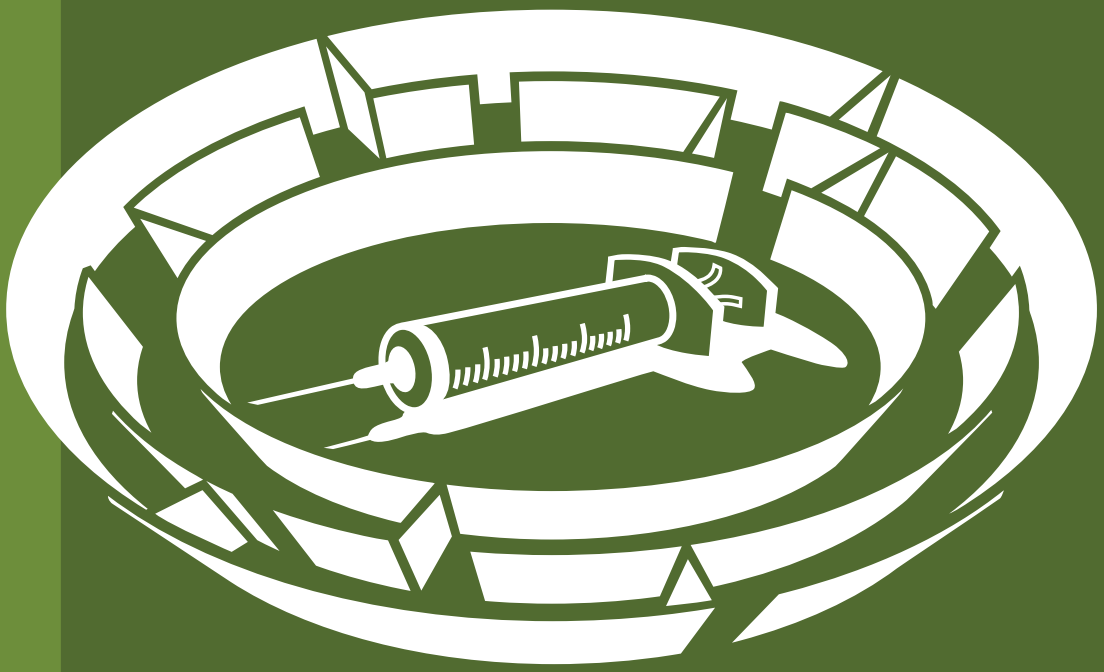

Sticking Points:

Barriers to Access to Needle and Syringe Programs in Canada

Canadian HIV/AIDS Legal Network | Réseau juridique canadien VIH/sida

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Canadian HIV/AIDS Legal Network
April 2007

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About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education, and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

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Executive Summary

Needle and syringe programs (NSPs) are a proven, cost-effective way of reducing the transmission of blood-borne viruses such as HIV and Hepatitis C (HCV) among people who use drugs. They do not result in increased crime in neighbourhoods nor do they lead to drug use. Harm reduction, including NSPs, has been endorsed by Canadian federal, provincial and territorial governments. Moreover, international law guarantees people who use drugs the right to the highest attainable standard of health without discrimination and requires governments to take positive measures to prevent and control diseases, including HIV/AIDS.

However, barriers persist that prevent people who use drugs from free access to sufficient sterile injection equipment. Although there is limited data on the number of people who use injection drugs in Canada, studies have estimated that NSPs currently distribute only about 5% of the number of syringes needed to ensure sterile equipment at every injection.

This report begins with a brief overview of NSPs in Canada. Next it examines barriers to NSP access identified through literature review and personal communications with key informants. Identified barriers include:

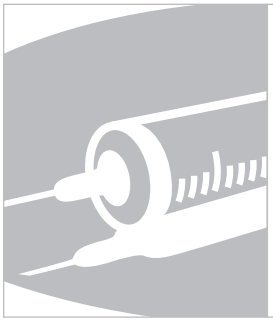
- Criminal drug and paraphernalia laws;
- Police law enforcement practices;
- Judicially imposed conditions of release that restrict access to neighbourhoods where NSPs are located;
- Program design-related barriers, including:
  - restricted operating hours;
  - inadequate geographic coverage;
  - restrictions on the amount of injection equipment delivered per visit;
  - reluctance of some NSPs to distribute other drug use equipment, such as cookers, filters, or safer crack use kits;
  - reluctance of some NSPs distribute equipment to people under 18 years old; and
  - Failure to meet users' preferences for mode of service delivery (e.g., distribution from health centres as opposed to community-based organizations);
- Stigma and privacy concerns;
- Community resistance;

- Inappropriate use of municipal zoning laws; and
- Insufficient funding.

Finally, the report lists a number of recommendations to address and eliminate barriers to access to NSPs in Canada. These include:

NSP coverage and funding

- Provincial and territorial governments need to identify explicitly that NSPs are necessary services in every health region. Where they do not already do so, provinces and territories should require that each region regularly assess whether such programs are needed. People who use drugs should be involved in the design of these needs assessments. Enforcement mechanisms are also needed to ensure that needs assessments are in fact conducted and that where services are needed, geographically accessible NSPs are established without undue delay, keeping in mind that NSPs may operate in different ways.



[I]nternational law guarantees people who use drugs the right to the highest attainable standard of health without discrimination and requires governments to take positive measures to prevent and control diseases, including HIV/AIDS.

- Stable funding must be guaranteed to all NSPs. Provincial and territorial governments must adequately fund NSPs directly, or, if service decisions are devolved to regional health authorities, must ensure that local pressures do not leave NSPs without sufficient funds. Provinces and territories could make up for shortfalls in funding allocated at the regional level or could legislatively require that public health units adequately fund harm reduction programs including NSPs. Provinces and territories should require public reporting of needs assessments and funding allocation decisions related to those needs assessments, and create effective enforcement measures so that programs or program clients could challenge local failures to provide adequate funding.
- The federal government should expand the Canada Health and Social Transfer to make federal health care funding available not only for hospital and physician services but also health protection and promotion services, including NSPs.
- Federal government funding earmarked for AIDS and HCV and Canada's Drug Strategy should be used to support harm reduction services, including NSPs.

Law and law enforcement

- The definition of a controlled substance in s. 2 of the *Controlled Drugs and Substances Act* should be amended so that it no longer includes items with trace amounts of drugs on them.

- The paraphernalia law in s. 462.2 of the *Criminal Code* should be repealed to ensure that policy-makers, police, NSP staff and NSP clients do not perceive any restrictions from the criminal law on the range of harm reduction equipment that can be distributed.
- Law enforcement and health policy branches of government should ensure that the enforcement of drug laws does not interfere with health policy. Clear, formal policies should be put in place throughout Canada to ensure that police activities not to interfere with NSP effectiveness.
- The Canadian Association of Chiefs of Police should reconsider their stated opposition to harm reduction and should adopt a resolution to encourage police forces to police in ways that do not interfere with harm reduction services.
- Judges should not impose bail, parole or probation conditions that prevent access to harm reduction services. In particular, they should not impose restrictions on carrying drug paraphernalia or designate areas where harm reduction services are offered as "no-go zones."

Program design

- NSPs should have regular, funded opportunities to develop and share best practices.
- Best practices should be determined in genuine consultation with communities of people who inject drugs.
- Programs should be designed with the primary goal of maximizing access to sterile injection equipment. There should be no limits, formal or informal, on the quantity of equipment distributed, types of equipment that can be distributed and the age of clients.
- Sterile injection equipment should be made available from as wide a variety of sources as possible and in conformity with the needs of the local population as determined through regular needs assessments and in consultation with people who use drugs.
- Governments, associations of pharmacists, and pharmacists should work together to ensure that sterile injection equipment is easily accessible in pharmacies.

Stigma and community resistance

- Public health departments should create public education campaigns to reduce stigma associated with NSPs.
- Zoning laws should not be used to create hurdles, such as community approval requirements, for the establishment of NSPs.

Introduction

Background: Public health and the distribution of sterile syringes

Illicit drug use is frequently associated with serious health, social and fiscal consequences.[1] People who use drugs are more likely to become infected with HIV and hepatitis C, and, if infected, suffer disproportionately poor infection-related health outcomes.[2] While there has been a slight decline in the proportion of new HIV cases attributed to injection drug use in Canada in recent years,[3] in many regions HIV prevalence remains unacceptably high among people who use drugs, particularly among youth, women and Aboriginal people.[4] A further concern relates to the growing number of HIV-positive people who inject drugs who are now developing AIDS, and the elevated rates of AIDS-related morbidity and mortality observed among people who use drugs.[5]

Needle and syringe programs (NSPs) aim to reduce the negative consequences of injection drug use by, among other things, providing sterile injection equipment so that people do not inject with used syringes that may be contaminated. NSPs have been shown to reduce risk for HIV transmission,[6] to be cost-effective,[7] and to facilitate access to care, treatment and support services.[8] There is no evidence that NSPs cause increases in

[1] E. Wood et al., "The healthcare and fiscal costs of the illicit drug use epidemic: the impact of conventional drug control strategies and the impact of a comprehensive approach," *British Columbia Medical Journal* 45, 3 (2003): 130–136; T. Kerr and W. O'Briain, "Drug policy in Canada – the way forward," *Canadian HIV/AIDS Policy and Law Review* 7, 1 (2002): 1–32.

