk of HIV transmission. Laws that require a prescription for the purchase of new syringes restrict the availability of sterile injection equipment and thus promote the sharing of contaminated equipment.

Until 1992, Connecticut had both types of laws. The state also had a serious problem associated with injection drug use: half of all AIDS cases reported in 1992 were in IDUs, and 60% of all AIDS cases were related to injection drug use (13). In July 1992, it became legal, but was not required, for health personnel and pharmacists to distribute or sell 10 or fewer syringes without a medical prescription. Restrictions on the possession of drug paraphernalia were also partially repealed. A complete description of these regulations can be found elsewhere (14).

This report forms part of a collaborative investigation by the Centers for Disease Control and Prevention (CDC) and the Connecticut Department of Public Health to evaluate the effect of changes in prescription and paraphernalia laws in Connecticut. Earlier reports focused on pharmacies' syringe sales and IDUs' and police officers' practices regarding syringes (14–16). Here we examine pharmacy policies, pharmacy managers' beliefs and practices, pharmacy and customer-related characteristics, and safety and selling conditions influencing the sale of syringes without a prescription after the July 1992 change in the laws.

METHODS

In December 1993 we obtained the most recent computerized lists of all pharmacies and pharmacy managers from the Connecticut Department of Consumer Protection, the agency responsible for state licensure of pharmacies. Community-based pharmacies (i.e., those that provide over-the-counter sales to the public) were eligible for the study; wholesale, hospital-based or nursing home–based pharmacies and those providing infusion therapy were excluded. We selected pharmacies using two strategies. We included all pharmacies from the five largest cities in Connecticut: Hartford, New Haven, Waterbury, Bridgeport, and Stamford. These pharmacies serve communities with the largest number of AIDS cases. From all other areas, we obtained a random sample of pharmacies. Typically these pharmacies serve suburban communities, small towns, and rural areas of the state.

Files of pharmacies and pharmacists were matched by the license number of the managing pharmacist to obtain the name and home address of the manager of each sampled pharmacy. All correspondence related to the study, including the questionnaire, was mailed to the home address of the current manager to ensure work-related confidentiality and to minimize potential reporting bias.

We conducted the mail survey from February through May 1994 using a modified Dillman total design method (17). To increase participation in the survey, all managers in the sample received a letter prepared by the Commissioners of the Departments of Public Health and of Consumer Protection that informed them of the study and requested their cooperation. Articles were also prepared for inclusion in newsletters mailed to pharmacists by the Department of Consumer Protection. Managers who did not respond to the survey received as many as two follow-up mailings and a phone call. When the pharmacy manager had changed or the mailing address was incorrect, we attempted to obtain the correct information by reviewing files of the Department of Consumer Protection or by contacting the pharmacy directly.

The questionnaire was developed in consultation with staff from the Departments of Public Health and of Consumer Protection, the School of Pharmacy at the University of Connecticut, and investigators from the CDC and by using data obtained from focus groups of pharmacists. A pilot of the questionnaire was conducted with 10 pharmacists who were participating in continuing education courses.

The survey contained questions on individual characteristics of the pharmacy managers, characteristics and current activities of the pharmacy including the pharmacy policy and changes in policy on the sale of syringes without a prescription, the pharmacy manager's willingness to support different practices and provide services, factors influencing their syringe sales practices, their interest in continuing education programs related to HIV and injection drug use, and their opinions on various HIV prevention programs and services.

Measures of influence on pharmacy managers' decisions were created and tested for internal consistency. Scales were constructed by summing the scores of items included in each dimension. Items included in each dimension are presented in Tables 2 through 4. The items were scored as follows. For Safety, Context, and Customer: 1, not willing or not at all important; 2, don't know; 3, willing or somewhat important; and 4, very willing or very important. For Benefit and Detriment: −2, strongly disagree; −1, disagree; 0, don't know; 1, agree; and 2, strongly agree. For Norms: −1, should not sell or very few or none; 0, don't know; and 1, should sell or half or more. A measure of internal consistency (α) is reported for each dimension with more than two variables.

The six Likert-type scaled dimensions were for safety issues (α = .75), context or circumstances associated with the sale of nonprescription syringes (α = .70), customer-related items (α = .47), perceived beneficial (r = .39) and detrimental (α = .72) effect of the sale of syringes without a prescription on health and community well-being, and perception of peer norms and practices on the sale of syringes without a prescription (r = .25).

Data were stored and processed using SAS version 6.12 (18). For univariate analysis, we compared proportions by using the Mantel-Haenszel χ^2 analysis or Fisher's exact test. For non-normal data, we used nonparametric tests (Kruskal-Wallis). For the multivariate analy-

*In this article the word syringe is used interchangeably for needle and syringe.

sis, we used multinominal logistic regression (19) to predict a scaled measure of mangers' level of support for the sale of syringes without a prescription, stratified by the pharmacy's current policy for the sale of syringes. The outcome category was scaled as follows: 0, not at all supportive; 1, don't know; 2, supportive; and 3, very supportive. The personal computer program LIMDEP version 6 (20) was used for the multivariate analysis.

RESULTS

In February 1994 study questionnaires were mailed to 418 pharmacy managers; of these, 10 (6.7%) were not eligible for inclusion in the study because the pharmacy was out of business or the survey material was returned. Additionally, 18 current mangers could not be located after repeated attempts. Of the remaining 390 pharmacy managers, 88.5% (345) responded to the survey; response rates did not differ significantly for managers in the five cities versus other locations. Some of the pharmacists who responded did not operate community-based pharmacies. This analysis was restricted to the 329 respondents who were current pharmacy managers and who operated pharmacies that provided over-the-counter sales to the public.

Manager Characteristics and Pharmacy Syringe Sales Practices

Of the pharmacy managers, 28.6% (94) worked a pharmacies in the five largest cities. Managers were predominately white (94.7%), male (78.7%), experienced practitioners (median, 19 years), and owner-operator (58.1%), and had managed the current pharmacy for median of 7.5 years (range, 0–54 years; Table 1). There was no difference in ownership patterns (i.e., independently owned versus chain or corporate) between the pharmacies operating in the five largest cities versus other cities. Overall, managers were personally supportive of the sale of syringes without a prescription.

Managers were asked to report whether the pharmacy they managed had ever sold syringes without a prescription since the July 1992 law went into effect. In the five largest cities, 89.3% of the pharmacies and 85.1% in the other areas had done so. Most of the pharmacies from both the five largest cities and other areas continued their policy of selling syringes either in all instances (32.3% and 39.6%, respectively) or at the pharmacist's discretion (53.8% and 52.3%, respectively). However, the number of monthly sales transactions without a prescrip

TABLE 1. *Selected characteristics of pharmacy managers and pharmacies by city group*

Characteristics	Five largest cities (n = 94) No.	%	No. responding	Other cities (n = 235) No.	%	No. responding	χ^2	p Va
Pharmacy managers								
White	82	89	92	222	97	229	8.0	.0
Male	84	89	94	173	75	232	8.8	.0
Median no. of years in practice	22		92	18		228	7.7	.0
Median no. of years at current pharmacy, by position	8		92	7		230	1.5	.2
Owner and manager	50	53		114	49		.59	.4
Nonowner/manager	44	46	94	121	52	235		
Support for sale of syringes without a prescription								
Not at all supportive	29	30		55	24		2.52	.
Don't know	4	4		12	5			
Supportive	46	48		134	57			
Very supportive	15	16	94	33	14	234		
Pharmacy								
Ownership								
Independent	59	63		132	56		1.2	
Chain/corporate	35	37	94	103	44	235		
>50% Poor clientele	31	34	91	6	3	226	62.1	
>50% Ethnic groups or persons of color	51	55	93	16	7	233	93.7	
Sold syringes without a prescription since law change	83	89	93	200	85	235	.98	
Current pharmacy policy on sale of syringes without a prescription								
In all instances	30	32		93	40		3.3	
Pharmacist's discretion	50	54		123	52			
Will not sell	13	14	93	19	8	235		
Monthly transactions for sale of syringes without a prescription (median)	12.9		80	2.0		216	41.3	
More restrictive policy on syringe sales since the law change	7	58	12	6	27	22		

[a] Fisher's exact test.

tion differed significantly by location. Pharmacies operating in the five largest cities had a median of 12.9 syringe transactions a month, compared with 2 transactions a month in the other areas ($\chi^2 = 41.3$; $p = .0001$).

Of the pharmacy managers surveyed, 22 reported changing their store policy on syringe sales between July 1992, when the law became effective, and when the survey was conducted in 1994. Of the total pharmacies, 13 (4%) made their policies more restrictive. The reasons for more restrictive policies focused on specific incidents that had occurred, fears about what might occur, or perceptions of IDUs. For example, used syringes were found in the pharmacy, a man was found dead from an apparent overdose in the pharmacy parking lot, there were fears of accidental needlesticks, and syringe purchasers were perceived as loud, pushy, the-world-owes-me-a-living types.

Influences on Pharmacy Managers' Decisions

All managers, regardless of pharmacy policy, were asked what influenced their personal decisions to sell syringes without a prescription. These influences might be expected to affect the development and direction of pharmacy policy and the sales practices in pharmacies where the decision was left to the pharmacist's discretion.

Influences were grouped into six dimensions: safety, context of sale, customer-related items, perceived beneficial and detrimental effect of the sale of syringes without a prescription on health and community well-being, and perception of peer norms and sales practices on the sale of syringes without a prescription. Only managers who reported having ever personally sold syringes without a prescription were included in this analysis ($n = 296$). We conducted bivariate analyses of each dimension by the current pharmacy syringe sales policy (sell in all instances, sell at discretion of the pharmacist, and will not sell). Analysis by location of the pharmacy (five largest cities vs. other cities) found no significant differences for any of the factors.

Safety Issues

Most pharmacists identified safety issues as very important in their personal decision about the sale of syringes without a prescription (Table 2). For managers of pharmacies with a will-not-sell policy, the risk of discarded syringes was most commonly mentioned (84.6%) as a very important influence in their decision to sell syringes without a prescription. However, two thirds of pharmacy managers in pharmacies where policy permitted them to decide to whom to sell also mentioned this as a very important factor. Risk of theft or robbery and concern for potential liability for the sale of nonprescription syringes were very important factors for managers in all three groups.

TABLE 2. *Influences on pharmacy managers' decision to sell syringes without a prescription by current pharmacy policy on syringe sales*

	In all instances ($n = 119$)		At discretion of pharmacist ($n = 160$)		Will not sell ($n = 17$)			
	No.	(%)	No.	(%)	No.	(%)	χ^2	*p* Value
Safety[a]								
Safety of self and staff	118	(58)	160	(69)	13	(62)	4.1	.127
Risk of theft or robbery	118	(55)	159	(68)	13	(69)	5.0	.081
Risk of discarded syringes	117	(49)	160	(66)	13	(85)	12.1	.002
Potential liability for sale	118	(36)	160	(46)	13	(54)	3.6	.165
Context of sale[a]								
Time of day	119	(2)	159	(7)	13	(23)	11.7	.003
Presence of other customers	119	(7)	160	(9)				
Presence of in-store security staff	118	(3)	159	(11)	13	(54)	29.7	.001
Customer sobriety	119	(29)	160	(61)	13	(31)	15.0	.001
Familiarity with customer	119	(2)	160	(24)	13	(69)	31.6	.001
					13	(62)	44.7	.001
Customer-related								
Concern for health of IDUs[a]	118	(61)	160	(66)	13	(39)	4.3	.118
IDU[b]	118	(31)	160	(19)	17	(0)	11.5	.003
Minor[b]	119	(6)	160	(1)	17	(0)	5.5	.063
Agency referral[b]	119	(56)	160	(49)	17	(6)	14.7	.001

[a] Percentage naming item as a very important influence.
[b] Percentage very willing to sell to these persons or under this condition.
IDU, injection drug user.

Circumstances Associated With Sale of Syringes

Pharmacy managers were also asked to state the relative importance of the circumstances associated with the sale of nonprescription syringes. Managers of pharmacies with a will-not-sell policy mentioned more often the presence of other customers (53.9%), the presence of in-store security staff (30.8%), and the time of day of the sale (23.1%) as very important influences in their decisions. A larger proportion of managers from the will-not-sell pharmacies said that customer sobriety (69.2%) and familiarity with the customer (61.5%) would be very important in their decision. Of managers of pharmacies where the sale decision was left to the pharmacist's discretion, most stated that customer sobriety was very important (61.3%). Familiarity with the customer was also reported to be very important by one fourth (24.4%) of pharmacists who could decide to whom syringes were sold. This response contrasted with that of managers of pharmacies that sold in all instances: only 28.6% considered sobriety very important, and only 1.7% considered customer familiarity very important.

Customer-Related Items

On the customer-related items, managers operating pharmacies with a will-not-sell policy less frequently reported that concern for health and HIV prevention among IDUs was a very important influence. Very few managers from any group would be very willing (vs. willing, not at all willing, or don't know) to sell to minors, even though the law did not restrict sales to minors. Although the purpose of the change in the prescription law was to provide expanded access to IDUs, only 31.4% of the managers who were allowed to sell to all custo ers and 18.1% of those who sold at their discretion w very willing to sell syringes to IDUs.

Perceived Impact on Health and Community Well-Being

Much of the controversy about expanding access sterile syringes concerns the perceived effect on he and community well-being. Managers were asked h they felt about six statements regarding the sale of ringes without a prescription (Table 3). Managers w operated pharmacies with a policy of sell in all instan or sell at the discretion of the pharmacist more frequer agreed or strongly agreed that sales would have a b eficial effect, including seeing sales as an important p of a comprehensive approach to HIV prevention and creasing HIV transmission among IDUs, their sex p ners, and their children. Additionally, fewer pharmac in these groups agreed or strongly agreed with stateme that sales would have a detrimental effect. For each it managers of pharmacies where the policy was to nonprescription syringes in all instances most freque saw sales as beneficial and least frequently viewed s as detrimental when compared with managers from other two groups.

Perception of Peer Norms and Sales Practices

Theoretical models of social and behavioral che have stressed the importance of peer and other sc norms and perception of those norms as an impor determinate of behavior (21,22). We assessed pharm

TABLE 3. *Pharmacy managers' opinions on the effect of the sale of syringes without a prescription for HIV prevention by current pharm policy on syringe sales*

	In all cases (n = 121)		At discretion of pharmacist (n = 170)		Will not sell (n = 32)			
	No.	(%)	No.	(%)	No.	(%)	χ^2	p
Beneficial impact[a]								
Important part of HIV prevention	121	(80)	169	(75)	32	(34)	27.4	
Decrease HIV transmission	121	(71)	170	(66)	32	(41)	10.4	
Detrimental impact[a]								
Increase number of discarded syringes	121	(35)	170	(51)	32	(88)	29.2	
Increase customer discomfort or fear	120	(38)	169	(41)	31	(81)	19.4	
Increase crime	120	(22)	170	(31)	32	(72)	29.7	
Increase drug use	121	(21)	170	(29)	31	(58)	16.9	

[a] Percentage of pharmacy managers who agreed or strongly agreed with the following statements: The sale of sterile needles and syringes v a prescription (a) is an important part of a comprehensive approach to HIV prevention; (b) will decrease HIV transmission among persons whc drugs, their sex partners, and their children; (c) will increase the total number of discarded needles and syringes in or around pharmacies; (d) wil other customers in my pharmacy uncomfortable or fearful; (e) will increase shoplifting and other crime in my pharmacy and the surro community; and (f) will increase the amount of drug use by clients, overall community levels of injection drug use, or both.

managers' beliefs about nonprescription syringe sales through two questions. Managers were asked, "Would you say that most of the pharmacists you know in Connecticut think you should or should not sell needles and syringes without a prescription in the pharmacy you manage?" and "How many of the pharmacists you know in Connecticut sell needles and syringes without a prescription in their pharmacies?"

More managers of pharmacies where nonprescription syringes were reported as sold in all instance believed that most pharmacists they knew in Connecticut thought they should sell syringes without a prescription (48.8%, vs. 4.7% and 3.2% for sell at discretion and will not sell, respectively; Table 4). Most of the managers in this group also reported that half or more of the pharmacists they knew also sell syringes without a prescription in their pharmacies (63.9%, vs. 49.7% and 16.1% for sell at discretion and will not sell, respectively). However, for both questions, overall, managers reported they did not know what other pharmacists thought (40.4%) or did (42.9%) regarding the sale of syringes.

Influences on Managers' Support for Sale of Syringes

The results of multiple logistic models are presented in Table 5. Only dimensions with good internal consistency or, for the dimensions that had two variables, good correlations were included in the model. The dimensions were safety, context of sale, perceived beneficial effect of the sale of syringes on health and community well-being, perceived detrimental effect of the sale of syringes on health and community well-being, and perceived pharmacist norms. Willingness to sell syringes to IDUs was also included in the model. Of pharmacies with a sell-in-all-instances policy, the perceived benefit of the sale of syringes was the only influence independently associated with managers' support for nonprescription sales; the odds increased twofold when supportive managers were compared with those who were not supportive. In the stratum for sales at the pharmacist's discretion, managers' beliefs about what other Connecticut pharmacists thought and did regarding the nonprescription sale of syringes remained a significant influence on the degree of support for sales. In this stratum the perceived effect of sales also influenced degree of support. Managers supportive of sales versus those who were not were concerned with the potential negative effects of nonprescription sales; however, considering the potential benefits of sales on health and community well-being increased the odds of pharmacists in this stratum being very supportive versus not supportive of syringe sales.

DISCUSSION

Public health policies have been increasingly recognized as an important intervention for promoting disease prevention and community health (23,24). In the recent National Institutes of Health Consensus Development Statement (25), a panel of experts concluded that "current evidence suggests that some of the most powerful effects on HIV risk behavior have been produced by legislative and regulatory changes. . . . Policy and legislative change can have rapid, powerful, and positive results. This key area of the field has been given little attention, a problem that should be remedied" (25). Connecticut serves as a policy natural experiment in which syringe laws were changed to reduce an important environmental constraint to the access to sterile syringes through pharmacies. The coupling of syringe deregulation and the sales of syringes through pharmacies has intuitive appeal because of the large number and wide geographic distribution of pharmacies, their relatively long hours of operation, and their health-related infrastructure (26).

TABLE 4. *Pharmacy managers' perceived beliefs about the sale of syringes without a prescription, by current pharmacy policy on syringe sales*

	In all cases (n = 121)[a]		At discretion of pharmacist (n = 171)[a]		Will not sell (n = 31)			
	No.	(%)	No.	(%)	No.	(%)	χ^2	p Value
Perceived position of other pharmacists in Connecticut								
Should sell	59	(49)	59	(35)	1	(3)		
Should not sell	17	(14)	31	(18)	17	(55)		
Don't know	45	(37)	80	(47)	13	(42)	36.9	.001
Perceived number of other pharmacists in Connecticut who sell								
Half or more	78	(64)	85	(50)	5	(16)		
Very few/none	1	(1)	12	(7)	12	(39)		
Don't know	43	(35)	74	(43)	14	(45)	58.8	.001

[a] One manager did not respond to the question on peers' position.

TABLE 5. *Influences on pharmacy managers' support for sale of syringes without prescription by current pharmacy syringe sale policy*[a]

	Very supportive		Supportive		Don't know	
	OR	95% CI	OR	95% CI	OR	95% CI
Sell syringes in all instances						
Safety	1.1	.8–1.4	1.0	.8–1.3	1.0	.8–1.4
Context of sale	1.0	.7–1.4	1.1	.8–1.5	1.0	.7–1.6
IDU	10.9	.8–151.5	3.8	.3–48.6	4.9	.2–108.7
Beneficial impact	2.0	1.2–3.4[b]	2.2	1.3–3.6[b]	1.7	.9–3.2
Detrimental impact	.7	.5–1.0	.9	.7–1.2	.9	.4–1.4
Norms	1.8	.7–4.5	1.8	.8–4.3	1.7	.3–2.3
Sell at discretion of pharmacist						
Safety	.8	.6–1.1	.9	.8–1.2	.9	.6–1.4
Context of sale	.9	.7–1.2	1.0	.9–1.2	.9	.7–1.2
IDU	21.8	2.8–168.5[b]	2.3	.4–2.6	2.2	.2–32.2
Beneficial impact	1.9	1.1–3.2[b]	1.2	.9–1.6	1.3	.8–2.1
Detrimental impact	.8	.6–1.1	.8	.6–.9[b]	1.1	.8–1.5
Norms	2.8	1.2–6.7[b]	2.4	1.3–4.4[b]	1.5	.5–4.1

[a] Not supportive is used as the reference category.
[b] 95% CI does not include 1.0.
CI, confidence interval; IDU, injection drug user; OR, odds ratio.

This study demonstrates that after the syringe laws were changed in July 1992, most pharmacies implemented and maintained policies permitting the sale of syringes without a prescription. Relatively few (4%) implemented more restrictive sales policies in response to adverse incidents. These results support findings of a 1993 study in Connecticut (14) and a 1995 study in Maine (27) that pharmacy-based sales increased the availability of sterile syringes. Pharmacy-based sales also offer an alternative to the street purchase of syringes (16) and can reduce the proportion of IDUs who report sharing syringes (16,28).

Pharmacy managers, in particular, play a pivotal role in developing and implementing policy that governs the sales practices of their pharmacies. As HIV prevention programs for IDUs seek to establish linkages with community organizations and other gatekeepers, pharmacists should be recognized as important potential partners. Other studies conducted in Canada (29) and England (30) and Louisiana (31) have also recognized that community-based pharmacies can provide HIV prevention opportunities with IDUs but that pharmacists are often underused as a point of contact.

Although these results indicate the potential role of pharmacists in HIV prevention among IDUs, several limitations exist. Self-reports are subject to recall bias and willingness to report information or practices that may be viewed as socially unacceptable or discriminatory. For example, studies to determine the influence of race and ethnicity of the buyer on pharmacy sales have reported differences in sales to blacks versus whites (32). Additionally, our study did not examine actual sales but rather pharmacy policies and the characteristics, beliefs, and attitudes of managers that may influence sales. Additionally, we surveyed pharmacy managers, whose views and practices may not represent those of all pharmacists. Finally, we cannot assess from these data whether or how particular factors have varied over time in importance and influence. The relative importance of particular issues may change with individual experience and other social and political pressures.

Although pharmacy sales can provide access to sterile syringes and thus support prevention efforts to reduce the transmission of HIV among IDUs, the number of nonprescription syringe sales in Connecticut is still small relative to the need. Although many pharmacies reported policies that permitted syringe sales without a prescription, the number of transactions was small. Even if the maximum 10 syringes were sold per transaction, this falls well below the estimated 36 million syringes needed to provide IDUs in Connecticut with a sterile syringe for each injection (33).

Although pharmacy-based syringe sales hold promise as one component of HIV prevention activities for IDUs, these data suggest that several considerations reduced pharmacists' willingness to sell syringes without a prescription. One issue mentioned by pharmacy managers was the risk of discarded contaminated syringes around their businesses and in the community. Unlike needle exchange programs, pharmacies that sell syringes do not collect blood-contaminated syringes for safe disposal. Pharmacies in the United States are not equipped to receive used syringes, nor do pharmacists in Connecticut favor pharmacies as needle exchange sites (34). For drug users, the potential for criminal penalties for possessing syringes containing drug residue may foster rapid but

risky disposal rather than safer alternatives (35,36). Given the concern for discarded syringes and the potential risk for needlestick injuries, safe alternatives for disposal and community acceptance of these options need to be explored (37).

Second, although the law change was enacted to expand IDUs access to sterile syringes, many pharmacy managers were reluctant or unwilling to sell to IDUs. Overall, in pharmacies where sales were permitted, only one fourth of managers were very willing to sell to IDUs. Willingness to sell nonprescription syringes was also influenced by the pharmacist's assessment of whether the client was "high" and whether the pharmacist knew the customer.

The reluctance to sell sterile syringes to IDUs contrasted with their overall positive opinions of the effect or the effectiveness of syringe sales. Most of the managers in the study said that they thought the provision of sterile syringes would have a beneficial effect on HIV prevention. These findings suggest that the legal availability of sterile syringes through pharmacies does not necessarily translate into access for IDUs. Although many pharmacists seem to understand that syringe sales to IDUs are important for HIV prevention, further efforts are needed to help translate this awareness into sales practice.

These findings also suggest that efforts to incorporate pharmacists as active partners in HIV prevention with IDUs should address the acceptability of selling syringes without a prescription. A nationwide study of pharmacy boards and pharmacists associations found moderate support for the repeal of laws that preclude easy access to syringes (38). Pharmacists, particularly those who can decide to whom to sell, need to view the sale of syringes as acceptable public health practice to reduce the risk of HIV transmission and as an opportunity to educate and refer IDUs to other health services. Based on results from this study, efforts to foster collaboration with pharmacists in the sale of nonprescription syringes to IDUs were initiated in 1995 by the Connecticut Department of Public Health in collaboration with the University of Connecticut School of Pharmacy (39). This pilot activity offers promise for further understanding and overcoming obstacles to sales and encouraging pharmacists to become partners in the state's HIV prevention efforts.

State officials, pharmacy leaders, and professional organizations in Connecticut should continue to promote the sale of syringes to IDUs as a standard of practice through educational efforts and the development of professional guidelines. The American Medical Association's recent resolution on the medical and public health consequences of drug abuse (12) may serve as a model for developing consensus among pharmacists and establishing the sale of nonprescription syringes as an important practice for diminishing the risk of HIV among IDUs. Developing the role of pharmacists as part of a comprehensive, community-based HIV prevention effort requires collaboration with public health officials, clarification of the legitimate medical purposes of sterile syringes, and commitment to address pharmacists's concerns about health, safety, and their business.

Acknowledgments: The authors thank William Ward, State of Connecticut Department of Consumer Protection, for his assistance in facilitating access to the data files on pharmacies and pharmacists and in the development of the survey; Michael Hennessy, CDC, for his assistance in the development of the sampling design and data analysis strategies; and Brian Edlin, University of California—San Francisco, for comments on earlier versions of the paper.

REFERENCES

1. Friedman GH, Klein RS. Transmission of the human immunodeficiency virus. *N Engl J Med* 1987;317:1123–35.
2. Centers for Disease Control and Prevention. *HIV/AIDS surveillance report.* 1996;8(1):1–39.
3. Des Jarlais DC, Casriel C, Friedman SR, Rosenblum A. AIDS and the transition to illicit drug injection—results of a randomized trial prevention program. *Br J Addict* 1992;87(3):493–8.
4. Reitmeijer CA, Kane MS, Simons PJ, et al. Increasing the use of bleach and condoms among injecting drug users in Denver: outcomes of a targeted, community-level HIV prevention program. *AIDS* 1996;10(3):291–8.
5. Siegal HA, Falck RS, Carlson RG, Wang J. Reducing HIV needle risk behaviors among injection-drug users in the Midwest: an evaluation of the efficacy of standard and enhanced interventions. *AIDS Educ Prev* 1995;7(4):308–9.
6. Watters JK, Estillo MJ, Clark GL, Lorvick J. Syringe and needle exchange as HIV prevention for injection drug users. *JAMA* 1994; 271(2):115–20.
7. Des Jarlais DC, Friedman P, Hagan H, Friedman SR. The protective effect of AIDS-related behavioral change among injection drug users: a cross-national study. *Am J Public Health* 1996;86: 1780–5.
8. Holmberg SD. The estimated prevalence and incidence of HIV in 96 large US metropolitan areas. *Am J Public Health* 1996;86:642–54.
9. Centers for Disease Control and Prevention. AIDS associated with injecting-drug use—United States, 1995. *MMWR* 1996;45:392–98.
10. Normand J, Vlahov D, Moses LE, eds. *Preventing HIV transmission: the role of sterile needles and bleach.* Washington, DC: National Academy Press, 1995.
11. U.S. Preventive Services Task Force. *Guide to clinical preventive services,* 2nd ed. Baltimore: Williams & Wilkins, 1996.
12. American Medical Association. *A physician guide to HIV prevention.* Chicago: American Medical Association, 1996.
13. *State of Connecticut AIDS annual report.* Hartford: State of Connecticut Department of Public Health and Addiction Services, 1992.
14. Valleroy LA, Weinstein B, Jones TS, Groseclose SL, Rolfs RT, Kassler WJ. Impact of increased legal access to needles and syringes on community pharmacies needle and syringe sales—Connecticut, 1992–1993. *J Acquir Immune Defic Syndr Hum Retrovirol* 1995;10:73–81.
15. Centers for Disease Control and Prevention. Impact of new legis-

lation on needle and syringe purchase and possession—Connecticut, 1992. *MMWR* 1993;42:145–8.
16. Groseclose SL, Weinstein B, Jones TS, Valleroy LA, Fehrs LJ, Kassler WJ. Impact of increased legal access to needles and syringes on practices of injecting-drug users and police officers—Connecticut, 1992–1993. *J Acquir Immune Defic Syndr Hum Retrovirol* 1995;10:82–9.
17. Dillman DA. *Mail and telephone surveys*. New York: John Wiley & Sons, 1978.
18. SAS Institute, Inc. *SAS/STAT user's guide, version 6*, 4th edition. Cary, NC: SAS Institute, Inc., 1990.
19. Agresti A. *Categorical data analysis*. New York: John Wiley & Sons, 1990.
20. Greene WH. *LIMDEP user's manual and reference guide, version 6.0*. Bellport, NY: Econometric Software, Inc., 1992.
21. Fishbein M, Middlestadt SE, Hitchcock PJ. Using information to change sexually transmitted disease-related behaviors: an analysis based on the theory of reasoned action. In Wasserheit JN, Aral SO, Holmes KK, Hitchcock PJ, eds. *Research issues in human behavior and sexually transmitted diseases in the AIDS era*. Washington, DC: American Society for Microbiology, 1991.
22. Bandura A. Social cognitive theory and exercise of control over HIV infection. In DiClemente RJ, Peterson JL, eds. *Preventing AIDS: theories and methods of behavioral interventions*. New York: Plenum Press, 1994.
23. Brownson RC, Newschaffer CJ, Ali-Abarghoui F. Policy research for disease prevention: challenges and practical recommendations. *Am J Public Health* 1997;87:735–9.
24. Schmidt TL, Pratt M, Howze E. Policy as intervention: environmental and policy approaches to the prevention of cardiovascular disease. *Am J Public Health* 1995;85:1207–11.
25. National Institutes of Health (NIH) Consensus Development Conference. *Interventions to prevent HIV risk behaviors*. Bethesda, MD: NIH, 1997.
26. Vlahov D. Deregulation of the sale and possession of syringes for HIV prevention among injection drug users. *J Acquir Immune Defic Syndr Hum Retrovirol* 1995;10:71–2.
27. Case P, Beckett GA, Jones TS. Access to sterile syringes in Maine: pharmacy practice after the 1993 repeal of the syringe prescription law. *J Acquir Immune Defic Syndr Hum Retrovirol* 1998;18(Suppl 1):S94–102.
28. Diaz T, Chu SY, Weinstein B, et al. Injection and syringe sharing among HIV-infected injection drug users: implications for prevention of HIV transmission. *J Acquir Immune Defic Syndr Hum Retrovirol* 1998;18(Suppl 1):S76–81.
29. Meyers T, Cockerill R, Millson P, Rankin J, Worthington C. *Canadian community pharmacies HIV/AIDS prevention and health promotion: result of a national survey*. Ottawa, Ontario: Canadian Public Health Association, 1995.
30. Sheridan J, Strang J, Barber N, Glanz A. Role of community pharmacies in relation to HIV prevention and drug misuse: findings from the 1995 national survey in England and Wales. *BMJ* 1996;313:272–4.
31. Farley T. Survey on needle sales. *La Morbid Rep* 1996;7(3):3.
32. Compton W, Cottler LB, Decker SH, et al. Legal needle buying in St. Louis. *Am J Public Health* 1992;82:595–6.
33. Lurie P, Jones TS, Foley J. A sterile syringe for every drug user injection: how many injections take place annually, and how might pharmacists contribute to syringe distribution? *J Acquir Immun. Defic Syndr Hum Retrovirol* 1998;18(Suppl 1):S45–51.
34. Wright-De Agüero L, Weinstein B, Jones TS, Miles J. Attitudes and practices of Connecticut pharmacists: workshop on sterile needles and syringes for drug users who continue to inject. Baltimore, MD: Johns Hopkins University, School of Public Health, 1995.
35. Gostin LO, Lazzarini Z, Jones TS, Flaherty K. Prevention of HIV/AIDS and other blood-borne diseases among injection drug users: a national survey on the regulation of syringes and needles. *JAMA* 1997;277:53–62.
36. Gostin LO. Syringe and needle regulation, blood-borne disease transmission, and concern for public safety [letter]. *JAMA* 1997;277:1203.
37. Riley E, Beilenson P, Vlahov D, et al. Operation Red Box: a pilot project of needle and syringe drop boxes for injection drug users in East Baltimore. *J Acquir Immune Defic Syndr Hum Retrovirol* 1998;18(Suppl 1):S120–5.
38. Zellmer WA. Pharmacists involvement in needle exchange programs. *American Pharmacy* 1994;NS34:48–51.
39. Weinstein B, Toce P, Katz D, Ryan LL. Peer education of pharmacists and supplying pharmacies with IDU packets to increase injection drug users' access to sterile syringes in Connecticut. [letter] *J Acquir Immune Defic Syndr Hum Retrovirol* 1998;18(Suppl 1):S146–7.

Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology
10:71–72 © 1995 Lippincott-Raven Publishers, Philadelphia

Editorial

Deregulation of the Sale and Possession of Syringes for HIV Prevention Among Injection Drug Users

Injection drug users are at risk for human immunodeficiency virus (HIV) and other blood-borne infections primarily through the sharing (or "multiperson" use) of blood-contaminated syringes and other equipment used to prepare and inject drugs (1). The reasons posited for equipment sharing included the belief that this behavior is a ritual within the subculture of drug injectors (2), however, more recently, there has been a recognition of pragmatic legal and economic motivations for sharing syringes (3,4). Laws which do not allow sale of syringes without a prescription and felony penalties for the possession of syringes originally designed to curtail drug use, may have contributed unwittingly to parenteral transmission of blood-borne infections (5,6). Also, the cost of syringes is not trivial and also could contribute to the practice of sharing syringes (4). In the past decade, hundreds of needle exchange programs have been established in Europe, Australia, and North America to provide injection drug users with increased legal access to sterile syringes (7,8).

However, due to limited funding, many syringe exchange programs provide mostly exchange functions and have only a small number of sites with limited hours of operation (7). These limited number of sites and hours per city translate into a limited potential impact for each of these programs.

In the absence of expanded funding for syringe exchange programs, an inexpensive and practical alternative to efficiently provide wider access to sterile syringes is to deregulate syringe sales by removing prescription requirements and relevant portions of paraphernalia possession laws. This would allow injection drug users to carry syringes purchased at local pharmacies. This alternative has immediate intuitive appeal because the number and geographic distribution of pharmacies with their relatively long hours of operation provide more convenience than the limited sites and hours of current syringe exchange programs. Moreover, the pharmacy infrastructure already exists.

In this issue, reports by Valleroy and colleagues (8) and Groseclose and colleagues (9), summarize information collected following deregulation of syringes in Connecticut. In July 1992, pharmacists were permitted to sell and individuals were permitted to possess up to 10 syringes without medical prescriptions. These studies showed that 83% of pharmacists in Connecticut sold non-prescription needles after the law changed and that drug users used the pharmacies. Specifically, in high drug use areas, the number of non-prescription syringes sold increased dramatically with little change in sales of prescription syringes, while in low drug use areas little change in any syringe sales was noted. This finding was corroborated in a separate survey of injection drug users who reported a dramatic increase in pharmacy purchases and a substantial decrease in "street" purchase of needles after the law changed. At the same time, the proportion of injection drug users who reported sharing syringes decreased, which is further supported in a separate letter in this issue (10). Needlestick injuries among police decreased over time; while this might be attributed to greater precautions exercised by police after the law change, an accompanying letter reports that syringes purchased were not carried but stored due to continuing fears of arrest among injection drug users (11).

These findings from Connecticut suggest promise for deregulation of syringes as an HIV prevention strategy, but raise additional questions. Behavior change was measured by self-reports which are subject to error; however, corroboration with pharmacy sales data at least partially offsets this concern. As another issue, these studies showed pharmacy-based sales are not without problems as several pharmacists reported unpleasant incidents that soured them on non-prescription sales; discussion of how these incidents might be avoided or minimized is worthwhile. Also, further work is needed to understand the basis for the fears among drug users about carrying syringes after the law

changed by studying the attitudes and behaviors of the police and the drug users (e.g., are individual police continuing to harass drug users who possess syringes). Another issue is the effect of establishing a maximum number of syringes injection drug users can purchase and carry. Would removing restrictions on the number of syringes or a higher limit be associated with a further reduction in multi-person use of syringes? Another issue not addressed in these reports is the disposal of contaminated needles and syringes; some plans and measures are needed to monitor patterns of discarded needles, as has been reported elsewhere (12). Finally, that such programs reduce HIV infection rates was suggested by an earlier study in Maryland, which noted lower HIV infection rates in diabetic compared to non-diabetic injection drug users who were otherwise comparable; this was attributed to unrestricted legal access to sterile syringes (13). Longitudinal follow-up, which includes HIV incidence data, could be helpful to measure the impact of this program.

On the basis of these reports from Connecticut, deregulation of syringes coupled with careful evaluation of impact should be enacted elsewhere. Specifically, states with prescription laws should repeal them, and states should repeal the section of drug paraphernalia laws that make possession and distribution of syringes a crime. It is important to note that Connecticut enacted simultaneous repeal of the two laws, which may have been an important factor in their "natural experiment." The data from Connecticut point towards deregulation of syringes as a useful element of a comprehensive HIV prevention strategy.

David Vlahov
Department of Epidemiology
The Johns Hopkins School of Hygiene and Public Health
Baltimore, Maryland

REFERENCES

1. Friedland GH, Klein RS. Transmission of the human imm nodeficiency virus. *N Engl J Med* 1987;317:1125–35.
2. Des Jarlais DC, Friedman SR, Strug D. AIDS and need sharing within the IV drug use subculture. In: Feldman I Johnson T, eds. *The social dimensions of AIDS: metho and theory*. New York: Preager, 1986.
3. Mandell W, Vlahov D, Latkin C, Oziemkowska M, Cohn Correlates of needle sharing among injection drug users. *A J Public Health* 1994;84:920–3.
4. Magura S, Shapiro JL, Grossman JI, et al. Determinants needle sharing among intravenous drug users. *Am J Publ Health* 1989:79:459–62.
5. Murphy S. Intravenous drug use and AIDS: notes on tl social economy of needle sharing. *Contemp Drug Pro* 1987;5:373–95.
6. Koester S, Booth R, Wiebel W. The risk of HIV transmi sion from sharing water drug mixing containers, and cott filters among intravenous drug users. *Internat J Drug Poli* 1990;1:28–30.
7. Lurie P, Reingold AL, Bowser B, et al. *The public heal impact of needle exchange programs in the United Stat and abroad*. San Francisco: University of California, 199
8. Valleroy LA, Weinstein B, Jones TS, et al. Impact of i creased legal access to needles and syringes on communi pharmacies needle and syringe sales—Connecticut 199 1993. *J Acquir Immun Defic Syndr Human Retrovir* 1995;10:73–81.
9. Groseclose SL, Weinstein B, Jones TS, et al. Impact of i creased legal access to needles and syringes on practices injecting drug users and police officers—Connecticut, 199 1993. *J Acquir Immune Defic Syndr Human Retrovir* 1995;10:82–9.
10. Singer M, Weeks MR, Himmelgreen D, Sales and exchan of syringes [letter]. *J Acquir Immune Defic Syndr Hum Retrovirol* 1995;10:104.
11. Grund JC, Heckathorn DD, Broadhead RS, Anthony DL, eastern Connecticut, IDUs purchase syringes from pharm cies but don't carry syringes (letter). *J Acquir Immune Def Syndr Human Retrovirol* 1995;10:104–5.
12. Doherty M, Gargein R, Vlahov D. No increase in discard needles following opening of needle exchange program. 2 National Meeting Retrovirus and Related Infections. Was ington D.C., January, 1995.
13. Nelson KE, Vlahov D, Cohn S, et al. Human immunode ciency virus infection in diabetic intravenous drug user *JAMA* 1991;266:2259–61.

Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology
10:73–81 © 1995 Lippincott-Raven Publishers, Philadelphia

Impact of Increased Legal Access to Needles and Syringes on Community Pharmacies' Needle and Syringe Sales—Connecticut, 1992–1993

Linda A. Valleroy, *Beth Weinstein, T. Stephen Jones, Samuel L. Groseclose, Robert T. Rolfs, and William J. Kassler

*Centers for Disease Control and Prevention, Atlanta, Georgia, *Connecticut Department of Public Health and Addiction Services, Hartford, Connecticut, U.S.A.*

Summary: In May 1992, the Connecticut legislature passed new laws aimed at increasing injecting drug users' (IDUs) access to sterile needles and syringes (syringes); as of July 1992, pharmacists were permitted to sell and individuals were permitted to possess up to 10 syringes without medical prescriptions (nonprescription syringes). We evaluated the impact of the new laws by conducting (1) prospective surveillance of syringe sales and policies at selected community pharmacies (pharmacies) and (2) a telephone survey of pharmacy managers' reports of syringe sales and policies at a statewide stratified random sample of pharmacies. Our data provide direct evidence that most, but not all, Connecticut pharmacies sold nonprescription syringes when permitted to do so by the new laws. For example, using the telephone survey data, we estimate that during November, 1993, 83% [95% CI: 77–89%] of all Connecticut pharmacies sold nonprescription syringes and 56,000 [95% CI: 44,000–68,000] nonprescription syringes were sold during November 1993. Our data provide indirect evidence that IDUs were purchasing nonprescription syringes at pharmacies. For example, in five Hartford pharmacies located in neighborhoods where injection drug use was prevalent, the total number of nonprescription syringes sold per month increased significantly from 460 in July 1992 to 2,482 in June 1993 ($p = 0.0001$). The data suggest that the new laws increased IDUs' access to sterile syringes in Connecticut. **Key Words:** HIV/AIDS—Legislation—Pharmacy legislation—Needles—Pharmacy—Primary prevention—Public policy—Substance abuse—Intravenous—Syringes.

