

Editorial

Sterile syringe access for injection drug users in the 21st century: progress and prospects

In 2000, we published an article entitled “*Evaluating the Effectiveness of Syringe Exchange Programmes: Current Issues and Future Prospects*” (Bastos & Strathdee, 2000). In this article, we discussed social policies, particularly drug control policies, which have directly and/or indirectly limited the functioning of syringe exchange programmes (SEPs) at local and national levels in various countries. We also discussed the need for future studies to take into account the structural components of SEP that are most and least effective at reducing the incidence of blood borne pathogens. We are pleased to report that some progress has been made in these areas, as evidenced by the reports summarised in this special issue of the *International Journal of Drug Policy*, which focuses on sterile syringe access for injection drug users (IDUs). Some of these articles were presented in part at the International Harm Reduction Association’s annual conference in Slovenia, in 2002. Throughout this issue, we have maintained the convention of referring to any operation that exchanges syringes as SEPs, whereas programmes that also distribute syringes are referred to as needle/syringe programmes (NSPs). However, the term “syringe” and “needle” are used interchangeably.

In addition to reports from Australia and the United Kingdom where efforts to provide IDUs’ with sterile syringes through SEPs and pharmacies have been most impressive (see Lawrie, Matheson, Bond, & Roberts, 2003; MacDonald, Law, Kaldor, Hales, & Dore, 2003; McVeigh, Beynon, & Bellis, 2003; Thein, Denoe, van Beek, Dore, & MacDonald, 2003), several reports herein describe SEPs in regions where the previous literature had been lacking. Sharma and colleagues (2003) describe a situation assessment of SEP in Manipur, where SEPs have been operating for over five years. Trubnikov, Khodakevich, Barkov, and Blagovo (2003) report upon syringe access in Moscow, soon after the implementation of SEPs in this city. Caiffa and colleagues (2003) report upon SEPs from six regions in Brazil, where more than 100 SEPs are currently operating. In each of these cases, non-governmental organisations should be applauded in their efforts to provide sterile syringes to IDUs; however, the attendance of IDUs is uneven and coverage of these programmes remains low due to lack of experienced staff, scarce resources and in some settings, intervention by police. Similarly, papers from the

U.S. cities of Sacramento, California (Anderson, Clancy, Flynn, Kral, & Bluthenthal, 2003) and Baltimore, Maryland (Latkin, Hua, Davey, & Sherman, 2003) attest to the fact that coverage of sterile syringes is lacking in many developed country settings, including the United States. In these settings, the value of secondary exchange was highlighted as an important means of extending programme coverage.

Despite the continued U.S. Congressional ban on the use of federal funds to support SEPs in this country, there have been slow, but nevertheless important advances in sterile syringe availability in some states. For example, in Rhode Island, Boutwell et al. (2003) report upon three major programmatic and policy approaches that have been recently adopted to increase syringe access for injection drug users: syringe exchange, legal reform, and syringe prescription. Deren, Fuller, Puget, and Blaney (2003) also report that in New York state, an evaluation of the Expanded Syringe Access Demonstration Program (which permits the legal sale of syringes to drug users at pharmacies found that pharmacies) found that pharmacies were becoming a supplemental source of syringes for active IDUs in communities served by SEPs. Such findings are encouraging. Several papers in this issue provide collective evidence from Australia, the United Kingdom and the United States that SEPs, pharmacies and syringe prescription programmes attract different types of clientele, with varying levels of risk behaviours, indicating that multiple syringe sources are needed to maximize coverage (see Boutwell et al., 2003; Deren et al., 2003; Fisher, Fenaughty, Cagle, & Reynolds, 2003; McVeigh et al., 2003; Thein et al., 2003). A surprising finding was that SEPs in the United Kingdom appeared to attract a significantly higher proportion of anabolic steroid users, a subgroup of which very little is known.

Also of interest in this issue is a thorough and updated review of 10 years of experience with SEPs in European prisons by Stover and Nelles (2003). To date, 46 SEPs have been implemented within European prisons. Available data indicate that none of the fears that prison-based SEPs would be associated with increased drug use or syringe misuse were substantiated. These authors point out that despite the fact that prison-based SEPs are feasible and efficient, few countries have implemented them, and in some cases (e.g. Hamburg, Germany), prison-based SEPs were discontinued after

6 years without incident, due to a change in government that opted for an abstinence-based rather than a harm-reduction based philosophy.

On a global level, SEPs have been introduced in approximately one third of countries that report HIV among IDUs (Strathdee & Vlahov, 2001). In the 21st century, providing IDUs with access to sterile syringes therefore remains a serious challenge in both developed and developing countries. Continued efforts are needed to broaden the nature and types of venues that provide sterile syringes to IDUs, ensuring that appropriate disposal and ancillary services are offered.

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