[2] E. Wood et al., "Socioeconomic status, access to triple therapy, and survival from HIV-disease since 1996," *AIDS* 16,15 (2002): 2065–2072; P.M. Spittal et al., "Risk factors for elevated HIV risk incidence rates among female injection drug users in Vancouver," *Canadian Medical Association Journal* 166, 7 (2002): pp. 894–899; J. Bruneau et al., "High rates of HIV infection among injection drug users participating in needle exchange programs in Montreal: results of a cohort study," *American Journal of Epidemiology* 146, 12 (1997): 994–1002.

[3] Health Canada. *HIV/AIDS Epi Updates*, HIV/AIDS Among Injecting Drug Users in Canada. May 2006, at 75. Available via www.phac-aspc.gc.ca.

[4] In 2003, 18.4 percent of new HIV infections in Canada were among people who use intravenous drugs. Among women, intravenous drug use accounted for 27 percent of new cases. HIV rates among people under the age of 24 who use intravenous drugs were 2.96 percent among men and boys and 5.69 percent among women, up from an overall incidence of 1.5 percent in 2000. See Ibid. at 74, 77. See also Spittal et al., *supra* note 1; K.J.P. Craib et al., "Risk factors for elevated HIV incidence among Aboriginal injection drug users in Vancouver," *Canadian Medical Association Journal* 168, 1 (2003): 19–24.

[5] E. Wood et al., "Adherence and plasma HIV RNA responses to highly active antiretroviral therapy among HIV-1 infected injection drug users," *Canadian Medical Association Journal* 169, 7 (2003): 656–661; E. Wood et al., "Prevalence and correlates of untreated HIV-1 infection in the era of modern antiretroviral therapy," *Journal of Infections Diseases* 188, 8 (2003): 1164–1170; E. Wood et al., "Antiretroviral medication use among injection drug users: two potential futures," *AIDS* 14, 9 (2000): 1229–1235.

[6] World Health Organization, *Effectiveness of ste*rile needle and syringe programming in reducing HIV/AIDS among injecting drug users (Evidence for action technical papers), 2004. Available at www.who.int/hiv/pub/idu/pubidu/en/; M. Macdonald et al., "Effectiveness of needle and syringe programmes for preventing HIV transmission," *International Journal of Drug Policy* 14 (2003): 353–357; R.N. Bluthenthal et al., "The effect of syringe exchange use on high-risk injection drug users: a cohort study," *AIDS* 14, 5 (2000): 605–611; D.R. Gibson et. al., "Effectiveness of syringe exchange programs in reducing HIV risk behavior and HIV seroconversion among injecting drug users," *AIDS* 15, 11 (2001): 1329–1341; Ksobiech, K., "A meta-analysis of needle sharing, lending and borrowing behaviors of needle exchange program attenders," *AIDS Education and Prevention* 15, 3 (2003): 257–268; A. Wodak and A. Cooney, "Effectiveness fo sterile needle and syringe programmes," *International Journal of Drug Policy* 16S (2005): S31-S344

[7] M. Gold et al., "Needle exchange programs: an economic evaluation of local experience," *Canadian Medical Association Journal* 157, 3 (1997): 255–262; F. Laufer, "Cost effectiveness of syringe exchange as an HIV prevention study," *Journal of Acquired Immune Deficiency Syndrome* 28, 3 (2001): 273–278.

[8] R. Heimer, "Can syringe exchange serve as a conduit to substance abuse treatment?" *Journal of Substance Abuse Treatment* 15, 3 (1998): 183–191; H. Hagan et al., "Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors," *Journal of Substance Abuse Treatment* 19, 3 (2000): 247–252.

either neighbourhood crime[9] or in the number of used syringes discarded improperly in public spaces,[10] or that they encourage drug use.[11]

Since the 1980s, most developed countries and a number of developing countries have introduced NSPs to reduce harms associated with injection drug use, including infection with HIV and hepatitis C.[12] In 2004, the World Health Organization concluded that the scientific evidence supporting the effectiveness of NSPs was "overwhelming."[13] The Joint United Nations Programme on HIV/AIDS (UNAIDS)[14] and the United Nations General Assembly[15] also endorse NSPs.

In Canada, NSPs have enjoyed the support of federal,[16] provincial and territorial,[17] and municipal[18] governments. For example, one of the four key pillars of Canada's Drug Strategy is harm reduction, including NSPs.[19] In 2005, *Leading Together: An HIV/AIDS Action Plan for All Canada (2005–2010)*[20] was produced with the support of the Public Health Agency of Canada. This blueprint for Canada's response to HIV/AIDS was the result of a multi-year process involving a broad cross-section of organizations and individuals involved in the Canadian response to the epidemic. Harm reduction programming figures heavily in the plan, which calls for, among other things, expanded access to NSPs.

With this widespread consensus, the early wave of research about whether NSPS "work" has given way to a second wave that investigates how they can be most effective at reducing harm for people who inject drugs.[21]

[9] M.A. Marx et al., "Trends in crime and the introduction of a needle exchange program," *American Journal of Public Health* 90, 12 (2000): 1933–1936. S. Galea et al., "Needle exchange programs and experience of violence in an inner-city neighbourhood," *Journal of Acquired Immune Deficiency Syndrome* 28, 3 (2001): 282–288.

[10] M.C. Doherty et al., "The effect of a needle exchange program on numbers of discarded needles: a 2-year follow-up," *American Journal of Public Health* 60, 6 (2000): 936–939.

[11] M.A. Marx et al., "Impact of a needle exchange program on adolescent perceptions about illicit drug use," *AIDS Behavior* 5 (2001): 379–386. (No evidence that needle exchange encourages drug use among adolescents); E.J.C. van Ameijden and R.A. Coutinho, "Large decline in injecting drug use in Amsterdam 1986–1998: explanatory mechanisms and determinants of injecting transitions," *Journal of Epidemiology and Community Health* 55 (2001): 356–363.

[12] See A.L. Ball, "Overview: Policies and interventions to stem HIV-1 epidemics associated with injecting drug use," in G.V. Stimson et al., *Drug Injecting and HIV Infection: Global Dimensions and Local Responses* (London: UCL Press, 1988). See also F.I. Bastos and S.A. Strathdee, "Evaluating effectiveness of syringe exchange programmes: current issues and future prospects," *Social Science and Medicine* 51 (2000): 1771–1782.

[13] *Supra* note 6 at 28.

[14] WHO/UNAIDS/UNODC, *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission*, 2004, available via www.wpro.who.int/sites/hsi/documents.

[15] Declaration of Commitment on HIV/AIDS. A/Res/2–26/2, 27 June 2001 at para 50.

[16] See Government of Canada, *The Federal Initiative to Address HIV/AIDS in Canada: Strengthening Federal Action in the Canadian Response to HIV/AIDS,* 2004; Government of Canada: *Canada's Drug Strategy: Working Together to Reduce the Harmful Use of Substances*, 2005. Health Canada, *Reducing the Harm Associated with Injection Drug Use in Canada*, 2001 at 11.

[17] E.g., Alberta Alcohol and Drug Abuse Commission, Stronger together: A provincial framework for action on alcohol and other drug use, October 2005. Available via http://corp.aadac.com; Ministry of Health and Social Services, Government of Quebec, Plan d'action interministérielle en toxicomanie 2006–2011, 2006; Government of Saskatchewan, Premier's Project Hope: Saskatchewan's action plan for substance abuse, August 2005. Available via www.gov.sk.ca/newsrel/releases/2005/08/04-732-attachment.pdf. Government of Yukon, Yukon substance abuse action plan: Working together for healthier communities (discussion draft), October 2005. (endorsing harm reduction generally).

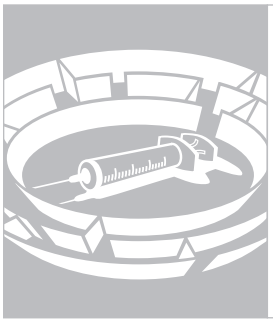
[18] E.g., Toronto Drug Strategy Advisory Committee, *The Toronto Drug Strategy: A comprehensive approach to alcohol and drugs*, December 2005 at 31–32; City of Vancouver, *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver,* April 2001.

[19] *Supra* note 16. In March 2007, the federal government announced that it would develop a "new National Anti-Drug Strategy in which no mention is made of harm reduction. See www.budget.gc.ca/2007

[20] Canadian Public Health Association (2005).