Use of blood-contaminated needles and syringes (syringes) and other drug-injecting equipment by injecting drug users (IDUs) contributes substantially to the transmission of human immunodeficiency virus (HIV) and other blood-borne pathogens (1–5). HIV-infected IDUs can then infect their sex partners through sexual transmission, and their offspring through vertical transmission (1,6–8). HIV infections associated with injection drug use could be prevented if uninfected IDUs either stopped injecting drugs or consistently used either sterile or

Preliminary data from the first months of this investigation were published in *Morbidity and Mortality Weekly Report* (1993; 42:145–8) and the *Proceedings of the Workshop on Needle Exchange and Bleach Distribution Programs*, Washington, DC: National Academy Press, 1994, and were presented in a poster at the IXth International Conference on AIDS and the IVth STD World Congress, Berlin, Germany, June 6–11, 1993 (abstract PO-C24-3189).

Address correspondence and reprint requests to Dr. Linda A. Valleroy at HIV Seroepidemiology Branch, Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention, 1600 Clifton Rd NE, Mailstop E-46, Atlanta, GA 30333, U.S.A.

Manuscript received November 15, 1994; accepted April 18, 1995.

adequately decontaminated syringes and other drug-injecting equipment (9,10).

One important source of sterile syringes is the community pharmacy (pharmacy). However, many states have either syringe prescription laws—which prohibit individuals from selling, distributing, or possessing syringes without a valid medical prescription—or drug paraphernalia laws—which prohibit individuals without medical purposes from possessing or distributing syringes—or both syringe prescription and drug paraphernalia laws (11–15). These laws can dissuade or prevent IDUs from purchasing syringes at pharmacies and possessing them for future use (16–19). As of March 1, 1995, 45 states and the District of Columbia had drug paraphernalia laws, and nine of these states and the District of Columbia also had syringe prescription laws (Fig. 1). Only five states—Alaska, Connecticut, Iowa, North Dakota, and South Carolina—had laws permitting both the purchase and possession of syringes by individuals who do not have medical prescriptions or purposes. However, Connecticut limits the number of syringes that can be purchase and possessed to 10 or fewer (20).

Connecticut has had a significant problem wi HIV infection associated with injection drug us and was one of the first states where the number reported AIDS cases in heterosexual IDUs e ceeded the number of cases in gay and bisexual m who were not IDUs (21). In 1992, the AIDS ca incidence among heterosexual IDUs was 10 p 100,000 of all Connecticut residents and account for 40% of all incident AIDS cases reported in 19 (22). Until 1992, Connecticut had both prohibiti syringe prescription and drug paraphernalia lav However, in May 1992, the Connecticut legislatu passed new laws (20). As of July 1, 1992, pharm cists and other health professionals were permitt but not required, to sell up to 10 syringes to in viduals who did not have medical prescriptio and, individuals without medical purposes w permitted to possess up to 10 syringes without d residue. The intent of the new laws was to incre IDU's access to sterile syringes, thereby decrea

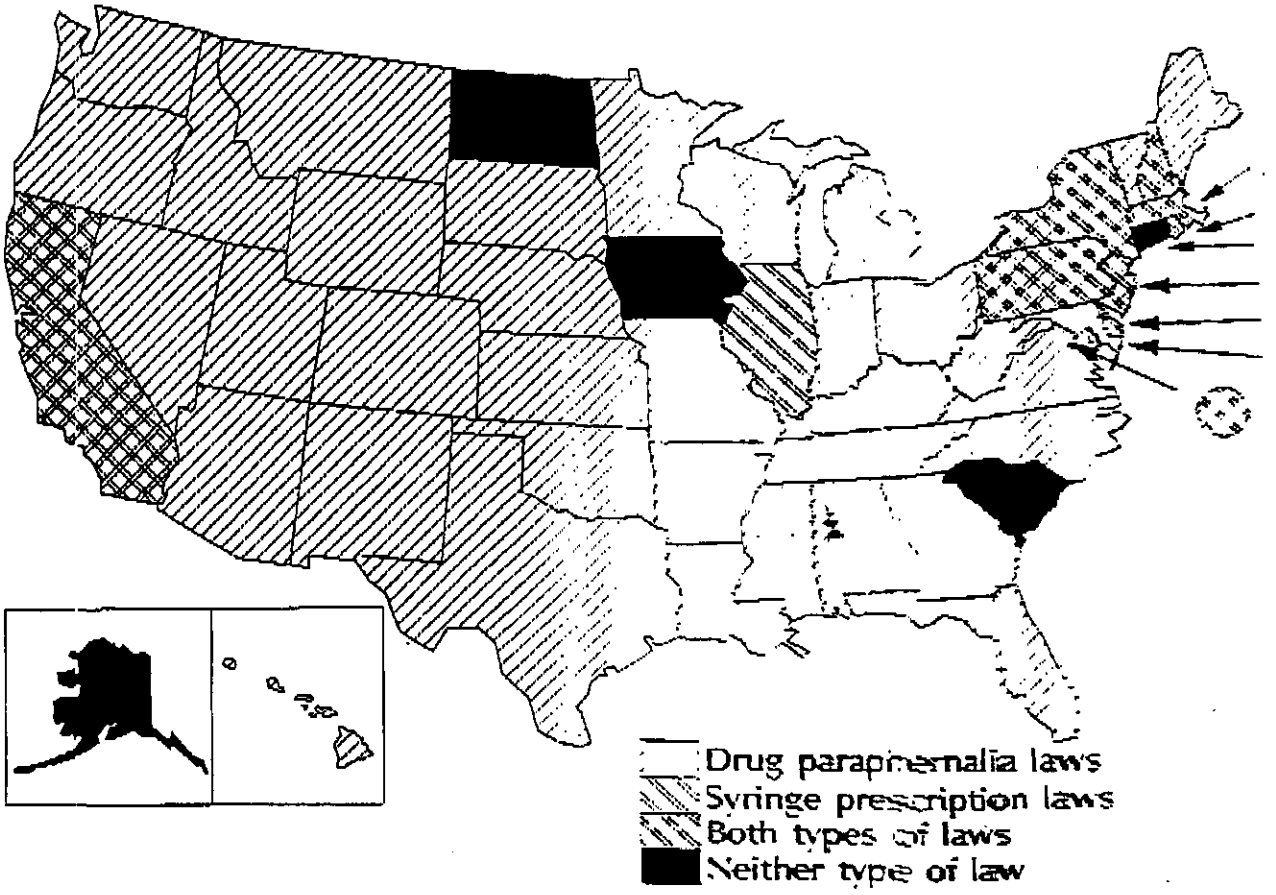


FIG. 1. States and the District of Columbia with syringe prescription or drug paraphernalia laws as of March 1, 1995 (s

multiperson use of blood-contaminated syringes, and decreasing injection-drug-use–related HIV transmission in Connecticut.

In June 1992, investigators from the Centers for Disease Control and Prevention (CDC) and the Connecticut Department of Public Health and Addiction Services began an evaluation of the impact of the new laws on (1) pharmacies' syringe sales and policies and (2) IDUs' and police officers' practices regarding syringes (23–26). In an accompanying report, we present the IDU and police officer components of our evaluation (27). In this report, we present the two parts of the pharmacy component: a prospective surveillance system of syringe sales and policies at selected pharmacies, and a telephone survey of pharmacy managers' reports or syringe sales and policies at a statewide stratified random sample of pharmacies.

METHODS

Prospective Surveillance System

In June 1992, we began the prospective surveillance system. Our objective was to determine whether the changes in syringe laws were associated with changes in syringe sales and policies at pharmacies in neighborhoods where injection drug use was prevalent, compared with pharmacies in neighborhoods where it was not.

For our sentinel pharmacies, located in neighborhoods with a high prevalence of injection drug use, we selected Hartford, Connecticut, a city with a median 1989 household income of $22,140 (28). In 1992, the AIDS case incidence among heterosexual IDUs was 67 per 100,000 of all Hartford residents and accounted for 64% of all incident AIDS cases reported in Hartford in 1992 (22). In June 1992, 25 pharmacies were operating in Hartford. We identified pharmacies in neighborhoods with a high prevalence of injection drug use by having six public health or addiction service officials, who were long-time Hartford residents, rank each Hartford pharmacy according to injection drug use in the neighborhood. We visited the 13 pharmacies with the highest rankings during June 1992, and asked each pharmacy manager to participate in the surveillance system.

For our comparison pharmacies, we selected Wethersfield, Connecticut, a town with a low prevalence of injection drug use. Wethersfield is suburban, next to Hartford, and had a 1989 household income of $43,888 (28). In 1992, the AIDS case incidence was 8 per 100,000 of all Wethersfield residents; neither of the two AIDS cases reported in 1992 was a heterosexual IDU (22). In June 1992, there were nine pharmacies in Wethersfield. We visited all nine during June 1992, and asked each pharmacy manager to participate in the surveillance system.

From June 1992 through June 1993, we collected data from all participating pharmacies. During June 1992, we interviewed all enrolling pharmacy managers with a questionnaire about pharmacy operation and plans and reasons for nonprescription syringe sales policies and practices as of July 1, 1992. From July 1, 1992, through June 30, 1993, all pharmacists recorded data on syringes sold to every customer purchasing syringes in an individual sale (syringe transaction). Pharmacists did this either by recording data on tally sheets kept at the pharmacy cash register, by using computerized sales records, or both. For every syringe transaction, data were collected on date of purchase, number of syringes sold, and whether the syringes were purchased with a prescription (prescription syringes) or without a prescription (nonprescription syringes). Research assistants visited all pharmacies monthly to collect data sheets, to learn about new developments at the pharmacy, and to encourage continuing participation.

Data were analyzed for increasing or decreasing linear trends in syringes sold and syringe transactions per month during the 12-month surveillance period using linear regression analyses (29).

Telephone Survey

In November 1993, we conducted a statewide telephone survey using a stratified random sample of pharmacies in two types of locations: (1) the five largest cities, i.e., Hartford, New Haven, Bridgeport, Stamford, and Waterbury, and (2) all other locations. We assumed that injection drug use was more prevalent in the former locations and less prevalent in the latter. In 1992, the AIDS case incidence among heterosexual IDUs in the five largest cities was 37 per 100,000 of all residents and accounted for 55% of all incident AIDS cases reported in these cities in 1992 (22). In all other locations, these figures were 4 per 100,000 of all residents and 23%, respectively (22). Our objectives were (1) to compare, in these two strata, syringe sales policies, incidents, and number of nonprescription syringes sold and (2) to estimate, for all Connecticut pharmacies, the percentage selling nonprescription syringes and the total number of nonprescription syringes sold.

We randomly selected 163 of the 697 Connecticut pharmacies: 80 from the 129 in the five largest cities and 83 from the 568 in all other locations. We telephoned these 163 pharmacies during weekday working hours from November 3 through November 19, 1993, and interviewed the pharmacy managers who agreed to participate and who worked in pharmacies that met our eligibility criteria. Pharmacies serving walk-in customers, which had been in business in both July 1992 and November 1993, and whose pharmacy manager had worked there for more than 2 weeks were eligible.

We asked each participating pharmacy manager questions concerning the pharmacy's ownership; the length of time he/she had worked at the pharmacy; presence of IDUs in the pharmacy's neighborhood; pharmacy policy regarding nonprescription syringe sales in July 1992 and in November 1993; whether or not there had been negative incidents involving nonprescription syringe sales since July 1992; if there had been negative incidents, descriptions thereof; and the estimated number of nonprescription syringes sold in a normal week at the time of the November 1993 telephone survey.

Proportions were compared using Mantel–Haenszel χ^2 (30). Means were compared using a two-sample t test assuming unequal variances (29). We estimated values for all Connecticut pharmacies in November 1993 by using stratified random sampling techniques (31).

RESULTS

Prospective Surveillance System

In June 1992, we enrolled eight of the thirteen (62%) Hartford pharmacies known to be in neighborhoods where injection drug use was prevalent and seven of the nine (78%) pharmacies in Wethersfield, where injection drug use was not prevalent. On July 1, 1992, all eight (100%) Hartford pharmacies began to sell nonprescription syringes during business hours, which averaged 76 hours per week. On June 30, 1993, five (63%) of the eight were still selling them. On July 1, 1992, five of the seven (71%) Wethersfield pharmacies began to sell nonprescription syringes during business hours, which averaged 73 hours per week. On June 30, 1993, the same five (71%) were still selling them.

Between July 1992 and June 1993, three of the eight Hartford pharmacies stopped selling nonprescription syringes. Using June 1992 and subsequent monthly visit interview data, we compared pharmacy managers' initial reasons for selling nonprescription syringes with reasons for not selling them in subsequent months. At Pharmacy A, in June 1992, the pharmacy manager was eager to sell, hoping to prevent new HIV infections. However, when a used, capped syringe was found on a display shelf in July 1992, the pharmacy manager decided to stop nonprescription syringe sales. At Pharmacy B, in June 1992, the pharmacy manager was enthusiastic about selling, hoping to slow the spread of HIV in his community. However, in August 1992, after an IDU disrupted business at the pharmacy counter a few hours after a robbery had taken place at the front cash register, Pharmacy B stopped selling nonprescription syringes. Although the robbery and disruption were not related, both the pharmacy manager and the owner became fearful of further negative incidents with IDUs. At Pharmacy C, in June 1992, the pharmacy manager was ambivalent about selling, being public-health-minded but worried about losing regular customers if more IDUs came to his pharmacy. Pharmacy C stopped selling in February 1993, after a regular customer complained about being hustled in the parking lot by a transvestite IDU requesting money to buy a syringe.

At the five Hartford pharmacies selling nonprescription syringes continuously from July 1, 1992 through June 30, 1993, the total number of nonprescription syringes sold per month increased steadily from 460 in July 1992, to 2,482 in June 1993 (Fig. 2). At the five Wethersfield pharmacies, the total number of nonprescription syringes sold per month remained low and stable, averaging 210. There was a significant increase in the number of nonprescription syringes sold per month in the Hartford pharmacies ($t = 9.6$ [$df = 10$], $p = 0.0001$), but not in the Wethersfield pharmacies ($t = 0.5$ [$df = 10$], $p = 0.96$).

At the five Hartford pharmacies, prescription syringes sold per month remained fairly stable ($t = 0.20$ [$df = 10$], $p = 0.85$), averaging 3,775 (Fig. 3). The proportion of all syringes sold by the five Hartford pharmacies that were nonprescription syringes rose from 11% in July 1992 to 43% in June 1993.

In June 1992 interviews, pharmacy managers reported that most prescription syringes were sold to diabetics who generally bought 100 syringes at a time for approximately $25.00. At the five Hartford pharmacies, during the 12-month surveillance period, prescription transactions averaged 63 syringes. Connecticut law limits customers' buying nonprescription syringes to 10 or fewer per transaction. At the five Hartford pharmacies, during the 12-month surveillance period, nonprescription transactions averaged three syringes. In monthly pharmacy visits, the Hartford pharmacists reported the average sales price for a ten-pack of nonprescription syringes was $3.95, and for a single nonprescription syringe, $0.51.

Because different numbers of syringes were sold in prescription and nonprescription transactions, we compared the number of transactions per month at the five Hartford pharmacies (Fig. 4). The num-

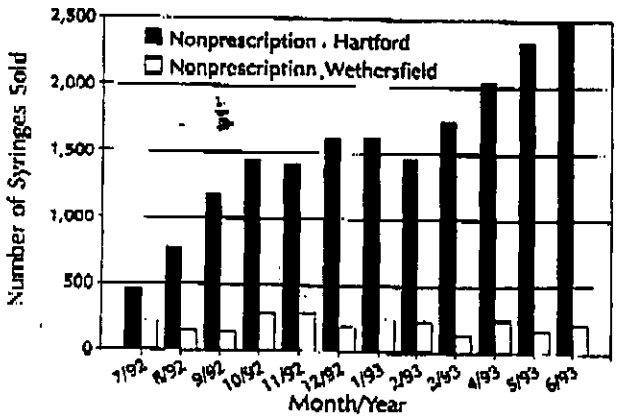


FIG. 2. Total number of nonprescription syringes sold per month at the five Hartford and five Wethersfield, Connecticut, pharmacies that sold nonprescription syringes continually from July 1, 1992, through June 30, 1993.

ber of nonprescription syringe transactions increased significantly from 107 in July 1992, to 950 in June 1993 ($t = 8.1$ [$df = 10$], $p = 0.0001$). The number of prescription syringe transactions remained low and stable ($t = 0.36$ [$df = 10$], $p = 0.73$), averaging 60 transactions. In June 1993, the ratio of nonprescription transactions to prescription transactions exceeded 17-to-1.

Telephone Survey

In November 1993, we telephoned 163 pharmacies; of these, 148 (91%) met our eligibility criteria. At these 148 pharmacies, 139 (94%) of the pharmacy managers agreed to be interviewed. Of these 139 pharmacy managers, 64 (46%) worked at pharmacies in the five largest cities, and 75 (54%) in all other locations (Table 1). Comparing strata, there was no difference in pharmacy ownership, (i.e., independently owned vs. either corporately owned or operator owned chains). Over 80% of the pharmacy managers interviewed had worked at these same pharmacies sine before July 1, 1992, when the new laws went into effect. When pharmacy managers were asked, "In your opinion, are there IDUs in the neighborhood of this pharmacy?", 75% in the five largest cities and 15% in all other locations reported "many IDUs" in the neighborhood (75% vs. 15%, [$\chi^2 = 51.5$; $p < 0.0001$]).

There were no significant differences between the strata in the percentage of pharmacies selling nonprescription syringes. In the five largest cities, 83% sold nonprescription syringes in July 1992, 73% in November 1993, and 72% in both July 1992 and November 1993. In all other locations, 87% sold nonprescription syringes in July 1992, 85% in November 1993, and 83% in both July 1992 and November 1993.

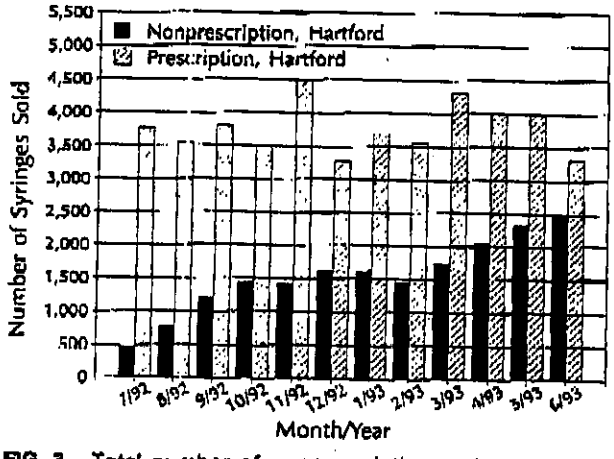


FIG. 3. Total number of nonprescription and prescription syringes sold per month at the five Hartford, Connecticut, pharmacies that sold nonprescription syringes continually from July 1, 1992, through June 30, 1993.

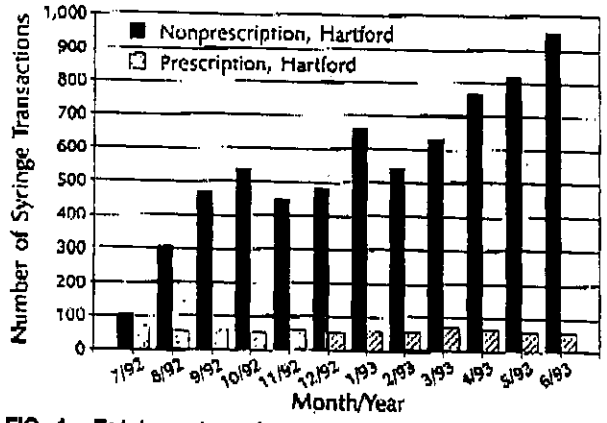


FIG. 4. Total number of nonprescription and prescription syringe transactions per month at the five Hartford, Connecticut, pharmacies that sold nonprescription syringes continually from July 1, 1992, through June 30, 1993.

Twenty-six (19%) of the 139 pharmacy managers responded "yes" when asked, "Between July 1992 and today, have there been any negative incidents or situations at the pharmacy where you are currently working with regard to the sale of needles and syringes to individuals who did not have medical prescriptions?" Twenty-one (33%) in the five largest cities and 5 (7%) from all other locations reported negative incidents (33% vs. 7% [χ^2 15.5; $p < 0.0001$]). When asked to explain, these 26 pharmacy managers reported a total of 37 incidents, ranging in seriousness from "having to fill orders for $0.50 nonprescription syringes at busy times" to "being attacked with a syringe by an IDU."

We categorized incidents as "less serious" or "more serious." Less-serious incidents included pharmacists' or customers' complaints about the inappropriate behavior of people buying nonprescription syringes, and pharmacists' complaints about having to sell nonprescription syringes to IDUs. Fourteen (10%) of the 139 pharmacy managers reported more serious incidents: 13 (20%) in the five largest cities and 1 (1%) from all other locations (20% vs. 1% [χ^2 13.7; $p = 0.0002$]). These 14 pharmacy managers reported a total of 17 more serious incidents: nonprescription syringe customers engaging in violent behaviors, e.g., attacks with syringes ($n = 2$); increases in shoplifting ($n = 1$); IDUs injecting drugs inside the pharmacy ($n = 1$); and used syringes found inside ($n = 5$) and outside

TABLE 1. *Results of the telephone survey of pharmacy managers of 139 pharmacies in November 1993*

Pharmacy characteristic	Reporting characteristics: Five largest cities (n = 64) No. (%)	All other locations (n = 75) No. (%)	χ^2	p
Independently owned pharmacy	38 (60)	37 (50)	1.4	0.24
Same pharmacy manager working there since before July 1992	53 (83)	58 (81)[a]	0.1	0.74
Many IDUs in pharmacy neighborhood	48 (75)	11 (15)	51.1	<0.000
Sold nonprescription syringes				
In July 1992	53 (83)	65 (87)	0.4	0.53
In November 1993	47 (73)	64 (85)	3.0	0.08
In July 1992 & November 1993	46 (72)	62 (83)	2.3	0.13
Any negative incidents regarding nonprescription syringe sales from July 1992 to November 1993	21 (33)	5 (7)	15.4	<0.000
More serious negative incidents regarding nonprescription syringe sales from July 1992 to November 1993	13 (20)	1 (1)	13.6	0.000

Pharmacy characteristic	Mean (range) (no. of pharmacies)	Mean (range) (no. of pharmacies)	t	p
Estimated number of nonprescription syringes sold in a normal week at pharmacies selling nonprescription syringes in November 1993	93 (0–500) (n = 46)[b]	12 (0–85) (n = 64)[b]	4.0	0.000

[a] Seventy-two of the 75 pharmacy mangers at all other locations responded to this question.
[b] Forty-six of the pharmacies in the five largest cities and 64 in all other locations sold nonprescription syringes in November 1993 and were asked to estimate number of nonprescription syringes sold.

(n = 8) the pharmacy. Thirteen (76%) of these 17 more serious incidents involved used syringe disposal. We examined the association between more serious incident occurrence between July 1992 and November 1993, and nonprescription syringe sales policy in November 1993: 6 (43%) of the 14 pharmacies reporting more serious incidents did not sell nonprescription syringes in November 1993, compared with 22 (18%) of the 125 pharmacies not reporting them (43% vs. 18% [χ^2 5.0; p = 0.03]).

Pharmacy managers at pharmacies selling nonprescription syringes in November 1993 reported estimates of numbers of nonprescription syringes sold in a current normal week. Significantly more nonprescription syringes were reportedly sold in the five largest cities than in all other locations—93 per pharmacy per week versus 12 (t = 4.0; p = 0.0002).

Using our data and the random samples of pharmacies in the two strata as sampling fractions, we estimate that 83% (95% CI: 77–89%) of all Connecticut pharmacies sold nonprescription syringes in November 1993, and that approximately 56,000 (95% CI: 44,000–68,000) nonprescription syringes were sold at Connecticut pharmacies in November 1993.

DISCUSSION

The Connecticut legislature passed new laws aimed at increasing IDUs' access to sterile syringes and decreasing injection-drug-use–related HIV transmission in Connecticut. For this to happen, pharmacies had to adopt new policies and sell nonprescription syringes, and IDUs had to purchase nonprescription syringes at pharmacies. Our data provide direct evidence that most, but not all, Connecticut pharmacies sold nonprescription syringes, when legally permitted to do so. A moderate percentage of pharmacies never sold nonprescription syringes or began selling them and later stopped. By November 1993—15 months after the new laws took effect—an estimated 83% of all Connecticut pharmacies were selling nonprescription syringes; approximately 56,000 were sold that month. Our data provide indirect evidence that IDUs purchased nonprescription syringes at pharmacies. The number of nonprescription syringes sold increased significantly in the Hartford but not in the Wethersfield pharmacies all during the 12-month surveillance period, and was significantly higher in the five largest cities than in all other locations in November 1993. In an accompanying paper, we provide direct

evidence of IDUs' reports of increased syringe-purchasing at pharmacies and decreased syringe-sharing after the new laws went into effect (27). These data suggest that the new Connecticut laws increased IDUs' access to sterile syringes in Connecticut, especially in areas where injection drug use was prevalent.

The prospective surveillance system had several limitations. We surveyed only Hartford and Wethersfield, which are not representative of all Connecticut towns. Our sample size was small, and of the 15 pharmacies, only 10 sold nonprescription syringes throughout the 12-month surveillance period. There may have been unrecorded sales. We assume that not all nonprescription syringes sold were sold to IDUs; other customers were purchasing them, e.g., diabetics who needed syringes before their next prescription purchases. It may be that the decrease in the number of pharmacies selling nonprescription syringes in Hartford during the 12-month surveillance period may partially explain the increase in the number of nonprescription syringes sold at the pharmacies that continued selling them.

The telephone survey also had limitations. The data were reported by pharmacy managers on the telephone. Some answers were based on subjective judgments, e.g., the presence of IDUs in the pharmacy neighborhood. A key variable, viz., the number of nonprescription syringes sold in a normal week, was based on estimates rather than on actual tallies. Although we measured negative incidents between July 1992 and November 1993, we have no data from before July 1992 for a comparison. Negative incidents like those reported in the telephone survey may also have occurred before July 1992. Although the data show that most Connecticut pharmacies sold nonprescription syringes, individual pharmacists may not have been selling nonprescription syringes to all customers. Studies in New Orleans, Louisiana, and St. Louis, Missouri, where there are no syringe prescription laws, both showed that individual pharmacists selectively refused to sell nonprescription syringes to some customers (32,33).

These findings are limited to Connecticut. On the one hand, access to sterile syringes through pharmacy purchase may be higher in Connecticut than in other states. The laws only recently changed, and the public health and pharmacy communities supported the shift to nonprescription syringe sales. Because of the considerable prevalence of HIV infection associated with injection drug use in Connecticut, pharmacists may be more willing to sell nonprescription syringes. Although many states permit nonprescription syringe purchase at pharmacies, Connecticut is one of only five states permitting *both* nonprescription syringe purchase and possession. Thus, individuals may be more likely to purchase nonprescription syringes at pharmacies, knowing that they can also legally possess them. On the other hand, access to sterile syringes through pharmacy purchase may be lower in Connecticut than in other states. Connecticut only partially repealed its syringe prescription and drug paraphernalia laws, limiting individuals to 10 or fewer nonprescription syringes. No other state permitting nonprescription syringe purchase or possession limits the number of syringes.

Although there have been pharmacy and pharmacist surveys in Australia (34–36), Canada (37), and Europe (18,38–41), there are few data from the United States for comparison (32,33). Public health workers in the 40 other states with no syringe prescription laws should consider conducting telephone or postal surveys. Ours was relatively easy and inexpensive to conduct. If a low percentage of pharmacies is found to be selling nonprescription syringes, then public health workers might initiate programs to educate pharmacists about HIV/AIDS, IDUs, and state laws. Pharmacists are both health professionals and business people who weigh the pros and cons of nonprescription syringe sales. Public health workers might increase the number of pharmacies selling nonprescription syringes by telling pharmacists the public health pros.

Public health workers trying to increase IDUs' access to syringes through pharmacy purchase should also consider what we learned about pharmacists' cons regarding nonprescription syringe sales. A moderate percentage (10%) of pharmacy managers reported more serious negative incidents regarding nonprescription syringe sales, and the occurrence of more serious incidents was significantly associated with pharmacies not selling nonprescription syringes in November 1993. A high percentage (76%) of the 17 more serious incidents involved used syringe disposal. Public health workers might deal with the issue of used syringe disposal by offering educational materials to IDUs or other solutions. For example, the Connecticut Department of Public Health and Addiction Services developed an illustrated leaflet in English and Spanish aimed at educating IDUs about appropriate used syringe disposal. The leaflet was given to pharmacists and

community health outreach workers for distribution to IDUs.

Removing legal barriers to sterile syringe access is important: because HIV-contaminated syringe use remains a major mode of HIV transmission (19), because many IDUs are unwilling or unable to stop injecting drugs (42,43), because recent findings show that bleach is less effective for syringe decontamination than was previously thought (44–49), and because needle exchange programs largely remain illegal and reach limited populations (10). Purchasing sterile syringes at pharmacies can provide an inexpensive and effective intervention with IDUs. Pharmacies are located in most neighborhoods, are open many hours, and are staffed by health professionals. States and other jurisdictions should modify or repeal laws that restrict access to sterile syringes as part of a strategy for reducing HIV transmission among IDUs (19).

Acknowledgment: We acknowledge the contributions of the pharmacists from Hartford and Wethersfield who participated in the surveillance system; the pharmacy managers who responded to the telephone survey; Michael J. Dunne, M.S.W., and Kimberly Rajotte of Connecticut Planning Associates, research assistants for the surveillance system; and Elizabeth A. Wolfe, Melanie A. Duckworth, M.S.W., William B. Longdon III, and Richard G. Miller of CDC, interviewers for the telephone survey. We also acknowledge the contributions of William P. Ward of the Connecticut Department of Consumer Protection; Patricia J. Checko, M.P.H., and Mariano Ortiz, Jr., of the Connecticut Department of Public Health and Addiction Services; Daniel C. Leone, Ph.D., of the Connecticut Pharmacists Association; and, Ronald R. Fichtner, Ph.D., John M. Karon, Ph.D., Vincent P. Raimondi, M.S., and P. Imani Thompson, M.C.P., Ed.M., of CDC.

REFERENCES

1. Centers for Disease Control and Prevention. *HIV/AIDS surveillance report, third quarter edition.* Atlanta, GA: Public Health Service, National Center for Infectious Diseases, Division of HIV/AIDS; U.S. Dept of Health and Human Services. [October 1993;5(no.3).]
2. Chaisson RE, Osmond D, Moss AR, Feldman HW, Bernacki P. Human immunodeficiency virus in heterosexual intravenous drug users in San Francisco. *Am J Public Health* 1987;77:169–72.
3. Celentano DD, Vlahov D, Cohn S, Anthony JC, Solomon L, Nelson KE. Risk factors for shooting gallery use and cessation among intravenous drug users. *Am J Public Health* 1991;81:1291–5.
4. Lange WR, Snyder FR, Lozovsky D, Kaistha V, Kaczaniuk MA, Jaffe JH. Geographic distribution of human immunodeficiency virus markers in parenteral drug abusers. *Am J Public Health* 1988;78:443–6.
5. Schoenbaum EE, Hartel D, Selwyn PA, et al. Risk factors for human immunodeficiency virus infection in intravenous drug users. *N Engl J Med* 1989;321:874–9.
6. Murphy DL. Heterosexual contacts of intravenous drug abusers: implications for the next spread of the AIDS epidemic. *Adv Alcohol Subst Abuse* 1987;7:89–97.
7. Moss A. AIDS and intravenous drug use: the real heterosexual epidemic [Editorial]. *Br Med J* 1987;294:389–90.
8. Sorensen JL, Wermuth LA, Gibson DR, Choi K-H, Guydish JR, Batki SL. *Preventing AIDS in drug users and their sexual partners.* New York: The Guilford Press, 1991.
9. National Commission on AIDS. *AIDS: an expanding tragedy. The final report of the National Commission on AIDS.* Washington, DC: National Commission on AIDS, 1993.
10. Lurie P, Reingold AL, Bowser B, et al. *Public health impact of needle exchange programs in the United States and abroad, volume 1.* San Francisco: University of California, 1993.
11. Gostin L. The needle-borne HIV epidemic: causes and public health responses. *Behav Sci Law* 1991;9:287–304.
12. Gostin L. The interconnected epidemic of drug dependency and AIDS. *Harvard Civil Rights–Civil Liberties Law Rev* 1991;26:113–84.
13. Healey KM. *State and local experience with drug paraphernalia laws.* Washington, DC: U.S. Department of Justice, National Institute of Justice, 1988.
14. Webb v. United States, 249 US 96,99, 1919.
15. Pascal CB. Intravenous drug abuse and AIDS transmission: federal and state laws regulating needle availability. In: *NIDA research monograph no. 80.* Rockville, MD: NIDA, 1988:119–36.
16. Magura S, Grossman JI, Lipton DS, et al. Determinants of needle sharing among intravenous drug users. *Am J Public Health* 1989;79:459–62.
17. Calsyn DA, Saxon AJ, Freeman G, Whittaker S. Needle-use practices among intravenous drug users in an area where needle purchase is legal. *AIDS* 1991;5:187–93.
18. Ingold FR, Ingold S. The effects of liberalization of syringe sales on the behaviour of intravenous drug users in France *Bull Narc* 1989;41:67–81.
19. National Commission on AIDS. *The twin epidemics of substance abuse and HIV.* Washington, DC: National Commission on AIDS, 1991.
20. Connecticut General Statutes, Sections 21a-65, 21a-240, 21a 267, 1992.
21. Centers for Disease Control and Prevention. Update: acquired immunodeficiency syndrome associated with intravenous-drug use—United States, 1988. MMWR 1989;38:16: 70.
22. *State of Connecticut AIDS annual report.* Hartford: State Connecticut Department of Public Health and Addicti Services, 1992.
23. Centers for Disease Control and Prevention. Impact of n legislation on needle and syringe purchase and possessior Connecticut, 1992. MMWR 1993;42:145–8.
24. Groseclose SL, Weinstein B, Jones TS, Kassler W, Valle L, Fehrs L. Legal purchase and possession of clean nee and syringes in Connecticut: Do they make a difference? Abstract book of the IXth International Conference AIDS; June 6–11, 1993, Berlin, Germany. Abstract PO-I 4185.
25. Valleroy L, Weinstein B, Groseclose S, Kassler W, Jone Evaluating the impact of a new needle/syringe law: surlance of needle/syringe sales at Connecticut pharmacies Abstract book of the IXth International Conferenc AIDS; June 6–11, 1993; Berlin, Germany. Abstract PO-3189.
26. Groseclose SL, Valleroy LA, Weinstein B, Jones Kassler WJ, Fehrs LJ, Rolfs RT. New Connecticut la

improve access to needles and syringes: What is their impact? In: Proceedings of the Workshop on Needle Exchange and Bleach Distribution Programs. Washington, DC: National Academy Press, 1994.
27. Groseclose SL, Valleroy LA, Weinstein B, Jones TS, Fehrs LJ, Kassler WJ. Impact of increased legal access to needles and syringes on practices of injecting-drug users and police officers—Connecticut, 1992–1993. *J Acquir Immune Defic Syndr Hum Retrovirol* 1995;10:82–9.
28. *Census of Population and Housing. 1990: Summary Tape File 3A*. Washington DC: U.S. Census Bureau, 1990.
29. SAS Institute Inc. SAS/STAT User's Guide. Version 6. Fourth Edition, Cary, NC: SAS Institute, 1990.
30. Dean AD, Dean JA, Burton AH, Dicker RC. Epi Info, Version 5: a word processing, database, and statistics program for epidemiology on microcomputers. Atlanta, GA: Centers for Disease Control and Prevention, 1990.
31. Kish L. *Survey sampling*. New York: Wiley, 1965.
32. Lawrence D, Lawrence M, Atkinson W, Risi G, Lauro A. Needle-sharing among intravenous drug users in New Orleans. *J L State Med Soc* 1991;143:18–21.
33. Compton W, Cottler L, Decker S, Mager D, Stringfellow R. Legal needle buying in St. Louis. *Am J Public Health* 1992; 82:595–6.
34. Keys Young MSJ. *Fitpacks evaluation study*. Melbourne: Australia: New South Wales Health Department, AIDS Bureau, 1992.
35. Tsai R, Goh EH, Webeck P, Mullins J. Prevention of human immunodeficiency virus infection among intravenous drug users in New South Wales, Australia: the needles and syringes distribution programme through retail pharmacies. *Asia-Pac J Public Health* 1988;2:245–51.
36. Mullins RM. Needles and syringes for IVDUs. *Med J Aust* 1990;152:672.
37. Millson P, Coates R, Rankin J, et al. *Surveys regarding AIDS and injection drug users for City of Toronto pharmacists*. Toronto: University of Toronto, 1991.
38. DePhilippis D, Metzger DS. Needle acquisition difficulty is associated with needle-sharing not drug use. In: *Program of the meetings of the American Psychological Society*. Chicago, 1993.
39. Glanz A, Byrne C, Jackson P. Role of community pharmacies in prevention of AIDS among injecting drug misusers: findings of a survey in England and Wales. *Br Med J* 1989; 299:1076–9.
40. Stimson GV, Keene J, Parry-Langdon N, Jones S. Evaluation of the syringe exchange programme in Wales, 1990-1991: final report to Welsh office. Wales: Centre for Research on Drugs and Health Behaviour, 1991.
41. Millar T. *Pharmacies and syringe exchange in Liverpool, England*. Liverpool: Mersey Regional Health Authority, The Drugs and HIV Monitoring Unit, 1989.
42. Buning EC, Coutinho RA, Van Brussel GHA, et al. Preventing AIDS in drug addicts in Amsterdam. *Lancet* 1986;79: 1355–7.
43. Stimson GV, Lart R. HIV, drugs, and public health in England: New words, old tunes. *Int J Addict* 1991;26:1263–77.
44. Curran JW, Scheckel LW, Millstein RA. *HIV/AIDS prevention bulletin*. Atlanta: Centers for Disease Control and Prevention, Center for Substance Abuse and Treatment, and National Institute on Drug Abuse, 1993.
45. Flynn N, Jain S, Keddie EM, et al. In vitro activity of readily available household materials against HIV-1: Is bleach enough? *J Acquir Immune Defic Syndr* 1994;7:747–53.
46. Shapshak P, McCoy CB, Shah SM, et al. Preliminary laboratory studies of inactivation of HIV-1 in needles and syringes containing infected blood using undiluted household bleach. *J Acquir Immune Defic Syndr* 1994;7:754–9.
47. Vlahov D, Astemborski J, Solomon L, Nelson KE. Field effectiveness of needle disinfection among injecting drug users. *J Acquir Immune Defic Syndr* 1994;7:760–6.
48. Gleghorn AA, Doherty MC, Vlahov D, Celentano DD, Jones TS. Inadequate bleach contact times during syringe cleaning among injection drug users. *J Acquir Immune Defic Syndr* 1994;7:767–72.
49. McCoy CB, Rivers JE, McCoy HV, et al. Compliance to bleach disinfection protocols among injecting drug users in Miami. *J Acquir Immune Defic Syndr* 1994;7:773–9.

Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology
10:82–89 © 1995 Lippincott–Raven Publishers, Philadelphia

Impact of Increased Legal Access to Needles and Syringes on Practices of Injecting-Drug Users and Police Officers—Connecticut, 1992–1993

Samuel L. Groseclose, ‡Beth Weinstein, *T. Stephen Jones, †Linda A. Valleroy, Laura J. Fehrs, and §William J. Kassler

*Division of Field Epidemiology, Epidemiology Program Office, Centers for Disease Control and Prevention (CDC); *Office of HIV/AIDS, Office of the Director, CDC; †Division of Sexually Transmitted Diseases and HIV Prevention, National Center for Prevention Services (NCPS), CDC, Atlanta, Georgia; ‡AIDS Division, Connecticut Department of Public Health and Addiction Services, Hartford, Connecticut U.S.A.*

Summary: To determine whether the simultaneous, partial repeal of needle prescription and drug paraphernalia laws in Connecticut affected purchasing and usage of needles and syringes (syringes) by injecting-drug users (IDUs) and risk of needlestick injuries to police officers, we conducted two serial cross-sectional surveys with IDUs recruited in drug treatment centers, correctional facilities, and health department settings. Reports of needlestick injuries among Hartford police officers were reviewed before and after the new laws. Among IDUs who reported ever sharing a syringe, syringe-sharing decreased after the new laws (52% before vs. 31% after; $p = 0.02$). Fewer IDUs reported purchasing syringes on the street after the new laws (74% before vs. 28% after; $p < 0.0001$). More IDUs reported purchasing syringes from a pharmacy after the new laws (19% before vs. 78% after; $p < 0.0001$). Eight to eleven months after the new laws were enacted, over two thirds (91 of 134) of active IDUs interviewed were aware of both new laws. Needlestick injury rates among Hartford police officers were lower after the new laws (six injuries in 1,007 drug-related arrests for 6-month period before new laws vs. two in 1,032 arrests for 6-month period after new laws). The changes in Connecticut laws were associated with decreases in self-reported syringe-sharing and increases in purchasing by IDUs of sterile syringes from reliable sources, suggesting that the simultaneous repeal of both prescription and paraphernalia laws is an important HIV prevention strategy. Key Words: Injecting-drug users—Needle prescription law—Drug paraphernalia law—Needle and syringe sharing—Needlestick injury.