[21] W. Small, "Examining barriers to syringe access among injection drug users," *International Journal of Drug Policy* 16 (2005): 291–292 at 291.

Even where NSPs exist, barriers to access can result in persistent high-risk needle sharing.[22] In Vancouver, one of the first municipalities in Canada to establish an NSP, difficulty getting new syringes was a found to be a significant factor contributing to syringe sharing among people who inject drugs.[23] In practice, the success of NSPs in providing access to sterile syringes varies. Incidence and prevalence of HIV among people who use drugs vary widely among cities with active NSPs.[24] One researcher asks, "Why did HIV prevalence among [people who use drugs] in San Francisco, Amsterdam and New York stabilize at such different rates (12, 30, and 50% respectively)?"[25] Programs are diverse in their design and operation, function in different contexts, and may not always receive the support they need from police, governments, and local communities.



[T]he early wave of research about whether NSPS "work" has given way to a second wave that investigates how they can be most effective at reducing harm for people who inject drugs.

The human rights context

All people, including those who use drugs, have the right to life-saving health services. The right to health is protected in numerous international human rights documents.[26] The International Covenant on Economic, Social and Cultural Rights (ICESCR), which binds Canada, recognizes in Article 12, "the right of everyone to the enjoyment of the highest attainable standard of health"[27] and requires states to take all necessary steps for "the prevention, treatment, and control of epidemic . . . diseases."[28]

[22] E. Wood et al., "Factors associated with persistent high-risk syringe sharing in the presence of an established needle exchange program," *AIDS* 16, 6 (2002): 941–943; R. Heimer et al., "Structural impediments to operational syringe-exchange programs," *AIDS and Public Policy Journal* 11, 4 (1996): 169–184; T. Rhodes et al., "Situational factors influencing drug injecting, risk reduction and syringe exchange in Togliatti City, Russian Federation: a qualitative study of micro risk environment," *Social Science and Medicine* 57, 1 (2003): 39–54. E. Wood et al., "An external evaluation of a peer-run 'unsanctioned' syringe exchange program," *Journal of Urban Health* 80, 3 (2003): 455–464; A. Peak et al., "Declining risk for HIV among injecting drug users in Kathmandu, Nepal," *AIDS* 9, 9 (1995): 1067–1070; M. Singer et al., "The social geography of AIDS and hepatitis risk: qualitative approaches for assessing local differences in sterile-syringe access among injection drug users," *American Journal of Public Health* 90, 7 (2000): 1049–1056.

[23] E. Wood et al., "Needle exchange and difficulty with needle access during an ongoing HIV epidemic," *International Journal of Drug Policy* 13 (2002): 95–102.

[24] S. Friedman et al., "Laws prohibiting over the counter syringe sales to injection drug users: relations to population density, HIV prevalence and HIV incidence," *American Journal of Public Health* 91, 5 (2001): 791–793.

[25] B. Tempalski et al., "What predicts which metropolitan areas in the USA have syringe exchanges?" *International Journal of Drug Policy* 14, 5 (2003): 417–424 at 418.

[26] *Universal Declaration of Human Rights*, U.N. General Assembly, Resolution 217 A(III), U.N. GAOR, 3rd Session, 183rd plenary meeting, 71, U.N. Doc. A/910 (1948), art. 25(1); *International Convention on the Elimination of All Forms of Racial Discrimination*, U.N. General Assembly, Resolution 2106 (XX), annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966) art. 5(e); *International Convention on the Elimination of All Forms of Discrimination against Women* , U.N. General Assembly Resolution 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, (1979) arts. 11(f) and 12; *Convention on the Rights of the Child*, U.N. General Assembly, Resolution 44/125, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49, (1989) art. 24. *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural* Rights ("Protocol of San Salvador") O.A.S. Treaty Series No. 69 (1988), art. 10. *International Covenant on Economic, Social and Cultural Rights*, (ICESCR) U.N. General Assembly, Resolution 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), art. 12(1).

[27] ICESCR, Ibid.

[28] Ibid., art. 12 (2)(c).

The right to health "requires the establishment of prevention and education programmes for behaviour related health concerns such as sexually transmitted diseases, including HIV/AIDS.[29] States must "make available . . . technologies"[30] for disease prevention.

They may not limit people's access to available preventive health care[31] and must ensure that other community members do not interfere with people's access to existing health-related services.[32] States must also ensure that there is no discrimination in the provision of health care; this obligation extends to ensuring that health care resources are distributed equitably and cost-effectively.[33] States must adopt a national public health strategy that is devised through participatory and transparent processes and which gives particular attention to marginalized or vulnerable groups.[34] In addition, laws and policies that "are likely to result in bodily harm, unnecessary morbidity and preventable mortality" constitute violations of the right to health.[35]

The ICESCR requires states to "take steps . . . to the maximum available resources . . . with a view to achieving progressively the full realization of the rights."[36] This qualification recognizes that resource constraints and other realities may impede the immediate full realization of economic, social and cultural rights. However, where preventive health services can be provided and barriers removed with minimum resource implications (often with substantial long-term savings), as in the case of NSPs, governments must take immediate action to make programs universally available.

Methodology

Information for this paper was collected through literature review and interviews conducted in person, by telephone, or by e-mail. Published literature from Canadian sources was sought wherever possible, but was supplemented by literature from other jurisdictions where Canadian sources were unavailable or insufficient. Where basic information about NSPs (such as the number of needle and syringe programs in Canada, or policies relating to program design), was absent from published literature, facts and data were requested from government officials and from NSP staff. These are identified as key informants in the paper. A first draft of the paper was circulated among stakeholders, including government officials, NSP staff, researchers and people who inject drugs, for comment and contribution; they are also identified as key informants.

Terminology

The term "needle and syringe program" (NSP) is used in this paper to describe any program that provides sterile injection equipment to people who inject drugs, whether in exchange for used injection equipment or not. It includes services that have variously been described as "needle exchange programs," "syringe exchange programs," "sterile syringe distribution programs" and "sterile injection equipment distribution programs," among others. Sale and free distribution of syringes in pharmacies may also be considered part of a needle and syringe program.

[29] UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health: Art 12/E/C.12/2000/4, 11 May 2000, para. 16.

[30] Ibid.

[31] Ibid. at para 34.

[32] Ibid. at para. 25.

[33] Ibid. at paras. 18, 19, 52.

[34] Ibid. at para. 43 (f).

[35] Ibid. at para. 50.

[36] ICESCR, *supra* note 26, Art. 2(1).

Paper structure

This paper begins with an overview of the state of needle and syringe programs in Canada. In doing so, it addresses in part the lack of comprehensive information on the extent and operation of NSPs across the country. Next, it explores the public health and social science literature on barriers to access to NSPs, and the degree to which these barriers operate in Canada. Finally, it makes recommendations for improving access to NSPs in Canada.

Overview of needle and syringe programs in Canada

As health services, NSPs fall within the authority of provincial and territorial ministries of health. Although the federal government provides some funding to NSPs (e.g. through time-limited project-funding grants from the Public Health Agency of Canada's Hepatitis C Prevention, Support and Research Program), the primary responsibility for developing and supporting NSPs lies with the provinces and territories.

The first official NSP in Canada was established in Vancouver in 1989,[37] and a few months later, similar programs were established in Toronto[38] and Montréal.[39] By 2001, Health Canada reported that there were over 200 NSPs in the country, with more under development.[40] At this writing, the ministries of health in every Canadian province and two of three territories were providing some form of support for NSPs.[41]

There is significant variation in the development of NSPs among Canada's provinces and territories. In Ontario, Quebec and British Columbia, which have had NSPs from the earliest days, programs are more developed. In Ontario, local boards of health are required by law to provide access to NSPs as a harm reduction strategy to prevent the transmission of blood-borne disease.[42] Since the legal requirement was established in 1997, the number of health units offering NSPs has risen from 12 to 30; as of 2004, NSPs were available in all but three public health regions.[43] In Quebec, regulatory guidelines require the Minister of Health and Social Services to publish updated lists of sites where sterile syringes are available.[44] The 2005–2006 list reports that 16 of 18 health regions have some form of NSP.[45]

By contrast, AIDS PEI opened Prince Edward Island's first NSP in 2002, with private donations as the sole source of funds. When donations were scarce, there were no syringes to distribute. The provincial government provided no contribution or input until February 2006, when it agreed to provide needles and swabs in response to growing concerns about hepatitis C rates in the province.[46] In the Northwest Territories, free needles and syringes can be obtained on the premises of all four public health units and, in principle, in

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[37] Health Canada, *Harm reduction and injection drug use: an international comparative study of contextual factors influencing the development and implementation of relevant policies and programs*. September 2001 at 13.

[38] Ontario Ministry of Health and Long-Term Care. Infections Disease Branch, Public Health Division. *Needle Exchange Programs in Ontario: 2004*. February, 2006 at 5.

[39] http://cactusmontreal.org/en/historique.html.

[40] Health Canada, *Harm reduction and injection drug use*, *supra* note 37 at 13.

[41] As of February 2006, Prince Edward Island became the last province in Canada to provide material support for NSP when it agreed to supply syringes and swabs to AIDS PEI. The community-based AIDS service organization had previously been running the province's only NSP through private donations. Personal communication with A. MacKinnon, Program Coordinator, AIDS PEI, 23 June 2006. Nunavut does not provide needle exchange, on the ostensible basis that there is no injection drug use in the territory. Personal communication with G. Osborne, Associate Chief Medical Officer of Health for Nunavut, 24 April 2006.

[42] Section 5 of the *Health Protection and Promotion Act* R.S.O. 1990, c. H.7 specifies that boards of health, as defined in the *Health Protection and Promotion Act*, must provide or ensure the provision of a minimum level of public health programs and services in specified areas. Section 7 of the *Health Protection and Promotion Act* authorizes the Minister of Health to develop and publish guidelines that represent minimum standards for these programs and services. In December 1997, the Public Health Branch of the Ontario Ministry of Health published the *Mandatory Health Programs and Services Guidelines* pursuant to s. 7 which provide, under the goal of reducing the incidence of and complications arising from all STD including HIV/AIDS:

> The board of health shall ensure that injection drug users can have access to sterile injection equipment by the provision of needle and syringe exchange programs as a harm reduction strategy to prevent transmission of HIV, hepatitis B, hepatitis C and other blood-borne infections and associated diseases in areas where drug use is recognized as a problem in the community. The strategy shall also include counselling and education and referral to primary health services and addiction/treatment services. The board of health shall produce an annual report of program activities and forward a copy to the Minister of Health.

[43] *Supra* note 37.

[44] Quebec Ministry of Health and Social Services, *Lignes directrices sur la récupération des seringues usagées* (2003), available via www.mddep.gouv.qc.ca.

[45] Quebec Ministry of Health and Social Services and the National Institute of Public Health, *Liste Officielle des centres d'accès aux seringues du Quebec (distribution, vente, récupération)* 2005/2006.

[46] Personal communication with A. MacKinnon, *supra* note 41.

its 33 community health centres. However, no community agencies provide the service and there is concern, especially in remote communities, that people who inject drugs do not use NSPs in community health centres and public health units.[47] Across the country, NSPs have tended to operate in urban centres with larger known populations of people who inject drugs.

How many needle and syringe programs are there in Canada?

It is difficult to estimate the number of programs or sites providing clean injection equipment in Canada because of variability in distribution modes and in the definition of what constitutes a "site" or a "program." For example, a Quebec government report counts 780 sites where one can obtain clean syringes in the province, but only 180 of them actually distributed any syringes during the year-long study period.[48] Free injection equipment can be obtained from:

- 4 community agencies in Montréal and Québec City specialized in harm reduction;
- 65 multiple-use community organizations;
- mobile units operated by community agencies;
- over 200 CLSC/CSSS (local community service centres and health and social service centres;
- 40 hospitals; and
- over 200 pharmacies.[49]

Despite this apparent breadth, 89.5% of requests for syringes among people who use drugs are made at community organizations. Similarly, the number of NSP sites in the Northwest Territories may be something of a fiction if, as noted above, they are not attracting the targeted clientele.

Moreover, many programs have satellites that operate with varying degrees of formality. For example, Ontario counts 30 NSPs[50] (fewer than the number of discrete NSP sites and one twenty-sixth the number counted by Quebec). Toronto's program, "The Works," which is operated by Toronto Public Health, is considered a single program even though it supplies injection equipment to at least 34 community organizations operating satellites throughout the city.[51] One of those satellites, COUNTERfit, which operates out of the South Riverdale Community Health Centre, supplies large volumes of syringes to individuals in the community who distribute clean syringes to their peers.[52] These "secondary distributors" may effectively operate as less formal satellite NSPs, and not all programs track the number of secondary distributors closely.

Finally, lack of clear information about pharmacy sales adds to the difficulty of determining the availability of sterile injection equipment. Whether needles and syringes are available in pharmacies tends to depend on the individual pharmacists. For example, the Ontario College of Pharmacists (OCP) encourages pharmacists to sell

[47] Personal communication with W. White, Communicable Disease Nurse Consultant, Department of Health and Social Services, Northwest Territories, 12 June 2006.

[48] Quebec Ministry of Health and Social Services and the National Institute of Public Health, *Statistiques sur les services relative aux programmes de prévention du VIHet des hépatites B et C offert aux utilisateurs de drogues par injection du Québec*. Institut national de santé public, Ministère de la Santé et des Services sociaux (March 2006).

[49] Ibid. at 5.

[50] *Supra* note 37 at 5.

[51] Ibid. at 11–12.

[52] Personal communication with R. Balian, Project Coordinator, COUNTERfit Harm Reduction Program, 14 June 2006.

syringes to anyone who requests them, but leaves the ultimate decision to individual pharmacists.[53] The OCP does not keep track of the various policies of individual pharmacists.

Is the demand for clean needles and syringes being met?

The important question is not so much how many programs exist, but whether enough injection equipment is being distributed and whether it is distributed widely enough to facilitate the use of sterile equipment for each injection.[54] For every person who injects drugs, it has been estimated that 1000 needles are required per year,[55] although the figure varies depending on numerous factors, including drug of choice and frequency of injection. (Typically, people who inject cocaine perform a greater number of injections per day than those who inject heroin.)

The number of syringes distributed per year through NSPs is tracked in some provinces but not in others.[56] It is also very difficult to estimate the number of people who inject drugs in any population.[57] Nonetheless, in Ontario, it has been estimated that only 53 needles are distributed per injector per year — about 5% of the number required.[58] A recent study in Montréal found that 6.6% of the needles required to achieve the goal of one syringe per injection were distributed.[59] In Ottawa, researchers estimated that NSPs distribute about 5% of the required needles.[60]

It is especially difficult to know the extent to which needs are being met outside urban centres in which NSPs have tended to operate. There is a lack of reliable information on the number of people who use drugs in rural communities. Although injection drug use is clearly not limited to urban centres, many regions have no NSPs.[61] In Saskatchewan, only 7 of 13 health regions have NSPs.[62] Many parts of Manitoba have no NSPs.[63] In Alberta, the only NSPs are in Calgary, Edmonton, Red Deer, Grande Prairie, Lethbridge and Medicine Hat.[64] In British Columbia, which has the longest history of NSPs and has a relatively well-developed NSP

[53] Ontario College of Pharmacists, Policy Handbook *available via* www.ocpinfo.com.

[54] C. Strike et al., *Ontario Needle Exchange Programs: Best Practice Recommendations*. Ontario Needle Exchange Coordinating Committee, 2006.

[55] D.R. Holtgrave et al., "Cost and cost-effectiveness of increasing access to sterile syringes and needles as an HIV prevention intervention in the United States," *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology,* 18 (suppl.1) (1998): S133–S138; P. Lurie et al., "An economic analysis of needle exchange and pharmacy-based programs to increase sterile syringe availability for injection drug users." *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 18 (suppl. 1)(1998): S126–S132.

[56] In the most recent year studied in each province, British Columbia's NSP distributed 6.2 million syringes. (Personal communication with R. Mooney, 29 March 2006). Ontario distributed 3 280 125, *supra* note 37 at 7. In Quebec, 1 248 531 were distributed, *supra* note 48. In Saskatchewan 3 074 552 were distributed (Personal with S. Fairburn, HIV/BBP/IDU Consultant Population Health Branch, Saskatchewan Health, 2 March 2006). In Prince Edward Island's single NSP distributed 11 000 needles last year.(Personal communication with A. MacKinnon, *supra* note 41.) In Newfoundland and Labrador, 5604 needles and syringes were distributed in 2005 (Personal communication with T. Walsh, Harm Reduction Coordinator, AIDS Committee of Newfoundland and Labrador, 13 June 2006). (Other provinces and territories do not track the number of syringes distributed each year.)

[57] See S. Popova et al., "An overview of illegal opioid use and health services utilization in Canada," *Public Health* 120 (2006): 320–328 at 324 (citing estimates that 80 000 to 125 000 people inject illegal drugs per year in Canada, but also that "Canadian data related to illegal substance use are limited, often inconsistent and/or based on non-standardized measures.")

[58] M. Millson et al., *Injection drug use, HIV and HCV infection in Ontario: The situation in 2004*. University of Toronto: HIV Social, Behavioural and Epidemiological Studies Unit, 2005.

[59] P. Leclerc et al., "Le materiel stérile d'injection: combien faut-il en distribuer pour répondre aux besoins des UDI de Montréal?" Director of public health, Montréal health and social services agency, July 2006.