Multi-person use (sharing) of syringes* is a major mechanism for transmission of human immunodeficiency virus (HIV) and other bloodborne pathogens among injecting-drug users (IDUs) (1–5). In response to the acquired immunodeficiency syndrome (AIDS) epidemic and HIV prevention interventions, IDUs in some localities have adopted safer injection practices and decreased syringe

Presented in part in the *Morbidity and Mortality Weekly Report* 1993;42:145–8, at the IXth International Conference on AIDS, Berlin, Germany, June 7–11, 1993, and at the National Research Council's Workshop on Needle Exchange and Bleach Distribution Programs, Baltimore, Maryland, September 27–28, 1993.

At the time of this evaluation, Drs. Groseclose and Valleroy were Epidemic Intelligence Service officers with the CDC.

Address correspondence and reprint requests to Dr. Samuel L. Groseclose at Division of STD/HIV Prevention (E-63), Centers for Disease Control and Prevention, 1600 Clifton Road; Atlanta, Georgia 30333, U.S.A.

Manuscript received November 15, 1994; accepted April 18, 1995.

* We use the term "syringe" to include both needle and syringe.

sharing (6–10). Epidemiologic and ethnographic studies suggest that syringe-sharing even among IDUs knowledgeable of the means to avoid HIV infection has evolved, in part, as a response of IDUs to the restricted availability of syringes (9,11–17).

Effective July 1, 1992, Connecticut enacted new laws that removed some legal barriers to the purchase and possession of syringes as part of a strategy for reducing the spread of HIV among IDUs unable or unwilling to enter drug treatment (18). We conducted a study to determine whether changes in Connecticut's laws regulating needle prescriptions and drug paraphernalia affected syringe purchasing and usage by IDUs and police officers' risk of needlestick injuries.

Methods

Surveys of Active IDUs

We conducted two questionnaire surveys of active IDUs to assess their syringe-purchasing practices, their syringe-sharing behaviors, and their knowledge of the new syringe legislation. IDUs were enrolled consecutively and were interviewed by staff members at three health department–based HIV counseling and testing programs, three correctional facilities, and two-drug-treatment centers in four Connecticut towns—Bridgeport, Hartford, Montville, and Waterbury. Only male IDUs were interviewed in correctional facilities and they were interviewed within 7 days of being admitted or incarcerated.

To determine practices of IDUs before the new laws were enacted on July 1, 1992, we conducted an initial survey from August through November 1992. During this initial survey, IDUs were asked to describe their practices and behaviors in June 1992 (the 30-day period just before the laws were implemented and 2–4 months before the interview).

To determine practices of IDUs after the new laws went into effect, we conducted a second cross-sectional survey (follow-up survey) of different IDUs from March to June 1993 (8–11 months after enactment). IDUs interviewed during the follow-up survey were asked to describe their practices, focusing on the 30-day period before the interview.

We defined active IDUs as persons who reported using a syringe to inject drugs into their veins or muscles or under their skin. During both surveys, we limited eligibility to persons who reported injecting drugs during the month before the interview. During the initial survey, we restricted eligibility to IDUs who also reported injecting drugs in June 1992. We defined syringe-sharing as using a syringe (the IDU's own syringe or one that belonged to someone else) that the IDU knew had been used by someone else.

Police Department Data

To determine whether police officers were at greater risk for needlestick injuries after the new laws were enacted, Occupational Safety and Health Administration (OSHA)–mandated reports of occupational injuries and illnesses among Hartford police officers were reviewed for reports of needlestick injuries. We used data for drug-related violations likely to be associated with syringe use to provide some information about police drug enforcement activity before and after the new laws and to serve as a surrogate denominator for the incidence of needlestick injuries. We used Federal Bureau of Investigation Uniform Crime Reporting criteria to define a drug-related arrest as an arrest for possession of opiates, cocaine, or paraphernalia. We determined the number of needlestick injuries and drug-related arrests for the 6 months before (January 1992 through June 1992) and after (July 1992 through December 1992) the new laws were enacted.

Statistical Analysis

Data were analyzed by using Epi Info, Version 5.01b software (19). The sample means from the initial and follow-up surveys were compared by using an independent two-sample t test (20). Rates and proportions were compared by using an independent two-sample z test.

Results

Surveys of Active IDUs

Selected Demographic Characteristics and Syringe-Related Practices

During the initial survey, 187 persons were asked to participate: 124 (66%) IDUs were eligible; nine (5%) refused to participate; and 54 (29%) had never injected drugs or were no longer actively injecting drugs (ineligible). Of the 210 persons asked to participate in the follow-up survey, 134 (64%) were eligible; eight (4%) refused to participate; and 68 (32%) were ineligible. The sex and race/ethnicity of eligible IDUs interviewed during both surveys were similar (Table 1). During the follow-up survey, a significantly greater proportion of the IDUs were interviewed in drug treatment facilities than in the initial survey (68 vs. 51% in the initial survey; $p = 0.01$).

The age, duration of injecting-drug use, and frequency of injection for IDUs in our initial and follow-up survey samples were similar (Table 2). IDUs in the samples had a median age of 35 years (range: 17–56 years). IDUs reported using injecting-drugs for a median of 14 years (range: 1–33 years; Table 2). Three-percent (4 of 116) of IDUs in the initial sample and 5% (7 of 128) of IDUs in the follow-up sample reported that they began injecting drugs within the previous 12 months. Although the mean number of reported injections per month declined after the new laws (143 before vs. 124 after; $p = 0.13$), the reported number of injections did not vary significantly when data were adjusted for knowledge of the new laws or source of syringes.

More IDUs in the initial survey reported that they had ever shared syringes compared with IDUs in

TABLE 1. *Selected characteristics and practices of the initial and follow-up survey samples of active IDUs, Connecticut, 1992–1993*

Characteristic/ practice	Initial survey (total n = 124) n (% distribution)	Follow-up survey (total n = 134) n (% distribution)	p^a
Sex			
Male	98 (79)	111 (83)	0.52
Female	25 (20)	23 (17)	0.65
Race/ethnicity			
Non-Hispanic White	53 (43)	63 (47)	0.56
Hispanic	50 (40)	45 (19)	0.32
African-American	21 (17)	26 (19)	0.80
Site of interveiw			
Correctional facility	27 (22)	27 (20)	0.80
Drug treatment	63 (51)	91 (68)	0.01[b]
Health department	34 (27)	16 (12)	0.003[b]
Ever shared a needle and syringe?			
Yes	84 (68)	70 (52)	0.03[b]
Ever obtained a needle and syringe?			
On the street	109 (88)[c]	99 (74)	0.01[b]
In a pharmacy	58 (47)[c]	120 (90)	0.0001[b]
In a "shooting gallery"	43 (35)[c]	31 (23)	0.05[b]
Needle exchange	8 (6)[c]	25 (19)	0.01[b]
Other source	56 (45)[c]	21 (16)	<0.001[b]
Ever owned your own needle and syringe?			
Yes	114 (92)	133 (99)	0.004[b]

[a] Two-sided; z test.
[b] Significant at $p \leq 0.05$.
[c] Includes reported purchasing during the 2–5 months after the new laws and before the survey.

the follow-up survey (68 vs. 52%, respectively; p = 0.03; Table 1). More IDUs in the initial survey reported ever having obtained syringes on the street (p = 0.01) and from some other source (e.g., from persons with diabetes or other friends; $p < 0.0001$), and fewer reported ever having obtained syring from a pharmacy (p = 0.0001), from a "shooti gallery" (p = 0.05), or from a needle exchange (p 0.01) compared with IDUs in the follow-up surv (Table 1).

TABLE 2. *Self-reported practices of active IDUs interviewed during the initial and follow-up surveys, Connecticut, 1992–1993*

Practice	Initial survey (n = 124) Mean (range) [no. responding]	Follow-up survey (n = 134) Mean (range) [no. responding]	p^a
Duration of injecting drug use (years)	14 (1–33) [116]	13 (1–33) [128]	0.61
Number of injections in 30 days before interveiw	143 (2–405) [115]	124 (1–930) [130]	0.13
Number of syringes owned at one time[b]	9 (1–100) [81]	11 (1–100) [132]	0.63
Number of times a syringe reused	8 (0–63) [116]	7 (0–42) [131]	0.65

[a] Two-sided; t test.
[b] Among IDUs who reported owning at least one syringe.

09/03/99 12:45 ☎860 509 7853 CT DPHAS/AIDS

Reported Syringe-Sharing

Fifty-two percent (44 of 84) of IDUs who had ever shared syringes reported at least one episode of syringe-sharing in the 30-day period before the new laws. After the new laws, a smaller proportion of IDUs who had ever shared syringes reported doing so at least once in the 30-day period preceding the follow-up survey [31% (22 of 70); $p = 0.01$; Fig. 1)]. Reported syringe-sharing did not vary by interview site. Among the IDUs reporting that they purchased syringes only in a pharmacy after the new laws, 30% (14 of 46) reported at least one needle-sharing episode in the previous 30 days.

Sources of Syringes

Fewer IDUs reported purchasing syringes on the street after the new laws went into effect (92 of 124 before vs. 38 of 134 after; $p < 0.0001$; Fig. 2). More IDUs reported purchasing syringes from a pharmacy after the new laws (23 of 124 before vs. 105 of 134 after; $p < 0.0001$).

After the new laws were enacted, pharmacies replaced street sources as the most frequently reported source of syringes. In the follow-up sample, 78% (105 of 134) of IDUs reported purchasing at least one syringe from a pharmacy compared with 28% (38 of 134) who reported purchasing at least one syringe on the street. After the new laws, fewer IDUs reported using syringes obtained in "shooting galleries" (16 of 124 before vs. 6 of 134 after; $p = 0.01$). Also, after the new laws, more IDUs reported obtaining syringes from needle exchange programs in Connecticut (4 of 124 before vs. 15 of 134 after; $p = 0.01$). Fewer IDUs reported obtaining their syringes from some other source after the new laws were enacted (56 of 124 before vs. 21 of 134 after; $p < 0.0001$).

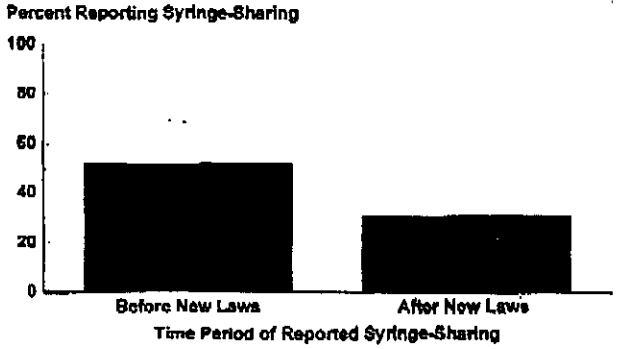


FIG. 1. Self-reported syringe-sharing before and after the new laws among active IDUs who ever shared. Connecticut, 1992–1993. Syringe-sharing was defined as at least one episode of syringe-sharing in the 30-day period before the new laws (initial survey; before) and the 30-day period before the follow-up survey (after).

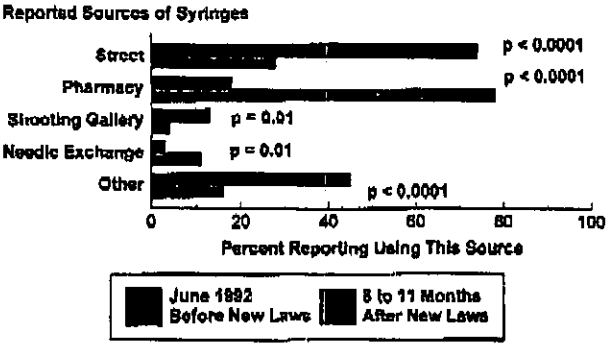


FIG. 2. Active IDUs' reported sources of syringes during 30-day periods before and after the new laws. IDUs could report multiple sources for syringes.

Reported Prices of Syringes

After the new laws, the reported street price of a syringe decreased from $2.35 (mean; range: $0.50–$5.00) before the laws to $1.79 ($0.50–$6.00; $p = 0.02$). The pharmacy prices reported by IDUs in our surveys remained unchanged at about 40 cents per syringe ($0.38 [$0.20–$0.60] before vs. $0.44 [$0.15–$1.00] after; $p = 0.07$).

Syringe Ownership and Reuse

More IDUs (99%, 133 of 134) reported owning at least one syringe after the new laws (during the 6 months preceding the follow-up interview) compared with IDUs reporting syringe ownership in the 6 months before the new laws (92%, 114 of 124; $p < 0.01$). Among IDUs who reported owning syringes, the mean number of syringes that IDUs owned did not differ before and after the new laws were enacted (Table 2). The number of times a syringe was reused before being discarded did not differ before and after the new laws were enacted (Table 2).

Syringe-Carrying Practices

Although self-reported syringe ownership increased, the percentage of IDUs reporting that they always carried syringes with them after the new laws did not increase significantly. Twenty-six percent (32 of 124) of IDUs in the initial survey reported always carrying at least one syringe on the

street before the new laws, compared with 34% (46 of 134) of IDUs in the follow-up survey ($p = 0.18$).

Thirteen percent (16 of 124) of IDUs in the initial survey reported that they were harassed by police for possession of clean syringes at least once during the 6-month period before the new laws were implemented. Under the new laws, the percentage was similar (14% [19 of 134] of IDUs interviewed during the follow-up survey).

Knowledge of New Laws

From 2 to 5 months after the new laws were enacted, 55% of IDUs reported they were aware that they could both purchase and possess clean syringes legally. Eight to 11 months after the new laws, 68% of IDUs reported that they were aware of the provisions of both new laws ($p = 0.04$; Fig. 3). During both periods, 21% of IDUs reported that they were aware they could legally purchase syringes, but did not know they could legally possess them. Less than 4% of IDUs interviewed during either survey period reported that they were aware of legal possession, but were not aware of legal over-the-counter purchase. During the follow-up survey, only 7% (10 of 134) did not know about either law compared with 23% (28 of 123) of IDUs interviewed just after enactment ($p = 0.001$). Sixty-four percent (18 of 28) of IDUs unaware of both laws in the initial survey and 60% (6 of 10) of those unaware of both laws in the follow-up survey were Hispanic. IDUs' knowledge of the new laws did not vary when the data were adjusted for interview site.

Police Officers' Risk of Needlestick Injury

Needlestick injury rates among Hartford police officers were higher during the 6 months before the law changed compared with the 6 months after (six needlestick injuries in 1,007 drug-related arrests before vs. two in 1,032 arrests after [two-sided $p = 0.27$; z test]).

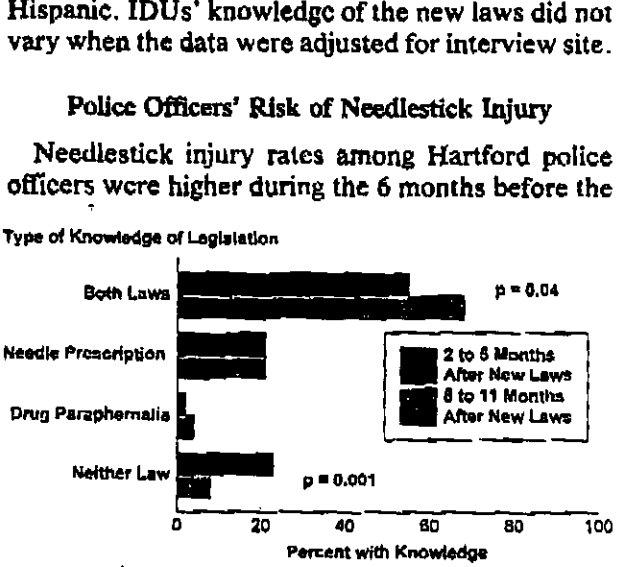


FIG. 3. IDUs' knowledge of partially repealed needle prescription and drug paraphernalia possession laws at 2–5 months (initial survey) and 8–11 months (follow-up survey) after the new Connecticut laws.

DISCUSSION

In the first year after the partial repeal of legal restrictions on both the purchase and possession of syringes in Connecticut, over two thirds of active IDUs interviewed were aware of both new laws, and many reported changes in their syringe-purchasing practices and their syringe-sharing behaviors. After the new laws went into effect, IDUs reported more purchasing of syringes in pharmacies, less purchasing on the street, and decreased syringe-sharing. These results are similar to those reported by IDUs in France after restrictions on the sale of syringes were removed (21,22). Increases in pharmacy sales of nonprescription syringes in Connecticut pharmacies after the new laws support the IDUs' self-reports of increased pharmacy purchasing (18).

The 39% decrease in syringe-sharing reported by IDUs in our samples (likely an underestimate because of the insensitive syringe-sharing definition) represents a significant reduction in risk that may lead directly to a decrease in the transmission of HIV and other bloodborne pathogens. Safer injection practices may have resulted from increased access to sterile syringes. In Washington State, where purchase of syringes in pharmacies is legal, IDUs who obtained syringes primarily from pharmacies were less likely to share injection equipment than were those with other primary sources (23). Other studies have suggested that increased access to sterile injection equipment may explain the stable HIV seroprevalence in Australia, New Zealand and the Netherlands; the decline in prevalence of hepatitis B surface antibody among IDUs in Australia, the Netherlands, and Tacoma, Washington and the lower HIV seroprevalence among diabetic IDUs (7,24–28).

Eight to 11 months after the new laws in Connecticut, 77% of the active IDUs we surveyed reported purchasing syringes from a pharmacy in the previous month; only 28% reported purchasing syringes on the street. In Washington State, where a prescription is not required, 66% of IDUs entering drug treatment reported buying syringes in a pharmacy as the primary method of obtaining syringes; 10% reported street purchasing as the primary method

09/03/99 12:47 ☎860 509 7655 CT DPHAS/AIDS

obtaining syringes (23). However, in Baltimore, Maryland, where purchasing syringes in pharmacies is legal but a law regulating paraphernalia is in effect, only 54% of IDUs had ever purchased from a pharmacy and 50% of those surveyed reported purchasing in the street as their main method of obtaining syringes (29). Although IDUs in Connecticut appear to have shifted their primary method of obtaining syringes after the new laws, data from Baltimore indicate that the absence of a needle prescription law does not necessarily result in purchasing sterile syringes in pharmacies by the majority of IDUs. Availability of sterile syringes in jurisdictions where purchase in pharmacies is legal may be limited because of racial bias or the pharmacist's unwillingness to sell syringes to IDUs (18, 30–34).

Findings from our evaluation and other studies suggest that barriers still exist which decrease the likelihood that IDUs will carry their own syringes with them, thus increasing the likelihood of unsafe syringe sharing (9,31,35). Even though IDU's knowledge of the new laws increased, the percentage of IDUs reporting that they always carried a syringe on the street increased only slightly (from 26 to 34%). Hispanic IDUs were less likely to know about both new laws, suggesting that language or cultural barriers limited knowledge. After the new laws, the percentage of IDUs reporting they had been harassed by police for possession of clean syringes did not decrease.

Police practices regarding the relative importance of syringe possession as a criminal offense may vary by individual officer–IDU interaction and by locality (Lieutenant Tom O'Connor, Hartford Police Department and Lieutenant Richard Walsh, Wethersfield Police Department, personal communications) (32). In focus groups with active IDUs in Connecticut, IDUs reported different police practices regarding possession of syringes. For example, an officer might request that the IDU dispose of the syringe safely in the presence of the officer with no further consequence; or another officer might arrest the IDU for paraphernalia possession pending further investigation (S. Groseclose, 1992, unpublished data). Different police responses to finding a syringe on an individual ensure that IDUs will continue to receive conflicting feedback regarding their ability to carry a clean syringe legally. Regardless of knowledge of the new laws, an IDU's perception that he/she can be harassed or arrested for possession of a clean syringe may continue to discourage the IDU from carrying a syringe—increasing the likelihood of unsafe syringe-sharing.

Another possible effect of the new laws could have been to increase the risk of needlestick injuries to police officers after the new laws were enacted. Although the officers' risk of needlestick injury may depend on factors that we did not measure, OSHA reports of needlestick injuries among Hartford police decreased after the new laws. Increased risk of needlesticks has not been observed in other localities where access to syringes has been increased (7,36). Interviews with AIDS outreach workers and police officers from several Connecticut towns did not indicate any significant increase in the number of discarded syringes in their communities after the new laws were enacted (S. Groseclose, 1993, unpublished data).

Our study has several limitations. Because our active IDU samples were not randomly selected, their representativeness is uncertain. Our samples from health department programs and drug treatment and correctional facilities may overrepresent ethnic and racial minorities. However, these communities are disproportionately affected by HIV and are, therefore, appropriate for evaluation. The poorly defined IDU population makes construction of a valid sampling frame almost impossible. Because the intervals for recall were not equal, self-reported data from our initial and follow-up surveys may be subject to differential recall bias. As with most self-reported behavioral data, the effect of social desirability on IDUs' self-reported behavior is difficult to assess. However, various studies have suggested that IDUs' self-reports of recent drug use and of arrests and hospitalizations correlate well with objective data (37,38).

This evaluation did not directly measure the impact of the legislation on HIV transmission. However, the proportional decrease in reported syringe-sharing of 39% that we report here would be expected to translate into cases of HIV infection prevented—the goal of increasing access to sterile syringes.

Although stopping drug use is the most effective means of HIV prevention among IDUs, many IDUs are unwilling or unable to stop (39,40). Therefore, multifaceted interventions must encourage risk reduction and entry into drug treatment. The National Commission on AIDS recommended the removal of legal barriers to the purchase and possession of syringes as part of a strategy for reducing the spread of HIV among IDUs unable or unwilling to enter

09/03/99 12:48 ☎860 509 7853 CT DPHAS/AIDS 030

drug treatment (41). Our data suggest that when legal restrictions on both the purchase and possession of syringes are removed, IDUs will change their syringe-purchasing practices and their syringe-sharing behaviors in ways that can reduce HIV transmission.

Acknowledgment: The authors thank the counselors and administrators of the Hartford Dispensary; Bridgeport Regional Network of Programs; Chemical Dependency Unit, Community Health Services, Hartford; Hartford Police Department; AIDS Program, Hartford Health Department; AIDS Program, Bridgeport Health Department; AIDS Program, Waterbury Health Department; Town of Wethersfield Police Department; Bureau of Addiction Services, Connecticut Department of Public Health and Addiction Services; and the Health Services Division, Connecticut Department of Correction. In addition, Henry R. Rolka, M.S., and P. Imani Thompson, Ed. M., provided valuable assistance during this evaluation.

REFERENCES

1. Friedland GH, Harris C, Buktus-Small C, et al. Intravenous drug abusers and the acquired immunodeficiency syndrome (AIDS): demographics, drug use, and needle sharing patterns. *Arch Intern Med* 1985;145:1413–7.
2. Marmor M, Des Jarlais DC, Cohen H, et al. Risk factors for infection with human immunodeficiency virus among intravenous drug users in New York City. *J Acquir Immune Defic Syndr* 1987;1:39–44.
3. Chaisson RE, Moss AR, Onishi R, Osmond D, Carlson JR. Human immunodeficiency virus infection in heterosexual drug users in San Francisco. *Am J Public Health* 1987;77:169–72.
4. Schoenbaum EE, Hartel D, Selwyn PA, et al. Risk factors for human immunodeficiency virus infection in intravenous drug users. *N Engl J Med* 1989;321:874–9.
5. Piot P, Goilav C, Kegels E. Hepatitis B: transmission by sexual contract and needle sharing. *Vaccine* 1990;8:S37–S40.
6. Vlahov D, Anthony JC, Celentano D, Solomon L, Chowdhury N. Trends of HIV-1 risk reduction among initiates into intravenous drug use, 1982–1987. *Am J Drug Alcohol Abuse* 1991;17:39–48.
7. Buning EC. Effects of Amsterdam needle and syringe exchange. *Int J Addict* 1991;26:1303–11.
8. Des Jarlais DC, Friedman SR, Casriel C. Target groups for preventing AIDS among intravenous drug users, 2. The "hard" data studies. *J Consult Clin Psychol* 1990;58:50–6.
9. Loxley WM, Marsh AM, Hawks DV, Quigley AJ. HIV risk behavior among injecting drug users in Perth: the Australian National AIDS and Injecting Drug Use Study. *Med J Aust* 1992;156:687–92.
10. Des Jarlais DC, Friedman SR, Sotheran JL, et al. Continuity and change within an HIV epidemic: injecting drug users in New York City, 1984 through 1992. *JAMA* 1994;271:121–7.
11. Friedman SR, Des Jarlais DC, Sotheran JL, et al. AIDS and self-organization among intravenous drug users. *Int J Addict* 1987;22:201–19.
12. Feldman HW, Biernacki P. The ethnography of needle sharing among intravenous drug users and implications for public policies and intervention strategies. In: Battjes RJ, Pickens RW, eds. *Needle sharing among intravenous drug abusers: national and international perspectives* (NIDA research monograph no. 80). Washington, DC: US Department of Health and Human Services; 1988:28–39.
13. Magura S, Grossman JI, Lipton DS, et al. Determinants of needle sharing among intravenous drug users. *Am J Public Health* 1989;79:459–62.
14. Metzger D, Woody G, DePhilippis D, McLellan T, O'Brien CP, Platt JJ. Risk factors for needle sharing among methadone-treated patients. *Am J Psychiatry* 1991;148:636–40.
15. Celentano DD, Vlahov D, Cohn S, Anthony JC, Solomon L, Nelson KE. Risk factors for shooting gallery use and cessation among intravenous drug users. *Am J Public Health* 1991;81:1291–5.
16. Grund JPC, Kaplan CD, Adriaans NFP. Needle sharing in the Netherlands: an ethnographic analysis. *Am J Public Health* 1991;81:1602–7.
17. Zule WA. Risk and reciprocity: HIV and the injection drug user. *J Psychoactive Drugs* 1992;24:243–9.
18. Valleroy LA, Weinstein B, Jones TS, et al. Impact of increased legal access to needles and syringes on community pharmacies' needle and syringe sales—Connecticut, 1992–1993. *J Acquir Immune Defic Synds Hum Retrovirol* 1995;10:73–81.
19. Dean AD, Dean JA, Burton JH, Dicker RC. *Epi Info, Version 5: a word processing, database, and statistics program for epidemiology on microcomputers*. Atlanta, Georgia: Centers for Disease Control and Prevention, 1990.
20. Bahn AK. *Basic medical statistics*. New York: Grune & Stratton, 1972:49–62, 136–143.
21. Ingold FR, Ingold S. The effects of the liberalization of syringe sales on the behavior of intravenous drug users in France. *Bull Narc* 1989;41:67–81.
22. Facy F, LeHuede E, Ramirez HD. Drug addicts and syringe sharing in France: epidemiological study, 1988. *Int J Addict* 1991;26:515–29.
23. Calsyn DA, Saxon AJ, Freeman F, Whittaker S. Needle-use practices among intravenous drug users in an area where needle purchase is legal. *AIDS* 1991;5:187–93.
24. Des Jarlais DC, Friedman SR. AIDS and legal access to sterile drug injection equipment. *Ann Am Acad Pol Soc Sci* 1992;521:42–63.
25. Swensen G, Quigley A, Lenton S. Hepatitis B infection — a proxy measure of risk factors for HIV infection in IVDUs? [Letter]. *Med J Aust* 1990;153:434–5.
26. Hagan H, Reid T, Des Jarlais DC, Purchase D, Friedman SR, Bell TA. The incidence of HBV infection and syringe exchange programs [Letter]. *JAMA* 1991;266:1646–7.
27. Nelson KE, Vlahov D, Cohn S, Lindsay A, Solomon L, Anthony JC. Human immunodeficiency virus infection in diabetic intravenous drug users. *JAMA* 1991;266:2259–61.
28. Dickson NP, Austin FJ, Paul C, Sharples KJ, Skegg DCG. HIV surveillance by testing saliva from injecting drug users: a national study in New Zealand. *J Epidemiol Community Health* 1994;48:55–7.
29. Jones TS, Gleghorn AA, Doherty MC, Vlahov D. How injecting drug users (IDUs) in Baltimore, Maryland, acquire and use needles and syringes for drug injection. In: *Final program and abstracts of the IX International Conference on AIDS; 1993;* Berlin (abstract PO-C24-3190).
30. Des Jarlais DC, Friedman SR, Sotheran JL, Stoneburner R. The sharing of drug injection equipment and the AIDS epidemic in New York City: the first decade. In: Battjes RJ, Pickens RW, eds. *Needle sharing among intravenous drug abusers: national and international perspectives* (NIDA research monograph no. 80). Washington, DC: US Department of Health and Human Services, 1988:160–75.
31. Olievenstein C. Drug addiction and AIDS in France in 1987. In: Battjes RJ, Pickens RW, eds. *Needle sharing among*

intravenous drug abusers: national and international perspectives (NIDA research monograph no. 80). Washington, DC: US Department of Health and Human Services, 1988:114–8.

32. Stimson GV. Injecting equipment exchange schemes in England and Scotland. In: Battjes RJ, Pickens RW, eds. *Needle sharing among intravenous drug abusers: national and international perspectives* (NIDA research monograph no. 80). Washington, DC: US Department of Health and Human Services; 1988:89–99.
33. Gaughwin MD, Ryan P, Treffke H, Lee M, All R. Can I buy a syringe? The availability of needles and syringes to intravenous drug users in Adelaide [Letter]. *Med J Aust* 1990; 153:569.
34. Compton WM, Cottler LB, Decker SH, Mager D, Stringfellow R. Legal needle buying in St. Louis. *Am J Public Health* 1992;82:595–6.
35. Hopkins W. Needle sharing and street behavior in response to AIDS in New York City. In: Battjes RJ, Pickens RW, eds. *Needle sharing among intravenous drug abusers: national and international perspectives* (NIDA research monograph no. 80). Washington, DC: US Department of Health and Human Services, 1988:18–27.
36. Oliver KJ, Friedman SR, Maynard H, Magnuson L, Des Jarlais DC. Impact of a needle exchange program on potentially infectious syringes in public places (Letter). *J Acquir Immune Defic Syndr* 1992;5:534–5.
37. Amsel Z, Mandell W, Matthias L, Mason C, Hocherman I. Reliability and validity of self-reported illegal activities and drug use collected from narcotic addicts. *Int J Addict* 1976; 11:325–36.
38. Maisto SA, Sobell LC, Sobell MB. Corroboration of drug abusers' self-reports through the use of multiple data sources. *Am J Drug Alcohol Abuse* 1982;9:301–8.
39. Buning EC, Coutinho RA, Van Brussel GHA, et al. Preventing AIDS in drug addicts in Amsterdam. *Lancet* 1986;79: 1355–7.
40. Stimson GV, Lart R. HIV, drugs, and public health in England: new words, old tunes. *Int J Addict* 1991;26:1263–77.
41. National Commission on Acquired Immune Deficiency Syndrome. *The twin epidemics of substance use and HIV*. Washington, DC: National Commission on Acquired Immune Deficiency Syndrome. 1991:10–11.

Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology
10:104–105 © 1995 Lippincott–Raven Publishers, Philadelphia

Letters to the Editor

Sale and Exchange of Syringes

To the Editor: Findings from our ongoing study of patterns of AIDS risk among out-of-treatment injection drug users (IDUs) in Hartford, CT support and extend the data presented by Linda Vallcroy and Sam Groseclose. As part of a National Institute on Drug Abuse project, we have interviewed 571 male and female active IDUs (verified by urine drug testing) recruited through street outreach. This data contributes to the evaluation of the Hartford Needle Exchange Program (NEP).

The Hartford NEP is coordinated by a community consortium under the direction of the Hartford Health Department. Services are provided through a mobile van and include one-for-one exchange of (up to ten) syringes, as well as HIV prevention education, assisted referral for drug treatment and health services, and distribution of prevention materials (e.g., condoms, bleach, prevention literature). The Hartford NEP exchanges approximately 3,000 syringes per month.

Our study has collected data from cross-sectional samples of IDUs during three time periods: (a) September 1992 to March 1993, following the enactment of state legislation decriminalizing needle possession and allowing non-prescription pharmacy sale of syringes for the first time in 14 years; (b) April 1993 to March 1994, following the start-up and initial implementation phase of the Hartford NEP; and (c) April 1994 to March 1995, the second year of NEP operations, by which time the program was well-known among drug injectors. The number of participants interviewed in each of these time periods was 179, 167, and 225 respectively.

Over the three time periods, there was a progressive reduction in the barriers to sterile needle access for IDUs. For each of these periods, there was a corresponding significant increase ($\chi^2 = 13.03$; $p = 0.04$) in the percentage of IDUs reporting that they purchase syringes from a pharmacy (63.1%, 71.2%, and 76.8%, respectively). Between the first and second NEP periods, there also was a significant increase (from 51.2% to 64.9%) in the percentage of IDUs reporting use of the NEP ($\chi^2 = 8.1$; $p = 0.08$). By the second NEP period, 50% of the IDUs surveyed reported that they get more than half to all of their syringes from the NEP.

These changes have contributed to a reduction in needle-related HIV risk behavior. There was a progressive drop (from 22% to 19% to 10%) across the three time periods ($F = 2.01$; $p = 0.05$) in the proportion of drug injections among study participants involving a previously used (and potentially HIV and/or hepatitis infected) syringe.

In sum our findings show increased syringe purchase from pharmacies and increased NEP use through time, and an associated drop in the relative frequency of HIV risk behavior (i.e., multi-person use of syringes) among IDUs. These findings confirm the beneficial effects of the 1992 changes in Connecticut's syringe purchase and drug paraphernalia laws, as well as the usefulness of needle exchange. We strongly recommend that states/counties with prescription requirements for syringe purchase and/or criminal penalties for possession or distribution of syringes repeal these laws. There is a critical need to continue the process of increasing access to sterile needles among IDUs. Needed changes include deregulating syringe sale and possession, implementing needle exchange, increasing the capacity of existing NEPs to serve all of the IDUs in their catchment area, recruiting shooting galleries as sterile syringe sites, promoting the ability of IDUs to discard syringes after every use, and exploring new avenues of sterile syringe exchange, such as vending machines.

*Merrill Singer
†Margaret R. Weeks
*David Himmelgreen
**Hispanic Health Council*
†*Institute for Community Research*
Hartford, Connecticut

In Eastern Connecticut, IDUs Purchase Syringes from Pharmacies But Don't Carry Syringes

To the Editor: In July 1992, new State of Connecticut laws went into effect that allowed the purchase of up to ten syringes without a prescription and possession of up to ten syringes. In two towns in Eastern Connecticut (New London and Willimantic) between March and November 1994, the Eastern Connecticut Health Outreach Project (funded in part by Grant RO1 DA08014 from the National Institute on Drug Abuse) interviewed injecting drug users (IDUs) who were not currently in drug treatment programs about purchasing and carrying syringes.

Pharmacies have become the leading source of syringes for Eastern Connecticut IDUs. Of the 147 respondents who had injected during the 30 days prior to interview, 79 (53.7%) obtained syringes primarily from pharmacies (see Fig. 1A). However, while 131 (89.1%) of respondents reported "no difficulty" obtaining sterile syringes, 33

09/03/99 12:50 ☎860 509 7853 CT DPHAS/AIDS ☎035

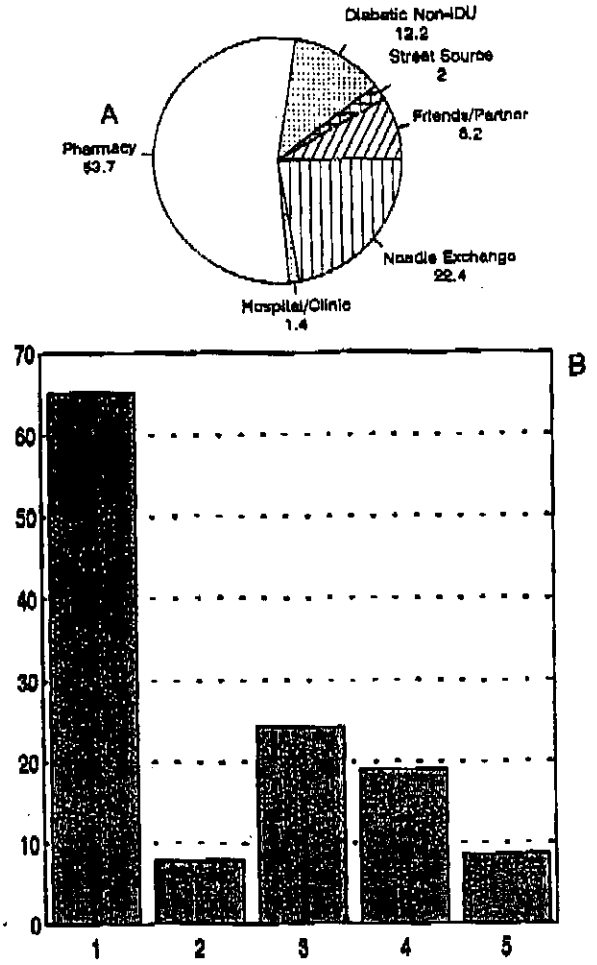


FIG. 1. Obtaining and carrying syringes. A: Primary sources of syringes for IDUs over the past 30 days. B: Reasons IDUs give for not carrying syringes with them. More than one answer possible. 1, fear of police; 2, fear of family; 3, not intending to inject; 4, injects in one place only; 5, other reasons.

(22.4%) reported obtaining syringes primarily from potentially unreliable sources such as diabetics, partners, and needle dealers.

Our data on IDUs' willingness to carry syringes are less encouraging. At the time of interview, only 37 of 158 respondents (23.4%) had syringes in their possession, and only 48 of 159 (30.2%) reported that they normally carried them. If IDUs are not carrying their own syringes, they may use other IDUs' syringes.

The primary reason (see Fig. 1B) given for not carrying syringes was fear of arrest (64.9%), a concern that did not significantly vary by gender, ethnicity or race. This fear is well-grounded. At least seven study participants reported recent arrests for possession of new syringes, used syringes, or for possession of other injecting equipment such as cookers. A sample of 66 local police reports in the Willimantic Chronicle and the New London Day from January to December of 1994 revealed that more than one-tenth (11.3%) of all reported arrests (35 of 310), and about one-fourth (28.5%) of drug-related arrests (35 of 123), included drug-paraphernalia possession charges.

IDUs' strategies for avoiding arrest for possession of syringes may increase the risk of HIV transmission. For example, we observed IDUs hiding syringes in public places (e.g., bushes) where they could potentially be found and used by other IDUs. We also observed a child find such a syringe.

In Eastern Connecticut, the current enforcement of the drug paraphernalia law for possession of syringes and the resulting concerns among IDUs about arrest for possession of syringes may increase the frequency of multiperson use of syringes and the possibility of transmission of HIV and other blood-borne infections among IDUs.

Jean-Paul C. Grund
Douglas D. Heckathorn
Robert S. Broadhead
Denise L. Anthony
Department of Sociology
University of Connecticut
Storrs, Connecticut

January 1995; "An Overview of 1995 State Legislative Activity," IHPP, Dec. 15, 1995; *APL*, January 1997; http://www.stateserv.hpts.org, NCSL, 1997 and 1998).

- If consent cannot be obtained, HIV **testing** of patients in cases of **medical emergencies** is allowed in at least 18 states—Arkansas, Connecticut, Delaware, Florida, Hawaii, Idaho, Iowa, Kentucky, Michigan, Montana, New Hampshire, New Mexico, North Dakota, North Carolina, Ohio, Pennsylvania, Rhode Island and West Virginia—for treatment purposes or if there is a threat to public health. A 1998 West Virginia law requires that patient testing in medical emergencies be done through a pseudonym to protect confidentiality if the patient is unable or unwilling to consent (*Intergovernmental AIDS Reports*, APC, October 1992; *A Summary of HIV/AIDS Laws from 1993*, APC, January 1994; *Changing Faces, Changing Directions*, APC, May 1995; *APL*, Jan. 22, 1999).

- All 50 states allow **minors to consent** to STD and HIV **services**. Eleven states—California, Colorado, Connecticut, Delaware, Iowa, Michigan, Montana, New Mexico, New York, Ohio and Rhode Island—have laws that explicitly authorize minors to consent to HIV testing and treatment. Eighteen states—Alabama, Florida, Georgia, Idaho, Illinois, Kentucky, Mississippi, Nevada, North Carolina, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, Vermont, Virginia, Washington and Wyoming—officially classify HIV/AIDS as a STD or **infectious disease** for which minors may consent to services. An Iowa law requires a parent to be notified if an HIV test is positive. In 16 states, a doctor may notify parents of the minor's consent to testing or treatment ("Teenagers' Right to Consent To Reproductive Health Care," Alan Guttmacher Institute, 1997).

- Virginia passed several laws in 1997 concerning HIV testing and informed consent. Witnesses and bystanders at **crime scenes** were given the right to **demand testing** if they were exposed to body fluids. Further, a person who exposes a law enforcement officer to body fluids in a manner that could transmit HIV or hepatitis B or C must consent to testing. Finally, law enforcement officers who expose others to body fluids also must be tested (*APL*, Dec. 26, 1997).

- In 1997, North Dakota passed legislation allowing a judge to confine a person for up to five days without a hearing if the defendant significantly **exposes a police officer, firefighter, paramedic or health worker to blood or other body fluids.** Exposure is defined as contact with broken skin or mucous membranes. Since 1995, North Dakota courts could order a defendant to submit to HIV testing if he or she caused a significant exposure of blood or body fluids to an emergency worker. The controversial law was passed to halt defendants from leaving a jurisdiction before undergoing testing (*APL*, Dec. 26, 1997).