[60] R.S. Remis et al., "Enough sterile syringes to prevent HIV transmission among injection drug users in Montreal? *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology,* 18(suppl. 1)(1998): S57–S59; L. Leonard et al., "Risk conditions impact individual HIV prevention practices of Ottawa injection drug users," 15th International AIDS conference, Bangkok, Thailand, 11–16 July 2004.

[61] Personal communication with D. Bailey, Director, Mainline Nova Scotia, 30 June 2006.

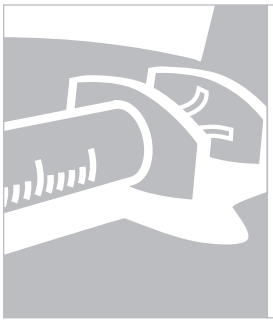
[62] Personal communication with Fairburn, *supra* note 56.

[63] Personal communication with D. Schuster, STD/HIV Program Specialist, Manitoba Health, 29 March 2006.

[64] Personal communication with M. Taylor, Executive Director, Street Works Edmonton, 3 July 2006.

policy, NSPs are available in only 14 cities and communities, and there continue to be areas without any programs.[65] P.E.I. and Newfoundland and Labrador each has a single NSP operated by an AIDS service organization in its capital city,[66] and New Brunswick and Nova Scotia each have NSPs only in their two largest cities.

In some places, outreach is provided to communities that are far from NSPs by more and less formal systems of secondary distribution. For example, NSPs in P.E.I. and Newfoundland and Labrador reported providing large numbers of sterile syringes to individuals seeking to do informal secondary distribution outside urban centres among people who use drugs.[67] Similarly, in New Brunswick, where the only NSPs are in Saint John and Fredericton; sterile syringes are distributed to outlying regions through secondary distribution. In Nova Scotia, NSPs in Halifax and Sydney provided outreach to other areas via more formalized secondary distributors known as "natural helpers" — individuals with a deep understanding of the social networks of people who use drugs.[68] Natural helpers either bring syringes to people who live far from NSPs or spread the word about NSPs among potential clients. Saskatchewan NSPs also supply equipment for informal secondary distribution, sometimes on reserves.[69] However, not all programs track distribution through secondary distribution closely.



Surveillance studies that track the prevalence and incidence of HIV and hepatitis C (HCV) among people who inject drugs support the view that distribution of clean syringes is far below what is required to stop the spread of blood-borne infections.

Surveillance studies that track the prevalence and incidence of HIV and hepatitis C (HCV) among people who inject drugs support the view that distribution of clean syringes is far below what is required to stop the spread of blood-borne infections.[70] Alarm over news about high rates of HCV among people who use drugs has led some provinces in Canada to seek to expand access to needle and syringe programs.[71]

[65] Government of British Columbia, Ministry of Health, *HIV/AIDS and Problematic Substance Use: Needle Exchanges*, 21 July 2005, available via www.healthservices.gov.bc.ca/hiv/needle.html; Personal communication with Mooney, *supra* note 56.

[66] Personal communication with MacKinnon, *supra* note 41. Personal communication with Walsh, supra note 56.

[67] Ibid.

[68] Nova Scotia Health, *Standards for Blood-Borne Pathogens: Prevention Services in Nova Scotia*. May 2004 at 24. See also Sharp Advice Needle Exchange, *Mission/Purpose*, available at www.accb.ns.ca/sane.html.

[69] Personal communication with Fairburn, supra note 56.

[70] HIV/AIDS Epi Updates, *supra* note 3 at 77; Health Canada. I-Track: Enhanced Surveillance of Risk Behaviours among Injecting Drug Users in Canada. Pilot Survey Report. February 2004 at 45 (finding an overall HCV prevalence rate of 63.8% among injection drug using study participants in Regina, Sudbury. Toronto and Victoria); R. Parent. "La surveillance épidémiologique du VIH chez les UDI.: faits saillants des observation du réseau SurvUDI," *L'intervenant,* 21(2)(2005) : 56–59 (finding a 63% prevalence of HCV among study participants in Quebec)

[71] E.g., A. MacKinnon of AIDS PEI attributes the provincial government's decision to provide injection equipment for NSP to the recent rise in HCV rates. Prior to 1998, most of the individuals with HCV could be traced to off-island contacts, but new cases have recently been diagnosed among people who have never left the island. Of the 350 individuals diagnosed with HCV on the island, 70% had a history of injection drug use. *Supra* note 41.

Barriers to access to needle and syringe programs

Barriers to access to needle and syringe programs include laws, policing and law enforcement practices, community opposition to NSPs, suboptimal program design, and stigma, among others.

Criminal law and its enforcement

The non-therapeutic production, distribution, possession and use of drugs are treated as criminal in most jurisdictions in the world. As Burris et al. observe, "[t]he fingerprints of the criminal justice system are everywhere to be found in the behaviour of [people who use illegal drugs], who live furtively in 'microcontexts' of police surveillance, crime, mistrust, and violence."[72] Access to, and use of, sterile injection equipment to inject illegal drugs, including from NSPs, is affected by:

(i) the "law on the books": statutes, regulations, and court decisions that punish drug use and related activities like paraphernalia possession;

(ii) law enforcement, including the standard policies of criminal justice and beliefs of those who enforce the law "on the street," including police and prosecutors; and

(iii) knowledge, attitudes and beliefs about the law and its enforcement held by people who inject drugs.

The law on the books

It is technically a criminal offence to possess needles containing traces of illegal drugs. The *Controlled Drugs and Substances Act* prohibits people from possessing, importing, exporting, or trafficking not only a controlled substance[73] itself, but also "any thing that contains or has on it a controlled substance and that is used or intended or designed for use . . . in introducing the substance into the human body."[74] There is no express exemption or protection in the law or regulations for NSP staff who will often be knowingly in possession of used equipment, or for NSP clients making efforts to safely dispose of needles. In principle, NSP clients and staff are therefore vulnerable to prosecution for possession of illegal drugs when they are in possession of used syringes.[75] Some commentators have argued that people who work in NSPs, unlike NSP clients, may not have sufficient knowledge or control of the drug residue contained in syringes to support a conviction for possession of trace amounts.[76] Indeed, it appears that no NSP staff member has ever been prosecuted for receiving syringes that contain drug residue. Similarly, there is no data on convictions of NSP clients for possession of trace amounts of drugs found in injection equipment. However, there have been reports that police have threatened prosecution against individuals based on residue contained in syringes.[77] People have also been convicted for possession of trace amounts of crack cocaine on crack pipes.

Although there tend not to be prosecutions for possession of trace amounts of illegal drugs in syringes, the fact that the law remains on the books can leave NSP clients vulnerable to police and other law enforcement actions. The law prohibiting possession of trace amounts can be used to justify, after the fact, police decisions

[72] S. Burris et al., "Addressing the 'risk environment' for injection drug users: the mysterious case of the missing cop," *The Milbank Quarterly* 82, 1 (2004) 125–156.

[73] Controlled substances are defined in s. 2(1) of the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 as any substances listed in Schedules I-V of the *Act*, including, among other things, opiates, cocaine and methamphetamine.

[74] Ibid., s. 2(2).

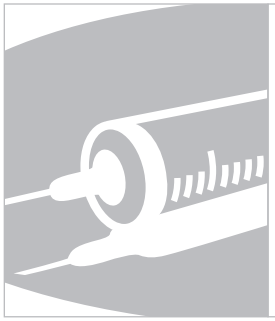
[75] See S.J. Upsrich and R. Solomon, "Notes on the potential criminal liability of a needle exchange program," *Health Law in Canada* 8, 3 (1988): 42–48; E. Oscapella and R. Elliott, "Injection drug use and HIV/AIDS: A Legal Analysis of Priority Issues," in Canadian HIV/AIDS Legal Network, *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues — Background Papers*, 2002, A52–A55, available via www.aidslaw.ca.

[76] Ibid.

[77] See *Injection Drug Use and HIV/AIDS*, Ibid. at A54.

to stop, question, search, warn, or arrest NSP clients. For example, police are entitled to arrest a person without a warrant where they believe that person has committed or is about to commit an indictable offence,[78] which includes possession of a controlled substance.[79] Police may also detain someone, for example for questioning, if there are reasonable grounds to suspect he or she is connected to a particular crime.[80] In addition, a person arrested for possession of used syringes might plead to a lesser charge, or he or she might be found in violation of existing parole conditions. Thus, even if people are not being convicted for possession of syringes with trace amounts, the continued criminalization can have numerous implications for NSP clients.

Paraphernalia laws contained in the *Criminal Code*[81] may also be relevant to NSP operation. Sterile syringes themselves appear to be exempt from the Code's definition of prohibited paraphernalia. However, although other drug consumption equipment distributed as part of harm reduction services should be viewed as similarly exempt, they have not always been.