Needle Exchange and Access to Sterile Syringes

- Fourteen states—Alaska, Connecticut, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, New Hampshire (pilot project), New Mexico, New York, Oregon, Rhode Island and Washington—and the District of Columbia **authorize needle exchange programs.** These states differ in their approach to sanctioning needle exchanges. Most have passed laws authorizing their operation. A small number of states have elected to remove legal barriers to needle exchanges without formally authorizing programs (by amending drug paraphernalia laws to exempt needles and syringes, or by repealing needle prescription laws). In New York, for example, the health commissioner is given authority to waive needle prescription laws ("Needle Exchange and Access to Sterile Syringes," *Issue Brief*, http://www.stateserv.hpts.org, NCSL, Aug. 14, 1998)

- According to the North American Syringe Exchange Network, **134 needle exchange programs** operate in 34 states, the District of Columbia and Puerto Rico. However, the exact number is difficult to pinpoint because, not all operations are sanctioned by authorities. Many of the programs operate with limited general public knowledge ("Needle Exchange and Access to Sterile Syringes," *Issue Brief*, www.stateserv.hpts.org, NCSL, Aug. 14, 1998).

- The National Institutes of Health (NIH) published a study on needle exchange programs in March 1997. The report concluded that the programs "**show a reduction in risk behaviors** as high as 80 percent in injecting drug users, with estimates of a 30 percent or greater reduction of HIV." The report also found either a decrease in injection drug use among participants or no changes in their current drug use. In October 1997, a study of needle exchange programs in Baltimore, Maryland, found that participants in the needle exchange programs that were closely linked or integrated with drug treatment programs, had high levels of retention in drug treatment programs (*Consensus Development Statement on Interventions to Prevent HIV Risk Behaviors*, NIH, March 1997 as cited in "Needle Exchange and Access to Sterile Syringes," *Issue Brief*, www.stateserv.hpts.org, NCSL, Aug. 14, 1998).

- One study, conducted in Vancouver, British Columbia, and published in 1997, found that participants in needle exchanges were two to three times more likely to become infected with HIV than were nonparticipants. The study also showed that 40 percent of **participants** continued to **frequently share needles**. A second study, published in 1996, found that participants from Montreal, Quebec, were more than twice as likely to become infected with HIV as were nonparticipants, and that a majority of program clients continued to share needles (*Addiction*, October 1997; *American Journal of Epidemiology*, December 1997).

- Julie Bruneau and Martin T. Schechter, authors of the Canadian needle exchange studies, published a letter to the editor in the *New York Times* claiming that the results of their studies had been misinterpreted. Although they agreed that addicts who took part in **needle exchange programs** in Vancouver and Montreal had **higher HIV infection rates** than addicts who did not participate, the researchers cited additional reasons for their increased risk. The populations that were served by these programs were from inner cities and therefore were less likely to be able to afford to buy their own needles and were more likely to engage in the riskiest behavior. Although the two programs exchanged over 1.5 million needles annually, the researchers calculated that a total of 20 million needles would need to be exchanged to meet the needs of the population and prevent re-use of syringes (*NYT*, April 9, 1998).

- A 1995 study by the Chemical Dependency Institute at Beth Israel Medical Center found that the average annual budget of a **needle exchange program** was $131,000. Other estimates are higher, averaging $160,000 annually. These programs are considered to be **cost-effective**. (*APL*, Feb. 21, 1997, as cited in "Needle Exchange and Access to Sterile Syringes," *Issue Brief*, http://www.stateserv.hpts.org, NCSL, Aug. 14, 1998).

- In April 1998, the Clinton **administration refused** to authorize **federal funds** to support the operation of **needle exchange programs**. The administration acknowledged the scientific evidence that such programs stem the spread of HIV without encouraging drug use; however, they deferred the decision of funding and implementation to local communities. The announcement came days before the U.S. House of Representatives voted to permanently ban federal funding for the program. In the District of Columbia, an independent nonprofit group will run the city's needle exchange program using only private funding. To operate,

the program required authorization from the city, which was provided by the D.C. Corporation Counsel. The program, which distributes 17,000 needles each month, previously was funded by the D.C. AIDS Administration ("Needle Exchange and Access to Sterile Syringes," *Issue Brief*, www.stateserv.hpts.org, NCSL, Aug. 14, 1998; *Washington Post*, Dec. 2 and 4, 1998).

- Maryland considered a number of **needle exchange bills** during the 1998 session after its 1997 vote to allow Baltimore's pilot program to continue indefinitely. The legislature ultimately approved legislation that sanctions needle exchanges in Prince George's County. Under the legislation, the program must refer clients to drug counseling and treatment services and educate users about the dangers of contracting HIV from unsafe needle-sharing and sex practices ("Needle Exchange and Access to Sterile Syringes," *Issue Brief*, www.stateserv.hpts.org, NCSL, Aug. 14, 1998).

- Nearly half the states have **pharmacy regulations** that **restrict access to syringes**. State pharmacy regulatory bodies establish pharmacy regulations or practice guidelines regulating the sale of syringes. These agencies do not have the force of law, but noncompliance could cause a pharmacist to be subjected to professional sanctions ("Needle Exchange and Access to Sterile Syringes," *Issue Brief*, www.stateserv.hpts.org, NCSL, Aug. 14, 1998).

- Current **drug paraphernalia laws** that "prohibit the sale, distribution and/or possession of syringes known to be used to introduce illicit drugs into the body" are considered by needle exchange supporters to present major barriers to access to clean needles for drug users. These laws exist in 47 states and the District of Columbia. At least seven states—Hawaii, Maine, Maryland, Massachusetts, New York, Rhode Island and Washington—and the District of Columbia provide exceptions in their drug paraphernalia laws for needle exchange programs. A 1997 Minnesota law redefined "drug paraphernalia" to exclude hypodermic needles (*Emory Law Journal*, Spring 1997, as cited in Needle Exchange and Access to Sterile Syringes," *Issue Brief*, www.stateserv.hpts.org, NCSL, Aug. 14, 1998).

- Eight states and one territory (California, Delaware, Illinois, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island and the Virgin Islands) **require prescriptions to purchase hypodermic needles and syringes.** Ten additional states restrict the purchase of hypodermic needles and syringes without a prescription. These restrictions may involve age requirements or limits on the amounts of syringes purchased without a prescription. Six states—Michigan, Nevada, Ohio, Texas, Virginia and Washington—permit the **sale of syringes without a prescription** if a person has a legitimate medical need. Only three states—Connecticut, Massachusetts and Rhode Island—exempt needle exchange programs from syringe prescription laws. In other states, regulations have had to be modified to allow the programs to operate legally (*Emory Law Journal*, Spring 1997; "Needle Exchange and Access to Sterile Syringes," *Issue Brief*, http://www.stateserv.hpts.org, NCSL, Aug. 14, 1998).

- When **legal restrictions** on both the **purchase and possession of syringes** are **removed,** injection drug users will change their syringe-buying practices and syringe-sharing behaviors in ways that can reduce HIV transmission, according to studies conducted by the CDC and the Connecticut Department of Public Health. It was found that needle-sharing among drug users fell 39 percent after Connecticut passed a law (HB 5015, Act 185, 1992 Laws) permitting pharmacies to sell syringes without a prescription and legalizing the possession of syringes that are not contaminated with illegal drugs. The studies found that 83 percent of the state's pharmacies were selling nonprescription syringes, compared with none of

the pharmacies before the law was changed. Seventy-eight percent of drug users surveyed had bought syringes from a pharmacy less than a year after the law took effect. Of those who bought them from a pharmacy, 31 percent said they had shared a needle, a sharp drop from the 52 percent who were surveyed immediately after the laws took effect. Seventy-five percent of Connecticut's AIDS cases are related to intravenous drug use (*Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, Sept. 1, 1995; *Detroit Free Press*, Aug. 31, 1995).

Newborn Testing

- New York and Indiana mandate **routine HIV testing of newborns.** The New York law requires health officials to notify the parents of the results. The Indiana law, which became effective July 1, 1998, allows doctors to test newborns if the mother has not been tested, if the mother refused testing, and if testing is believed to be medically necessary (http://www.stateserv.hpts.org, NCSL, 1998).

- California, Florida, Iowa and Rhode Island have laws that provide for **surveillance and testing of newborns.** California requires that the number of babies born with HIV, drug dependencies and STDs be reported to the Legislature and governor annually. Florida allows HIV testing of hospitalized infants when necessary to provide medical care and when the parent cannot be contacted to provide consent. Iowa authorizes the Department of Public Health to conduct blind studies through HIV testing of newborns to determine the prevalence of HIV. Rhode Island empowers the Department of Health to make rules and regulations to mandate testing of newborns when there is a strong medical suspicion that a child may have HIV and the doctor is unable to obtain the mother's written consent (*Changing Faces, Changing Directions*, APC, May 1995; *HIV/AIDS Quarterly Report*, APC, Oct. 27, 1995).

- On May 11, 1995, the **CDC suspended the Survey of Childbearing Women.** This also suspended the blinded newborn HIV testing that was conducted in 45 states, the District of Columbia, Puerto Rico and the Virgin Islands since 1988. The testing tracked the HIV epidemic in women delivering infants. Results of the survey were used to estimate the needs for HIV services, to stimulate development of HIV prevention programs and to target resources. HIV testing was conducted on leftover blood specimens that were drawn for routine newborn screenings. All personally identifying information was separated from the blood specimens, therefore making the results unavailable. The CDC suspended the survey because it was felt that the $10 million cost for conducting the testing could be better used on efforts to prevent perinatal transmission (Letter from James Curran, M.D., M.P.H, CDC associate director for HIV/AIDS, May 12, 1995; CDC *National AIDS Hotline Training Bulletin #103*, June 15, 1994).

- The 1996 amendments to Ryan White CARE Act had several provisions relating to **perinatal transmission of HIV:** states must determine the rate of reported AIDS cases resulting from prenatal transmission, the CDC must implement a reporting system for tracking perinatal transmission AIDS cases, and the secretary of HHS must determine whether it has become routine practice to conduct mandatory **HIV newborn testing** of all infants whose mothers have not undergone prenatal HIV testing. If it is determined that testing has become routine, a state must demonstrate, by April 2000, one of three measures to reduce transmission in order to receive Title II funding. The three measures are: 1) a 50 percent reduction in the rate of new perinatal transmission AIDS cases; 2) at least 95 percent of

Salem Concord Monitor 9/3/99

Needle sticks woman in play area

SALEM – The woman stuck with a hypodermic needle in a fast food restaurant play area is taking drugs to guard against AIDS, and other parents are wondering if their children are at risk.

The town ordered the restaurant to sanitize the area, but Burger King closed the play area at its 181 South Broadway location and will proceed with previous plans to dismantle it.

The police said they had no suspects and are not sure if it was a prank or if someone lost the needle.

The Andover, Mass., woman, whom police did not identify, waded into a ball pit Tuesday to get one of her children, who did not want to leave. The police said she was pricked in the lower back and again in her foot as she searched for the sharp object in the pit full of colorful balls.

The police said they have not received any calls from parents concerned that their children also were pricked by the needle.

– The Associated Press

HOUSE COMMITTEE RESEARCH OFFICE
New Hampshire House of Representatives
4th Floor, Legislative Office Building
Concord, New Hampshire 03301
TDD Access: Relay NH
1-800-735-2964

603-271-3600

TO: Representative Maxwell D. Sargent
Criminal Justice and Public Safety Committee

FROM: Marie-Hélène Bailinson, Committee Researcher MHB
House Committee Research Office

DATE: September 7, 1999

RE: HB 427; relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

QUESTION:

(1). In states (Connecticut and Maine) that have lifted prescription requirements, **is there a needle disposal program?**

There is a needle exchange program in Portland, Maine and in at least one city in Connecticut.

(2). In states that have lifted prescription requirements, **are HIV and Hepatitis, injection drug use on the increase?**

ANSWER:
I interviewed Beth Weinstein in Connecticut. She stated that there is no way to measure whether there has been an increase in disease or drug use. However, in a survey on injection drug users (hereinafter IDU) in Connecticut, published in the *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology 10:82-89, (Page 82)* fewer IDU's reported purchasing syringes on the street after the new laws (74% before vs. 28% after) More IDU's reported purchasing syringes from a pharmacy after the new laws (19% before vs. 78% after). Also there was a 39% decrease in needle sharing reported. *(Page 86)*

Also, there was data published in the journal that showed, in five Hartford pharmacies located in neighborhoods where injection drug use was prevalent, the total number of

non-prescription syringes sold per month increased significantly from 460 in July 1992(one months after the law changed) to 2,482 in June 1993. The data suggest that the new laws increased IDU's access to sterile syringes in Connecticut.

The study published in the *Journal* also states that "Although pharmacy sales can provide access to sterile syringes and thus support prevention efforts to reduce the transmission of HIV among IDU's, the number of non-prescription syringe sales in Connecticut is still small relative to need. Several considerations reduced pharmacists' willingness to sell syringes without a prescription. One issue mentioned by pharmacy managers was the risk of discarded contaminated syringes around their business and community." *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology 10:82-89* (S108)

Although the law change was enacted to expand IDU's access to sterile syringes, only one fourth of managers were willing to sell to IDU's. The findings suggest that legal availability of sterile syringes through pharmacies does not necessarily translate into access for IDU's. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology 10:82-89* (S109)

In Maine, I interviewed Ms. Debra Shields at the Maine Bureau of Health. She stated that there is has been no study on the increase of disease or drug use due to lifting of prescription requirements. The rate of HIV in Maine has stayed even or gone down slightly since the change in laws.

In Maine, I interviewed Mr. Nate Nickerson who is in charge of the needle exchange program in Portland. He believes that the change in law has had little or no effect. This is because pharmacists are reluctant to sell without a prescription. IDU's are aware of this and therefore are not going in to pharmacies to buy new needles. Because they have low self-esteem, it does not take much to discourage them from entering pharmacies. In Mr. Nickerson's opinion, the issue is still one of access. Mr. Nickerson stated that the Bureau of Health did an undercover study. An average person went into pharmacies and attempted to buy needles without a prescription, the result was that less than half of the pharmacists would sell. I did interview one pharmacist in Portland who stated that IDU's did not belong in a retail pharmacy and disposal was an issue.

The needle exchange program in Portland has 25 enrollees. A methadone program close by has 300 enrollees.

Also, between 1993, when prescription requirements were lifted and 1997, possession of needles was a crime. For a long time some pharmacists believed they were supposed to report those that purchased non-prescription needles to the police.

A couple of other issues in Maine are that some pharmacists believe that if they sell to IDU's, they are in jeopardy of loosing their licenses. Mr. Nickerson explained that there will soon be meeting with the Board of Pharmacy to have them clarify their policy on this issue.

Another issue is that if the needle has traces of drug on it, the user may be prosecuted.

Mr. Nickerson believes that the needle exchange progam in Portland serves the enrollees well because they have someone to talk to about their problems.

Most of the pharmacists I interviewed in Maine stated that they mostly sell needles to diabetics. Even in a downtown Portland CVS stated that they sell non-prescription needles only a little more often than twice a week.

(3). In states that have lifted prescription requirements, **did the cost of needles increase?**

ANSWER:
In Connecticut, after the new laws, the pharmacy prices reported by IDU's remained unchanged at about 40cents per syringe. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology 10:82-89.*

In Maine, the pharmacists I interviewed found no increase in the cost of needles due to the changed law.

(4). Do suppliers of needles hand out disposal information/ equipment, anti-drug information?

Neither Connecticut nor Maine hand out disposal information. One pharmacy in Portland stated that they refer people who ask about disposal of needles to the Needle Exchange Progam in Portland.

One pharmacist in Portland stated that a small number of people who buy needles also buy a disposal container. The pharmacist stated that some people use milk jugs at home to dispose of their needles.

Enclosure: *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*

adequately decontaminated syringes and other drug-injecting equipment (9,10).

One important source of sterile syringes is the community pharmacy (pharmacy). However, many states have either syringe prescription laws—which prohibit individuals from selling, distributing, or possessing syringes without a valid medical prescription—or drug paraphernalia laws—which prohibit individuals without medical purposes from possessing or distributing syringes—or both syringe prescription and drug paraphernalia laws (11–15). These laws can dissuade or prevent IDUs from purchasing syringes at pharmacies and possessing them for future use (16–19). As of March 1, 1995, 45 states and the District of Columbia had drug paraphernalia laws, and nine of these states and the District of Columbia also had syringe prescription laws (Fig. 1). Only five states—Alaska, Connecticut, Iowa, North Dakota, and South Carolina—had laws permitting both the purchase and possession of syringes by individuals who do not have medical prescriptions or purposes. However, Connecticut limits the number of syringes that can be purchased and possessed to 10 or fewer (20).

Connecticut has had a significant problem with HIV infection associated with injection drug use, and was one of the first states where the number of reported AIDS cases in heterosexual IDUs exceeded the number of cases in gay and bisexual men who were not IDUs (21). In 1992, the AIDS case incidence among heterosexual IDUs was 10 per 100,000 of all Connecticut residents and accounted for 40% of all incident AIDS cases reported in 1992 (22). Until 1992, Connecticut had both prohibitive syringe prescription and drug paraphernalia laws. However, in May 1992, the Connecticut legislature passed new laws (20). As of July 1, 1992, pharmacists and other health professionals were permitted, but not required, to sell up to 10 syringes to individuals who did not have medical prescriptions; and, individuals without medical purposes were permitted to possess up to 10 syringes without drug residue. The intent of the new laws was to increase IDU's access to sterile syringes, thereby decreasing

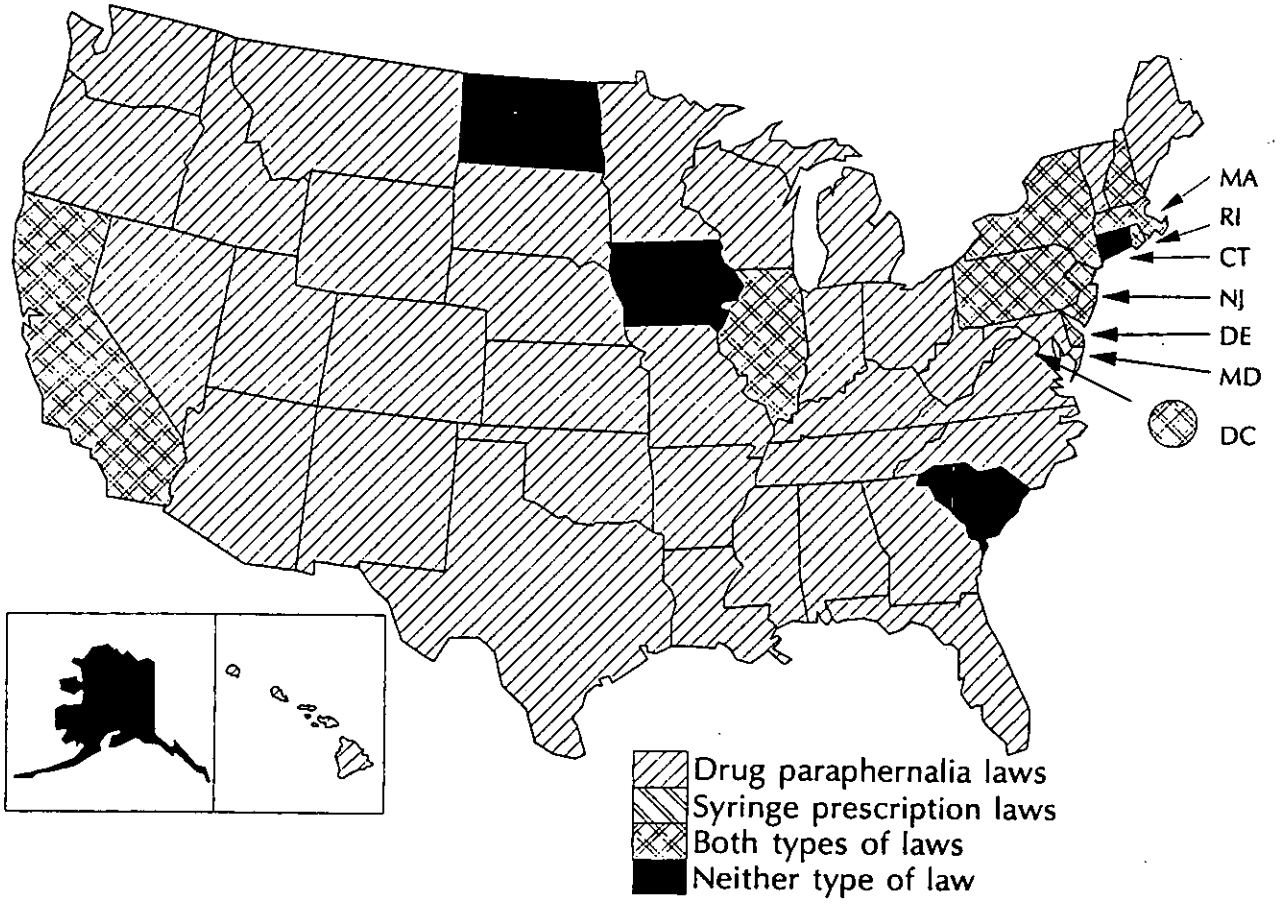


FIG. 1. States and the District of Columbia with syringe prescription or drug paraphernalia laws as of March 1, 1995 (see text).

Testimony of Gerry Scoppettuolo

President, GMFA, Inc. (LifeGuard Project), Portsmouth, N.H.
HIV Prevention Coordinator, The AIDS Project, Portland, ME.

Good Afternoon. I am happy to be here today to testify on behalf of H.B. 427. the Needle Availability Bill. I work full time trying to prevent new HIV infections and re-infections in N.H. and Maine. Our programs follow closely new and effective strategies to reduce the spread of HIV. Needle Availability is such an approach. I trust that you will let scientific evidence and public health necessity be your guide when it comes time to vote on this bill.

Needle Availability is, simply put, a strategy to replace dirty, HIV-infected needles with sterile ones. When such substitution occurs, needle-sharing is reduced and HIV transmission between needle-users and their sexual partners is reduced. Only shared needles can spread HIV. This is a virtually cost-free program. In addition to its other benefits, it will require that pharmacists provide drug treatment referral information to purchasers of needles.

Effective strategies to curtail the spread of HIV from intravenous drug users (IDU's) are needed in New Hampshire when our major population centers are just a short distance to heavy needle-using cities in states on our borders. IDU-related transmissions are the fastest growing segment of the epidemic and the chief transmission factor for women. Any needle availability or needle exchange program will provide needed help to women-at-risk.

In 1969 I was co-founder of Project Rap, a drug treatment program in Beverly, Massachusetts and today, as part of Health Education Services, one of the oldest continuing programs for injection drug users in Massachusetts. Back then, our community was responding to a tidal wave of new heroin users – especially among young people. We could not foresee then that heroin use would lead eventually to the spread of HIV or Hepatitis C. We struggled to promote drug treatment as an alternative response to criminalization. Today we must defend needle availability and needle exchange against charges that we are promoting drug use. Drug use is not spread by needles; people shoot heroin for a complex set of psychological and socioeconomic reasons coupled with the street availability of heroin. Drug users will obtain needles one way or the other, driven, as they are, by the need and the addiction. We don't eliminate the addiction or drug use by making needles scarce- but we do make HIV transmission more likely. More needle scarcity = more HIV transmission. Is this what we want?

We urge you not to spurn this opportunity to reduce new infections in New Hampshire. I hope that, a year or two from now, we will not look back to today counting infections that could otherwise been avoided. New Hampshire legislators demonstrated their compassion and good judgment recently by passing Needle Exchange enabling legislation. Until a New Hampshire program can enact that strategy, needle availability can provide the help we need.

Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology
10:71–72 © 1995 Lippincott-Raven Publishers, Philadelphia

tt B 927

Editorial

Deregulation of the Sale and Possession of Syringes for HIV Prevention Among Injection Drug Users

Injection drug users are at risk for human immunodeficiency virus (HIV) and other blood-borne infections primarily through the sharing (or "multiperson" use) of blood-contaminated syringes and other equipment used to prepare and inject drugs (1). The reasons posited for equipment sharing included the belief that this behavior is a ritual within the subculture of drug injectors (2), however, more recently, there has been a recognition of pragmatic legal and economic motivations for sharing syringes (3,4). Laws which do not allow sale of syringes without a prescription and felony penalties for the possession of syringes originally designed to curtail drug use, may have contributed unwittingly to parenteral transmission of blood-borne infections (5,6). Also, the cost of syringes is not trivial and also could contribute to the practice of sharing syringes (4). In the past decade, hundreds of needle exchange programs have been established in Europe, Australia, and North America to provide injection drug users with increased legal access to sterile syringes (7,8).

However, due to limited funding, many syringe exchange programs provide mostly exchange functions and have only a small number of sites with limited hours of operation (7). These limited number of sites and hours per city translate into a limited potential impact for each of these programs.

In the absence of expanded funding for syringe exchange programs, an inexpensive and practical alternative to efficiently provide wider access to sterile syringes is to deregulate syringe sales by removing prescription requirements and relevant portions of paraphernalia possession laws. This would allow injection drug users to carry syringes purchased at local pharmacies. This alternative has immediate intuitive appeal because the number and geographic distribution of pharmacies with their relatively long hours of operation provide more convenience than the limited sites and hours of current syringe exchange programs. Moreover, the pharmacy infrastructure already exists.

In this issue, reports by Valleroy and colleagues (8) and Groseclose and colleagues (9), summarize information collected following deregulation of syringes in Connecticut. In July 1992, pharmacists were permitted to sell and individuals were permitted to possess up to 10 syringes without medical prescriptions. These studies showed that 83% of pharmacists in Connecticut sold non-prescription needles after the law changed and that drug users used the pharmacies. Specifically, in high drug use areas, the number of non-prescription syringes sold increased dramatically with little change in sales of prescription syringes, while in low drug use areas little change in any syringe sales was noted. This finding was corroborated in a separate survey of injection drug users who reported a dramatic increase in pharmacy purchases and a substantial decrease in "street" purchase of needles after the law changed. At the same time, the proportion of injection drug users who reported sharing syringes decreased, which is further supported in a separate letter in this issue (10). Needlestick injuries among police decreased over time; while this might be attributed to greater precautions exercised by police after the law change, an accompanying letter reports that syringes purchased were not carried but stored due to continuing fears of arrest among injection drug users (11).

These findings from Connecticut suggest promise for deregulation of syringes as an HIV prevention strategy, but raise additional questions. Behavior change was measured by self-reports which are subject to error; however, corroboration with pharmacy sales data at least partially offsets this concern. As another issue, these studies showed pharmacy-based sales are not without problems as several pharmacists reported unpleasant incidents that soured them on non-prescription sales; discussion of how these incidents might be avoided or minimized is worthwhile. Also, further work is needed to understand the basis for the fears among drug users about carrying syringes after the law

GSAC
PO BOX 2753
CONCORD NH 03302-2753

changed by studying the attitudes and behaviors of the police and the drug users (e.g., are individual police continuing to harass drug users who possess syringes). Another issue is the effect of establishing a maximum number of syringes injection drug users can purchase and carry. Would removing restrictions on the number of syringes or a higher limit be associated with a further reduction in multi-person use of syringes? Another issue not addressed in these reports is the disposal of contaminated needles and syringes; some plans and measures are needed to monitor patterns of discarded needles, as has been reported elsewhere (12). Finally, that such programs reduce HIV infection rates was suggested by an earlier study in Maryland, which noted lower HIV infection rates in diabetic compared to non-diabetic injection drug users who were otherwise comparable; this was attributed to unrestricted legal access to sterile syringes (13). Longitudinal follow-up, which includes HIV incidence data, could be helpful to measure the impact of this program.

On the basis of these reports from Connecticut, deregulation of syringes coupled with careful evaluation of impact should be enacted elsewhere. Specifically, states with prescription laws should repeal them, and states should repeal the section of drug paraphernalia laws that make possession and distribution of syringes a crime. It is important to note that Connecticut enacted simultaneous repeal of the two laws, which may have been an important factor in their "natural experiment." The data from Connecticut point towards deregulation of syringes as a useful element of a comprehensive HIV prevention strategy.

David Vlahov
Department of Epidemiology
The Johns Hopkins School of Hygiene and Public Health
Baltimore, Maryland

REFERENCES

1. Friedland GH, Klein RS. Transmission of the human immunodeficiency virus. *N Engl J Med* 1987;317:1125–35.
2. Des Jarlais DC, Friedman SR, Strug D. AIDS and needle sharing within the IV drug use subculture. In: Feldman D, Johnson T, eds. *The social dimensions of AIDS: methods and theory*. New York: Preager, 1986.
3. Mandell W, Vlahov D, Latkin C, Oziemkowska M, Cohn S. Correlates of needle sharing among injection drug users. *Am J Public Health* 1994;84:920–3.
4. Magura S, Shapiro JL, Grossman JI, et al. Determinants of needle sharing among intravenous drug users. *Am J Public Health* 1989;79:459–62.
5. Murphy S. Intravenous drug use and AIDS: notes on the social economy of needle sharing. *Contemp Drug Probl* 1987;5:373–95.
6. Koester S, Booth R, Wiebel W. The risk of HIV transmission from sharing water drug mixing containers, and cotton filters among intravenous drug users. *Internat J Drug Policy* 1990;1:28–30.
7. Lurie P, Reingold AL, Bowser B, et al. *The public health impact of needle exchange programs in the United States and abroad*. San Francisco: University of California, 1993.
8. Valleroy LA, Weinstein B, Jones TS, et al. Impact of increased legal access to needles and syringes on community pharmacies needle and syringe sales—Connecticut 1992–1993. *J Acquir Immun Defic Syndr Human Retrovirol* 1995;10:73–81.
9. Groseclose SL, Weinstein B, Jones TS, et al. Impact of increased legal access to needles and syringes on practices of injecting drug users and police officers—Connecticut, 1992–1993. *J Acquir Immune Defic Syndr Human Retrovirol* 1995;10:82–9.
10. Singer M, Weeks MR, Himmelgreen D, Sales and exchange of syringes [letter]. *J Acquir Immune Defic Syndr Human Retrovirol* 1995;10:104.
11. Grund JC, Heckathorn DD, Broadhead RS, Anthony DL. In eastern Connecticut, IDUs purchase syringes from pharmacies but don't carry syringes (letter). *J Acquir Immune Defic Syndr Human Retrovirol* 1995;10:104–5.
12. Doherty M, Gargein R, Vlahov D. No increase in discarded needles following opening of needle exchange program. 2nd National Meeting Retrovirus and Related Infections. Washington D.C., January, 1995.
13. Nelson KE, Vlahov D, Cohn S, et al. Human immunodeficiency virus infection in diabetic intravenous drug users. *JAMA* 1991;226:2259–61.

does needle exchange work?

why do we need needle exchange?

More than a million people in the United States inject drugs, at a cost to society (in health care, lost productivity, accidents, and crime) of more than $50 billion a year.[1] People who inject drugs imperil their health. If they contract HIV, their needle sharing partners, sexual partners and offspring may also be endangered.

One-third of all AIDS cases are linked to injection drug use. For women, 64% of all AIDS cases are due to injection drug use or sex with partners who inject drugs. Injection drug use is the source of infection for more than half of all children born with HIV.[2]

Around the world and in more than sixty locations in the United States, needle exchange programs have sprung up to address drug injection risks. These programs not only distribute clean needles and safely dispose of used ones for injection drug users (IDUs), they generally offer a variety of related services, including referrals to drug treatment and HIV counseling and testing.[3]

why do drug users share needles?

In part because there are not enough needles and syringes to go around. The overwhelming majority of IDUs are aware of the risk of the transmission of HIV and other diseases if they share contaminated equipment. However, sterile needles are not always available or affordable.

Most US states have paraphernalia laws that make it a crime to possess or distribute drug paraphernalia not for a "legitimate medical purpose," which subjects drug injectors to prosecution. In addition, ten states and the District of Columbia have laws that require a prescription to buy a needle and syringe. Even where over-the-counter sales of syringes are permitted by law, pharmacists are often unwilling to sell to IDUs.[4]

In July of 1992, the state of Connecticut passed a law permitting the purchase and possession of up to ten syringes without a prescription. After the new law went into effect, the sharing of needles among IDUs decreased, and there was a shift from street needle and syringe purchasing to pharmacy purchasing.[5]

how can injection risks be reduced?

Getting drug injectors into treatment and off drugs is the best answer. Unfortunately, not all drug injectors are ready to quit. Even those who are highly motivated may find few services available. Drug treatment centers frequently have long waiting lists and fewer than 15% of IDUs are in treatment at any given time.[6]

For those who cannot or will not stop injecting drugs, the best way to avoid spreading HIV is to use a sterile needle for each injection, or at least not to share needles. Users who share should disinfect their injection equipment thoroughly with bleach, although this is not as safe as always using a sterile needle and syringe.[7]

does needle exchange encourage drug use?

There is no evidence that needle exchange programs increase the amount of drug use by needle exchange clients or in the wider community.[3] A study of a San Francisco needle exchange program that opened in 1988 found that from 1987 to 1992, frequency of injecting drugs among street-recruited IDUs declined from 1.9 to 0.7 injections per day. The mean age of IDUs increased from 36 to 42 years, and the percentage of new initiates into injection drug use dropped from 3% to 1%.[8] Drug abuse and the recruitment of new or younger users did not increase in the presence of the exchange; in fact, the exchange may have helped *decrease* the amount of drug abuse in the area.

...ays who?

1. Rice DP, Kelman S, Miller LS. Estimates of economic costs of alcohol and drug abuse and mental illness, 1985 and 1988. *Public Health Reports.* 1991;106:280-292.

2. CDC. HIV/AIDS Surveillance Report. 1993;5:1-30.

3. Lurie P, Reingold AL, Bowser B, et al. *The Public Health Impact of Needle Exchange Programs in the United States and Abroad.* Prepared for the Centers for Disease Control and Prevention. September, 1993.

4. Compton W, Cottler L, Decker S, et al. Legal needle buying in St. Louis. *American Journal of Public Health.* 1992;82:595-596.

5. Groseclose SL, Valleroy LA, Weinstein B, et al. New Connecticut laws to improve access to needles and syringes: what is their impact? In: *Proceedings of Workshops on Needle Exchange and Bleach Distribution Programs.* National Academy Press. Washington DC;1994.

6. Wiley J, Samuel M. Prevalence of HIV infection in the USA. *AIDS.* 1989;3(Suppl. 1):71-78.

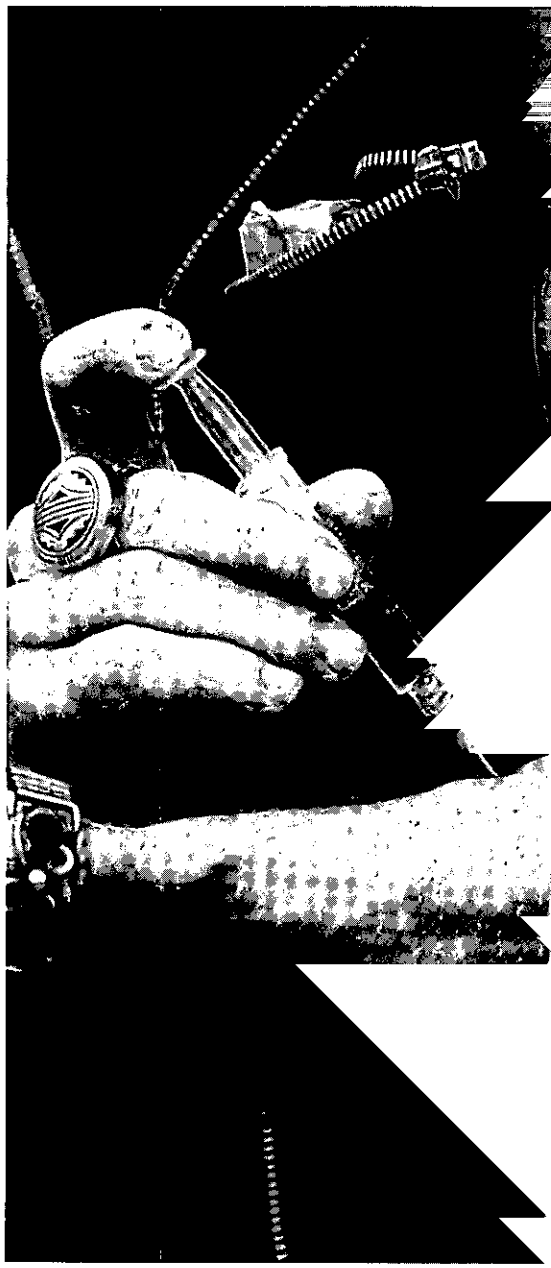
7. Curran JW, Scheckel LW, Millstein RA. *HIV/AIDS Prevention Bulletin.* April 19, 1993.

8. Watters JK, Estilo MJ, Clark GL, et al. Syringe and needle exchange as HIV/AIDS prevention for injecting drug users. *Journal of the American Medical Association.* 1994;271:115-120.

A publication of *HIV Prevention: Looking Back, Looking Ahead*, a project of the Center for AIDS Prevention Studies (CAPS), University of California, San Francisco, and the Harvard AIDS Institute. Thomas J. Coates, PhD and Harvey J. Makadon, MD, co-principal investigators.

Funded by a grant from The Henry J. Kaiser Family Foundation

Needle exchanges: Prevention or problem?



Are needle exchanges a successful HIV prevention tactic or do they only exacerbate existing illegal drug problems?

BY MATTHEW A. BOWDY

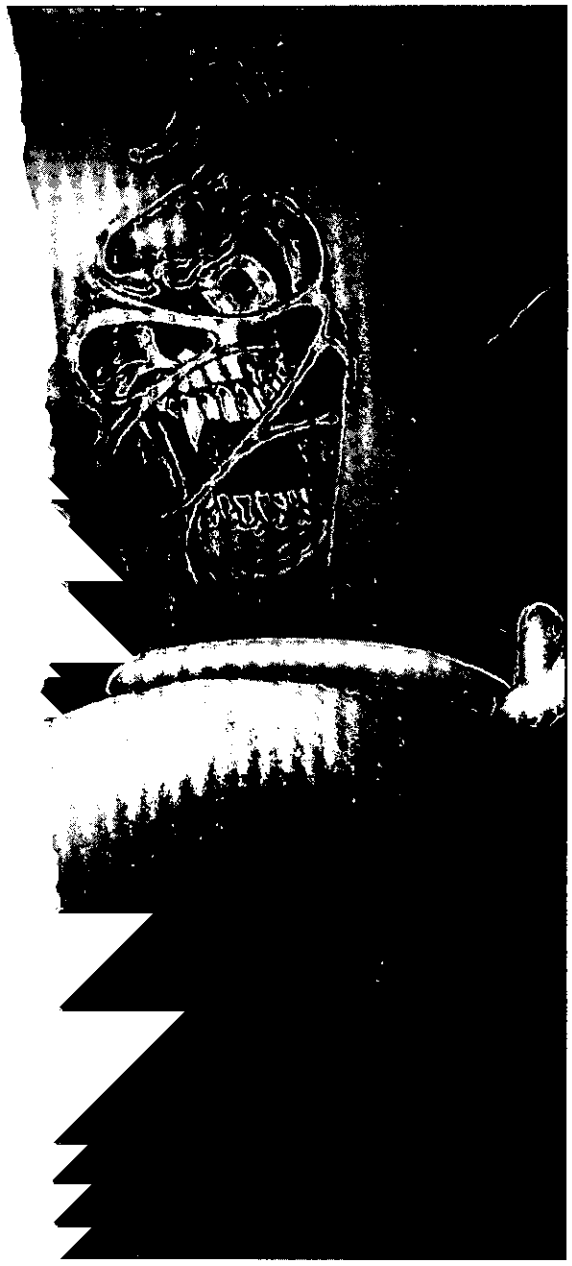
Matthew A. Bowdy is a health policy analyst for The Council of State Governments.

Despite increasing support, needle exchange programs are not yet being touted as a panacea for HIV prevention among intravenous drug users.

In the quest to stop the spread of HIV, the virus that causes AIDS, state and local officials face a decision that may make the difference between life and death for some of their constituents. One way people spread HIV infection is through sharing tainted needles during drug use. This has created a demand for programs to supply clean needles to intravenous drug users. In response, there are at least 113 needle exchange programs operating within 80 cities in 30 states.

Until now, the Clinton administration and Congress have agreed that state and local officials should decide which HIV prevention strategies to implement. Some, however, see needle exchange programs as the wrong solution.

For example, the federal budget signed into effect last October includes a ban on federal and District of Columbia funding for needle exchange programs within the district. The budget provision also calls for revoking all federal funding to any agency in the district that trades needles, even if the agency does so with private funds. The provision of the budget only applies to the district and not to programs oper-



ating in some 30 states. States, however, are experiencing problems of their own.

African-Americans in New Jersey are not seeing the same rapid decline in HIV infection rates as other groups in the United States are. In an effort to curb rates of infection, New Jersey's Senate Health Committee in September approved two bills to establish a needle-exchange program and authorize pharmacies to sell hypodermic needles without a prescription. Gov. Christine Todd Whitman promised to veto any bill the Legislature passes that promotes needle exchange.

States such as New Jersey are under immense pressure to decide on HIV prevention strategies. The decision is not easy when it comes to making a choice on needle exchange programs. Proponents and opponents each hold valuable resources and information in their corners.

No easy answer

States are left with the daunting prospect of finding, analyzing and evaluating numerous studies and viewpoints that both support and refute the success of needle exchanges.

The needle exchange debate raises two primary issues. First, some fear that needle exchanges will perpetuate the nation's drug problem. Second, HIV is spreading more rapidly than ever before among intravenous drug users. These two issues merge where the use of intravenous drugs not only creates HIV risk from injection with tainted needles, but also increases risk of contracting HIV and other sexually transmitted diseases through promiscuous sex, possibly related to drug use.

A plethora of research data, oftentimes conflicting, and opinion muddy the waters of definitive judgment on the issue. Experts disagree on the effectiveness of needle exchanges. Some maintain the programs might encourage drug use and sexual behavior that spreads HIV infection. Dr. Janet Lapey, former president of Drug Watch International, a volunteer nonprofit information network and advocacy organization, wrote in a 1998 report, "Any societal intervention which encourages drug use will also result in increased AIDS rates. It is important to note that needle sharing is not the only way drug users are infected with AIDS since they are at high risk for acquiring AIDS sexually through promiscuity or prostitution."

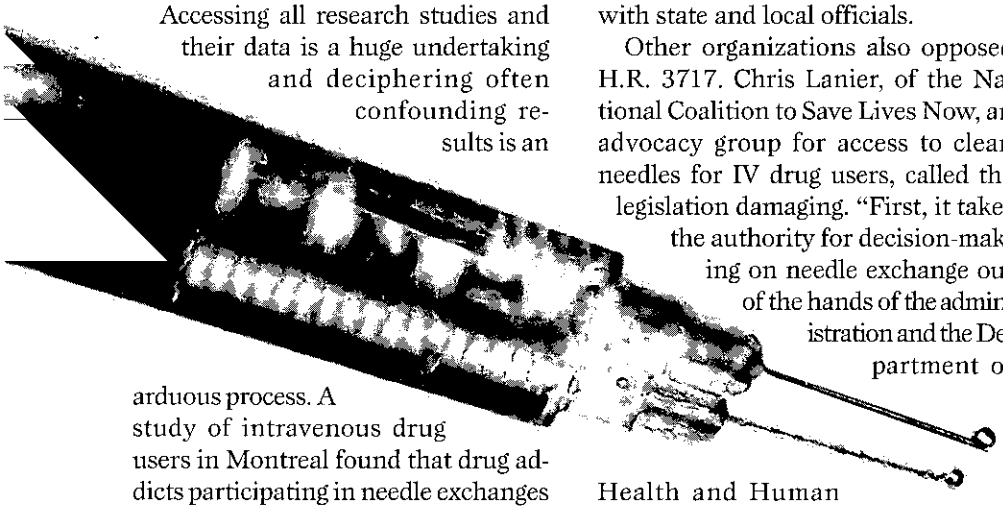
A 1998 article in *The American Journal of Public Health* discussed the relationship between drug use and HIV. One of its findings noted that stimulants such as cocaine are reported to increase sexual drive and may delay satisfaction. Thus, illicit drug use may prolong and increase frequency of sexual episodes, which increases exposure to sexually transmitted diseases such as HIV.

> ***"A comprehensive approach that includes needle exchange, health care, treatment, social support and counseling is also needed."***

Other study results, conducted in 1997 and published in the British medical journal *The Lancet*, found that worldwide in 29 cities with needle exchanges, HIV infection dropped by an average of 5.8 percent a year among drug users. In 51 cities without needle exchanges, drug-related HIV rates rose by 5.9 percent a year.

Middle ground may exist. Julie Bruneau, assistant professor of psychiatry at the University of Montreal, and Martin Schechter, professor of epidemiology at the University of British Columbia, suggest a balanced approach. *The New York Times* quoted them as saying, "A comprehensive approach that includes needle exchange, health care, treatment, social support and counseling is also needed." Per-

haps this is a merger of strategies, from both opponents and proponents of needle exchanges, to contain drug-related HIV infection.



Accessing all research studies and their data is a huge undertaking and deciphering often confounding results is an arduous process. A study of intravenous drug users in Montreal found that drug addicts participating in needle exchanges are 2.2 times more likely to contract HIV than addicts not participating in such programs.

The authors of the Montreal study, Julie Bruneau and her colleagues, hypothesize that needle exchanges might have attracted existing groups of marginalized individuals who were engaging in more high-risk activities. Bruneau said, "We caution against trying to prove directly the causal relation between [needle exchange program] use and reduction in HIV incidence. Evaluating the effect of [needle exchange programs] per se without accounting for other interventions and changes over time in the dynamics of the epidemic may prove to be a perilous exercise."

Leaving it to the states

Early last year, President Bill Clinton opposed a congressional proposal, H.R. 3717, to ban use of federal funds for the distribution of needles or syringes for the hypodermic injection of illegal drugs. He called the ban "unnecessary and unwarranted."

The White House said the secretary of Health and Human Services should have the authority to determine the scientific and public health merit of needle exchange programs as they affect rates of HIV transmission and injection drug use. Additionally, the administration said the decision on which HIV prevention strategies to use should rest with state and local officials.

Other organizations also opposed H.R. 3717. Chris Lanier, of the National Coalition to Save Lives Now, an advocacy group for access to clean needles for IV drug users, called the legislation damaging. "First, it takes the authority for decision-making on needle exchange out of the hands of the administration and the Department of Health and Human Services. Second, it makes the ban we already have a permanent one, which would require more action by Congress to reverse."

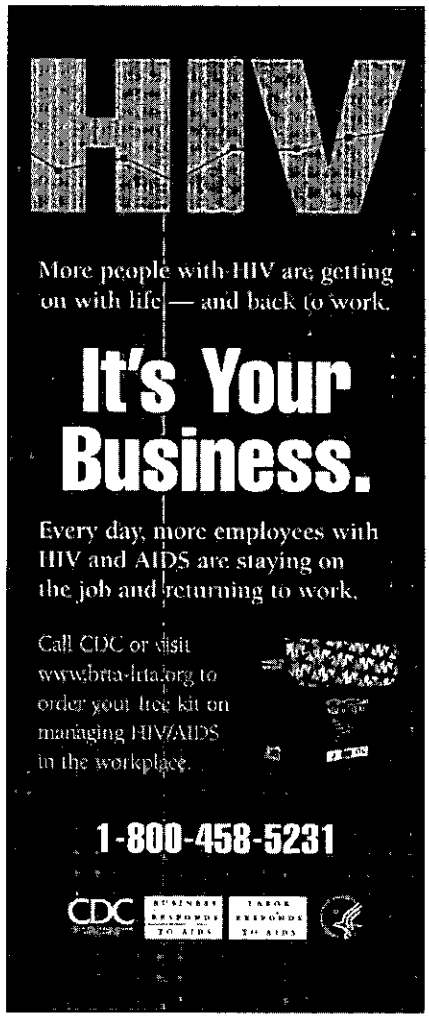
Another important issue to consider is public opinion of needle exchange programs. Some popular media outlets condone these programs, but the public is less supportive. In 1997, The Family Research Council, a nonprofit organization that strives to reaffirm and promote the traditional family unit, polled 1,000 registered voters to examine their views on needle exchanges. Most (62 percent) opposed exchanges, thinking that federal funding of these programs condones illegal drug use. Additionally, most voters (64 percent) believed government-funded needle exchanges encourage illegal drug use among teen-agers.

The 1997 Family Research Council poll results also document that nearly nine of 10 Americans are concerned that needle exchanges will result in increased crime and create public health hazards due to tainted and discarded needles. Six in 10 want their members of Congress to terminate needle exchanges and focus on abstinence and drug rehabilitation.

States are searching for definitive answers. U.S. Reps. Maxine Waters, D-Calif., and Xavier Becerra, D-Calif., called upon Donna E. Shalala, secretary of the Department of Health and Human Services, "to make an immediate determination that [needle exchange programs] reduce the risk of HIV transmission and do not promote the use of illegal drugs."

Shalala on April 20, 1998, answered the call, stating that "needle exchange programs can be an effective part of a comprehensive strategy to reduce the incidence of HIV transmission and do not encourage the use of illegal drugs."

Shalala and the Department of Health and Human Services strengthen support for the idea that needle exchanges can be effective in prevention of HIV. The question now is what the states will do with the information that is sitting before them.



A smoky windfall

The fight is erupting over how to spend the giant tobacco settlement.

BY JULIE ANDERSON

Who says money buys friends? As the states await their first $2.4 billion check from the tobacco companies, they are anticipating a battle with the federal government and a loud cry from counties and farmers over who should receive the money.

"The biggest fight is to fight the federal government from reaching into our pocket," Ohio Attorney General Betty Montgomery told delegates in December at The Council of State Governments' annual meeting in San Antonio.

Governors aim to prevent the federal government from seizing funds for Medicaid reimbursement. According to a release from the National Governors' Association, states are claiming that "if a settlement is state-specific or part of a national agreement, the federal government is not entitled to seize tobacco funds from the states."

U.S. Sen. Bob Graham, D-Fla., championed legislation during the 1998 federal budget negotiations to prevent the U.S. government from appropriating settlement money.

White House spokesman Joe Lockhart hinted at a Nov.16 press briefing that the U.S. government was entitled to a portion of the settlement.

"The federal government is under some obligation to claim some of this money under the Medicaid program," Lockhart said. "But we look forward to working with the states to figure out the best way to do that or the best way to come up with some comprehensive way to make sure the money is used for children in the reduction in teen smoking."

On the state level, Montgomery also said, "Communities can bring suit on their own. If they win, their verdict comes out of their state's share of the settlement."

Montgomery suggested states cap the size of local awards.

Meanwhile, National Association of Counties Executive Director Larry Naake was quoted in *County News* as saying, "It is up to counties to make their case to state officials for legitimate reimbursements for their past tobacco-related health expenditures."

Counties in Texas have already won $2.5 billion from the state, and Florida distributed $15 million of its first payment to county health departments.

Tobacco farmers also want compensation from the settlement. Until this class action suit, farmers have worked with the federal government to establish guidelines for tobacco issues. Farmers now are negotiating with states.

Spoils for the negotiators

Attorneys have emerged victorious in the settlement. Under the agreement, the tobacco companies will pay attorneys' fees for 46 states from a $500 million annual pool, that may run for decades.

However, in Texas, Florida and Mississippi, states that settled before the multistate agreement, fees were determined by an arbitration panel comprising a Texas Tech law school dean, a former chairman of the Federal Mediation and Conciliation Service, and a former federal judge.

The committee ruled that the 30 firms from the three states will receive up to $8.2 billion over an unspecified time period, more money than Alabama, Alaska, Arizona and Arkansas together received in their settlements.



Julie Anderson is an intern with The Council of State Governments.

In Kentucky, Karen Armstrong-Cummings, managing director of the Commodity Growers Cooperative Association, is working in conjunction with farm bureaus, state officials and anti-smoking groups to guarantee that tobacco farmers can weather the potential decline in tobacco products.

"We want to make sure that funds are made available for sustaining family farms. We are blessed to still have these farms. We need to ensure that they can make any transition and thrive," she said.

Governors from nine states and four tobacco companies met Dec.18 to discuss the fate of tobacco farmers. At the meeting a $5.15 billion trust fund was proposed to help farmers. The deal hasn't been confirmed.



Terms of the settlement

Cigarette makers agree to:

- pay states $206 billion over 25 years
- fund a $1.5 billion anti-smoking campaign
- open secret documents
- establish a $250 million foundation to reduce teen smoking
- remove cartoon characters in advertising
- remove billboards and transit advertising
- stop the distribution of tobacco apparel, such as shirts and backpacks
- provide $50 million for an enforcement fund to pursue violations of the settlement
- pay all attorneys' fees and reimburse states for their expenses

State plans

Because the tobacco suit was filed to recoup costs of treating smokers, most states plan to invest some, if not all, of the money in health care.

Arizona Gov. Jane Hull has proposed that the money be put aside for tobacco prevention and health-care funding.

"We have a wonderful opportunity to make a real difference in the lives of all Arizonans, thanks to this settlement. Not only will the national settlement stop the dangerous practice of enticing young people to smoke, it will provide literally billions of dollars to improve health care for all Arizonans," Hull said in a release.

Florida, one of four states to settle with Big Tobacco before the multistate settlement, has spent the majority of its first payment on health care. The late Gov. Lawton Chiles saw that $75 million of Florida's first payment was earmarked for children's health coverage and more than $180 million has gone to other health-care programs.

"Children were important to Gov. Chiles," said Tom Weaver, acting policy coordinator of Health and Human Services. "Children's-type issues have received the most money from the Legislature."

In addition to Florida's first payment, it received a one-time payment of $200 million to spend on anti-smoking programs over two years. The state created The Tobacco Pilot program, which received $93 million for anti-tobacco marketing and advertising.

Florida has also invested $7 million in computer health information services and $10 million in programs that intervene in the abuse and neglect of children.

Many states may take advantage of the no-strings-attached spending policy of the settlement.

Maryland Gov. Parris Glendening has suggested that some of the money go to education goals, such as refurbishing schools and offering teachers' scholarships.

"No firm proposals have been made," said Don Vandrey, Glendening's assistant press secretary. "I suspect it will be spring before we have any idea of where it will go."

Hawaii Gov. Ben Cayetano said he would like to see some of the money go to tobacco prevention programs.

The Alabama Legislature has reserved $85 million for children's programs, while in Maine, Gov. Angus King has appointed a committee to make recommendations on how to spend the money.

Mississippi Treasurer Marshall G. Bennett proposed setting aside $50 million each year for a permanent trust and using the interest for health-care funding or other programs. In a newsletter of the National Association of State Treasurers, Bennett explained, "the annual contribution could quickly grow to a $1 billion to $2 billion permanent trust, paying yearly dividends of $100 million-$200 million, which could be used forever."

Payments may shrink

If tobacco use declines, states may not receive all their estimated settlement. Under the terms of the agreement, future payments will be based on cigarette sales. If sales decline, so do payments.

The agreement required tobacco companies to finance a $1.5 billion anti-smoking campaign and establish a $250 million fund to prevent teen smoking. If these campaigns are successful, annual payments will decrease.

Also, the agreement stated that if U.S. Congress imposes costly legislation, payments will shrink.

Even with the stipulations on the payments and the fight over the money, states have succeeded in winning the nation's largest civil suit in history. Former Minnesota Attorney General Hubert H. Humphrey III, who sued on behalf of his state, said in a *New York Times* editorial: "The states win because the settlement will compensate them, at least in part. ... The tobacco companies are winners because they no longer will face the most immediate threat of catastrophic judgments."

file

Department of Health and Human Services
Testimony on HB 427
March 2, 1999
before the
Committee on Health, Human Services & Elderly Affairs

Good afternoon. My name is Bill Kassler, I am a practicing physician, and am here today representing the Department of Health and Human Services as the State Medical Director. I will be speaking in favor of House Bill 427. As you know, this bill will amend current New Hampshire law so that a prescription to purchase a hypodermic needle and syringe will not be needed, except for persons under the age of 18 years of age. The bill maintains the requirement that syringes can only be purchased in registered pharmacies, and would limit purchases to no more than 10 syringes per single purchase. The bill also initiates a system so that the users of syringes can learn how to dispose of used syringes properly. For clarity, I will use the term syringe to include both syringes and needles.

Before explaining why we support this bill, let me present you with a few facts. First, there are an estimated 6,000 injection drug users in New Hampshire. These individuals are at high risk for infection with HIV and other blood borne infections such as Hepatitis B and Hepatitis C every time they use a syringe previously used by another injection drug user. Each time someone injects drugs, the syringe becomes contaminated with that persons blood. If another person uses the same syringe, he or she is exposed to the previous users blood.

Nationally, about one third of the 40,000 new HIV cases are linked to injection drug use. About 20% of the 300,000 new Hepatits B cases are linked to injection drug use, and over half of the estimated 200,000 new cases of Hepatitic C are due to syringe sharing.

However, this is just the tip of the iceberg. HIV, Hepatitis B & Hepatitis C transmission that occurs through injecting drug use have a cascading effect as these infections are passed to their children and to their sexual partners who then further spread these infectious diseases in the community. Thus, reducing the risk of disease transmission among injection drug users is a legitimate medical and public health rationale for increasing access to clean syringes.

So, why does the Department believe that easing legal restrictions to syringes, as proposed in HB 427, will reduce the level of HIV infection and other blood borne diseases? First, a number of well done scientific research published in respected journals have concluded that legal restrictions are the primary reason that injection drug users share syringes. Second, as demonstrated in good scientific research, injection drug users who receive syringes from pharmacists rather than from street sellers are less likely to share syringes and less likely to attend so called shooting galleries, where syringe sharing is rampant.

In reviewing the evidence, the National Academy of Sciences concluded:

- For injection drug users who cannot or will not stop injecting drugs, access to sterile syringes remains the safest, most effective practice for limiting the transmission of blood borne infections.
- Paraphernalia laws that make it a criminal offense to possess injection equipment were designed to decrease injection drug abuse, but they also inhibit users from using sterile syringes.
- Laws requiring a prescription for the purchase of syringes promote sharing.

- Legislative bodies should repeal laws in the *(then)* nine states that require a prescription in order to purchase sterile syringes.
- There is **no** evidence that legal access to clean syringes increases drug use.
- There **is** evidence that access to clean syringes decreases HIV transmission.

Next, we support this bill because of the many public health, medical and scientific organizations that support increased access to sterile syringes as a legitimate strategy for the purpose of preventing blood borne diseases among injecting drug users. The American Medical Association in 1997 adopted the following policy, which appeared in an editorial in the prestigious Journal of the American Medical Association. "The AMA encourages the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such ... modification of laws and regulations is urgent, considering the contribution of injecting drug use to the epidemic of HIV infection."

In an article appearing in another issue of the Journal of the American Medical Association that year entitled "Prevention of HIV/AIDS and Other Blood-Borne Disease Among Injection Drug Users" the authors noted that "Over-the counter sale of syringes is likely to be a highly cost effective means of increasing the availability of sterile syringes through an extensive network of retail pharmacies , and together with the expertise of pharmacists, would help ensure wide access to syringes and professional advice."

It is important to note that only eight states (California, Delaware, Illinois, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island) still require prescriptions to purchase syringes. You should also know that two northeast states have enacted legislation similar to what is proposed in HB 427: In 1992, the state of Connecticut passed a law (HB 5015, Act 185) which permitted pharmacies to sell syringes without a prescription, and in 1993, the state of Maine (HB 587 Chapter 791) removed the requirement for prescriptions to buy syringes for people 18 years of age or older.

Following 1992, when Connecticut adopted legislation similar to HB 470, I supervised a team of scientists from the US Centers for Disease Control and Prevention, who joined the Connecticut Department of Public Health to evaluate its impact. What we found was published in two articles in the Journal AIDS, for which I was co-author. When legal restriction on both the purchase and possession of syringes was removed the following facts were documented:

- Most (83%) pharmacists sold non-prescription syringes after the law changed.
- In high drug using neighborhoods, the number of non-prescription syringes rose dramatically, while in low-drug using areas, little changed.
- Injecting drug users changed both their syringe buying practices and syringe sharing behaviors. It was found that syringe-sharing among drug-users **fell** thirty-nine percent after the laws passage.
- Most (78%) drug users surveyed **bought** syringes from a pharmacy. Fewer bought them on the street, and fewer bought them in shooting galleries.

Lele

TESTIMONY on HB 427

relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

CRIMINAL JUSTICE AND PUBLIC SAFETY COMMITTEE

Tuesday, March 2, 1999 – 3:00 p.m.
Room 204, LOB

by Representative Marion L. Copenhaver

Grafton County, District 10

My name is Marion Copenhaver from Grafton, District 10 representing Lyme and Hanover. I am here in strong support of HB 427, a bill that more appropriately should have been heard in the Health, Human Services and Elderly Affairs Committee. This is clearly a health issue, not a criminal one. Representative Splaine has covered the main points of the bill.

It is important that we not get into a posture of pitting the very legitimate concerns of the law enforcement community against the equally real health issues of the transmission of a deadly virus such as HIV that causes AIDS. As you know, as yet there is no cure for this disease. It is incumbent upon us as policymakers to bring these two parties together in the best interest of the public we represent.

In this state, there are an estimated 6,000 drug users. These individuals are at high risk for infection with HIV, Hepatitis C and B, and other blood borne infections every time they use a needle previously used by another injection drug user. These people are often married, have families and thus spread HIV to their sex partners and children who are born to them. Persons who use injection drugs, children of IV drug users and their sexual partners accounted for the largest proportion of new cases in the state – greater than homosexuals.

This bill decriminalizes the possession of needles and syringes and allows persons over 18 to buy the needles thus curbing the dangerous practice of sharing dirty needles.

I have a lot of material I can share with this committee put forth by the Centers for Disease Control in Atlanta, the Johns Hopkins University Program on Law and Public Health, Harvard School of Public Health and others. These clearly are not fly-by-night correspondence schools.

In closing, I think we have a lot of educating to do, particularly with the law enforcement community that have often based their attitudes on misinformation such as being able to buy needles will encourage drug use. it is well known, that is utter nonsense, but the myth persists.
I urge the committee to study this bill and its ramifications on public health in decreasing the spread of these dreaded diseases. Thank you.

Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology
10:71–72 © 1995 Lippincott–Raven Publishers, Philadelphia

file

Editorial

Deregulation of the Sale and Possession of Syringes for HIV Prevention Among Injection Drug Users

Injection drug users are at risk for human immunodeficiency virus (HIV) and other blood-borne infections primarily through the sharing (or "multiperson" use) of blood-contaminated syringes and other equipment used to prepare and inject drugs (1). The reasons posited for equipment sharing included the belief that this behavior is a ritual within the subculture of drug injectors (2), however, more recently, there has been a recognition of pragmatic legal and economic motivations for sharing syringes (3,4). Laws which do not allow sale of syringes without a prescription and felony penalties for the possession of syringes originally designed to curtail drug use, may have contributed unwittingly to parenteral transmission of blood-borne infections (5,6). Also, the cost of syringes is not trivial and also could contribute to the practice of sharing syringes (4). In the past decade, hundreds of needle exchange programs have been established in Europe, Australia, and North America to provide injection drug users with increased legal access to sterile syringes (7,8).

However, due to limited funding, many syringe exchange programs provide mostly exchange functions and have only a small number of sites with limited hours of operation (7). These limited number of sites and hours per city translate into a limited potential impact for each of these programs.

In the absence of expanded funding for syringe exchange programs, an inexpensive and practical alternative to efficiently provide wider access to sterile syringes is to deregulate syringe sales by removing prescription requirements and relevant portions of paraphernalia possession laws. This would allow injection drug users to carry syringes purchased at local pharmacies. This alternative has immediate intuitive appeal because the number and geographic distribution of pharmacies with their relatively long hours of operation provide more convenience than the limited sites and hours of current syringe exchange programs. Moreover, the pharmacy infrastructure already exists.

In this issue, reports by Valleroy and colleagues (8) and Groseclose and colleagues (9), summarize information collected following deregulation of syringes in Connecticut. In July 1992, pharmacists were permitted to sell and individuals were permitted to possess up to 10 syringes without medical prescriptions. These studies showed that 83% of pharmacists in Connecticut sold non-prescription needles after the law changed and that drug users used the pharmacies. Specifically, in high drug use areas, the number of non-prescription syringes sold increased dramatically with little change in sales of prescription syringes, while in low drug use areas little change in any syringe sales was noted. This finding was corroborated in a separate survey of injection drug users who reported a dramatic increase in pharmacy purchases and a substantial decrease in "street" purchase of needles after the law changed. At the same time, the proportion of injection drug users who reported sharing syringes decreased, which is further supported in a separate letter in this issue (10). Needlestick injuries among police decreased over time; while this might be attributed to greater precautions exercised by police after the law change, an accompanying letter reports that syringes purchased were not carried but stored due to continuing fears of arrest among injection drug users (11).

These findings from Connecticut suggest promise for deregulation of syringes as an HIV prevention strategy, but raise additional questions. Behavior change was measured by self-reports which are subject to error; however, corroboration with pharmacy sales data at least partially offsets this concern. As another issue, these studies showed pharmacy-based sales are not without problems as several pharmacists reported unpleasant incidents that soured them on non-prescription sales; discussion of how these incidents might be avoided or minimized is worthwhile. Also, further work is needed to understand the basis for the fears among drug users about carrying syringes after the law

GSAC
PO BOX 2753
CONCORD NH 03302-2753

changed by studying the attitudes and behaviors of the police and the drug users (e.g., are individual police continuing to harass drug users who possess syringes). Another issue is the effect of establishing a maximum number of syringes injection drug users can purchase and carry. Would removing restrictions on the number of syringes or a higher limit be associated with a further reduction in multi-person use of syringes? Another issue not addressed in these reports is the disposal of contaminated needles and syringes; some plans and measures are needed to monitor patterns of discarded needles, as has been reported elsewhere (12). Finally, that such programs reduce HIV infection rates was suggested by an earlier study in Maryland, which noted lower HIV infection rates in diabetic compared to nondiabetic injection drug users who were otherwise comparable; this was attributed to unrestricted legal access to sterile syringes (13). Longitudinal follow-up, which includes HIV incidence data, could be helpful to measure the impact of this program.

On the basis of these reports from Connecticut, deregulation of syringes coupled with careful evaluation of impact should be enacted elsewhere. Specifically, states with prescription laws should repeal them, and states should repeal the section of drug paraphernalia laws that make possession and distribution of syringes a crime. It is important to note that Connecticut enacted simultaneous repeal of the two laws, which may have been an important factor in their "natural experiment." The data from Connecticut point towards deregulation of syringes as a useful element of a comprehensive HIV prevention strategy.

David Vlahov
Department of Epidemiology
The Johns Hopkins School of Hygiene and Public Health
Baltimore, Maryland

REFERENCES

1. Friedland GH, Klein RS. Transmission of the human immunodeficiency virus. *N Engl J Med* 1987;317:1125–35.
2. Des Jarlais DC, Friedman SR, Strug D. AIDS and needle sharing within the IV drug use subculture. In: Feldman D, Johnson T, eds. *The social dimensions of AIDS: methods and theory*. New York: Preager, 1986.
3. Mandell W, Vlahov D, Latkin C, Oziemkowska M, Cohn S. Correlates of needle sharing among injection drug users. *Am J Public Health* 1994;84:920–3.
4. Magura S, Shapiro JL, Grossman JI, et al. Determinants of needle sharing among intravenous drug users. *Am J Public Health* 1989;79:459–62.
5. Murphy S. Intravenous drug use and AIDS: notes on the social economy of needle sharing. *Contemp Drug Probl* 1987;5:373–95.
6. Koester S, Booth R, Wiebel W. The risk of HIV transmission from sharing water drug mixing containers, and cotton filters among intravenous drug users. *Internat J Drug Policy* 1990;1:28–30.
7. Lurie P, Reingold AL, Bowser B, et al. *The public health impact of needle exchange programs in the United States and abroad*. San Francisco: University of California, 1993.
8. Valleroy LA, Weinstein B, Jones TS, et al. Impact of increased legal access to needles and syringes on community pharmacies needle and syringe sales—Connecticut 1992–1993. *J Acquir Immun Defic Syndr Human Retrovirol* 1995;10:73–81.
9. Groseclose SL, Weinstein B, Jones TS, et al. Impact of increased legal access to needles and syringes on practices of injecting drug users and police officers—Connecticut, 1992–1993. *J Acquir Immune Defic Syndr Human Retrovirol* 1995;10:82–9.
10. Singer M, Weeks MR, Himmelgreen D, Sales and exchange of syringes [letter]. *J Acquir Immune Defic Syndr Human Retrovirol* 1995;10:104.
11. Grund JC, Heckathorn DD, Broadhead RS, Anthony DL. In eastern Connecticut, IDUs purchase syringes from pharmacies but don't carry syringes (letter). *J Acquir Immune Defic Syndr Human Retrovirol* 1995;10:104–5.
12. Doherty M, Gargein R, Vlahov D. No increase in discarded needles following opening of needle exchange program. 2nd National Meeting Retrovirus and Related Infections. Washington D.C., January, 1995.
13. Nelson KE, Vlahov D, Cohn S, et al. Human immunodeficiency virus infection in diabetic intravenous drug users. *JAMA* 1991;226:2259–61.

does needle exchange work?

why do we need needle exchange?

More than a million people in the United States inject drugs, at a cost to society (in health care, lost productivity, accidents, and crime) of more than $50 billion a year.[1] People who inject drugs imperil their health. If they contract HIV, their needle sharing partners, sexual partners and offspring may also be endangered.

One-third of all AIDS cases are linked to injection drug use. For women, 64% of all AIDS cases are due to injection drug use or sex with partners who inject drugs. Injection drug use is the source of infection for more than half of all children born with HIV.[2]

Around the world and in more than sixty locations in the United States, needle exchange programs have sprung up to address drug injection risks. These programs not only distribute clean needles and safely dispose of used ones for injection drug users (IDUs), they generally offer a variety of related services, including referrals to drug treatment and HIV counseling and testing.[3]

why do drug users share needles?

In part because there are not enough needles and syringes to go around. The overwhelming majority of IDUs are aware of the risk of the transmission of HIV and other diseases if they share contaminated equipment. However, sterile needles are not always available or affordable.

Most US states have paraphernalia laws that make it a crime to possess or distribute drug paraphernalia not for a "legitimate medical purpose," which subjects drug injectors to prosecution. In addition, ten states and the District of Columbia have laws that require a prescription to buy a needle and syringe. Even where over-the-counter sales of syringes are permitted by law, pharmacists are often unwilling to sell to IDUs.[4]

In July of 1992, the state of Connecticut passed a law permitting the purchase and possession of up to ten syringes without a prescription. After the new law went into effect, the sharing of needles among IDUs decreased, and there was a shift from street needle and syringe purchasing to pharmacy purchasing.[5]

how can injection risks be reduced?

Getting drug injectors into treatment and off drugs is the best answer. Unfortunately, not all drug injectors are ready to quit. Even those who are highly motivated may find few services available. Drug treatment centers frequently have long waiting lists and fewer than 15% of IDUs are in treatment at any given time.[6]

For those who cannot or will not stop injecting drugs, the best way to avoid spreading HIV is to use a sterile needle for each injection, or at least not to share needles. Users who share should disinfect their injection equipment thoroughly with bleach, although this is not as safe as always using a sterile needle and syringe.[7]

does needle exchange encourage drug use?

There is no evidence that needle exchange programs increase the amount of drug use by needle exchange clients or in the wider community.[3] A study of a San Francisco needle exchange program that opened in 1988 found that from 1987 to 1992, frequency of injecting drugs among street-recruited IDUs declined from 1.9 to 0.7 injections per day. The mean age of IDUs increased from 36 to 42 years, and the percentage of new initiates into injection drug use dropped from 3% to 1%.[8] Drug abuse and the recruitment of new or younger users did not increase in the presence of the exchange; in fact, the exchange may have helped *decrease* the amount of drug abuse in the area.

...ays who?

1. Rice DP, Kelman S, Miller LS. Estimates of economic costs of alcohol and drug abuse and mental illness, 1985 and 1988. *Public Health Reports.* 1991;106:280-292.

2. CDC. HIV/AIDS Surveillance Report. 1993;5:1-30.

3. Lurie P, Reingold AL, Bowser B, et al. *The Public Health Impact of Needle Exchange Programs in the United States and Abroad.* Prepared for the Centers for Disease Control and Prevention. September, 1993.

4. Compton W, Cottler L, Decker S, et al. Legal needle buying in St. Louis. *American Journal of Public Health.* 1992;82:595-596.

5. Groseclose SL, Valleroy LA, Weinstein B, et al. New Connecticut laws to improve access to needles and syringes: what is their impact? In: *Proceedings of Workshops on Needle Exchange and Bleach Distribution Programs.* National Academy Press. Washington DC;1994.

6. Wiley J, Samuel M. Prevalence of HIV infection in the USA. *AIDS.* 1989;3(Suppl. 1):71-78.

7. Curran JW, Scheckel LW, Millstein RA. *HIV/AIDS Prevention Bulletin.* April 19, 1993.

8. Watters JK, Estilo MJ, Clark GL, et al. Syringe and needle exchange as HIV/AIDS prevention for injecting drug users. *Journal of the American Medical Association.* 1994;271:115-120.

A publication of *HIV Prevention: Looking Back, Looking Ahead*, a project of the Center for AIDS Prevention Studies (CAPS), University of California, San Francisco, and the Harvard AIDS Institute. Thomas J. Coates, PhD and Harvey J. Makadon, MD, co-principal investigators.

Funded by a grant from THE HENRY J. KAISER FAMILY FOUNDATION

Prevention of HIV/AIDS and Other Blood-Borne Diseases Among Injection Drug Users

A National Survey on the Regulation of Syringes and Needles

Lawrence O. Gostin, JD; Zita Lazzarini, JD, MPH; T. Stephen Jones, MD, MPH; Kathleen Flaherty, JD

We report the results of a survey of laws and regulations governing the sale and possession of needles and syringes in the United States and its territories and discuss legal and public health proposals to increase the availability of sterile syringes, as a human immunodeficiency virus (HIV) transmission prevention measure, for persons who continue to inject drugs. Every state, the District of Columbia (DC), and the Virgin Islands (VI) have enacted state or local laws or regulations that restrict the sale, distribution, or possession of syringes. Drug paraphernalia laws prohibiting the sale, distribution, and/or possession of syringes known to be used to introduce illicit drugs into the body exist in 47 states, DC, and VI. Syringe prescription laws prohibiting the sale, distribution, and possession of syringes without a valid medical prescription exist in 8 states and VI. Pharmacy regulations or practice guidelines restrict access to syringes in 23 states. We discuss the following legal and public health approaches to improve the availability of sterile syringes to prevent blood-borne disease among injection drug users: (1) clarify the legitimate medical purpose of sterile syringes for the prevention of HIV and other blood-borne infections; (2) modify drug paraphernalia laws to exclude syringes; (3) repeal syringe prescription laws; (4) repeal pharmacy regulations and practice guidelines restricting the sale of sterile syringes; (5) promote professional training of pharmacists, other health professionals, and law enforcement officers about the prevention of blood-borne infections; (6) permit local discretion in establishing syringe exchange programs; and (7) design community programs for safe syringe disposal.

JAMA. 1997;277:53-62

THE MAGNITUDE OF THE EPIDEMICS OF DRUG USE AND BLOOD-BORNE DISEASES

The dual epidemics of drug use and the human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS) are highly destructive of public health and social life in America.[1] The drug-related health problems of the estimated 1.5 million injection drug users (IDUs) in the United States[2,3] range from blood-borne infections such as hepatitis B and C, HIV/AIDS, endocarditis, and malaria[4-7] to physical deterioration and death. Illegal drug use and the drug industry that fuels it are associated with a multitude of crimes against persons and property. Drug use induces family disintegration, child neglect, economic ruin, and social decay. Drug use exacts an estimated annual cost to society of $58.3 billion—in lost productivity, motor vehicle crashes, crime, stolen property, and drug treatment.[8]

Injection drug use is the second most frequently reported risk for AIDS, accounting for 184 359 cases through December 1995.[9] In 1995, 36% of all AIDS cases occurred among IDUs, their heterosexual sex partners, and children whose mothers were IDUs or sex partners of IDUs.[10] In contrast, in 1981, only 12% of all reported AIDS cases were associated with injection drug use.[11] In some areas, seroprevalence among IDUs is as high as 65%; in other areas, the rates are significantly lower.[12-17] Minorities, moreover, bear a disproportionately high burden. The rate of IDU-associated AIDS per 100 000 population is 3.5 for whites, 21.9 for Hispanics, and 50.9 for African Americans.[18]

Transmission of HIV infection through injection drug use has a cascading effect; infections spread from IDUs to their sexual and needle-sharing partners and from HIV-infected mothers to their children. Of the 71 818 AIDS cases among women reported through December 1995, nearly 65% were IDUs or were sexual partners of an IDU. Further, of the 6256 perinatally acquired AIDS cases reported through December 1995, 60% had mothers who were IDUs or had sex with an IDU.[10] These data suggest that drug use and related behaviors[19] are potent catalysts for spreading HIV throughout the population.[11] It has been estimated that approximately half of all new HIV infections in the United States occur among IDUs.[20]

THE ROLE OF SYRINGES IN THE TRANSMISSION OF BLOOD-BORNE DISEASE

Injection drug users transmit HIV infection and other blood-borne diseases to other users primarily through multiperson use (often called "sharing") of syringes.[21] (For the purpose of this article, "syringe" includes both syringes and needles.) Each time an IDU injects drugs, the syringe

From the Georgetown/Johns Hopkins Program in Law and Public Health, Washington, DC, and Baltimore, Md (Mr Gostin and Ms Flaherty); Harvard School of Public Health, Boston, Mass (Ms Lazzarini); and the Centers for Disease Control and Prevention, Atlanta, Ga (Dr Jones).

The views expressed herein are those of the authors and do not necessarily reflect the official policy of the US Department of Health and Human Services, the Carter Presidential Center, the Centers for Disease Control and Prevention, or the cosponsors of the consultation held at the Carter Presidential Center.

Corresponding author: Lawrence Gostin, JD, Georgetown University Law Center, 600 New Jersey Ave NW, Washington, DC 20001 (e-mail: gostin@law.georgetown.edu).

Health Law and Ethics section editors: Lawrence O. Gostin, JD, Georgetown/Johns Hopkins University Program on Law and Public Health, Washington, DC, and Baltimore, Md; Helene M. Cole, MD, Contributing Editor, *JAMA*.

Table 1.—Drug Paraphernalia Laws*

	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE	NV
DP law†	X		X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X
MDPA-based law	X		X	X	X	X	X	X	X	X	a	X	X	X	b		X	X	X	b	X	c	X	X	X	X	X	X	X
Exception for SEPs									X			X									X	X							
Local ordinance(s)		X				i										X					j		k						

*Footnotes after Table 3 provide full explanation of all lowercase letter designations. In all three tables, GU indicates Guam; NMI, Northern Mariana Islands; PR, Puerto Rico; SA, American Samoa; VI, Virgin Islands; DP, drug paraphernalia; MDPA, Model Drug Paraphernalia Act; and SEP, syringe exchange program.

†Drug paraphernalia laws prohibit the sale, distribution, possession, manufacture, and/or advertisement of items known to be used to introduce illicit drugs into the body.

‡The total of 46 includes two states (Oregon and Wisconsin) that specifically exclude syringes and needles from the statutory definition of drug paraphernalia.

becomes contaminated with that person's blood and blood-borne pathogens. If another IDU uses the same syringe, he or she is exposed to the previous user's blood with each injection. Decontamination efforts, such as flushing the syringe with bleach, can reduce the risk of exposure, but they are not as safe as using a new, sterile syringe for each injection.[22] Reducing the circumstances in which IDUs are likely to reuse equipment lowers the probability of spreading disease. Consequently, experts in preventive medicine and public health advise persons who continue to inject drugs to use a new syringe for each injection.[22-25] Reducing the risk of disease transmission among IDUs constitutes a legitimate medical and public health rationale for increasing access to syringes.

Multiperson use of syringes is a complex behavior initially reported as part of the subculture of the drug world; sharing was thought to be a sign of social bonding in the drug use community.[26-31] Increasingly, however, researchers have identified scarcity of syringes—not solely a culturally created norm—as a leading factor in sharing behavior.[32,33] In an effort to control drugs, federal, state, and local governments made a conscious policy choice to limit the supply of sterile syringes. Thus, laws and regulations have made it difficult for IDUs to use a sterile syringe for each injection.[23,25]

To determine the extent of laws and regulations controlling access to syringes, we conducted 2 surveys in the 50 states, the District of Columbia, and five territories concerning three sets of legal rules: drug paraphernalia laws, syringe prescription laws, and pharmacy regulations (Tables 1 through 3). A survey was sent by the Association of State and Territorial Health Officials to state and territorial attorneys general who were asked to consult with their respective health departments. A second survey was sent to state and territorial boards of pharmacy in consultation with the National Association of Boards of Pharmacy. Attorneys general and boards of pharmacy were asked to describe the law in their jurisdictions and to provide copies of relevant statutes, ordinances, and regulations. Attorneys general and boards of pharmacy were subsequently sent summaries of their laws and regulations and asked to confirm the accuracy. This article analyzes the full range of laws and regulations that restrict access to syringes and discusses potential legal and public health approaches for the prevention of HIV/AIDS and other blood-borne pathogens among IDUs, particularly those who will not or cannot stop injecting drugs.

STATE AND LOCAL DRUG PARAPHERNALIA LAWS

Drug paraphernalia statutes ban the manufacture, sale, distribution, possession, or advertising of a broad array of devices known to be used (or reasonably should be known to be used) to introduce illicit substances into the body. In contrast to syringe prescription laws, most drug paraphernalia laws include the element of intent by defining the prohibited activity in terms of objects "intended" or "marketed" for unlawful use. Thus, selling or distributing syringes—without knowledge that they will be used to inject illicit drugs—does not constitute an offense under these statutes. For example, a pharmacist who sells syringes over-the-counter to an IDU, believing that the purchaser is a diabetic who will use the equipment to inject insulin, does not violate drug paraphernalia laws.

Legislative History

Drug paraphernalia laws were enacted as a response to the proliferation of the drug paraphernalia industry. Beginning in the late 1960s, cigarette-rolling papers began to be marketed for use with marijuana.[34] By 1976, drug paraphernalia had spawned a $3 billion industry; between 15 000 and 30 000 "head shops" operated nationwide.[35] The Select Committee on Narcotics Abuse Control observed that "there were head shops no matter where [we] looked." An assortment of drug paraphernalia publications also appeared, ranging from books on the use of marijuana, hashish, and cocaine to magazines. Community groups and law enforcement officials expressed concern that "the drug paraphernalia industry, through its glamorizing of the drug culture, acts to undermine parental authority, as well as educational and community programs designed to prevent drug abuse among our youth."[36]

In response, and with increasing frequency during the 1960s and 1970s, state legislatures promulgated "needle laws" and "pipe laws." Many of these laws were inherently vague and were subsequently found to be unconstitutional.[37,38] To surmount the drafting difficulties of these early laws, the Drug Enforcement Administration in 1979 wrote the Model Drug Paraphernalia Act (MDPA), at the request of President Carter. In 1982, the Supreme Court signaled its approval by upholding a law that included a broad definition of drug paraphernalia.[39] Thereafter, lower courts upheld the constitutionality of statutes based on the MDPA.[40,41]

Given the era in which they emerged—where the young celebrated drug use and entrepreneurs openly flouted drug control efforts—drug paraphernalia laws seem reasonable. The social and legislative history of drug paraphernalia laws reveal that only one group opposed government restrictions: the drug paraphernalia industry. Remarkably absent from the debate was the public health perspective, particularly regarding the health consequences of limiting IDUs' access to syringes.