The law prohibiting possession of trace amounts can be used to justify, after the fact, police decisions to stop, question, search, warn, or arrest NSP clients.

Section 462.2 of the *Criminal Code* prohibits the promotion or sale of "instruments for illicit drug use". As defined in the *Criminal Code*, such instruments include "anything . . . intended under the circumstances for consuming or to facilitate the consumption of an illicit drug", but exclude an "article, instrument or apparatus . . . for use in . . . the . . . mitigation or prevention of disease."[82] Therefore, distribution of sterile needles and syringes should not, in principle, run afoul of paraphernalia laws. Neither should other sterile injection equipment, such as cookers, filters, acidifiers (used to convert insoluble drugs into water-soluble form), sterile water ampoules, alcohol swabs and tourniquets, all of which have been identified as presenting actual or potential health risks if shared or otherwise used improperly.[83]

Nonetheless, some NSPs have been reluctant to distribute other injection related equipment such as cookers, filters, and vitamin C powder (an acidifier) for fear of running afoul of paraphernalia laws. On February 17, 2003, the Ontario Ministry of Health sent a letter to all medical officers of health in the province's health units indicating that distribution of some injection equipment would contravene paraphernalia laws. Equipment other than needles and syringes might "place their programs at risk" because of alleged insufficient scientific literature supporting their effectiveness in reducing disease transmission. "If your health unit is supplying additional measures that might be construed as 'drug paraphernalia,' as part of the [NSP]," the letter advised,

[78] *Criminal Code*, R.S.C. 1985, c. 46, s. 495 (1)(a).

[79] S. 4(3) of the *Controlled Drugs and Substances Act*, *supra* note 73 provides that prosecutions for possession of a controlled substance may proceed by indictment.

[80] *R. v. Mann*, [2004] 3 S.C.R. 59 (Supreme Court of Canada) at paras. 34 and 45.

[81] R.S.C., 1985, F-27.

[82] Section 462.1 of the *Criminal Code*, *supra* note 78, provides that an, "'instrument for illicit drug use' means anything designed primarily or intended under the circumstances for consuming or to facilitate the consumption of an illicit drug, but does not include a "device" as that term is defined in section 2 of the Food and Drugs Act.". For its part, s. 2 of the *Food and Drugs Act* R.S., 1985, c. F-27, defines a "device" as "any article, instrument, apparatus or contrivance, including any component, part or accessory thereof, manufactured, sold or represented for use in (*a*) the diagnosis, treatment, mitigation or prevention of a disease, disorder or abnormal physical state, or its symptoms, in human beings or animals . . ."

[83] For a thorough review of the scientific literature on risks associated with sharing injection-related equipment, see Strike et al., supra note 54.

"you may wish to consider ceasing the practice and seeking the advice of counsel."[84] NSP staff received a copy of the letter.

In October 2006, the then-Chief Medical Officer of Health and Assistant Deputy Minister sent a memorandum that signalled a change in policy. The memorandum announced that in light of new evidence that infection can occur through sharing of other injection equipment, the Ontario Ministry of Health and Long-Term Care would establish the Ontario Harm Reduction Distribution Program (OHRDP) to provide additional harm reduction equipment such as sterile water, alcohol swabs, filters, acidifiers and tourniquets.[85] The OHRDP was created by Ontario's Hepatitis C secretariat, which provides $1 million for the purchase of sterile injection equipment. The Toronto Drug Strategy has likewise supported the distribution of other drug consumption equipment,[86] and the Ontario needle exchange best practice recommendations came out strongly in favour of supplying other injection-related equipment as part of NSP operations.[87] Despite this overwhelmingly explicit support by the Ministry of Health and other actors for the distribution of other harm reduction equipment, the letter is still relied on by some Ontario NSPs to refuse to supply other injection-related equipment.[88]

In the United States, where many states criminalize syringe possession,[89] a substantial body of ethnographic, qualitative and quantitative research indicates that laws prohibiting syringe possession undermine the effectiveness of NSPs. Less needle sharing has been reported in Seattle, where syringe possession is legal, compared to regions where the purchase and possession of needles are illegal.[90] Bluthenthal et al. found that people who use drugs in Oakland, California, where they could not legally carry syringes under any circumstances, had more police contact than those in Chicago, Illinois and Hartford, Connecticut, both of which had less restrictive laws governing syringe possession.[91] A survey of 42 NSPs in 35 cities in 18 U.S. states revealed that the street price of syringes depended on the individual states' laws governing possession of syringes by people who use drugs. Prices were lowest when there was no law on syringe possession, significantly higher when there was an unenforced law, and highest when there was an enforced law.[92] Finally, Friedman et al. found that prescription laws restricting over-the-counter syringe sales to people who use drugs were associated with higher incidence and prevalence of HIV.[93] U.S. courts have held that penalizing participants in NSPs for possession of new or used needles subverts the legislative intent behind permitting such programs in the first place.[94]

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[84] Memorandum from Dr. E.-S. Chan, Physician Manager, Disease Control Service, Public Health Branch, Ontario Ministry of Health and Long-Term Care to All Medical Officers of Health, 14 February, 2003, on file. See also S. Burris et al., "Lethal Injections: The Law, Science, and Politics of Syringe Access for Injection Drug Users," *University of San Francisco Law Review* 37 (2003): 813–886 at 829 (noting that "with the political focus on syringe access, the potential legal ambiguity [related to possession and distribution of other equipment like cookers and cotton] was largely ignored. In recent years, however, there have been anecdotal reports of [NSPs] being deterred from offering, and [people who use drugs] being arrested for possession, sterile cookers and cotton."

[85] Memorandum from Dr. S. Basrur, Chief Medical Officer of Health and Assistant Deputy Minister to all Medical Officers of Health, 2 October 2005, on file.

[86] *Toronto Drug Strategy*, *supra* note 18, recommendation 26 at p. 32.

[87] Strike et al., *supra* note 54.

[88] Personal communication with S. Hopkins, Manager, The Works, 6 July 2006.

[89] See Burris et al., *supra* note 84 at 828–829.

[90] D.A. Calsyn et al., "Needle use practices among intravenous drug users in an area where needle purchase is legal," *AIDS* 5, 2 (1991): 187–93.

[91] R.N. Bluthenthal et al., "Sterile syringe access conditions and variations in HIV risk among drug injectors in three cities," *Addiction* 99, 9 (2004): 1136–1146.

[92] J.D. Rich et al., "High street prices of syringes correlate with strict syringe possession laws," *American Journal of Drug and Alcohol Abuse* 26, 3 (2000): 481–487.

[93] S.R. Friedman et. al., "Laws prohibiting over-the-counter syringe sales to injection drug users: Relations to population density, HIV prevalence and HIV incidence," *American Journal of Public Health* 91, 5 (2001): 791–3.

[94] See *Com v. Landry*, 779 N.E.2d 638 (Mass. Sup. Ct. 2002); *Roe v. City of New York*, 232 F.Supp.2d 240 (S.D. N.Y. 2002).; *Doe v. Bridgeport Police Dept.*, 198 F.R.D. 325 (D. Conn. 2001).

Knowledge, attitudes and perceptions of the law and law enforcement on the part of people who use drugs

Where syringe possession is or may be illegal, numerous qualitative studies report that people who use drugs are reluctant to carry their own syringes due to fear of arrest for violating laws against syringe possession.[95] In an ethnographic study of syringe distribution and exchange practices in Togliatti City, Russian Federation, fear of being stopped or detained by police was found to be one of the factors most commonly mentioned by people who use drugs as influencing the extent to which injection equipment was exchanged or purchased. The researchers noted: "Even if not actually the case, many perceived the syringe exchange projects to be in some way associated with the police. [Some stated]: 'These exchanges should be independent—not controlled by the police.'"[96]

Even where syringe possession is legal and the police support NSP activities, fear of law enforcement leaves some people reluctant to participate in NSPs. After a 1992 change in Connecticut prescription laws that allowed the purchase of up to 10 syringes without a prescription, only 30% of surveyed people who use drugs reported that they regularly carried their own syringes; 65% cited fear of arrest as the main reason why they did not carry their own syringes.[97] Similarly, one third to one half of people who inject drugs in a New York study either thought that carrying a needle was illegal or did not know if carrying a needle was illegal. This remained the case before and after it became legal to purchase syringes from a pharmacy without a prescription.[98]

Reluctance to carry injection equipment has been linked with increased risk of sharing injection equipment and other unsafe injection practices.[99] In particular, Bluthenthal et al. found in two separate studies that people who inject drugs who feared arrest for carrying paraphernalia where its possession was illegal were over one-and-a-half[100] to two times[101] more likely to share syringes than those who were not concerned about arrest.