Survey Results

Forty-seven states, the District of Columbia, and the Virgin Islands have enacted drug paraphernalia laws; only Alaska, Iowa, South Carolina, and four territories have no state- or territory-wide drug paraphernalia statute (Table 1). (Alaska and Iowa have local drug paraphernalia provisions covering some counties and cities.) In 44 states, the District of Columbia, and the Virgin Islands, the drug paraphernalia laws

	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	GU	NMI	PR	SA	VI	Total
	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X					X	49
	X	X	X	X	X	X	d	X	e	X	X		X	X	X	X	X	f	X		g	X					X	46‡
				X							X								h									7
																												5

are at least partially based on the MDPA. The statutes often enumerate the objects deemed to be drug paraphernalia, including, for instance, "hypodermic syringes, needles, and other objects used, intended for use, and designed for use in parenterally injecting controlled substances into the human body."[42] Oregon and Wisconsin specifically exclude syringes from the statutory definition of "drug paraphernalia," but both states include the word "inject" in their general definition of the offense. In contrast, Montana does not expressly include or exclude syringes in its definition of "drug paraphernalia." Maine, Massachusetts, Ohio, and Virginia have enacted legislation in addition to their drug paraphernalia laws that specifically restricts the sale of syringes.

The MDPA permits states to designate the penalty for an offense. Most states classify possession as a misdemeanor and delivery as a felony. Delivery to a minor, when the seller is at least 3 years older than the purchaser, often elicits a more severe penalty. Second and subsequent offenses frequently provoke more serious punishment than a first offense. Drug paraphernalia are often subject to seizure and forfeiture. Three states and one territory assess civil, as well as criminal, penalties for violation of drug paraphernalia laws (California, Louisiana, New Hampshire, and the Virgin Islands). These civil penalties include suspension or revocation of business, liquor, and/or occupational licenses or permits. New Hampshire, for example, levies special civil penalties on pharmacists who violate the drug paraphernalia law, including a fine of up to $5000 for repeated violations.

Five states (Hawaii, Maryland, Massachusetts, New York, and Rhode Island) and the District of Columbia carve out an exception in their drug paraphernalia laws for operators of syringe exchange programs (SEPs) and their participants. In addition, the state of Washington recognizes such an exemption based on case law that interprets the state's public health and criminal statutes.[43] These provisions exempt SEP participants who possess and distribute syringes from prosecution under drug paraphernalia laws. Five states require SEP users to carry a certificate or other evidence of SEP participation (Connecticut, Maryland, Massachusetts, New York, and Rhode Island).

In at least five states (Alaska, Colorado, Iowa, Maryland, and Michigan), local ordinances regulate the possession, sale, or manufacture of drug paraphernalia; of these states, only Alaska and Iowa do not also have a state-wide drug paraphernalia law. New York is the only state that explicitly construes its law to preempt local ordinances.[44,45]

THE FEDERAL MAIL ORDER DRUG PARAPHERNALIA CONTROL ACT

The Federal Mail Order Drug Paraphernalia Control Act (Mail Order Act), passed as part of the Anti-Drug Abuse Act of 1986, was expanded in 1990.[46] At the time the Mail Order Act was enacted, the MDPA was considered a triumph; law enforcement officials had succeeded in closing head shops in 38 states. State-level efforts were so effective that they produced a different problem: the interstate commerce of drug paraphernalia.[47] While the head shop business faltered, the mail order drug paraphernalia business flourished:

> All across America children are receiving catalogs and advertisements for the bongs and drug merchandise which we have worked very hard to eliminate. Some of these ads are finding their way into the family mailbox unsolicited.[47]

The Mail Order Act was originally designed to prohibit the use of the US Postal Service to ship equipment to ingest drugs. The statute was later amended to proscribe "any offer for sale and transportation in interstate or foreign commerce" or import or export of drug paraphernalia. In 1994, the Supreme Court upheld the constitutionality of the Mail Order Act.[48]

The Mail Order Act is significant in that it interjects federal law into an area traditionally reserved for the states.[49] In deference to public health, state and local law enforcement officials may choose to relax their enforcement of drug paraphernalia laws. State and local decisions, however, do not preclude federal authorities from vigorously enforcing the Mail Order Act.

In 1986, the year the Mail Order Act was passed, HIV was known to be a blood-borne disease, and the HIV epidemic was a widely recognized public health problem.[46] Despite the foreseeable health effects of restricting access to injection equipment during this epidemic, public health and HIV prevention were not discussed at congressional hearings. Moreover, federal courts that reviewed the Mail Order Act,[50,51] including the Supreme Court,[48] expressed no reservations about potential health consequences.

SYRINGE PRESCRIPTION STATUTES

Syringe prescription statutes prohibit persons from dispensing or possessing hypodermic syringes without a valid medical prescription. Most prescription laws circumscribe a physician's power to prescribe syringes by requiring a legitimate medical purpose. The "legitimate medical purposes" doctrine strengthens the regulatory effect of syringe prescription laws and is intended to hold a prescription invalid unless issued for a therapeutic purpose. Unlike drug paraphernalia laws, a violation of prescription laws does not require criminal intent. For example, to violate the statute, a pharmacist who dispenses a hypodermic syringe without a prescription need not know that the buyer intends to administer illegal drugs; the very act of dispensing the syringe without a prescription constitutes an offense. The defendant, moreover, carries the burden of proving by a preponderance of the evidence that the hypodermic instrument was legally sold or obtained.[52,53] Lacking the element of intent, prescription statutes potentially encompass many more transactions than paraphernalia laws. Furthermore, syringe prescription laws may restrict syringe displays and require pharmacists to maintain sales records. Courts have upheld the constitutionality of syringe prescription laws.[54,55]

Legislative History

Prescription laws can be traced to the widespread use of opium, morphine, cocaine, and heroin during the late 19th and

Table 2.—Laws Limiting Syringe Sales*

	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE	NV
SP law†					X		l	X		m				X						n		X							
Other limitations																							p			q			r
Record keeping§				X	X		X		X					X				X				X							
Disposal requirement					X		X	X										X											
Display limitations‖					X		X	X										X											
Pharmacy sales	X				X		y		X											z		aa							X
Exception for SEPs							X							cc								X							
Other exceptions					dd		ee	ff						gg								hh							ll
Local ordinance(s)										pp													qq						

*Footnotes after Table 3 provide full explanation of all lowercase letter designations.
†Syringe prescription (SP) laws prohibit the sale, distribution, and possession of syringes without a valid medical prescription.
‡This total of 9 includes only those states which require a prescription by law for most sales to adults.
§"Record keeping" may include name and address of purchaser, number of syringes sold, intended use, and inspections permitted by law enforcement.
‖"Display limitations" include requirements that syringes and needles be stored in particular areas and not made available to customers on a self-service basis.

early 20th centuries. Physicians and pharmacists dispensed opium to treat a myriad of afflictions. In the 1890s, public concern led to a call for restricting physicians' freedom to dispense these drugs. The medical profession reacted with "fear that the state would dominate the practice of medicine."[56] The ensuing debate produced the 1914 Boylan Act, New York's syringe prescription law. The law's intent was to reduce drug addiction by posing obstacles to obtaining narcotic drugs and the instruments to administer them. The Boylan Act strictly regulated the distribution of syringes by pharmacists and physicians. Other states followed suit, adopting prescription laws primarily as a drug abuse prevention strategy.[57] Not surprisingly, states that have enacted syringe prescription laws are those that have experienced the longest history of, or the deepest problems with, drug abuse.

Survey Results

Eight states and one territory statutorily mandate medical prescriptions for most syringe sales (Table 2).[58] These and other jurisdictions, however, do allow exceptions for certain authorized users (eg, manufacturers, wholesalers, researchers, licensed holders, and persons using syringes for agricultural, medical, and industrial purposes).[59] Ten additional states restrict the purchase of syringes without a prescription by law or local ordinance. These laws may require prescriptions to establish a legitimate purpose for specific classes of purchasers (eg, minors) or for certain types of purchases (eg, bulk). In 1992, Connecticut amended its law to require prescriptions only for sales of more than 10 syringes. Virginia requires prescriptions for sale to individuals under the age of 16 years, and Florida requires them for sale to individuals under the age of 18 years. Maine specifies that only certain people can sell syringes; however, anyone over the age of 18 years may purchase from an authorized seller. Alternatively, states or localities may permit nonprescription sales only to persons with a legitimate medical need (eg, Michigan, Nevada, Ohio, Texas, Virginia, and Washington). For example, in Nevada, hypodermic devices may be sold without a prescription for medical, veterinary, industrial, and hobby purposes, as long as the seller is satisfied that the device will be used lawfully.

In addition to criminal penalties, physicians and pharmacists may face sanctions from professional licensing boards for violating state laws concerning syringes. In 1994, the California Board of Pharmacy, for example, accused a pharmacy of allowing a nonpharmacist employee to sell syringes without asking for identification or recording the sale. The board fined the pharmacy and temporarily suspended the licenses of the pharmacy and the pharmacist.[60]

Only three states specifically exempt SEP operators and participants from syringe prescription laws (Connecticut, Massachusetts, and Rhode Island). These states usually require SEP users to carry a syringe exchange card or other proof of participation. The exemption applies only to possession of equipment obtained from the SEP.

Several localities have promulgated syringe prescription ordinances. Michigan does not require prescriptions for sale of needles and syringes; the cities of Warren, Westland, and Detroit, however, place certain restrictions on the purchase or possession of syringes. Florida state law does not require a prescription for adults purchasing syringes; yet Dade and several other counties have prescription ordinances that regulate the sale of syringes. Local ordinances may exist in other states, but they were not reported in this survey.

PHARMACY REGULATIONS AND PRACTICE GUIDELINES

Pharmacy regulations are established under state law by pharmacy boards or other governmental agencies such as a department of consumer protection, department of health, or department of drug control. Pharmacists are legally required to comply with regulations for the sale of syringes. Practice guidelines are typically established by state pharmacy boards. While these guidelines do not have the force of law and technically are not legally binding, failure to comply could leave the pharmacist susceptible to professional sanction or civil liability under state tort law. Legal and public health scholarship has not previously recognized the importance of pharmacy regulations and practice guidelines in restricting access to sterile syringes. While it was previously assumed that over-the-counter sale of syringes was regulated in only a small minority of states with syringe prescription laws, this survey reveals that restrictive regulations are in force in many of the United States.

Twenty-three jurisdictions have pharmacy regulations or practice guidelines that restrict access to syringes by IDUs and persons who need sterile syringes for medical conditions (Table 3).[61] Seventeen of these states do not have syringe prescription laws.[62] In 11 of these states, regulations or mandatory practice standards significantly impede IDUs' access.[63] These rules require the seller to demand of purchasers identification and a prescription or other proof of medical need and/or impose record-keeping requirements. Pharmacists are

	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	GU	NMI	PR	SA	VI	Total
	X	X		X							X							o									X	9‡
							s		t						u			v	w									8
	X	X		X			X				X							X									X	14
							X				X																X	7
							X																					5
	X	X									bb							X										11
											X																	3
	jj	kk		ll			mm				nn							oo									rr	13
																												2

often expressly authorized to refuse to sell syringes if they believe the intended use is illegal (eg, Georgia, Maryland, South Carolina, and Tennessee). Some states require purchasers to produce valid identification such as a driver's license (eg, Indiana, South Carolina, and Virginia).

Eighteen jurisdictions track the sale of needles and syringes by law or regulations requiring pharmacists to maintain records[64] and to permit their inspection by various state agencies. The information requested often includes the purchaser's name and address and the intended use. Purchasers may also be required to sign a register. Pharmacists must usually retain the records for a period of time set forth in the regulations and ensure their availability for inspection by law enforcement or other government agencies.

Seven states and one territory regulate the traffic in syringes to guard against having lawfully obtained equipment used for nonlegitimate purposes.[65]

Three states require syringe purchasers to carry evidence of lawful possession (Delaware, Illinois, and Rhode Island). Delaware and Illinois laws require some or all persons possessing syringes to have a certificate of medical need authorized by a physician or allied medical practitioner. The Rhode Island health department advises patients to carry the pharmacy's dispensing label when transporting syringes.

At least three states that do not require prescriptions for syringe sales report having "voluntary" syringe prescription requirements or guidelines to determine legitimate users (Missouri, New Mexico, and Wyoming). In these states, pharmacists voluntarily screen syringe purchasers and sell only to persons whom the pharmacists consider to have a legitimate medical need for syringes. Missouri has no law restricting syringe purchases, but individual pharmacies may establish their own policies; some require purchasers to present a written statement of legitimate medical need. Moreover, the Missouri Board of Pharmacy maintains that pharmacists are ethically obligated to ascertain whether syringes will be used lawfully. In New Mexico, pharmacists voluntarily question syringe and needle purchasers about their intended use and may refuse the sale. In other states—including those without specific laws or regulations requiring prescriptions—pharmacist discretion likely plays a key role in syringe sales.[66]

PUBLIC HEALTH EFFECTS OF SYRINGE REGULATION: ANALYSIS OF SURVEY RESULTS

The survey reveals that every state and the District of Columbia have enacted state or local laws that restrict the sale, distribution, or possession of syringes (Table 2). Only four territories did not report any restrictions. Forty-nine states, the District of Columbia, and the Virgin Islands have passed drug paraphernalia statutes or local ordinances. Only South Carolina and four territories do not have drug paraphernalia provisions. Ten states and one territory have statutes, regulations, or local ordinances that require a prescription for the purchase of syringes.[67] Sixteen additional states have statutes, regulations, practice guidelines, or local ordinances that can significantly limit the sale and purchase of syringes.[68] To the extent that these laws, regulations, and ordinances restrict access to sterile syringes, they contribute to the spread of blood-borne diseases among IDUs, their sexual contacts, and their children. In addition, because of criminal and professional sanctions, they deter pharmacists, physicians, and public health professionals from providing important HIV prevention services to persons who continue to inject drugs.

RESTRICTIONS ON ACCESS TO SYRINGES AND THE TRANSMISSION OF BLOOD-BORNE PATHOGENS

Legal restrictions on access to syringes are a contributing factor in the multiperson use of syringes, the primary risk behavior in the blood-borne spread of infection. Researchers from a variety of different vantage points conclude that IDUs will use sterile syringes if given the opportunity and the means.[69] First, IDUs report, and ethnographers confirm, that legal restrictions are a primary reason for sharing syringes.[32,33] Second, IDUs who receive syringes from pharmacists rather than street sellers are less likely to share syringes or to attend shooting galleries.[70] Third, IDUs with a history of diabetes have significantly lower HIV seroprevalence than nondiabetic IDUs. This is attributed to safer injection practices afforded by their legal access to sterile syringes.[71] Finally, a significant increase in pharmacy sales of syringes to IDUs and a substantial reduction in the multiperson use of contaminated syringes were reported after Connecticut partially deregulated the sale and possession of syringes.[72,73]

The principal concern about syringe deregulation or SEPs is that they could result in increased initiation into injection drug use or encourage continued drug use. However, despite careful study, most researchers have found no correlation between greater availability of syringes and increased drug use.[11,74] Moreover, since legal access to syringes, particularly through SEPs, affords greater opportunities for referrals to drug treatment and counseling messages about the harms of drug use, it is possible that SEPs and deregulation of syringes could facilitate, rather than hinder, drug control efforts. The effect of increased access to syringes on drug use is important from a public health perspective and deserves rigorous evaluation.

IMPLEMENTATION OF DISEASE PREVENTION AMONG IDUS

Obtaining and using a sterile syringe to avoid transmission of blood-borne disease can pose acute legal problems for

Table 3.—Regulations Limiting Syringe Sales

	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE	NV
Prescription required																													
"Medical need"											ss	u							tt		uu				vv	ww		yy	zz
Pharmacy sales					X		fff				ggg				X				tt		X	hhh							
Display limitations§					X			X			X							X	tt			X		X					X
Disposal requirements					X			X										X											
Record keeping‖					X										X			lll	tt		X	X							
Any restriction(s)¶					X			X	X	X	X			X	X			X			X	X	X		X	X			X

*Totals do not include pharmacy rules from Louisiana, which were never implemented.
†Includes only states that require a prescription by regulation for most sales to adults.
‡Syringe purchaser must present proof of medical need or legitimate purpose.
§"Display limitations" include requirements that syringes and needles be stored in particular areas and not made available to customers on a self-service basis.
‖"Record keeping" may include name and address of purchaser, number of syringes sold, intended use, and inspections permitted by law enforcement.
¶Includes significant restrictions imposed by law or local ordinance (Table 2) as well as regulations, rules, and practice guidelines (Table 3).
a. GA, drug paraphernalia (DP) law is partially based on MDPA.
b. ME, has a drug paraphernalia law based on MDPA but also regulates syringe and needle violations under a separate statute.
c. MA, has a DP law based on MDPA but also regulates needles and syringes under a separate statute.
d. OH, law is based on the MDPA; there is an additional statute regarding the possession of needles/syringes.
e. OR, specifically excludes needles/syringes from the definition of DP.
f. VA, in addition to DP law, there is a specific regulation on syringes and needles.
g. WI, specifically excludes needles/syringes from the definition of DP.
h. WA, *Health District v Brocket*, 839 P2d 324 (Wash 1992): syringe exchange program subject to specific public health statute and not general criminal drug paraphernalia law.
i. CO, Denver, Colorado Springs, and Aurora.
j. MD, Annapolis and Howard County.
k. MI, cities of Dearborn, Detroit, Sterling Heights, Warren, and Westland.
l. CT, only applies to sale of more than 10 syringes.
m. FL, purchasers under 18 years of age must have a prescription for syringes.
n. ME, only persons eighteen years of age or older may purchase syringes without a prescription.
o. VA, purchasers under 16 years of age must have a prescription for syringes.
p. MI, local ordinances restrict access to and possession of syringes.
q. MO, no statutory requirement. Individual pharmacies may set own policies, some require physician's written statement that buyer has legitimate medical need.
r. NV, no state law mandates prescription for syringe purchases. However, the seller must be satisfied that the customer's intended use is legitimate.
s. OH, no prescription is required, but pharmacist must know or reasonably believe user is authorized.
t. OR, minors must be have authorization of physician, parent, or guardian or "other acceptable" party to purchase syringes.
u. TX, pharmacists may sell if in their judgment the sale is "for legitimate purposes."
v. VA, sale requires identification and written evidence of legitimate purpose.
w. WA, seller must be satisfied that use will be for "legal purposes."
y. CT, health professionals may also sell/distribute needles and syringes.
z. ME, licenses authorized sellers (pharmacies and certain others); any person aged 18 years or older may buy from an authorized seller.
aa. MA, specified professionals, persons licensed by Department of Public Health, and manufacturers are also permitted to sell syringes.
bb. RI, sellers must be licensed by RI Department of Public Health.
cc. IL, the Chicago City Attorney has interpreted the research exception to the state syringe prescription law to include syringe exchange programs.
dd. CA, no prescription required for syringes used for insulin or adrenaline, for animals, or by manufacturers, wholesalers, or surgical suppliers.
ee. CT, manufacturers, wholesalers, licensed holders, researchers, agricultural, medical, or industrial users.
ff. DE, agricultural, wholesale, jobbers, manufacturers, and industrial users.

IDUs, including prosecution for possessing drug injection equipment.[75] An IDU is unlikely to present a legally acceptable reason for requiring a syringe and, thus, is likely to violate both syringe prescription and drug paraphernalia laws. Drug users may be arrested for carrying syringes.[76]

Why would the potential legal consequences of carrying injection equipment dissuade a drug user, when he or she is already engaged in far more serious criminal behavior? From the IDU's perspective, laws that penalize the possession of syringes are problematic for a number of reasons. First, drug users who are arrested on a drug paraphernalia charge are subject to fines and possible incarceration.[32] Second, the violation itself marks the person as a drug user and may subject him or her to more intense police surveillance.[77] Third, once an individual is found to possess drug paraphernalia, he or she is more likely to undergo a police search for illicit drugs.[32,77] Discovery of a syringe, or even bleach, may provide probable cause under the Fourth Amendment to conduct a broader search of the drug user and his or her possessions, leading to confiscation of illicit drugs and prosecution for sale or use.

Ethnographic studies vividly illustrate that drug users, fearing detection of syringes under these laws, often fail to carry sterile syringes.[32,77,78] Syringe laws and regulations, therefore, create a marked disincentive for drug users to possess sterile syringes when they purchase or inject drugs. Ironically, this is precisely the time when users most need sterile injection equipment because they will otherwise share blood-contaminated syringes and potentially transmit bloodborne pathogens. The threat of arrest and prosecution for possession of drug injection equipment makes it less likely that active IDUs will use sterile syringes.

OVER-THE-COUNTER SALE OF SYRINGES: THE ROLE OF PHARMACISTS

Pharmacists face substantial legal and professional hurdles in selling syringes to IDUs. By requiring prescriptions or proof of medical need, identification, and record-keeping, states impede pharmacists and customers from instituting safer means for drug injection. Drug users, wary of the legal consequences, may avoid pharmacies out of apprehension of intrusive questioning.[79] Pharmacists, wary of criminal prohibitions and professional sanctions, may decline to sell syringes to suspected IDUs.

Nationwide, pharmacists retain considerable discretion in deciding whether, and to whom, to sell syringes. Some pharmacists sell to all buyers; others refuse to sell to purchasers who demonstrate visible signs of injection drug use or who cannot offer a plausible medical justification; still others refuse sales for apparently discriminatory or capricious reasons.[80,81] Pharmacist discretion yields wide variation in the willingness to sell to IDUs.[82] Biases against, for example, racial minorities, young people, and homeless persons potentially limit opportunities for pharmacy customers to purchase syringes.[83,84]

NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	GU	NMI	PR	SA	VI	Total*
									X																		1
		aaa									bbb		X			ccc		ddd			eee						12
			X			lll			X		jjj		X						X								12
	X					X							X			kkk	X			X	eee						14
					X																						4
			X			mmm					nnn						X		X								10
X	X		X			X.			X	X	X		X	X			X	X	X							X	27

gg. IL, medical professionals, farmers, and researchers may purchase syringes without a prescription. Persons who have lost prescriptions may purchase without a prescription but must sign an affidavit that is given to the state police.
hh. MA, health professionals, persons licensed by the Department of Public Health, manufacturers, and researchers can buy syringes without a prescription.
ii. NV, prescriptions are not required for sale to/for asthmatics, diabetics, injection of medication prescribed by a practitioner, use in ambulances and by firefighters, veterinary uses, commercial or industrial, embalming, licensed medical use, research, and hobbyists "if the seller is satisfied that the device will be used for legitimate purposes."
jj. NH, industrial, medical, and research users can buy syringes without a prescription.
kk. NJ, health professionals, veterinarians, undertakers, clinical laboratories, and medical institutions can buy syringes without a prescription.
ll. NY, persons authorized by the health commissioner to obtain/possess syringes can purchase without a prescription.
mm. OH, manufacturers, medical, lawful, and agricultural users can buy syringes without a prescription.
nn. RI, manufacturers, wholesalers, dealers, embalmers, and medical users may purchase syringes without a prescription.
oo. VA, physicians, dentists, podiatrists, veterinarians, funeral directors, and embalmers may possess or distribute syringes without a prescription.
pp. FL, Dade and other counties require prescriptions, but no statewide requirement.
qq. MI, the cities of Detroit, Warren, and Westland restrict access to and possession of syringes.
rr. VI, health care professionals, veterinarians, undertakers, or registered pharmacies, hospitals, laboratories, or medical institutions may obtain syringes without a prescription.
ss. GA, sales shall not be made if seller has reasonable cause to believe that syringes would be used for unlawful purpose.
tt. LA, pharmacy rule, never implemented, would limit sales to authorized sellers, require identification and proof of medical need, impose display and record-keeping requirements, and provide for inspections.
uu. MD, purchasers must show identification and show good-faith indication of legitimate need.
vv. MS, pharmacists may sell without a prescription; some require proof of medical need or buyer signing a log before purchase.
ww. MO, according to state Board of Pharmacy, pharmacists have an ethical responsibility to decide whether needles/syringes would be used for legal purpose.
yy. NE, pharmacists are expected to exercise their professional judgment at the time of sale.
zz. NV, no state law mandates a prescription for syringe purchases. However, the seller must be satisfied that the customer's intended use is legitimate.
aaa. NM, no state law requires a prescription, but some pharmacists question potential purchasers about intended use and may refuse to sell.
bbb. SC, pharmacists must obtain either oral or written affirmation from purchasers that sale is for legitimate medical use.
ccc. VT, the Board of Pharmacy discourages sales of syringes not grounded in medical necessity.
ddd. WA, seller must determine whether syringe is to be used for a legal purpose.
eee. WY, guidelines, strictly voluntary, suggest syringes be kept in prescription department. Pharmacists may ask for identification or about intended use.
fff. CT, health professionals may also sell syringes.
ggg. GA, only pharmacies and physicians may sell syringes.
hhh. MA, persons licensed by the Department of Public Health (eg, manufacturers, dealers) may also sell syringes.
iii. OH, authorized dealers, hospitals, practitioners, and pharmacies are permitted to sell syringes.
jjj. SC, only pharmacists are permitted to make sales without prescriptions.
kkk. VT, the Board of Pharmacy encourages pharmacists to keep needles and syringes behind the counter.
lll. KY, pharmacists must keep records for nonprescription sales; pharmacists are not required to keep records of sales made with prescriptions.
mmm. OH, pharmacists may sell without prescription but pharmacists must keep records of sale and purchaser must provide identification.
nnn. SC, pharmacists must keep records of nonprescription sales.

'LEGITIMATE MEDICAL PURPOSES': THE ROLE OF PHYSICIANS AND OTHER HEALTH PROFESSIONALS

Physicians and other health professionals face potentially dire legal consequences when they prescribe syringes or otherwise directly assist IDUs in obtaining sterile syringes. Physician prescription practices, in particular, are guided by the "legitimate medical purposes" doctrine. Courts have held that physicians who prescribe controlled substances "for the purpose of maintaining [a patient's] habit" are not acting in the course of their professional duty.[85,86] It is unclear, however, whether physicians would be liable for prescribing syringes to a drug injector if they had a good faith intention to prevent the drug user from contracting or transmitting HIV infection. Many public health experts believe that increasing IDU access to sterile syringes will reduce the needle-borne transmission of disease.[23,25] Indeed, in other contexts, courts have concluded that physicians do not violate prescription laws if they act in good faith in accordance with reasonable medical judgment.[87] The most important characteristic of the physician-patient relationship is "the physician using [his or her] best efforts and expertise to promote the patient's total health."[88] If laws and regulations do not recognize access to sterile syringes as a legitimate means of preventing blood-borne disease, how can physicians and other health care professionals provide comprehensive prevention services to persons who will not or cannot stop injecting drugs?

THE LAWFUL OPERATION OF SYRINGE EXCHANGES

Although the users of one SEP were reported to have higher HIV incidence than nonusers,[89] the preponderance of research suggests that SEPs lower the rates of multiperson use of syringes[90-93]; offer a referral source for social services, health care, and drug abuse treatment; and serve as a conduit to HIV testing and counseling, health education, and condom distribution.[74] The National Research Council's review of the data concludes that SEPs constitute a vital component of a comprehensive strategy to prevent infectious disease. Syringe exchange programs reduce the number of contaminated syringes in circulation, which lowers a major risk factor for infectious disease transmission.[11]

Public health professionals or community advocates who run SEPs understand that distributed syringes will be used to inject illicit drugs; thus, absent some separate legal authority, SEPs appear to operate unlawfully under drug paraphernalia laws. Even where law enforcement agencies choose to ignore intent under drug paraphernalia laws, SEPs may be legally vulnerable. For example, SEP operators, who distribute syringes without prescriptions in states with syringe prescription laws or regulations, do so unlawfully. Consequently, in many jurisdictions, federal, state, or municipal police are authorized to arrest SEP participants, and the attorney general is entitled to seek an injunction against the program. At the very least, their uncertain legal status may

discourage drug users from participating in SEPs and communities from establishing SEPs.[94]

Public health officials and community activists have sought to support the lawfulness of SEPs through judicial declaration,[95,96] assertion of public health emergency,[97-99] and invocation of the necessity defense for prosecution of drug paraphernalia[100,101] and syringe prescription laws.[102,103] The results have been mixed.[104] Clearly, the cooperation of public health and law enforcement are essential for effective prevention of HIV transmission associated with illicit drug use.

PREVENTION OF BLOOD-BORNE DISEASE AMONG IDUS

Many public health,[105] medical,[11,106] and legal[107,108] organizations have supported the deregulation of syringes as a strategy to prevent HIV/AIDS and other blood-borne diseases among IDUs. Most laws, regulations, and practice guidelines that restrict the sale, possession, or distribution of syringes were promulgated (1) before HIV/AIDS among IDUs was recognized as a pressing public health problem and (2) without carefully contemplating the health implications. Since that time, the interconnected epidemics of drug use and HIV/AIDS have produced illness and death, particularly among poor, urban, minority communities.

We present the following legal and public health approaches that could be used to increase access to sterile syringes for persons who continue to inject drugs in order to reduce the transmission of blood-borne disease among IDUs, their sex partners, and children. These approaches would not affect current criminal proscriptions against the importation, sale, or possession of illicit drugs.

1. *Clarify the legitimate medical purposes of sterile syringes.* Possession and use of sterile syringes by IDUs serves the legitimate medical purpose of preventing blood-borne diseases. Distinguishing syringes from other drug paraphernalia would allow IDUs to legally buy and possess syringes, legitimize the professional decisions of physicians and pharmacists, and clarify the laws on which criminal justice authorities rely.

2. *Modify drug paraphernalia laws.* Drug paraphernalia laws could be modified to exempt authorized sellers, distributors, or possessors of syringes (eg, pharmacists, physicians, public health officials, registered SEPs, and their patients/clients). Permitting IDUs to obtain syringes from reliable sources would enable them to comply with public health advice to use a new syringe for each injection. The law could justifiably continue to criminalize the unauthorized sale of drug paraphernalia by drug dealers, shooting galleries, head shops, and mail order firms; but the law should not criminalize simple possesion of syringes by IDUs. Unauthorized sellers are dubious sources of sterile injection equipment; dealers and shooting gallery proprietors, for example, sometimes repackage used syringes and sell them as new.[109]

3. *Repeal syringe prescription laws.* Repeal of syringe prescription laws would legalize over-the-counter sale of syringes in pharmacies and would promote several public health benefits. Repeal would enable IDUs and persons who need sterile syringes for medical conditions such as insulin-dependent diabetes to secure sterile syringes, free physicians and pharmacists from risking criminal liability or professional sanction for prescribing or dispensing syringes to prevent transmission of blood-borne infections, and allow pharmacists to participate in public health efforts by educating and counseling customers about safer sex and drug injection practices. If permitted to perform within the scope of their professional practices, physicians and pharmacists could serve as a link to drug abuse treatment and education. Medical and pharmacy boards would retain the authority to sanction unprofessional behavior (eg, physicians or pharmacists who improperly encourage, or assist in, the illicit sale or use of drugs). Over-the-counter sale of syringes is likely to be a highly cost-effective means of increasing the availability of syringes: the extensive network, diverse locations, and extended hours of operation of pharmacies, together with the expertise of pharmacists, would help ensure wide access to syringes and professional advice. Furthermore, over-the-counter sales of syringes would remain within the private sector.

4. *Repeal restrictive pharmacy regulations and practice guidelines.* Repeal of restrictive pharmacy regulations and practice guidelines would increase the availability of sterile syringes to IDUs. States could achieve this public health objective by repealing regulations and guidelines that require purchasers to present prescriptions or other proof of legitimate medical need, proffer identification, or sign a log book prior to purchasing sterile injection equipment. Although they seem reasonable on their face, these regulations and guidelines impede both pharmacists and their clients in transactions involving sterile syringes. Reasonable practice guidelines could be maintained to ensure high professional standards and to limit sales of syringes to licensed pharmacies.

5. *Promote professional training.* Professional in-service training for pharmacists, other health professionals, and criminal justice personnel would advance public health goals. Education about the transmission of blood-borne infections would equip pharmacists to make well-informed decisions about the sale of syringes, encourage health care professionals to offer the best prevention education to IDUs, and inform criminal justice personnel about public health prevention strategies.

6. *Permit local discretion in establishing SEPs.* Permitting public health officials to establish SEPs would augment public health strategies to prevent blood-borne diseases. Many communities have found SEPs to be an important element of a comprehensive HIV prevention program. Local health officials are best situated to assess the community's response to, and the potential effectiveness of, such a program.

7. *Design programs for safe syringe disposal.* Public health officials, health care professionals, and pharmacists are well situated to collaborate in designing and directing effective programs for safe syringe disposal. Programs to ensure the safe disposal of used drug injection equipment would decrease the number of contaminated syringes in circulation and reduce health risks to the public. Indeed, criminal penalties for possession can thwart initiatives for safe disposal of syringes. Injection drug users may discard their syringes once they have been used rather than returning them to an SEP or taking them to a place for safe disposal.

CONCLUSION: HARMONIZING PERSPECTIVES ON DRUG USE AND HIV/AIDS

Public health efforts to control the spread of HIV/AIDS and other blood-borne infections must respect the legitimate concerns of the community and law enforcement about the moral and societal aspects of drug use. Law enforcement and community leaders (eg, police, churches, businesses, parents,

teachers, and residents) are understandably concerned that allowing access to syringes sends the wrong message, encourages initiation into drug use, and accelerates the disintegration of families. Residents and business owners fear increased street crime, lower property values, and health risks from discarded syringes. Respecting community views requires both public health and law enforcement to work closely with neighborhood groups.

The evidence suggests that deregulation of syringe sale and possession would reduce morbidity and mortality associated with blood-borne disease among IDUs, their sexual partners, and their children and can be implemented without harmful social repercussions. Deregulation of syringe sale and possession does not itself increase the availability of illicit drugs and is not equivalent to condoning drug use. These observations, however, require rigorous ongoing evaluation.

Finally, it is important to emphasize that deregulation of syringe sale and possession should constitute only one component of a comprehensive, well-financed strategy to impede the dual epidemics of drug use and HIV/AIDS.[105] A realistic and sound national program must devote sufficient resources for expanded access to high-quality treatment for drug and alcohol dependency; education and counseling regarding the harms of illicit drugs; effective community efforts to discourage drug use; crime prevention in schools and communities; rehabilitation for offenders; and support and community activities for families and young people. Ultimately, both law enforcement and public health seek the same end—to promote the health and safety of the population through a comprehensive program designed to prevent HIV/AIDS and drug dependency.

The syringe law project was supported by the Centers for Disease Control and Prevention (CDC), the Association of State and Territorial Health Officials, the Association of Schools of Public Health, and the Kaiser Family Foundation. The legal and public health approaches presented in this article were derived in part from a consultation in May 1996 at the Carter Presidential Center in Atlanta, under the auspices of the CDC, the Task Force for Child Survival and Development, and leading medical, public health, substance abuse, and criminal justice organizations. The authors warmly acknowledge the participants at the Carter Presidential Center Consultation on Syringe Laws and Regulations to Address the Dual Epidemics of HIV Infection and Substance Abuse and the following organizations that cosponsored the consultation: the American Association of Diabetes Educators, the American Foundation for AIDS Research, the American Medical Association, the American Pharmaceutical Association, the American Public Health Association, the American Probation and Parole Association, the Council of State and Territorial Epidemiologists, the Council of State Governments, the Francois-Xavier Bagnoud Center for Health and Human Rights at Harvard University, the Harvard AIDS Institute, the Health Services and Resources Administration, the Legal Action Center, the Massachusetts Medical Society, the National Alliance of State and Territorial AIDS Directors, the National Association of People With AIDS, the National Association of Retail Druggists, the National Medical Association, the Police Foundation, the Substance Abuse and Mental Health Services Administration, and the United Nations Joint Programme on AIDS. The American Bar Association was a cooperating organization for the Carter Center consultation. The authors are grateful to Mark Smith, MD, MBA (Kaiser Family Foundation), Verla Neslund, JD (CDC), William Foege, MD (Carter Presidential Center), Jeff Stryker (Kaiser Family Foundation), Allyn Nakashima, MD (CDC), and Kathleen Maguire, RN, JD (Georgetown/Johns Hopkins Program on Law and Public Health).

The full report of the syringe law project will become available from the National AIDS Information Clearinghouse, and a considerably expanded article will appear in the *Emory Law Review*.

References

1. Gostin LO. The interconnected epidemics of drug dependency and AIDS. *Harvard CR-CL Law Rev.* 1991;26:113-184.
2. Turner C, Miller H, Moses L. *AIDS: Sexual Behavior and Intravenous Drug Use.* Washington, DC: National Academy Press; 1989.
3. Centers for Disease Control. Human immunodeficiency virus infection in the United States: a review of current knowledge. *MMWR Morb Mortal Wkly Rep.* 1987;36(suppl 5-6):1-48.
4. Garfein RS, Vlahov D, Galai N, et al. Viral infections in short-term injection drug users: the prevalence of the hepatitis C, hepatitis B, human immunodeficiency, and human T-lymphotrophic viruses. *Am J Public Health.* 1996;86:655-661.
5. Cherubin CE, Sapira JD. The medical complications of drug addiction and the medical assessment of the IV drug user: twenty-five years later. *Ann Intern Med.* 1993;119:1017-1028.
6. Hagan H, Reid T, Des Jarlais D, et al. The incidence of HBV infection and syringe exchange programs. *JAMA.* 1991;266:1646-1647.
7. Alter MJ. Epidemiology of hepatitis C in the West. *Semin Liver Dis.* 1995;15:5-14.
8. Rice DP, Kelman S, Miller LS. Estimates of economic costs of alcohol and drug abuse and mental illness, 1985 and 1988. *Public Health Rep.* 1991;106:280-292.
9. Centers for Disease Control and Prevention. First 500,000 AIDS cases—United States, 1995. *MMWR Morb Mortal Wkly Rep.* 1995;44:849-853.
10. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report, 1995.* Atlanta, Ga: US Dept of Health and Human Services, Public Health Service; 1996.
11. Normand J, Vlahov D, Moses LE, eds. *Preventing HIV Transmission: The Role of Sterile Needles and Bleach.* Washington, DC: National Academy Press; 1995.
12. Hahn RA, Onorato IM, Jones S, Dougherty J. Prevalence of HIV infection among intravenous drug users in the United States. *JAMA.* 1989;261:2677-2684.
13. Prevots DR, Allen DM, Lehman JS, et al. Trends in HIV seroprevalence among injection drug users entering drug treatment centers, United States, 1988-1993. *Am J Epidemiol.* 1996;143:733-742.
14. Allen DM, Onorato IM, Green TA. HIV infection in intravenous drug users entering drug treatment, United States, 1988-1989. *Am J Public Health.* 1992;82:541-546.
15. Des Jarlais DC, Friedman SR, Novick DM, et al. HIV-1 infection among intravenous drug users in Manhattan, New York City, from 1977 through 1987. *JAMA.* 1989;261:1008-1012.
16. Newmeyer JA. The prevalence of drug use in San Francisco in 1987. *J Psychoactive Drugs.* 1988;20:185-189.
17. Chaisson R, Moss A, Onishi R, et al. Human immunodeficiency virus infection in heterosexual intravenous drug users in San Francisco. *Am J Public Health.* 1987;77:169-172.
18. Centers for Disease Control and Prevention. AIDS associated with injecting-drug use—United States, 1995. *MMWR Morb Mortal Wkly Rep.* 1996;45:392-398.
19. Paone D, Caloir S, Des Jarlais DC. Sex, drugs, and syringe exchange in New York City: women's experiences. *J Am Wom Assoc.* 1995;50:109-114.
20. Holmberg SD. The estimated prevalence and incidence of HIV in 96 large US metropolitan areas. *Am J Public Health.* 1996;86:642-654.
21. Friedland GH, Klein RS. Transmission of the human immunodeficiency virus. *N Engl J Med.* 1987;317:1125-1135.
22. Haverkos HIV, Jones TS. HIV, drug-use paraphernalia, and bleach. *J Acquir Immune Defic Syndr.* 1994;7:741-742.
23. US Preventive Services Task Force. *Guide to Clinical Preventive Services.* 2nd ed. Baltimore, Md: Williams & Wilkins; 1996.
24. Centers for Disease Control and Prevention. Improper infection control practices during employee vaccination programs—District of Columbia and Pennsylvania, 1993. *MMWR Morb Mortal Wkly Rep.* 1993;42:969-971.
25. American Medical Association. *A Physician Guide to HIV Prevention.* Chicago, Ill: American Medical Association; 1996.
26. Des Jarlais DC, Friedman SK. The psychology of preventing AIDS among intravenous drug users. *Am Psychologist.* 1988;43:865-869.
27. Donoghoe MC, Stimson GV, Dolan K, et al. Changes in HIV risk behavior in clients of syringe-exchange schemes in England and Scotland. *AIDS.* 1989;3:267-272.
28. Black JL, Dolan MP, Deford HA, et al. Sharing of needles among users of intravenous drugs. *N Engl J Med.* 1986;314:446-447.
29. Magura S, Grossman J1, Lipton DS, et al. Determinants of needle sharing among intravenous drug users. *Am J Public Health.* 1989;79:459-462.
30. Koester S, Booth R, Wiebel W. The risk of HIV transmission from sharing water, drug-mixing containers, and cotton filters among intravenous drug users. *Int J Drug Policy.* 1990;1:28-30.
31. Celentano DD, Vlahov D, Cohn S, et al. Risk factors for shooting gallery use and cessation among intravenous drug users. *Am J Public Health.* 1991;81:1291-1295.
32. Koester SK. Copping, running, and paraphernalia laws: contextual variables and needle risk behavior among injection drug users in Denver. *Hum Organization.* 1994;53:287-295.
33. Heimer R, Kaplan EH, O'Keefe E, et al. Three years of needle exchange in New Haven: what have we learned? *AIDS Public Policy J.* 1994;9:59-74.
34. Veal GR. The Model Drug Paraphernalia Act: can we outlaw head shops—and should we? *Georgia Law Rev.* 1981;16:137-169.
35. *Drug Paraphernalia: Hearing Before the House Select Committee on Narcotics Abuse and Control*, 96th Cong, 1st Sess, 1979:79 (testimony of Dan Leonard, staff investigator for the House Select Committee on Narcotics Abuse and Control).
36. *Mid-Atlantic Accessories Trade Ass'n v Maryland*, 500 Supp 834, 841 (D Md 1980).
37. *McKoy v United States* (Case 2), 263 A2d 649 (DC 1970).
38. *Geiger v City of Eagan*, 618 F2d 26 (8th Cir 1980).
39. *Village of Hoffman Estates v Flipside, Hoffman Estates, Inc*, 455 US 489, *reh'g denied*, 456 US 950 (1982).

40. *Garner v White*, 726 F2d 1274 (8th Cir 1984).
41. *Camille Corp v Phares*, 705 F2d 223 (7th Cir 1983).
42. See, eg, Neb Code 28-439(3).
43. *Spokane County Health District v Brockett*, 839 P2d 324 (Wash 1992).
44. *Dougal v County of Suffolk*, 477 NYS2d 381 (App Div 1984), *aff'd*, 481 NE2d 254 (NY 1985).
45. *Gless v City of New York*, 483 NYS2d 715 (App Div), *aff'd*, 481 NE2d 254 (NY 1985).
46. 21 USC §857, reenacted 21 USC §863 (1990).
47. *Mail Order Drug Paraphernalia Control Act, 1986: Hearings on HR 1625 Before the Subcommittee on Crime of the House Committee on the Judiciary*, 99th Cong, 2nd Sess, 1986:16 (testimony of Joyce Nalepka, president of the National Federation of Parents for a Drug-Free Youth).
48. *Posters 'N' Things Ltd v United States*, 114 S Ct 1747, *reh'g denied*, 114 S Ct 2771 (1994).
49. Pascal C. Intravenous drug abuse and AIDS transmission: federal and state laws regulating needle availability. In: Battjes RJ, Pickens RW, eds. *Needle Sharing Among Intravenous Drug Abusers: National and International Perspectives*. Rockville, Md: National Institute on Drug Abuse; 1988. NIDA monograph No. 80.
50. *United States v 57,261 Items of Drug Paraphernalia*, 869 F2d 955 (6th Cir), *cert denied*, 493 US 933 (1989).
51. *United States v Murphy*, 977 F2d 503 (10th Cir 1992).
52. *People v Saul*, 176 NYS2d 405 (Columbia County Ct 1958).
53. *People v Strong*, 365 NYS2d 310 (4th Dept 1975), *aff'd*, 366 NE2d 867 (NY 1977).
54. *People v Bellfield*, 230 NYS2d 79 (Sup Ct 1961), *aff'd*, 183 NE2d 230 (NY 1962).
55. *Dyton v State*, 250 A2d 383 (Del 1969).
56. Musto DF. *The American Disease: Origins of Narcotic Control*. New York, NY: Oxford University Press; 1987.
57. Fernando MD. *AIDS and Intravenous Drug Use: The Influence of Morality, Politics, Social Science, and Race in the Making of a Tragedy*. Westport, Conn: Praeger; 1993:44, 55.
58. CA, DE, IL, MA, NH, NJ, NY, RI, VI.
59. CA, CT, DE, IL, MA, NV, NH, NJ, NY, OH, RI, VA.
60. Case No. 1640, accusation against SAV-ON-DRUGS (decision effective March 4, 1994).
61. CA, CT, DE, GA, IN, KY, MD, MA, MN, MO, NV, NJ, NY, ND, OH, PA, SC, TN, VT, VA, WV, WI, WY.
62. GA, IN, KY, MD, MN, MO, NV, ND, OH, PA, SC, TN, VT, VA, WV, WI, WY.
63. GA, IN, KY, MD, NV, OH, PA, SC, TN, VA, WV.
64. AR, CA, CT, DC, IL, IN, KY, MD, MA, NH, NJ, NY, OH, RI, SC, VA, VI, WV.
65. CA, CT, DE, KY, ND, OH, RI, VI.
66. Compton WM, Cottler LB, Decker SH, et al. Legal needle buying in St. Louis. *Am J Public Health*. 1992;82:595-596.
67. CA, DE, FL, IL, MA, NH, NJ, NY, PA, RI, VI.
68. DC, GA, IN, KY, MD, MI, MS, MO, NV, OH, SC, TN, TX, VA, WA, WV.
69. Des Jarlais DC, Friedman SR, Southern JL, et al. Continuity and change within an HIV epidemic: injecting drug users in New York City, 1984-1992. *JAMA*. 1994;271:121-127.
70. Gleghorn AA, Jones TS, Doherty M, et al. Acquisition and use of needles and syringes by injecting drug users in Baltimore, Maryland. *J Acquir Immune Defic Syndr Hum Retrovirol*. 1995;10:97-103.
71. Nelson KE, Vlahov D, Cohn S, et al. Human immunodeficiency virus infection in diabetic intravenous drug users. *JAMA*. 1991;266:2259-2261.
72. Singer M, Weeks MR, Himmelgreen D. Sale and exchange of syringes. *J Acquir Immune Defic Syndr Hum Retrovirol*. 1995;10:104.
73. Groseclose SL, Weinstein B, Jones TS, et al. Impact of increased legal access to needles and syringes on practices of injecting-drug users and police officers—Connecticut, 1992-1993. *J Acquir Immune Defic Syndr Hum Retrovirol*. 1995;10:82-89.
74. Lurie P, Reingold AL, Bowser B, et al. *The Public Health Impact of Needle Exchange Programs in the United States and Abroad*. San Francisco: University of California, Institute for Health Policy Studies; 1993:vol 1.
75. In response to the survey, Boise, Idaho, Boston and Cambridge, Mass, and the state of New Jersey reported arrests and/or convictions for possession of drug paraphernalia or syringes.
76. Stryker J. IV drug use and AIDS: public policies and dirty needles. *J Health Policy Politics Law*. 1989;14:719-740.
77. Grund J-PC, Heckathorn DD, Broadhead RS, Anthony DL. In Eastern Connecticut, IDUs purchase syringes from pharmacies but don't carry syringes. *J Acquir Immune Defic Syndr Hum Retrovirol*. 1995;10:104-105.
78. Feldman HIV, Biernacki P. The ethnography of needle sharing among intravenous drug users and implications for public policies and intervention strategies. In: Battjes RI, Pickens RW, eds. *Needle Sharing Among Intravenous Drug Abusers: National and International Perspectives*. Rockville, Md: National Institute on Drug Abuse; 1988:28-39. NIDA Monograph No. 80.
79. Valleroy LA, Weinstein B, Jones TS, et al. Impact of increased legal access to needles and syringes on community pharmacies' needle and syringe sales—Connecticut, 1992-1993. *J Acquir Immune Defic Syndr Hum Retrovirol*. 1995; 10:73-81.
80. Croatto JP, Ewart FJ, Hage BH, et al. The role of the pharmacist in preventing a 'second wave' of the HIV epidemic among IV drug users. *Aust J Pharm*. 1987;68:602-604.
81. Glantz A, Byrne C, Jackson P. Role of community pharmacies in prevention of AIDS among injecting drug misusers: findings of a survey in England and Wales. *BMJ*. 1989;299:1076-1079.
82. Ettelson R. Sell needles and syringes to IV drug abusers? *Pharm Times*. 1991;57:107-114.
83. Compton WM III, Cottler LB, Decker SH, et al. Legal needle buying in St. Louis. *Am J Public Health*. 1992;82:595-596.
84. Zellmer WA. Pharmacist involvement in needle exchange programs. *Am Pharm*. 1994;34(9):48-51.
85. *People v Lipton*, 429 NE2d 1059 (NY 1981).
86. *People v Goldberg*, 369 NYS2d 989 (Sup Ct 1975).
87. *People v Lonergan*, 267 Cal Rptr 887 (Ct App), *review denied*, 1990 Cal LEXIS 2801 (Cal June 27, 1990).
88. *Perzik v Superior Court*, 4 Cal Rptr 2d 1 (Ct App 1991).
89. Bruneau J, Franco E, Lamothe F, et al. Increased HIV seroprevalence and seroincidence associated with participation in needle exchange program: unexpected findings from the Saint-Luc cohort study in Montreal. In: Proceedings and abstracts from the XI International Conference on AIDS; July 1996; Vancouver, British Columbia. Abstract Tu.C.323.
90. Watters JK. Syringe and needle exchange as HIV/AIDS prevention for injection drug users. *JAMA*. 1994;271:115-120.
91. Kaplan EH, Heimer K. HIV prevalence among intravenous drug users: model-based estimates from New Haven's legal needle exchange. *J Acquir Immune Defic Syndr*. 1992;5:163-169.
92. Hartgers C, Buning ED, van Santen GW, Vester AD, Coutinho RA. The impact of the needle and syringe-exchange programme in Amsterdam in injecting risk behavior. *J Acquir Immune Defic Syndr*. 1989;3:571-576.
93. Ljunberg B, Christensson B, Tuning K, et al. HIV prevention among injecting drug users: three years' experience from a syringe exchange program in Sweden. *J Acquir Immune Defic Syndr*. 1991;4:890-895.
94. Burris S, Finucane D, Gallagher H, Grace J. The legal strategies used in operating syringe exchange programs in the United States. *Am J Public Health*. 1996;86:1161-1166.
95. *Spokane County Health District v Brockett*, 839 P2d 324 (Wash 1992).
96. *Allen v City of Tacoma*, No. 89-2-09067-3 (Wash Super Ct, Pierce County, May 9, 1990).
97. Clark C. Grand jury calls for needle exchange. *San Diego Union-Tribune*. June 29, 1994:B1.
98. Hoge P. Needle laws force a political balancing act. *Sacramento Bee*. December 5, 1994:A1.
99. Cheevers J. Needle exchanges battle AIDS and the law; addicts spread HIV by sharing contaminated syringes. *Los Angeles Times*. January 9, 1995:A1.
100. *Commonwealth v Parker*, No. 89-0123 (Boston Mun Crim Ct January 23, 1991) (Order and Findings); Bench Ruling No. 89-01213, January 9, 1990 (defendant acquitted).
101. *State v Sorge*, 591 A2d 1382 (NJ Super Ct Law Div 1991) (necessity defense unsuccessful, conviction upheld).
102. *People v Bordowitz*, 588 NYS2d 507 (Crim Ct 1991) (defendants acquitted).
103. *Commonwealth v Leno*, 616 NE2d 453 (Mass 1993) (necessity defense not allowed, conviction upheld).
104. Gostin LO. Law and policy. In: Stryker J, Smith MD, eds. *Dimensions of HIV Prevention: Needle Exchange*. Menlo Park, Calif: Henry J Kaiser Family Foundation; 1993.
105. National Commission on AIDS. *The Twin Epidemics of Substance Use and HIV*. Washington, DC: Presidential Commission on AIDS; 1991.
106. American Medical Association. House of Delegates Resolution 405 (I-96): Intravenous drug use, syringes, substance abuse treatment, and HIV prevention. Chicago, Ill: American Medical Association; 1996.
107. Committee on Medicine and Law. *Legalization of Non-Prescription Sale of Hypodermic Needles: A Response to the AIDS Crisis*. New York, NY: Association of the Bar of the City of New York; 1986.
108. ABA AIDS Coordinating Committee. *AIDS: The Legal Issues*. Washington, DC: American Bar Association; 1988.
109. Des Jarlais DC, Hopkins W. 'Free' needles for intravenous drug users at risk for AIDS: current developments in New York City. *N Engl J Med*. 1985;313:1476.

file

Testimony of Gerry Scoppettuolo

President, GMFA, Inc. (LifeGuard Project), Portsmouth, N.H.
HIV Prevention Coordinator, The AIDS Project, Portland, ME.

Good Afternoon. I am happy to be here today to testify on behalf of H.B. 427. the Needle Availability Bill. I work full time trying to prevent new HIV infections and re-infections in N.H. and Maine. Our programs follow closely new and effective strategies to reduce the spread of HIV. Needle Availability is such an approach. I trust that you will let scientific evidence and public health necessity be your guide when it comes time to vote on this bill.

Needle Availability is, simply put, a strategy to replace dirty, HIV-infected needles with sterile ones. When such substitution occurs, needle-sharing is reduced and HIV transmission between needle-users and their sexual partners is reduced. Only shared needles can spread HIV. This is a virtually cost-free program. In addition to its other benefits, it will require that pharmacists provide drug treatment referral information to purchasers of needles.

Effective strategies to curtail the spread of HIV from intravenous drug users (IDU's) are needed in New Hampshire when our major population centers are just a short distance to heavy needle-using cities in states on our borders. IDU-related transmissions are the fastest growing segment of the epidemic and the chief transmission factor for women. Any needle availability or needle exchange program will provide needed help to women-at-risk.

In 1969 I was co-founder of Project Rap, a drug treatment program in Beverly, Massachusetts and today, as part of Health Education Services, one of the oldest continuing programs for injection drug users in Massachusetts. Back then, our community was responding to a tidal wave of new heroin users – especially among young people. We could not foresee then that heroin use would lead eventually to the spread of HIV or Hepatitis C. We struggled to promote drug treatment as an alternative response to criminalization. Today we must defend needle availability and needle exchange against charges that we are promoting drug use. Drug use is not spread by needles; people shoot heroin for a complex set of psychological and socioeconomic reasons coupled with the street availability of heroin. Drug users will obtain needles one way or the other, driven, as they are, by the need and the addiction. We don't eliminate the addiction or drug use by making needles scarce- but we do make HIV transmission more likely. More needle scarcity = more HIV transmission. Is this what we want?

We urge you not to spurn this opportunity to reduce new infections in New Hampshire. I hope that, a year or two from now, we will not look back to today counting infections that could otherwise been avoided. New Hampshire legislators demonstrated their compassion and good judgment recently by passing Needle Exchange enabling legislation. Until a New Hampshire program can enact that strategy, needle availability can provide the help we need.

NEW HAMPSHIRE MEDICAL SOCIETY

For the betterment of public health since 1791

7 N. State Street, Concord, New Hampshire 03301-4018
(603) 224-1909 Toll Free (800) 564-1909
FAX (603) 226-2432
E-Mail NHMED@AOL.COM
http: / / www.nhms.org

March 2, 1999
HB 427
An act relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

PRESIDENT
Georgia A. Tuttle, M.D.

PRESIDENT-ELECT
David C. Charlesworth, M.D.

VICE PRESIDENT
Ishwar C. Chopra, M.D.

SECRETARY
Alexander G. Reeves, M.D.

TREASURER
Gary A. Sobelson, M.D.

SPEAKER OF THE HOUSE
John D. Bloom, M.D.

VICE SPEAKER OF THE HOUSE
Albee L. Budnitz, M.D.

IMMEDIATE PAST PRESIDENT
Barry L. Stern, M.D.

PAST PRESIDENT
James P. Pilliod, M.D.

DELEGATES AT LARGE
Judith E. Frank, M.D.
Seddon R. Savage, M.D.
John H. Robinson, M.D.
Peter L. Forsseil, M.D.

AMA DELEGATE
Gary L. Woods, M.D.

AMA ALTERNATE DELEGATE
Georgia A. Tuttle, M.D.

TRUSTEES
John M. Sherwin, M.D.
Don A. Holshuh, M.D.
Dudley J. Weider, M.D.

EXECUTIVE VICE PRESIDENT
Palmer P. Jones

The NH Medical Society is supporting HB 427 to allow persons 18 years or older to purchase hypodermic needles without a prescription. The Medical Society has historically supported such legislative efforts based upon the recommendations of NH infectious disease specialists and because the containment of HIV and hepatitis depends upon the public and private sectors working together to reduce risk factors.

In the past, opponents of this legislation have expressed fear that enactment would increase the incidence of IV drug abuse. This is a total misconception. In fact, just the opposite has occurred. When IV drug abusers obtain needles either from pharmacies or from needle exchange programs and are provided with educational materials about needle safety and drug rehabilitation programs, IV drug use has actually decreased. In addition, the educational materials have increased the number of IV drug users who voluntarily enter drug rehabilitation programs.

Intravenous drug use is the second leading cause of HIV transmission and this represents a difficult group of people to reach. HB 427 would provide a positive step towards preventing the transmission of HIV within this population. Enactment of HB 427 will **not provide free needles to drug abusers.** It will allow IV drug abusers to purchase sterile needles along with information about the safe disposal of needles and more importantly, information on treatment options for drug addiction. The opportunity for a positive contact with IV drug abusers will discourage drug abuse, not encourage illegal drug use.

Every available means must be used to combat the spread of AIDS and hepatitis. Infected IV drug abusers are the ones who are rapidly infecting the heterosexual community, including spouses and children. Six years ago, HIV infection became the number one cause of death among Americans 25 to 44 years old. If we can reduce the number of people sharing needles, we can reduce the spread of HIV and the number of cases of AIDS. The Medical Society urges you to support this important public policy change. Thank you.

Georgia A. Tuttle, MD
President

NEW HAMPSHIRE NURSES' ASSOCIATION

48 West Street, Concord, NH 03301-3595 Tel (603) 225-3783 Fax (603) 228-6672

Bill: **HB 427, relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.**
Position: **SUPPORT**
Date: **March 30, 1999**

The New Hampshire Nurses' Association supports HB 427. Enactment of this bill will reduce transmission of the HIV virus, which causes Acquired Immune Deficiency Syndrome ("AIDS"), and will reduce illegal intravenous drug use – two significant public health problems.

HB 427 will reduce the number of HIV cases in New Hampshire.

According to the Center for Disease Control, as of December 1997, more than one third (36%) of the 641,086 reported cases of AIDS were linked to illegal intravenous drug use. Research now proves that legal access to sterile hypodermic syringes, coupled with changes in paraphernalia laws to decriminalize possession of syringes, reduces the transmission of HIV and other blood-borne diseases, such as Hepatitis B and Hepatitis C.

A study published in Lancet, June 1997, examined the rate of HIV infection among illegal intravenous drug users seeking treatment in the United States between 1988 and 1993. The researchers found that in cities with needle exchange programs, HIV infection rates for illegal intravenous drug users dropped by 5.8% per year. In cities without needle exchange programs, HIV infection rates increased by 5.9% per year. A second study, conducted in Hartford, Connecticut and published in Medical Anthropology, December 1997, supported findings.

HB 427 will lead to decreased incidence of illegal intravenous drug use.

While some fear that enactment of HB 427 could lead to an increase in illegal intravenous drug use, several states' experiences have proven the opposite to be true. Laws similar to HB 427, in Baltimore, MD and Hartford, CT, which require pharmacists to provide syringe purchasers with information regarding treatment for addiction, including a local phone number, have resulted in *decreased* illegal intravenous use and increased requests for drug abuse treatment.

HB 427 will reduce the financial impact on the healthcare system of New Hampshire.

The United States government has determined the average cost of treatment for one HIV infection to be $55,640 over the course of the victim's life. A study published in Lancet, May 1997, found that the number of HIV infections that could have been prevented in the United States from 1987 to 1995, through needle exchange programs and legalized purchase at pharmacies, was between 4394 and 9666. This represents a total burden on the United States health care system of $244 million and $538 million. By the year 2000, it is estimated that an additional 5150 to 11,329 more preventable cases of HIV infection will occur, at a present cost to taxpayers of $286 million to $630 million.

The studies mentioned above represent a small fraction of the research proving that legal access to sterile needles and providing information on rehabilitation are effective in stemming the modern plagues of AIDS and illegal intravenous drug use. It is also sound fiscal policy.

Respectfully, NHNA urges the Legislature to pass HB 427.

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

ROBERT G. MARSHALL
P.O. BOX 421
MANASSAS, VIRGINIA 22110
THIRTEENTH DISTRICT

COMMITTEE ASSIGNMENTS:
PRIVILEGES AND ELECTIONS
COUNTIES, CITIES AND TOWNS
CLAIMS

Dear Fellow Lawmakers:

I am sure that protecting the health of your constituents is of primary concern to you. That is why I urge you make it a top priority to read the enclosed Special Report on the hepatitis B vaccine.

This new vaccine, mandated in many states, has become very controversial. Last October, the Minister of Health in France withdrew the hepatitis B vaccine requirement for school children because of adverse reaction reports and in the U.S. many parents are questioning its required use.

If you would like more information on the hepatitis B vaccine or other mandatory childhood vaccines, I encourage you to contact the National Vaccine Information Center at 1-800-909-shot or http://www.909shot.com.

The National Vaccine Information Center is a non-profit research and educational organization working to prevent vaccine injuries and deaths through public education.

Sincerely,

Robert G. Marshall

Robert G. Marshall

Not Printed at Public Expense

Authorized by Delegate Bob Marshall

THE VACCINE REACTION

"When it happens to you or your child, the risks are 100%"

Special Report | *Published by the National Vaccine Information Center* **Barbara Loe Fisher, Editor** | September 1998

HEPATITIS B VACCINE: THE UNTOLD STORY

Parents Question Forced Vaccination As Reports of Hepatitis B Vaccine Reactions Multiply

In increasing numbers, parents across the country are contacting the National Vaccine Information Center (NVIC) to report opposition to regulations being enacted by state health department officials that legally require children to be injected with three doses of hepatitis B vaccine before being allowed to attend daycare, kindergarten, elementary school, high school or college. Simultaneously, as more schools and employers bow to pressure from government health officials and require individuals to show proof they have been injected with hepatitis B vaccine before being allowed to get an education or a job, reports of serious health problems following hepatitis B vaccination among children and adults are multiplying.

The National Vaccine Information Center (NVIC) maintains that federal and state public health officials are promoting forced vaccination with hepatitis B vaccine without truthfully informing the public about the risks of hepatitis B disease in America or the known and unknown risks of hepatitis B vaccine. Without being provided with accurate and complete information about disease and vaccine risks, citizens cannot exercise informed consent, which becomes a human right when an individual considers undergoing a medical procedure that could cause injury or death.

Following is a general overview of what is and is not known about hepatitis B disease, the hepatitis B vaccine and the politics of hepatitis B vaccination.

HEPATITIS B NOT HIGHLY CONTAGIOUS - Unlike other infectious diseases for which vaccines have been developed and mandated in the U.S., hepatitis B is not common in childhood and is not highly contagious. Hepatitis B is primarily an adult disease transmitted through infected body fluids, most frequently infected blood, and is prevalent in high risk populations such as needle using drug addicts; sexually promiscuous heterosexual and homosexual adults; residents and staff of custodial institutions such as prisons; health care workers exposed to blood; persons who require repeated blood transfusions and babies born to infected mothers.

According to *CDC Prevention Guidelines: A Guide to Action* (1997), a book written by federal public health officials at the U.S. government Centers for Disease Control (CDC), "the sources of [hepatitis B] infection for most cases include intravenous drug use (28%), heterosexual contact with infected persons or multiple partners (22%) and homosexual activity (9%)." According to *Harrison's Principles of Internal Medicine* (1994), mother to child transmission of hepatitis B "is uncommon in North America and western Europe."

Although CDC officials have made statements that hepatitis B is easy to catch through sharing toothbrushes or razors, Eric Mast, M.D., Chief of the Surveillance Section, Hepatitis Branch of the CDC, stated in a 1997 public hearing that: " although [the hepatitis B virus] is present in moderate concentrations in saliva, it's not transmitted commonly by casual contact."

HEPATITIS B NOT A KILLER FOR MOST - Symptoms of hepatitis B disease include nausea, vomiting, fatigue, low grade fever, pain and swelling in joints, headache and cough that may occur one to two weeks before the onset of jaundice (yellowing of the skin) and enlargement and tenderness of the liver, which can last for three to four weeks. Fatigue can last up to a year. According to *Harrison's,* in cases of acute hepatitis B "most patients do not require hospital care" and "95 percent of patients have a favorable course and recover completely" with the case-fatality ratio being "very low (approximately 0.1 percent)."

Those who recover completely from hepatitis B infection acquire life-long immunity. Of those who do not recover completely, fewer than 5 percent become chronic carriers of the virus with just one quarter of these in danger of developing life threatening liver disease later in life, according to *Robbins Pathologic Basis of Disease* (1994), a medical college textbook.

The Guide to Clinical Preventive Services (1996), written under the supervision of the U.S. Department of Health and Human Services (DHHS), states that the risk of developing a chronic hepatitis B infection is higher in infected infants than in infected older children and adults: "Infections during infancy, while estimated to represent only 1-3% of cases, account for 20-30% of chronic infections." Because infants born to infected mothers are at highest risk for developing chronic hepatitis B infections, routine screening of pregnant women for hepatitis B infection is one of the most important public health measures that can be taken to prevent chronic hepatitis B carriers. *The Merck Manual* (1992), a major medical reference used by physicians, notes that "postexposure vaccination is recommended for newborn infants of hepatitis B positive mothers."

HEPATITIS B LOW IN U.S. - The U.S. and western Europe have always had among the lowest rates of hepatitis B disease in the world (0.1% to 0.5% of the general population) compared to countries in the Far East and Africa, where the disease affects 5-20% or more of the population. According to *Guide to Clinical Preventive Services,* in the U.S. "the greatest reported incidence [of hepatitis B] occurs in adults aged 20-39" and "the number of cases peaked in 1985 and has shown a continuous gradual decline since that time."

Even though hepatitis B disease is uncommon in the general population in the U.S., it continues to be high among those engaged in high-risk behaviors, especially IV drug use. *Guide to Clinical Preventive Services* states that "In recent years, a growing number of injection drug users have become infected; currently, between 60% and 80% of persons who use illicit drugs parenterally (through the skin such as with a needle stick) have serologic evidence of [hepatitis B] infection."

In 1991, there were 18,003 cases of hepatitis B reported in the U.S. out of a total U.S. population of 248 million. According to the October 31, 1997 *Morbidity and Mortality Weekly Report* published by the CDC, in 1996 there were 10,637 cases of hepatitis B reported in the U.S. with 279 cases reported in children under the age of 14 and the CDC stated that "Hepatitis B continues to decline in most states, primarily because of a decrease in the number of cases among injecting drug users and, to a lesser extent, among both homosexuals and heterosexuals of both sexes."

CDC RECOMMENDS ALL INFANTS GET HEP B VACCINE - Even though hepatitis B is an adult disease, is not highly contagious, is not deadly for most who contract it, and is not in epidemic form in the U.S. (except among high risk groups such as IV drug addicts), in 1991 the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) recommended that all infants be injected with the first dose of hepatitis B vaccine at birth before being discharged from the hospital newborn nursery. A similar recommendation was also made by the Committee on Infectious Diseases of the American Academy of Pediatrics (AAP). This, despite the fact very little is known about the health and integrity of an individual baby's immune and neurological systems at birth.

In 1991, media reports generated by the CDC used hepatitis B disease statistics that were not anchored in documented fact but are still used today to promote mass hepatitis B vaccination. Most of the inflated disease statistics originate with statements generated by the Centers for Disease Control. In the 1991 ACIP Recommendations calling for mass vaccination with hepatitis B vaccine published in the *Morbidity and Mortality Weekly Report,* the CDC states that there are an "estimated 1 million-1.25 million persons with chronic hepatitis B infection in the United States" and that "each year approximately 4,000-5,000 of these persons die from chronic liver disease" and that "an estimated 200,000-300,000 new [hepatitis B] infections occurred annually during the period 1980-1991." The CDC gives no scientific reference for this data other than the CDC.

Just one year before the government's call for mass vaccination, hepatitis B vaccine maker SmithKline Beecham in their 1990 hepatitis B vaccine product insert stated, "The CDC estimates that there are approximately 0.5 to 1.0 million chronic carriers of hepatitis B virus in the U.S. and that this pool of carriers grows by 2% to 3% (12,000 to 20,000 individuals) annually."

FEDERAL RECOMMENDATIONS BECOME STATE LAWS - Because vaccination requirements are controlled by states and not the federal government, in order for federal health officials to achieve their goal of a 100 percent vaccination rate with new vaccines marketed by drug companies, they must persuade states to turn federal vaccine policies into state law. And, because during the past 50 years, most state legislatures have completely turned over the power to mandate vaccines to state health department officials, very infrequently do state legislators take a vote to approve the mandating of a new vaccine such as hepatitis B. So, while American children born in 1948 were only required by state health officials to show proof of smallpox vaccination to enter school, American children born in 1998 are required by most states to be injected with 33 or 34 doses of 9 or 10 different viral and bacterial vaccines to enter school, including three doses of hepatitis B vaccine.

FEDERAL HEALTH OFFICIALS GIVE STATE HEALTH OFFICIALS MONEY TO FORCE HEP B VACCINATION - Following the 1991 CDC recommendation for universal use of hepatitis B vaccine by all children, state health department officials began issuing mandates requiring children

to show proof they have been injected with three doses of hepatitis B vaccine in order to attend daycare or school. By the end of 1997, 35 states had regulations on the books requiring children to get 3 doses of hepatitis B vaccine and, yet, only 15 states had passed laws requiring prenatal screening of pregnant mothers for hepatitis B infection.

To encourage states to mandate use of hepatitis B vaccine by all children, federal health officials at the Centers for Disease Control give grants and other financial incentives to state health departments to reward them for promoting mass vaccination. Since 1965, the CDC has given state health departments hundreds of millions of dollars through categorical grant programs to promote mass use of federally recommended vaccines. At the same time, if state health officials do not show federal health officials proof they have attained a certain vaccination rate in their state, federal grants to state health departments can be withheld.

In 1993, the Comprehensive Childhood Immunization Act of 1993 was passed giving the Department of Health and Human Services (DHHS) the authority to award more than $400 million to states to set up state vaccine registries to tag and track children and enforce mandatory vaccination with federally recommended vaccines, including hepatitis B vaccine. The Performance Grant Program rewards a state with either $50, $75 or $100 per child who is fully vaccinated with all federally recommended vaccines, including hepatitis B vaccine and, in 1995, DHHS Secretary Donna Shalala gave the states the power to approve a newborn's social security number in order to set up vaccine tracking registries in more than half the states. The CDC plan is to hook up the state vaccine tracking registries in order to create a de facto centralized electronic database containing every child's medical records.

PHARMACEUTICAL INDUSTRY ALSO FUNDS FORCED HEP B VACCINATION -

In addition to federal grants, many states get money from the Robert Wood Johnson Foundation (Johnson & Johnson), which operates All Kids Count, to set up vaccine tracking systems to enforce state vaccination mandates. (In 1989, Merck & Co., the U.S. manufacturer of the measles, mumps, rubella (MMR), chicken pox and hepatitis B vaccines, joined with Johnson & Johnson to form Worldwide Consumer Pharmaceuticals Co. with the goal of becoming "one of the premier worldwide consumer products companies." Merck's 1997 vaccine sales reached 1 billion dollars.)

All Kids Count is a project of the Task Force for Child Survival and Development headquartered at The Carter Center (former President Jimmy Carter) in Atlanta, which is directed by former CDC director Dr. William Foege. The Task Force is supported by the World Health Organization, World Bank, Rockefeller Foundation, United Nation's Population Fund and vaccine manufacturers, entities which also sponsor the Children's Vaccine Initiative (CVI). The CVI, headquartered in Geneva, was launched in 1990 at the World Summit for Children and promotes "the development and utilization" of vaccines by all of the world's children.

Forced vaccination with hepatitis B vaccine is also promoted in states by non-profit organizations such as Every Child by Two, founded in 1991 by former First Lady Rosalyn Carter and Betty Bumpers, wife of Arkansas Senator Dale Bumpers. Every Child by Two is funded in part by grants from Merck, Lederle and Connaught, the three largest U.S. vaccine manufacturers.

The non-profit CDC Foundation, which began operation in 1995, has raised more than $15 million in the past four years to augment the CDC's campaign to enforce mass vaccination. The CDC Foundation, the Task

Force for Child Survival & Development and vaccine manufacturers funded the recent National Immunization Conference held in Atlanta.

The five-year-old non-profit Immunization Action Coalition operates the Hepatitis B Coalition, which nationally promotes hepatitis B vaccination for all children. Funding comes from private donations, including a grant from SmithKline Beecham, manufacturer of the hepatitis B vaccine, and a new $750,000 grant from the Centers for Disease Control. A newsletter produced by this group contains the assurance that "Everything herein is reviewed by the Centers for Disease Control and Prevention for technical accuracy (unless it is an opinion piece written by a non-CDC author)."

PHARMACISTS NOW VACCINATE - SmithKline Beecham, through the American Pharmaceutical Association, has also funded a nationwide campaign called "Pharmacy-Based Immunization Advocacy" which allows pharmacists to vaccinate children and adults. As of 1998, the Hepatitis B Coalition reports that 23 states have passed laws giving pharmacists the right to sell and administer hepatitis B and other vaccines.

FAMILIES PENALIZED FOR REFUSING HEP B VACCINE - As state health departments accumulate power and money to force vaccination with all federally recommended vaccines, including hepatitis B vaccine, child and adult citizens are punished by both federal and state health officials with economic sanctions for refusing to comply. Refusal to be injected with hepatitis B vaccine can result in citizens being denied an education, including enrollment in daycare, elementary school, high school, college and graduate school; denial of health insurance; denial of employment; denial of federal entitlement benefits for poor children including food under the Women, Infants and Children (WIC) program and medical care under Medicaid. In some states, like Texas, a needy family loses $25 per month per child in state health benefits if all children have not received all federally recommended vaccines, including hepatitis B vaccine.

HEP B VACCINE LICENSED BY FDA WITHOUT ADEQUATE PROOF OF LONG TERM SAFETY - In 1986, the FDA gave Merck & Co. a license to market the first recombinant DNA hepatitis B vaccine, which replaced the old hepatitis B vaccines made from blood taken from human chronic hepatitis B virus carriers. In awarding Merck & Co. and, later, SmithKline Beecham Pharmaceuticals, licenses to market their genetically engineered hepatitis B vaccines in the U.S., the FDA allowed both drug companies to use "safety" studies which only included a few thousand children monitored for only four or five days after vaccination to check for reactions. As "proof" their hepatitis B vaccine is safe to be used in children, Merck & Co. stated in their 1993 product insert that "In a group of studies, 1636 doses of RECOMBIVAX HB were administered to 653 healthy infants and children (up to 10 years of age) who were monitored for 5 days after each dose."

Merck & Co. found that injection site and systemic complaints, such as fatigue and weakness, fever, headache and arthralgia (joint pain), were reported following up to 17 percent of all hepatitis B injections. Because the FDA did not require drug companies to provide scientific evidence that hepatitis B vaccine does not compromise the immune and neurological systems of children and adults over weeks, months or years post-vaccination, Merck & Co. warns in the 1996 product insert that "As with any vaccine, there is the possibility that broad use of the vaccine could reveal adverse reactions not observed in clinical trials" and SmithKline Beecham (1993) has a similar warning that "it is possible that expanded commercial use of the vaccine could reveal rare adverse reactions.

Another warning in the Merck 1996 product insert is "it is also not known whether the vaccine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity" and "it is not known whether the vaccine is excreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when the vaccine is administered to a nursing woman."

And, although doctors routinely inject hepatitis B vaccine into children along with many other vaccines such as DPT, HIB, MMR and chicken pox vaccine, Merck & Co. state in the 1996 product insert: "Specific data are not yet available for the simultaneous administration of RECOMBIVAX HB with other vaccines."

HEP B VACCINE EFFICACY ALSO QUESTIONED - All vaccines stimulate only an artificial, temporary immunity, and the length of immunity conferred by the hepatitis B vaccine and the future need for more "booster" doses later in life is still not clear. Merck & Co state in their 1996 hepatitis B vaccine product insert that "the duration of the protective effect of RECOMBIVAX HB in healthy vaccinees is unknown at present and the need for booster doses is not yet defined."

In the *CDC Prevention Guidelines: A Guide to Action* (1997), the CDC states "The duration of protection [of hepatitis B vaccine] and need for booster doses are not yet fully defined. Between 30% and 50% of persons who develop adequate antibody after three doses of vaccine will lose detectable antibody within 7 years but protection against viremic infection and clinical disease appears to persist." If immunity only lasts 7 years, babies vaccinated with hepatitis B vaccine may be candidates for more shots at age seven.

IOM REPORT REVEALS LACK OF ADEQUATE SCIENTIFIC STUDIES - In *Adverse Events Associated with Childhood Vaccines* published in 1994 by the Institute of Medicine, National Academy of Sciences, observations about the limitations of hepatitis B vaccine studies included the statements that "it is important to note that individual trials usually involved a few hundred subjects for study...when larger vaccination programs were monitored, observations of adverse events were necessarily less detailed and less accurately reported" and "the studies were not designed to assess serious, rare adverse events; the total number of recipients is too small and the follow-up generally too short to detect rare or delayed serious adverse reactions."

The IOM report also noted that no controlled observational studies or controlled clinical trials have ever been held to evaluate repeated reports that hepatitis B vaccine can cause Guillain-Barre syndrome; arthritis; transverse myelitis, optic neuritis, multiple sclerosis and other central demyelinating diseases of the nervous system (degeneration of the myelin sheath of the brain that helps transmit nerve impulses); or sudden infant death syndrome (SIDS).

A major conclusion of the Institute of Medicine report was that almost no basic science research has been undertaken to define at the cellular and molecular level the biological mechanism of vaccine-induced injury and death. The report concluded that "The lack of adequate data regarding many of the adverse events under study was of major concern to the committee...the committee encountered many gaps and limitations in knowledge bearing directly or indirectly on the safety of vaccines. These include inadequate understanding of the biologic mechanisms underlying adverse events following natural infection or immunization, insufficient or inconsistent information from case reports and case series...and inadequate size or length of follow-up of many population-based epidemiologic studies...."

MEDICAL LITERATURE CITES IMMUNE SYSTEM/BRAIN DAMAGE - During the past decade, there have been many reports in the medical literature (primarily in international medical journals rather than U.S. medical journals) that hepatitis B vaccination is causing chronic immune and neurological disease in children and adults, including *lupus:* Tudela & Bonal (1992); Mamoux & Dumont (1994); Guiserix (1996); *arthritis, including polyarthritis and rheumatoid arthritis:* Christan & Helin (1987); Hachulla et al (1990); Rogerson & Nye (1990); Biasi et al (1993),(1994); Vautier & Carty (1994); Hassan & Oldham (1994); Rheumatic Review (1994); Gross et al (1995); Pope et al (1995); Cathebras et al (1996); Soubrier et al (1997); *Guillain Barre Syndrome GBS):* Shaw et al (1988), Tuohy (1989); *demyelinating disorders such as optic neuritis, Bell's Palsy, demyelinating neuropathy, transverse myelitis and multiple sclerosis:* Shaw et al (1988); WHO (1990); Reutens et al (1990); Herroelen et al (1991); Nadler (1993); Brezin et al (1993); Mahassin et al (1993); Kaplanski et al (1995); Baglivo et al (1996); Marsaudon & Barrault (1996); Berkman et al (1996); Waisbren (1997); *diabetes mellitus:* Poutasi (1996); Classen (1996); *chronic fatigue:* Salit (1993); Delage et al (1993); *vascular disorders:* Fried et al (1987); Goolsby (1989); Cockwell et al (1990); Poullin & Gabriel (1994); Mathieu et al (1996); Graniel et al (1997); and others.

In 1996, Burton A. Waisbren, M.D., a cell biologist and infectious disease specialist, who is a founding member of the Infectious Disease Society of America and past President of the Infectious Disease Society of Milwaukee, pointed out in the *Wisconsin Medical Journal* that "there is an increasing number of reports in the refereed medical literature about demyelinizing diseases occurring after an individual has received the hepatitis B vaccination...since the hepatitis B virus itself has been reported to cause autoimmune problems, should we not be wary of giving antigens that seem to have triggered these problems?" Waisbren, in a presentation before a 1996 Institute of Medicine Vaccine Safety Forum, warned that genetically engineered hepatitis B vaccines contain polypeptide sequences that are present in human neurologic tissues such as myelin and that, by a mechanism called molecular mimicry, these polypeptides can act as autoantigens which can induce autoimmune demyelinating diseases of the brain such as multiple sclerosis.

In that same year, Montinari et al published a study in Italy evaluating 30 children and adults, the majority aged 3 to 9 months, who suffered central nervous system disorders, such as seizures and autism, following hepatitis B vaccination. The purpose of the study was to investigate whether there is an immunogenetic basis (autoimmune type) responsible for the demyelination process in the brain that can occur following recombinant hepatitis B vaccination. The authors concluded "autoimmune diseases are more frequent in nations where vaccines are widely used, the so called "clear" communities" and they identified several potential genetic markers that "may visualize risk patients for autoimmune diseases following hepatitis B vaccination.

Montinari's work to identify genetic factors for predisposition to hepatitis B vaccine reactions is important in light of the study in 1989 by Alper et al to identify genetic factors for those who do not respond to hepatitis B vaccination. In that study, the authors concluded that there was genetic predisposition to failure to respond to the vaccine. They stated: "These results support our hypothesis that the production of anti-HBsAg [vaccine-induced antibodies] is a dominant trait and that the inability to produce high titers of anti-HBsAG after adequate immunization is a recessive trait..." The authors concluded that the genetic markers they identified are most prevalent in caucasians of European descent "and is associated with a wide variety of diseases with autoimmune features in this population, including Type 1 diabetes mellitus..."

In 1996, Barthelow Classen, M.D., CEO of Classen Immunotherapies Inc., published an epidemiologic study in the *New Zealand Medical Journal* and reported that there was a 60 percent increase in Type 1 diabetes (juvenile diabetes) following a massive campaign in New Zealand from 1988 to 1991 to vaccinate babies six weeks of age or older with hepatitis B vaccine. His analysis of a group of 100,000 New Zealand children prospectively followed since 1982 showed that the incidence of diabetes before the hepatitis B vaccination program began in 1988 was 11.2 cases per 100,000 children per year while the incidence of diabetes following the hepatitis B vaccination campaign was 18.2 cases per 100,000 children per year.