Law enforcement and crackdowns

Police crackdowns[102] and increased arrests related to drug activity can have the unintended consequence of interfering with NSP access, particularly among marginalized groups. Arrests of NSP clients and volunteers have been shown to reduce NSP attendance, to limit their expansion, and to increase the length of time that

[95] See S. Koester, "Copping, running and paraphernalia laws: Contextual and needle risk behaviour among injection drug users in Denver," *Human Organization* 53 (1994): 287–295; D. Waldorf et al., "Needle sharing, shooting galleries, and AIDS risk among intravenous drug users in San Francisco," *Criminal Justice Policy Review* 3 (1990): 321–343; W. Zule, "Risk and Reciprocity: HIV and the injection drug user," *Journal of Psychoactive Drugs* 24 (1990): 242–249; See also Rhodes et al., *supra* note 22; J.C. Grund, "A candle lit from both ends: the epidemic of HIV infection in Central and Eastern Europe," in K. McElrath (ed.) *HIV and AIDS: A Global View* (Westport, CT: Greenwood Press, 2001), 41–67.

[96] Rhodes et al., Ibid. at 49.

[97] J-P.C. Grund et al. "In Eastern Connecticut, IDUs purchase syringes from pharmacies but don't carry syringes," *JAIDS* 10, 1 (1995): 104–105.

[98] S. Deren et al., "Impact of expanding syringe access in New York on sources of syringes for drug users in Harlem and the Bronx, NYC, USA," *International Journal of Drug Policy* 14, 5–6 (2003): 373–379 at 377.

[99] M. Clatts et al. "The impact of drug paraphernalia laws on HIV risk among people who inject illegal drugs: Implications for public policy," In J.M. Fish, ed., *How to Legalize Drugs* (Northvale, NJ: Jason Aronson, Inc., 1998), pp. 80–101; J-P.C. Grund et al., "Drug use contexts and HIV consequences: The effect of drug policy on patterns of everyday drug use in Rotterdam and the Bronx," *British Journal of Addiction* 92 (1992): 381–392; P. Bourgois, "The moral economies of homeless heroin addicts: confronting ethnography, HIV risk, and everyday violence in San Francisco shooting gallery encampments," *Substance Abuse & Misuse* 33, 11 (1998): 2323–2351.

[100] R.N. Bluthenthal et al. "Collateral Damage in the War on Drugs: HIV Risk Behaviors Among Injection Drug Users," *International Journal of Drug Policy*, 10 (1999): 25–38.

[101] R.N. Bluthenthal et al., "Drug paraphernalia laws and injection-related infectious disease risk among injection drug users," *Journal of Drug Issues*, 29, 1 (1999): 1–16.

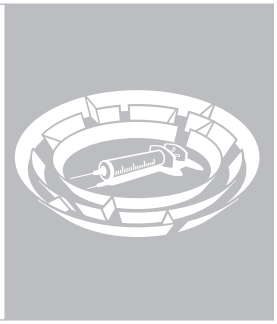
[102] H. Cooper et al. "Characterizing perceived police violence: Implications for public health," *American Journal of Public Health* 94, 7 (2004): 1109–1118 at 1110. (Defining a crackdown as "a centrally organized, rapidly initiated, sustained policing effort[s] to reduce the possession and sale of illegal drugs through heightened surveillance and arrest of drug users and street-level dealers.")

contaminated needles circulated on the street.[103] A number of studies have examined the effects of police drug crackdowns on NSP, of which some are summarized below.

Canada

A quantitative study examined the effects of a police crackdown known as "Operation 24/7" on Vancouver's only fixed-site NSP open at night, which had been initiated by the Vancouver Area Network of Drug Users (VANDU).[104] The operation involved a highly visible police presence on the street corner in front of the small tent where syringes were distributed. Controlling for the effect on syringe distribution of day of the week and day of the month, the study identified a statistically significant 26.7% decline in sterile syringes distributed during four seven-day periods measured during the crackdown. There was no similar decline in the same periods one year prior.[105]

Even where syringe possession is legal and the police support NSP activities, fear of law enforcement leaves some people reluctant to participate in NSPs.



The effects of a broader-scale Vancouver police crackdown known as "Operation Torpedo" on NSPs was the subject of two studies[106] and a Human Rights Watch report.[107] The crackdown, which began in April 2003, was the largest visible enforcement operation ever undertaken in the Vancouver's Downtown Eastside, one of North America's largest open drug markets. Its goal was to maintain a very visible police presence in the area in order to discourage drug-related activity. Reportedly, 50 additional officers were redeployed to the neighbourhood.[108] This crackdown also involved an intensive round of arrests of alleged drug traffickers.[109]

Human Rights Watch reported observations of police misconduct, including excessive force, arbitrary arrest, harassment, and illegal searches, and concluded that "Operation Torpedo" violated fundamental human rights. In addition, the report concluded that the crackdown interfered with NSP functioning. In particular, the authors found that a VANDU-operated NSP, which included the only mobile street-based service in the Downtown Eastside, distributed only two thirds the normal number of syringes in the first days of the

[103] R.N. Bluthenthal et al., "Impact of law enforcement on syringe exchange programs: a look at Oakland and San Francisco," *Medical Anthropology* 18 (1997): 61–83.

[104] E. Wood et al., "The impact of a police presence on access to needle exchange programs," *Journal of Acquired Immune Deficiency* Syndrome 34, 1 (2003): 116–117.

[105] Ibid. at 116.

[106] W. Small et al., "Impacts of intensified police activity on injection drug users: Evidence from an ethnographic investigation," *International Journal of Drug Policy* 17 (2006): 85–95; E. Wood et al., "Displacement of Canada's largest public illicit drug market in response to a police crackdown," *Canadian Medical Association Journal* 170, 10 (2004): 1551–1556.

[107] J. Csete and J. Cohen, "Abusing the user: Police misconduct, harm reduction and HIV/AIDS in Vancouver," *Human Rights Watch* 15, 2b (2003): 1–28.

[108] F. Bula, "50 officers to target downtown drug trade," *Vancouver Sun*, 7 March 2003.

[109] P. Fong and F. Bula, "90 arrested in drug sweep: The first five days of a major campaign has produced hundreds of trafficking charges," *Vancouver Sun*, 12 April 2003. See also Police Board, Vancouver Police Department, Minutes of a regular meeting held on 23 April 2003, cited in E. Wood et al., "Displacement of Canada's largest public illicit drug market in response to a police crackdown," *Canadian Medical Association Journal* 170, 10 (2004): 1551–1556 at note 11.

crackdown.[110] Program volunteers expressed numerous concerns about the effects of the crackdown on NSP operation. For example, they reported that needles were being returned taped together or with dull points, and that people were asking for bleach and packs of matches to sharpen old needles, all of which indicated that syringes were being used more than once.[111] There were also indications that clients were afraid to carry new syringes, leaving them unprepared to inject safely. For example, some individuals took fewer new syringes at once.[112] One client returned unused syringes still in their wrappers to the disposal container. "He just didn't want them on him," a program volunteer stated.[113]

An ethnographic study of the effects of Operation Torpedo also suggests that the crackdown discouraged the use of NSPs, particularly among the most marginalized groups.[114] Qualitative data were collected from interviews and observations conducted during the crackdown and seven months prior to it. A principal finding of the study was that the highly concentrated police presence at the site of the original core of the drug scene resulted in dispersal of drug activities to other parts of the Downtown Eastside and to other areas of the city.[115] Elevated police presence in the core deterred some people from using their customary source of sterile syringes and encouraged lending and borrowing of injection equipment. Some people were displaced to areas where NSPs operated with restricted hours or areas not served by NSPs.[116] Interviewees discussed how police had confiscated or destroyed their needles during police searches and questioning, and explained that being found with syringes led to more problems when scrutinized by police. This led to reluctance to obtain and carry sterile or used syringes.[117] Providers of mobile NSP services reported that clients, particularly those without fixed addresses, were more difficult to locate as they were "spread out all over the city".[118]

A study of Vancouver's oldest and largest fixed-site NSP (known as the DEYAS site, located in the Downtown Eastside) showed no reduction in syringe distribution during Operation Torpedo. The study examined the number of syringes distributed during the three months before and after the crackdown, and found that there were no fewer syringes distributed during the crackdown.[119] However, Operation Torpedo does appear to have resulted in more unsafe disposal or syringes outside the Downtown Eastside. Within the Downtown Eastside, the number of used syringes found on the streets decreased significantly during the three-month period after the crackdown began, and use of public safe-disposal boxes also decreased. Outside the Downtown Eastside, however, researchers found more unsafe syringe disposal and less use of safe–disposal boxes.[120]

The finding that the VANDU NSP showed a reduction in distribution of injection equipment during Operation Torpedo while the DEYAS site did not might relate to the fact that the VANDU NSP served a particularly marginalized population. Wood et al. reported that users of VANDU's peer-run nighttime NSP were more likely to be frequent cocaine injectors, to inject in public, and to require help injecting, all of which are associated with HIV risk in previous studies. There was also evidence that participants involved in the sex trade were more likely to obtain syringes at VANDU's site.[121]

[110] *Supra* note 107 at 19.