VACCINE INJURIES REPORTED AT NVIC CONFERENCE ON VACCINATION - At the First International Public Conference on Vaccination sponsored by the NVIC on September 13-15, 1997 in Alexandria, Virginia, physicians and scientists from around the world gathered to speak about vaccine-induced chronic illness. Canadian physician Byron Hyde, M.D., Chairman of the Nightingale Research Foundation, and an internationally recognized authority on myalgic encephalomyelitis (also known as chronic fatigue syndrome), spoke about the data he has accumulated on more than 200 cases of serious immune and neurological dysfunction following hepatitis B vaccination. Dr. Hyde said:

"There was a nurse in Wisconsin who had had two immunizations against hepatitis B. After the second, she started to complain. They insisted that she have three more [shots], full dosage. They gave her the first, she complained of headaches, pain, and they told her this was anxiety neurosis. They gave her the fourth and fifth and she lost I.Q., measurable loss of intelligence, measurable loss in stamina, all of the things you see in the worst cases of ME or chronic fatigue syndrome.....A lot of these cases that we've looked at suggest demyelinating disease, disseminated myelitis, localized injuries, three unexplained deaths...the problem with all of this is that nobody has ever seriously studied it...."

Dr. Hyde was particularly critical of the poor science and medicine that hurts patients. He concluded "Almost all of these people who had adverse reactions after the first immunization, after the second immunization were individuals who had immunological side effects and who told their physicians and the physicians did nothing about it but continued to proceed with immunization... I think part of the problem is the pharmaceutical companies and the governments themselves have attempted to say 'Here, take this sugar pill, it is danger-free, it is a wonderful thing, it has no risk, no problems' and doctors have become lazy and actually believed this dangerous philosophy put out by the pharmaceutical companies and the governments."

HEP B VACCINE INFANT DEATHS REPORTED IN VAERS - Even though fewer than 10 percent of all doctors report health problems following vaccination, there are more than 16,000 reports of hospitalizations, injuries and deaths following hepatitis B vaccination that have been reported to the U.S. government Vaccine Adverse Event Reporting System (VAERS) since July 1990. There are reports of deaths in infants under one month of age following hepatitis B vaccination in VAERS, with most of the deaths being classified as sudden infant death syndrome (SIDS), even though SIDS is not historically recognized in the medical literature as occurring in babies under two months of age.

One of those death reports was made for a 15-day old baby boy who died within 48 hours of his first dose of hepatitis B vaccine. His father testified at a 1995 Institute of Medicine Vaccine Safety Forum workshop. He described what happened:

"For the first 13 days of his life, Nicholas was no different than any other baby. He ate well. When he slept, he slept well. He acted just like my first son acted when he came home from the hospital." Nicholas was given a hepatitis B shot at his regular check up at the pediatrician's office on the 13th day of his life. His father said:

"That night when I got home from work, I noticed that Nicholas was crying a lot more than usual. In fact, he was screaming some of the time. He was acting differently, but because we had just taken him to the doctor for a checkup and they told us he was a big healthy boy, we thought everything was OK. When he was just acting fussy, like babies sometimes do, we didn't know anything about vaccines or that they can cause problems for some babies."

"Nicholas cried on and off for most of the night. When I got up and went to work the next day, he was still crying on and off. He continued during most of the day and into the evening. The next morning, his mother found him dead in his crib. From the way he looked, he had been dead for several hours."

An autopsy was done the next day. A couple of weeks later, our pediatrician told us over the phone that the autopsy showed Nicholas had died of sudden infant death syndrome. He told us Nicholas was one of the healthiest babies he had ever seen.... What I didn't know then but I know now is that the pediatrician had made a report within 17 days of Nicholas' death to the government's Vaccine Adverse Event Reporting System, VAERS. In VAERS, Nicholas' death is listed as SIDS. Even though I didn't know anything about vaccines or SIDS, something told me that there was a reason why Nicholas died, and I had to find out why."

After seeing an article in the *Washington Post* about the Institute of Medicine report on adverse events associated with childhood vaccines, Nicholas's father called the National Vaccine Information Center and began talking to experts and researching infant death and vaccines. Eventually a clinical professor of pathology, who had reviewed Nicholas' medical records, autopsy and slides, stated in writing that Nicholas did not die of SIDS but died a cardiac death, caused by passive congestive changes with pulmonary edema and hemorrhage caused by the active immunization with hepatitis B vaccine. The pathologist stated "I do not believe this was a sudden infant death syndrome death. Sudden infant death syndrome is the most abused diagnosis in pediatric pathology. In this particular case, the infant was two weeks old. Sudden infant death at two weeks old is so rare as to be virtually unheard of."

The pathologist went on to say that Nicholas was at high risk for congestive heart failure because his mother had gestational diabetes, but that he would definitely have survived were it not for the stress induced by the hepatitis B vaccination.

Nicholas's father, in his testimony before the Institute of Medicine, asked "How many other newborn babies are dying from the effects of hepatitis B vaccine, but are being wrongly diagnosed as SIDS and no one ever knows the difference? I looked at the computer printouts of VAERS reports at the National Vaccine Information Center, and I saw there were other reports of babies just a few days or weeks old, who have died shortly after hepatitis B vaccination. Many are listed as SIDS deaths, but are they?"

ADULTS REPORT HEP B VACCINE INJURY AND DEATH TO NVIC - As hepatitis B requirements force more adults to get vaccinated as a condition for getting a higher education or working in the health care field, NVIC is receiving more and more reaction reports like this one from a disabled nurse, who recently wrote in:

"24 hours after my first [hepatitis B] shot, I had muscle pain in legs and arms - was told this was 'normal.' Same thing after 2nd shot. Six weeks after 2nd shot I had my first episode of Raynauds [temporary loss of blood flow to fingers resulting in tingling, throbbing, swelling, intense pain] and also began having rashes on arms and neck. At this point it was minor and not constant. I asked if it had anything to do with the vaccine and was told no.

"Six months after the 1st shot, I received the booster. From then (1995) to today, I have constant daily fevers up to 100.5, tormenting rashes and prickling on arms, hands, neck and legs, muscle degeneration, joint pain with restricted movement, difficulty swallowing and Raynauds has become severe.

"I was perfectly healthy until the hepatitis B vaccinations and still all the doctors tell me it has nothing to do with my illness. I had reactions to two of the drugs they tried to treat me with. I am on total disability because of these symptoms. I am an RN but was taught that the vaccines were perfectly safe."

PARENTS OPPOSE HEPATITIS B VACCINE MANDATE IN ILLINOIS - In the spring of 1997, a suburban Chicago mother of two daughters, ages 9 and 11, became concerned when she received a notice from the school system stating that her older daughter had to be vaccinated with hepatitis B vaccine by September 1997 or she would be barred from attending school. Although both of Kathy Rothschild's daughters were fully vaccinated with all other childhood vaccines, she didn't know anyone with hepatitis B and couldn't understand why her daughter had to get the vaccine. Her research led her to a public library and then to NVIC.

With the help of Kathy Rothschild's State Senator, Kathy Parker, an agreement by the Illinois Department of Health to not voice opposition, and with support from NVIC members around the state, a bill passed the Illinois Senate 52-2 on March 20, 1997, allowing parents the right to philosophical exemption to vaccination. The bill also created a Task Force and required the Board of Health to hold public hearings to review how Illinois public health employees add new vaccines to state vaccination laws and how they implement those laws.

After the bill overwhelmingly passed the Senate, the Illinois Department of Health went back on its pledge not to oppose the bill and vigorously fought against the bill in the House, successfully killing it in committee before it had a chance to come to a floor vote. However, the health department did agree to roll back the hepatitis B mandate for one year (until September 1998) and to hold three public hearings, which resulted in testimony from physician expert witnesses and parents and reinforced the dangers of hepatitis B vaccine and the need for informed consent rights to be established within state vaccine requirements.

DOCTOR, MOTHERS SAY VACCINE SAFETY DATA POOR - In a December 1997 public hearing in Chicago before the Illinois Board of Health, Mayer Eisenstein, M.D., M.P.H., who is board certified in public health and preventive medicine, quality assurance utilization review, by the National Board of Medical Examiners and has recently completed a law degree, testified against the proposed hepatitis B mandate. He said: "The idea of giving this vaccine to a one-day old baby, a newborn, is preposterous. There is no scientific evidence for this. In fact, I called up the [hepatitis B vaccine] manufacturer and I had [a representative] come to St. Mary of Nazareth Hospital, where I am Chairman of the Department of Medicine, and I asked him: 'Show me your evidence on one-day old infants as to side effects [from the hepatitis B vaccine]' - we have none. Our studies were done on 5 and 10 year olds....As a father, grandfather,

a physician, as a lawyer, I want the option of not giving it to my children unless I believe the scientific evidence is there."

Later during the public hearing, a mother whose child reacted to the hepatitis B vaccine testified that "We were told unless we had the shot our children were not getting into school. In the past, I got the shots for my children. So I went and got the [hepatitis B] shot. First shot, my daughter got slightly sick. We didn't associate it with the shot. We associated it with possible flu. Her legs hurt. Her back hurt...."

"The second shot, within two days of this shot, my daughter's symptoms went from mild to severe abdominal pain around the clock. She couldn't eat. She couldn't sleep. Her legs hurt. She broke out in a rash. She had eczema over most of her body. Going to the doctor, we were told it was in her head, that she needed a psychiatrist. Then we decided we would find out for ourselves.

"It was the people who gave me [information on the vaccine], the list that I should have gotten first that said what the reactions were, including severe abdominal pain, eczema, rash, hair loss. My doctor didn't tell me that. I was given a piece of paper that said reactions would be a minimum, maybe a small fever. She had a fever the whole time.

"I never knew any of this existed, and this is $18,000 later, a child who [had to be] out of school for the first three months and was tutored at home. I don't want to see other kids go through this. I think there should be more testing done. I think the parents should know that this shot isn't for something that's easily picked up. This is for sexual transmission or drug use. My child is ten years old. She plays with Barbie dolls and paints her fingernails. She doesn't know about this stuff. I don't want to give her a shot to protect her from something and someplace she's not at yet."

CITIZENS MAKE PLEA FOR INFORMED CONSENT - Before testifying at a Board of Health public hearing held in Springfield on March 26, 1998, NVIC held a press conference in the State Capitol building. Then, along with scores of Illinois parents who traveled to Springfield to make public comment, NVIC President Barbara Loe Fisher Reverend Robert VandenBosch, President of the American Research Foundation, and Bonnie Dunbar, Ph.D., professor of cell biology at Baylor College of Medicine in Houston, presented formal testimony.

Fisher told the Board of Health "There is a six year old girl named Katherine lying in a bed in Skokie, Illinois unable to lift her head off her pillow or walk to the bathroom. Just 13 weeks ago, Katherine was an ice skater with boundless energy and a dream of going to the Olympics. Her mother didn't want her to get the hepatitis B shot but her pediatrician told her it was a political issue like AIDS and the American Academy of Pediatrics (AAP) was going to mandate the vaccine soon. Katherine got that hepatitis B shot and now she may never skate again. Where were her informed consent rights? And where will the doctors from the state health department and the CDC and the AAP be when her mother carries her up the stairs to the bathroom? And will the state of Illinois pay her medical bills when her insurance runs out after DHHS and the Justice Department oppose giving her federal compensation?"

During limited public comment time, all of the parents asked the Board of Health to allow citizens to follow the judgement of their conscience when making vaccination decisions for their children, including the right

to exercise informed consent to vaccination without suffering harassment and punishment at the hands of state health and school officials. Some, like a young man who was kicked out of an Illinois college in the middle of the semester because of his sincere religious beliefs, asked for the right to follow his religious convictions without being punished by doctors employed by the state. He said:

"They have refused to give me credit for this semester and have told me not to attend class and have cancelled my appointment with my advisors. I applied for a religious exemption. Both my parents wrote letters identifying my objection. We were refused on the grounds that, in order for a religious exemption to occur, I must identify 'a recognized church or religious organization.' I don't believe that anyone has a right to judge my religion. How does recognition of my belief by another human being make it more or less? I am confused by the word 'organized.' How does the number of people or the structure under which they operate validate my beliefs? This is a violation of my Constitutional right to religious freedom."

Rev. Robert VandenBosch, an ethicist, warned that "The First Amendment [of the U.S. Constitution] clearly defines the free exercise of religious beliefs and the moral rights of individuals to obey the judgement of their conscience in matters of life and death. The Ninth Amendment of the Constitution guarantees that governmental authority cannot override individual rights of conscience. It states: 'The enumeration of the Constitution of certain rights shall not be construed to deny or disparage others retained by the people.' One of the rights retained by the people is the right of conscience."

PROFESSOR OF CELL BIOLOGY INVESTIGATES HEP B VACCINE DAMAGE -

Professor Bonnie Dunbar, Ph.D., who has a distinguished 25 year career in academic and laboratory science and has been honored by the U.S. National Institutes of Health (NIH) for her pioneering work in contraceptive vaccine development, presented at the March 26 Illinois Board of Health hearing and described disabling reactions to hepatitis B vaccine suffered by her brother and a research assistant.

"Three years ago my brother, who is a geologist Ph.D. agronomist with four college degrees, came to work with me at Baylor College of Medicine to work on a collaborative project in molecular genetic engineering of wheat proteins. He was required to take the hepatitis B vaccine. Within 24 hours to four days after the first injection, he had fever and severe fatigue for one week. Two to four weeks after that injection, he ended up with a whole series of symptoms that now 15 doctors have said are clearly symptoms of an adverse reaction to this vaccination. Even workman's compensation for the state of Texas is compensating him for over $300,000 worth of medical expenses."

"At about the same time, a 21-year old girl, a medical student, came to work in my lab for the summer, She, too, had to get the hepatitis B vaccine. After the first injection, she had fever and fatigue. Three weeks following her second injection, she lost vision in her one eye but, after 6 months, regained most of her sight. She was reluctant to get the third dose of vaccine, and talked with her doctor and he told her this [hepatitis B] vaccine is the safest, there's no problem. After the third injection, she ended up in the hospital for two months extremely ill and she has lost all of her eyesight in one eye."

Dr. Dunbar went on to explain to the Board of Health members that during the past three years of collecting data on the hepatitis B vaccine, she has been contacted by hundreds of doctors and patients around the world who have reported severe autoimmune and neurological complications to hepatitis B vaccination in previously

healthy children and adults, including serious rashes, fever, joint pain, chronic fatigue, multiple sclerosis and lupus-like symptoms, rheumatoid arthritis and neurological dysfunction. As a basic science researcher with expertise in cell and molecular biology, she is investigating the possibility that molecular mimicry or other autoimmune mechanisms may be the reason why the genetically engineered hepatitis B vaccine "tricks" the immune systems of genetically susceptible individuals into attacking their own bodies, causing debilitating autoimmune disorders.

After analyzing the data she has accumulated, Dr. Dunbar, in collaboration with colleagues at other academic and medical institutions, applied for a NIH research grant to investigate the role that genetic factors may play in hepatitis B vaccine reactions and in vaccine failures. Their goal is to identify genetic markers so high risk children and adults could be screened out of the mass vaccination program and spared injury and death. The grant was turned down twice by the government in July 1997 and July 1998 but Dr. Dunbar and her colleagues are in the process of refiling the grant, along with additional data.

HEP B VACCINE VICTIMS IN FRANCE SUE - An article in the July 31, 1998 issue of *Science,* an American scientific journal, reports that French attorneys representing 15,000 French citizens filed a lawsuit against the French government "accusing it of understating the vaccine's risks and exaggerating the benefits for the average person." One French physician has reportedly collected data on more than 600 people suffering from serious immune and neurological dysfunction following hepatitis B vaccination, many with symptoms resembling multiple sclerosis. Science quotes a World Health Organization official as saying "These fears [of the hepatitis B vaccine] are quite unfounded" and reveals that CDC employee Robert Chen, who is responsible for monitoring vaccine safety for the U.S. government, has a simple explanation for the growing number of reports of hepatitis B vaccine associated injury and death in the U.S., Canada and Europe. His scientific analysis leads him to believe that "It's human nature to attribute cause to almost anything that precedes a tragedy."

HEP B VACCINATION CAN MEAN A POSITIVE HEP B BLOOD TEST - A little known fact about hepatitis B vaccine is that those who are vaccinated can test positive for hepatitis B on some routine blood tests. NVIC has received calls from adults who report that, after getting hepatitis B vaccine, they are testing positive for hepatitis B when they undergo routine blood tests in doctor's offices. The Red Cross maintains that more sensitive lab tests used by blood banks can differentiate between hepatitis B antibodies produced by disease and those produced by the vaccine.

HIV vaccines now being tested in humans also produce positive tests for HIV. As noted in a September 1997 *Washington Post* article about HIV vaccine trials: "Foremost among the worries of many would-be volunteers is the problem of forever testing positive for AIDS antibodies...although sophisticated laboratory tests can usually tell the difference between AIDS antibodies caused by a vaccine and those that indicate a real HIV infection, few laboratories are equipped to make that distinction. Moreover, as vaccines get better by more closely mimicking the real infection, it will become more difficult to distinguish between the two."

IS FORCED HEPATITIS B VACCINATION PAVING WAY FOR FORCED VACCINATION WITH AIDS VACCINE? - Hepatitis B is the first disease transmitted not by casual contact like smallpox or polio, but by high risk behavior such as IV drug use and sexual promiscuity, that has been mandated for use by all children. With the identical transmission routes as HIV, there are

strong indications that forced vaccination of infants and children with hepatitis B is a trial run for forced vaccination with an AIDS vaccine when it is put on the market in the next few years. AIDS vaccines are currently in human trials as a race to bring them to market intensified after a call last year by President Clinton to make the creation and use of an AIDS vaccine "a national mission."

CDC PLANS FOR MASS VACCINATION OF ALL CHILDREN WITH AIDS VACCINE - In a February 12, 1997 meeting of the CDC's Advisory Committee on Immunization Practices (ACIP), Neal Halsey, M.D., chairman of the American Academy of Pediatrics (AAP) Committee on Infectious Diseases, AAP liaison member of the ACIP and Director of the Institute of Vaccine Safety at John's Hopkins University, reminded HIV vaccine researchers and developers at the meeting that the CDC plans to target 11 to 12 year old children for "universal application" of an HIV vaccine. Halsey told them:

"One of the things that's happened in the past with vaccines is that sometimes the manufacturers have developed them and tested them primarily in an age group or a population which may not be the final target population that this committee has considered. Over the last few years we have developed a statement on adolescent immunization and it probably would be worth your reading that, and others, because we really see age 11 to 12 as the target age for introduction of vaccines for prevention of sexually transmitted diseases. And I know that, at this time, you are really studying adults and you're also some distance away from the actual - having a [HIV] vaccine in hand that might be licensed and approved - but at least it would be nice if there were studies that were planned in parallel when you move another step in the direction of actually having a candidate vaccine, realizing where WE think we would want to use universal application of such a vaccine. And so I think maybe [you should get] a copy of the adolescent immunization statement."

With the Children's Vaccine Initiative (CVI) and pharmaceutical industry setting up the mechanism for global mass vaccination of children and adults, including the creation of national and international vaccine tracking systems, countries with low HIV rates like the U.S. and Europe will be forced to use an HIV vaccine in order to pay for the vaccination of populations in Asia and Africa where HIV infection rates are skyrocketing. In 1996, HIV vaccine developer Stanley Plotkin, M.D., of Pasteur Merieux Pharmaceuticals (who developed the rubella vaccine and has been a vaccine policymaker member of the AAP Committee on Infectious Disease and AAP liaison member of the ACIP) explained why mandatory vaccination in rich countries like the U.S. help deliver vaccines to Third World markets:

"The keystone of the [global mass vaccination] system is that the research costs [of drug companies] are recouped in North America and Europe and the vaccines are sold in the developing world at much, much lower margins...the relatively high rate of childhood vaccination seen lately in most parts of the world is the result of that system," explained Plotkin.

CDC TELLS CONGRESS ABOUT FUTURE VACCINES - In testimony before the U.S. Senate Committee on Labor and Human Resources in 1997, CDC official Walter Orenstein, M.D., made a bid to persuade Congress to reauthorize 288 million dollars for the CDC's Immunization Grant Program in the $427 million 1998 DHHS budget request for immunization activities. In a review of the history of vaccination, Dr. Orenstein recounted that, although almost a century passed between the development of the smallpox vaccine in 1796 and that of the rabies vaccine in the 1880's, by the middle of the 20th century there were nearly two dozen vaccines on the market.

Painting a picture of the future, Orenstein said: "On the horizon are vaccine technologies that would have been considered science fiction just a decade ago, but are now reported at scientific meetings. Snippets of synthetic DNA have worked as experimental vaccines in animals. Edible plants have been bioengineered to become vaccine factories....vaccines have been enclosed in microscopic capsules, permitting them to be released slowly over time..."

Orenstein reminded legislators that "Every day about 11,000 babies are born in this country. Each of these children starts with immunization coverage of zero. There is why our responsibility to our Nation's children never ends; it must be sustained every day of every year....completing state-based immunization registries is the cornerstone of assuring disease prevention."

VACCINE REGISTRIES TO TAG, TRACK, FORCE VACCINATION -

Even though CDC officials admit that there is already a 96 percent vaccination rate in the U.S. with federally recommended vaccines, they are setting up state vaccine tracking registries and plan to link them together to create a de facto national electronic tracking system to ensure mass compliance with federal vaccine policies. Citizens will be tagged with a number at birth and tracked even when moving from state to state.

In 1995, DHHS Secretary Donna Shalala appropriated the social security numbers assigned to newborns to allow states to enter all babies in state vaccine tracking systems. In 1996, the Health Insurance Portability and Accountability Act (HIPAA), also known as the Kennedy-Kassebaum legislation, outlined plans for a "unique health care identifier" number, which is an alternative to the social security number, to be assigned to citizens at birth and electronically monitor their medical records, including vaccination records.

In a 1998 CDC publication entitled *Initiative on Immunization Registries,* the CDC states that "we see [vaccine] registries as a possible first step in the development of an electronic pediatric record" and "computerized registries will eventually be capable of capturing immunization for individuals of all ages" and "until a unique personal identifier can be established on a national basis, multiple means of identification must be used [in state vaccine registries]." Core data that is now collected in many state vaccine tracking systems include a citizen's name, address, phone number, social security number, birth date, sex, race, primary language, patient birth order, patient birth registration number, patient Medicaid number, mother's name (including maiden name) and social security number and father's name and social security number.

Most often state officials automatically enroll newborns into the vaccine registry without informing parents or giving them the right to "opt-out" of the registry. In the state of Texas, PROVE, a parent group led by Dawn Richardson, worked to get legislation passed in 1997 requiring the state health departments to obtain a parent's prior written consent to enroll a child in a vaccine registry.

The CDC goes on to state that one of their main goals is "establishing a target date to achieve the goal of establishing immunization registries in every community in the Nation" and "promoting the inter-operability of registries with other developing medical information systems" and "promoting the automated exchange of immunization records between registries."

THE NATIONAL VACCINE INFORMATION CENTER (NVIC), founded in 1982, is a non-profit, educational organization dedicated to preventing vaccine injuries and deaths through public education. NVIC promotes scientific research into the biological causes of vaccine injury and death in order to identify factors which place individuals at high risk for suffering vaccine reactions and advocates the institution of oversight mechanisms within the mass vaccination system to more effectively monitor the vaccine research, development, regulation and promotion activities of federal and state public health agencies and drug companies.

After launching a national vaccine safety and informed consent movement in the U.S. in the early 1980's, NVIC's co-founders worked with Congress to create the National Childhood Vaccine Injury Act of 1986. This historic law set up a vaccine injury compensation program and included vaccine safety provisions such as mandatory recording and reporting of hospitalizations, injuries and deaths following vaccination.

In 1989, NVIC conducted an International Scientific Workshop on Pertussis and Pertussis Vaccines and in 1996, one of NVIC's major goals was realized when a purified pertussis vaccine was licensed for American babies after a decade and a half of public advocacy work. In 1997, NVIC held the First International Public Conference on Vaccination at which scientists and physicians from the U.S., Great Britain and Canada discussed scientific evidence for vaccine-associated chronic autoimmune disease and neurological dysfunction.

NVIC maintains that well designed, independent scientific research must be conducted to define the biological mechanism of vaccine injury and death and to evaluate the long term effects of multiple vaccination on individuals and the public health. Simultaneously, with respect for the Nuremberg Code, the Helsinki Declarations and the moral principles embodied in every faith, NVIC defends the human right for all people to make informed, voluntary decisions about medical interventions which can cause injury or death, including vaccination.



Barbara Loe Fisher is a co-founder and president of the National Vaccine Information Center. She is co-author of *DPT: A Shot in the Dark* (Harcourt Brace Jovanovich, 1985; Warner, 1986; Avery, 1991) and author of *The Consumer's Guide to Childhood Vaccines* (NVIC, 1997). She is editor of the quarterly newsletter *THE VACCINE REACTION*. During the 1980's, she helped launch a national grassroots effort to bring the issue of vaccine safety to public attention, including leading demonstrations at the Centers for Disease Control in Atlanta and at the White House in 1986. Later that year, Congress passed the National Childhood Vaccine Injury Act.

She served on the National Vaccine Advisory Committee at the Department of Health and Human Services for four years, where she was chair of the subcommittee on vaccine adverse events. She was appointed to the Vaccine Safety Forum at the Institute of Medicine in 1995, where she has helped coordinate five public workshops on vaccine safety. She has recently been appointed as the consumer voting member of the FDA Vaccines and Related Biological Products Advisory Committee. The mother of three children, her oldest son was left with multiple learning disabilities and attention deficit disorder after a severe reaction to his fourth DPT shot in 1980 when he was two and a half years old.

Subscriptions to *THE VACCINE REACTION* are $18 per year. Professional memberships are $50, which include a subscription to this quarterly newsletter as well as *The Vaccine Hotline* and other news alerts concerning vaccine safety issues. Reprints of this special report on Hepatitis B vaccine are $1.25 each. Send mail orders to NVIC, 512 W. Maple Ave., Suite 206, Vienna VA 22180 or call 1-800-909-SHOT to place an order. The NVIC website is http://www.909shot.com.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
1275 K Street, N.W., Suite 800, Washington, D.C. 20005-4006
(202) 371-9090 FAX (202) 371-9797

RECEIVED
OCT 21 1999

October 20, 1999

William J. Kassler, MD, MPH
Medical Director
NH Dept. of Health & Human Svcs.
6 Hazen Drive
Concord, NH 03301-6527

Dear Dr. Kassler:

Enclosed is a joint statement from five leading national health-related organizations, including the Association of State and Territorial Health Officials (ASTHO), encouraging State leaders in their respective fields to work together to address the issue of the sale of sterile syringes by community pharmacies to help prevent blood-borne pathogen transmission. A list of names and contact information for the leaders of these organizations in your state is also enclosed.

Injection drug use contributes substantially to the transmission of HIV, hepatitis C, and hepatitis B. These blood-borne pathogens are of major public health concern among injection drug users, their sex partners, and their children. Approximately one-third of all AIDS cases and one-half of hepatitis C cases are directly or indirectly related to injection drug use.

In 1995, ASTHO adopted policy which, among other findings, stated that: (1) the most certain method of preventing transmission of injection-related blood borne infections, including HIV, is to abstain from the practice of injecting illicit substances; (2) injecting drug users who continue to inject should to be referred to the most appropriate source for counseling and treatment; and, (3) as a possible public health strategy to reduce the transmission of injection-related blood-borne infections, states should explore the removal of legal barriers such as drug paraphernalia and prescription laws, which criminalize the distribution and/or possession of needles and syringes.

In 1997, the U. S. Public Health Service recommended that drug users who continue to inject use a new, sterile syringe for each injection to prevent the transmission of blood-borne pathogens, and that they obtain syringes from reliable sources such as pharmacies. However, access to sterile syringes from reliable sources such as community pharmacies is often limited by state law and/or pharmacy regulations, making it difficult for those injection drug users who continue to inject to follow sound medical and public health advice concerning the "once-only" use of sterile syringes.

ASTHO has now joined with these other national medical, pharmacy, pharmaceutical, and public health organizations to encourage state leaders to work together to address the question of the sale of sterile syringes by pharmacies. Should an action plan to improve the availability of sterile syringes through pharmacy sales be deemed an appropriate public health strategy in your state, you may wish to work with individuals from these organizations in your state to assist in the development of such a plan.

We hope this information is helpful. If we can provide any further assistance, or should you desire more information on this topic, please contact Helen Fox Fields, Senior Director for Infectious Disease Policy at (202) 371-9090 x234.

Sincerely,

George E. Hardy, Jr., MD, MPH
Executive Director

American Medical Association
Physicians dedicated to the health of America

American Pharmaceutical Association
APhA

ASTHO
The Association of State and Territorial Health Officials

NASTAD
National Alliance of State and Territorial AIDS Directors

October 1999

HIV Prevention & Access To Sterile Syringes

Dear Colleague:

Approximately one third of all AIDS cases and one half of hepatitis C cases are directly or indirectly linked to injection drug use. Limited access to sterile syringes contributes to the transmission of these blood-borne infections among injection drug users (IDUs), their sex partners, and their children.

The United States Public Health Service recommends that drug users who continue to inject use a new, sterile syringe for each injection to prevent the transmission of blood-borne pathogens and that they obtain syringes from reliable sources such as pharmacies.

In many states, there are legal and regulatory barriers to the pharmacy sale of sterile syringes to IDUs, including prescription and drug paraphernalia laws and pharmacy regulations on syringe sales. The American Medical Association (AMA), the American Pharmaceutical Association (APhA), the Association of State and Territorial Health Officials (ASTHO), and the National Alliance of State and Territorial AIDS Directors (NASTAD) have suggested that the removal or modification of legal barriers is an important step in increasing the availability of sterile syringes through pharmacies. Connecticut, Minnesota, and Maine have made such changes.

AMA, APhA, ASTHO, and NASTAD have adopted the following policies related to pharmacy sale of syringes.

AMA (1997)	That the AMA strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription.
APhA (1999)	APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases.
ASTHO (1995)	ASTHO policy states that as a possible public health strategy to reduce the transmission of injection-related blood-borne infections, states should explore the removal of legal barriers such as drug paraphernalia and prescription laws, which criminalize the distribution and/or possession of needles and syringes.
NASTAD (1997)	NASTAD calls on state and local legislative bodies to increase access to sterile needles and syringes through needle exchange programs; to deregulate possession of needles, syringes and associated injection equipment as drug

paraphernalia; to increase access to sterile syringes via sale by pharmacies; and to increase access to drug treatment for those individuals ready for such treatment.

NASTAD encourages each state health department to work with pharmacy boards and local law enforcement agencies to change local laws which would increase access to sterile injection equipment.

AMA, APhA, ASTHO, NASTAD, and the National Association of Boards of Pharmacy (NABP) believe that coordinated efforts of state leaders in pharmacy, public health, and medicine are needed to address access to sterile syringes as a means of preventing further transmission of blood-borne diseases.

We encourage you and other state leaders in these fields to meet, assess the situation in your state, and decide on appropriate approaches to these important public health issues. Other issues that may be important to consider are the availability of substance abuse treatment and options for safe disposal of syringes.

For more information, you can contact the following staff members of the organizations issuing this letter:

AMA	LJ Tan at (312) 464-4147, *litjen_tan@ama-assn.org*
APhA	Jann Skelton at (800) 237-2742 ext 7198, *jbs@mail.aphanet.org*
ASTHO	Helen Fox Fields at (202) 371-9090, *hffields@astho.org*
NABP	Jan Teplitz at (847) 698-6227, *jteplitz@nabp.net*
NASTAD	Julie Scofield at (202) 434-8090, *Jscofield@NASTAD.org*

We look forward to working with you to address these significant public health problems.

Sincerely,

E. Ratcliffe Anderson, Jr., MD
Executive Vice President
American Medical Association

John A. Gans, PharmD
Executive Vice President
American Pharmaceutical Association

Patti Shwayder
Interim Executive Vice President
Association of State and Territorial
Health Officials

Julie M. Scofield
Executive Director
National Alliance of State
and Territorial AIDS Directors

Carmen Catizone, MS, RPh
Executive Director / Secretary
National Association of Boards of Pharmacy

Voting Sheets

HOUSE COMMITTEE ON CRIMINAL JUSTICE AND PUBLIC SAFETY

EXECUTIVE SESSION on HB 427

BILL TITLE: **relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.**

DATE: March 4, 1999

LOB ROOM: 204

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. Sargent

Seconded by Rep. Christie

Vote: 15-1 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: 16-0

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Maxwell D. Sargent, Clerk

CRIMINAL JUSTICE AND PUBLIC SAFETY 1999 SESSION

HOUSE Bill # 429

Public Hearings 3/2/99 Executive Session 3/24/99

COMMITTEE REPORT: Re-refer

	YEAS	NAYS
Welch, David A, Chairman	✓	
Christie, Andrew, Jr, V Chairman	✓	
Hansen, Herbert R	✓	
Dunham, Vivian L	absent	
Sargent, Maxwell D, Clerk	✓	
Pepino, Leo P	✓	
Flora, Kathleen M	absent	
Mikowlski, Walter J		✓
Fesh, Robert M	✓	
MacDonald, Kenneth J	✓	
Weare, Everett A	✓	
Andrews, Frederick B	✓	
Johnson, James M	absent	
Knowles, William V	✓	
Doucette, Richard F	absent	
Berube, Roger R	✓	
Schanda, Frank M	✓	
O'Keefe, Patricia M	✓	
McCarthy, William J	absent	
Robertson, Timothy N	✓	
Callaghan, Frank D	absent	
Rodd, Beth	✓	
TOTAL VOTE	15	1

Appeared in Favor	Appeared in Opposition

HOUSE COMMITTEE ON CRIMINAL JUSTICE AND PUBLIC SAFETY

EXECUTIVE SESSION on {Type BILL NO.} HB 427

BILL TITLE: relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes

DATE: 10/26/99

LOB ROOM: 204

Amendments:

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Motions: (OTP), OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. O'Keefe

Seconded by Rep. Rodd

Vote: 11-2 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. _____

Seconded by Rep. _____

Vote: _____ (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: NO

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Maxwell D. Sargent, Clerk

CRIMINAL JUSTICE AND PUBLIC SAFETY 1999 SESSION

HOUSE Bill # 427

Public Hearings 3/24/99 Executive Session 10/26/99

COMMITTEE REPORT: Ought to pass

	YEAS	NAYS
Welch, David A, Chairman	✓	
Christie, Andrew, Jr, V Chairman	✓	
Hansen, Herbert R	absent	
Dunham, Vivian L	absent	
Sargent, Maxwell D, Clerk	✓	
Pepino, Leo P	absent	
Flora, Kathleen M	absent	
Mikowlski, Walter J		✓
Fesh, Robert M	absent	
MacDonald, Kenneth J	absent	
Weare, Everett A	✓	
Andrews, Frederick B	✓	
Johnson, James M		✓
Knowles, William V	✓	
Doucette, Richard F	absent	
Berube, Roger R	absent	
Schanda, Frank M	✓	
O'Keefe, Patricia M	✓	
McCarthy, William J	✓	
Robertson, Timothy N	✓	
Callaghan, Frank D	absent	
Rodd, Beth	✓	
TOTAL VOTE	11	2

Appeared in Favor | Appeared in Opposition

Committee Report

COMMITTEE REPORT

COMMITTEE: **Criminal Justice and Public Safety**

BILL NUMBER: HB 427

TITLE: relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

DATE: March 24, 1999 CONSENT CALENDAR YES ☒ NO ☐

☐ OUGHT TO PASS

☐ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☒ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

HB 424 would repeal the law requiring a prescription for purchasing hypodermic needles as well as requiring information on drug addiction treatment. The committee brought forth several questions for which there were no quick, concise answers. There was interest in data from other states without prescription laws including needle disposal, the willingness of pharmacists to participate, addict participation, addicts crossing state lines to purchase, etc. Therefore, it was determined these questions and concerns could be more thoroughly addressed in a concentrated study effort through the summer.

Vote 15-1.

Rep. Maxwell D. Sargent
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

CONSENT CALENDAR

Criminal Justice and Public Safety

HB 427, relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes. RE-REFER

Rep. Maxwell D. Sargent for **Criminal Justice and Public Safety:** HB 424 would repeal the law requiring a prescription for purchasing hypodermic needles as well as requiring information on drug addiction treatment. The committee brought forth several questions for which there were no quick, concise answers. There was interest in data from other states without prescription laws including needle disposal, the willingness of pharmacists to participate, addict participation, addicts crossing state lines to purchase, etc. Therefore, it was determined these questions and concerns could be more thoroughly addressed in a concentrated study effort through the summer. Vote 15-1.

COMMITTEE REPORT

COMMITTEE: **Criminal Justice and Public Safety**

BILL NUMBER: **HB 427**

TITLE: relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

DATE: October 26, 1999 CONSENT CALENDAR YES ☐ NO ☒

☒ OUGHT TO PASS

☐ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

The committee heard considerable testimony in favor of removing the prescription requirement for hypodermic syringes. Of greatest concern presently in many states, is the disposal of used syringes/needles. When a consumer purchases a needle today, there is no literature accompanying the product speaking to disposal. This legislation would provide that information. In states where the prescription requirement has been lifted, transmission rates of hepatitis and the HIV virus has gone down, and the disposal problem has actually lessened. In fact, needle stick incidents to police officers dropped in Connecticut after Connecticut removed their prescription requirement. A criticism of this type of legislation in the past has been that "it sends the wrong message – that drug use is okay." The committee feels that the message is actually one of health, savings lives, and increasing the incidence of proper disposal of needles and syringes. Health professionals who agree include the American Medical Association, the American Pharmaceutical Association, the Association of State and Territorial Health Officials, the National Alliance of State and Territorial AIDS Directors, the National Association of Boards of Pharmacy, the New Hampshire Medical Society, the New Hampshire Nurses' Association, the New Hampshire Board of Pharmacy, and the New Hampshire Department of Health and Human Services.

Vote 11-2.

Rep. Patricia M. O'Keefe
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

Criminal Justice and Public Safety

HB 427, relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes. OUGHT TO PASS

Rep. Patricia M. O'Keefe for **Criminal Justice and Public Safety:** The committee heard considerable testimony in favor of removing the prescription requirement for hypodermic syringes. Of greatest concern presently in many states, is the disposal of used syringes/needles. When a consumer purchases a needle today, there is no literature accompanying the product speaking to disposal. This legislation would provide that information. In states where the prescription requirement has been lifted, transmission rates of hepatitis and the HIV virus has gone down, and the disposal problem has actually lessened. In fact, needle stick incidents to police officers dropped in Connecticut after Connecticut removed their prescription requirement. A criticism of this type of legislation in the past has been that "it sends the wrong message – that drug use is okay." The committee feels that the message is actually one of health, savings lives, and increasing the incidence of proper disposal of needles and syringes. Health professionals who agree include the American Medical Association, the American Pharmaceutical Association, the Association of State and Territorial Health Officials, the National Alliance of State and Territorial AIDS Directors, the National Association of Boards of Pharmacy, the New Hampshire Medical Society, the New Hampshire Nurses' Association, the New Hampshire Board of Pharmacy, and the New Hampshire Department of Health and Human Services. Vote 11-2.

DRAFT

COMMITTEE REPORT

COMMITTEE: **Criminal Justice and Public Safety**

BILL NUMBER: **HB 427**

TITLE: relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

DATE: October 26, 1999 CONSENT CALENDAR YES ☐ NO ☒

☒ OUGHT TO PASS

☐ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

The committee heard considerable testimony in favor of removing the prescription requirement for hypodermic syringes. Of greatest concern presently in many states, is the disposal of used syringes/needles. When a consumer purchases a needle today, there is no literature accompanying the product speaking to disposal. This legislation would provide that information. In states where the prescription requirement has been lifted, transmission rates of hepatitis and the HIV virus has gone down, and the disposal problem has actually lessened. In fact, needle stick incidents to police officers dropped in Connecticut after Connecticut removed their prescription requirement. A criticism of this type of legislation in the past has been that "it sends the wrong message – that drug use is okay." The committee feels that the message is actually one of health, savings lives, and increasing the incidence of proper disposal of needles and syringes. Health professionals who agree include the American Medical Association, the American Pharmaceutical Association, the Association of State and Territorial Health Officials, the National Alliance of State and Territorial AIDS Directors, the National Association of Boards of Pharmacy, the New Hampshire Medical Society, the New Hampshire Nurses' Association, the New Hampshire Board of Pharmacy, and the New Hampshire Department of Health and Human Services.

Vote 11-2.

Rep. Patricia M. O'Keefe
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

COMMITTEE REPORT

COMMITTEE: CRIMINAL JUSTICE AND PUBLIC SAFETY

BILL NUMBER: HB427

TITLE: relative to the laws requiring a presumption to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

DATE: 10/26/99 CONSENT CALENDAR YES ☐ NO ☒

☒ OUGHT TO PASS

☐ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

attached.

Vote 11-2

Rep. O'Keefe
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

Criminal Justice and Public Safety Committee

Possible blurb for HB 427

The committee heard considerable testimony in favor of removing the prescription requirement for hypodermic syringes. Of greatest concern presently in many states, is the disposal of used syringes/needles. When a consumer purchase a needle today, there is no literature accompanying the product, speaking to disposal. This legislation would provide that information. In states where the prescription requirement has been lifted, transmission rates of Hepatitis and the HIV virus has gone down, and the disposal problem has actually lessened. In fact, needle stick incidents to police officers dropped in CT after CT removed their prescription requirement. A criticism of this type of legislation in the past has been that "it sends the wrong message - that drug use is o.k." The committee feels that the message is actually one of health, saving lives, and increasing the incidence of proper disposal of needles and syringes. Health professionals who agree include the N.H. Medical Society, the N.H. Nurses' Assn., the NH Board of Pharmacy, and the N.H. Dept. of Health and Human Services.

the American Medical Assn.
American Pharmaceutical Assn.
Association of State and Territorial Health Officials
National Alliance of State and Territorial AIDS Directors
National Assn of Boards of Pharmacy