[111] Ibid.

[112] Ibid.

[113] Ibid. at 19.

[114] Small et al., *supra* note 106.

[115] Ibid. at 87–89.

[116] Ibid. at 89–90.

[117] Ibid. at 90–91.

[118] Ibid.

[119] Wood et al., *supra* note 109 at 1554.

[120] Ibid.

[121] See Wood et al., *supra* note 22.

Australia

A December 2000 police crackdown in a Melbourne neighbourhood known for its burgeoning drug scene was found to have disrupted NSP access patterns.[122] The crackdown involved the deployment of 18 extra full-time police to the neighbourhood, including its train station. People whom the police judged to be intending to buy or sell drugs were stopped and questioned about their intentions, and if their answers were unsatisfactory they were "put back on the train" or asked to leave.[123] Police also tried to intercept people buying, selling and in possession of illegal drugs, and this effort was intensified with the additional officers deployed to the area. Finally, police presence was itself meant to deter drug activity. During the period of the crackdown, visits to the local NSP decreased by 7%, but 5.4% more needles were distributed compared to the same period the year before. Visits to the NSP decreased by 17% over the month previous to the crackdown, but the number of syringes distributed fell by only 12%. According to the study's authors, the data could support the conclusion that the crackdown reduced both the number of NSP clients and the number of syringes distributed, or that those clients who did use the facility collected more equipment than usual, either to avoid the police or to distribute to users unwilling to visit the site because of heightened police presence.[124]

United States

Police tactics employed during a 2000 New York City crackdown, such as police searches, were found to have discouraged people who use drugs from carrying injection equipment. Constant police surveillance made it more difficult for homeless people to inject safely.[125] A study conducted during a 2001 police crackdown in Philadelphia found a significant reduction in the use of NSPs, especially among African-Americans and men. The operation involved a change in police strategies, from arrests to deterrence and dispersal tactics through the placement of officers on targeted city corners. Staff of a local NSP reported instances of harassment of program clients, and at least one program user was arrested for possession of syringes obtained at the NSP. While police intervention successfully reduced the prevalence of open drug sales on the targeted corners, NSP use declined significantly when measured three, six and nine months following implementation of the crackdown. Use by African-Americans declined at more than twice the rate of use by whites, and use by men declined at or near twice the rate of use by women. By contrast, use the year before remained stable during the same period.[126]

Improving relations with police

Such evidence highlights the need for coordination of law enforcement and measures to enhance the health of people who use drugs through changes in laws, policies, or attitudes and practices of law enforcement agents.[127] However, changes in the behaviour of local police officers may be difficult where national police organizations fail to embrace harm reduction approaches. At their 100th annual conference in Ottawa in 2005, the Canadian Association of Chiefs of Police, whose tag line is "Leading progressive change in policing," adopted a skeptical, even hostile position on harm reduction and NSPs. Among other things, the position states that "harm reduction policies mislead people into thinking they can use drugs 'safely' and 'responsibly', as opposed to encouraging them not to use drugs at all"; that "it is unethical to provide drug

[122] C. Aitken et al., "The impact of a police crackdown on a street drug scene: Evidence from the street," *International Journal of Drug Policy* 13, 3 (2002): 189–198.

[123] Ibid. at 191.

[124] Ibid. at 192.

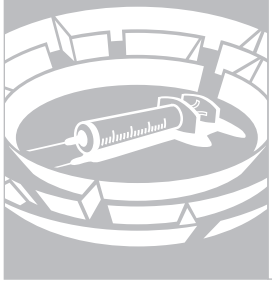
[125] H. Cooper et al., "The impact of a police drug crackdown on drug injectors' ability to practice harm reduction: A qualitative study," *Social Science and Medicine* 61 (2004)5) 673–684.

[126] C.S. Davis et al., "Effects of an intensive street-level police intervention on Syringe Exchange Program use in Philadelphia, PA," *American Journal of Public Health* 95, 2 (2005): 233–234.

[127] Burris et al., *supra* note 72; S. Burris and S.A. Strathdee, "To serve and to protect? Toward a better relationship between drug control policy and public health," *AIDS* 20 (2006): 117–118; R. Midford et al., "Cops, drugs and the community: establishing consultative harm reduction structures in two Western Australian locations," *International Journal of Drug Policy* 13 (2002): 181–188.

addicts with assistance in conducting behaviour that is harmful to themselves, and potentially to others (e.g. needle exchange programs, crack pipe kits etc.)"; and that "implementing harm reduction policies sends a message to drug addicts that society has given up on them, choosing to maintain their addiction in order to 'reduce the harm', as opposed to pursuing treatment and rehabilitation options."[128] Despite a wide body of scientific literature indicating that NSPs do not encourage drug use, reduce rates of transmission of blood-borne pathogens, and facilitate access to care, treatment and support services,[129] only two police chiefs opposed the adoption of the resolution.[130]

A study by Beletzky et al. indicates the challenge at the local level: qualitative interviews with police officers in Rhode Island following decriminalization of syringe purchase and possession revealed that only half of respondents knew that the law had been changed.[131] In addition, regardless of their knowledge of the law, all but one officer reported that they invariably seized and destroyed injection equipment of people suspected of using illegal drugs, even if no arrest was made.[132] Most officers also viewed possession of a syringe as "probable cause" justifying a search for illegal drugs.[133] (The study did not indicate how police came to learn about the possession of syringes in the first place). The authors cautioned that "policy changes unaccompanied by efforts to secure police co-operation through training, management changes, and monitoring are unlikely to succeed to the desired degree."[134]



Although reports of arrests and charges for possession of syringes alone **are rare, some police officers have reportedly seized syringes from program** participants.

In practice, NSPs in Canada rely on "working agreements" with varying degrees of formality in their efforts to protect providers and clients from legal consequences of their NSP-related activities, and in order to ensure that police activities do not interfere with NSP access.[135] In Ontario, NSPs must demonstrate that the local police service has agreed to support, or at least not interfere with, NSP activities in order to qualify for funding from the provincial Ministry of Health.[136] In most other provinces and territories, however, NSPs independently seek to foster smooth relations with police with varying degrees of success. Some NSPs have worked toward better coordination of their activities with law enforcement by including police representatives on advisory

[128] Canadian Association of Chiefs of Police, Resolutions adopted at the 100th annual conference. August 2005, Ottawa, Ontario, resolution #10-2005 at 34.

[129] See *supra* note 8-11.

[130] Personal communication with P. Lavigne, Harm Reduction Project Officer, City of Ottawa, 4 July, 2006.

[131] L. Beletzky et al., "Attitudes of police officers toward syringe access, occupational needle-sticks, and drug use: A qualitative study of one city police department in the United States," *International Journal of Drug Policy* 16 (2005): 267.

[132] Ibid. at 269.

[133] Ibid. at 270.

[134] Ibid. at 272.

[135] BC Partners for Mental Health and Additions Information, *State of the knowledge: Needle Exchange Programs*, 2003. Available via www.heretohelp.bc.ca/publications/stateofknowledge/index.html.

[136] C.J. Strike et al., "Finding a place for needle exchange programs," *Critical Public Health* 14, 3 (2004): 261–275 at 265.

committees for the establishment of NSP.[137] However, this strategy may not always be successful. Police representatives must be willing and in a position to educate and advocate for harm reduction within police services to ensure that law enforcement does not act as a barrier to access to NSPs.

The reliance on working agreements to ensure the harmonious operation of law enforcement and harm reduction raises a number of difficulties. Relationships between police and NSPs can break down despite these agreements, or where police and NSP staff disagree about what exactly they have agreed to. In 2005, when the City of Ottawa announced plans to distribute safer crack use kits (in addition to injection equipment, which had long been part of the city's harm reduction programs), the Ottawa police chief opposed the move and threatened that criminal charges could follow. In a showdown with the city's medical officer of health, the police chief argued that the scientific evidence was insufficient to support the distribution of inhalation equipment and that its distribution encouraged drug use.[138] In the media and to city council, community AIDS groups voiced their support for the medical officer of health's harm reduction policy to prevent the spread of HIV and hepatitis C.[139] The police chief finally withdrew his opposition when the city agreed not to distribute safer crack use kits to people under the age of 18. The compromise was not ideal from public health and human rights perspectives, because a minor who is addicted to crack would remain at greater risk of contracting HIV or hepatitis C than those 18 and over who have access to the program.[140] Moreover, the confrontation reportedly soured relations between Ottawa police and the city's harm reduction programs, and increased arrests and harassment of NSP clients.[141] Similarly, police officials in Halifax expressed concern that their city's NSP was supporting drug use when it began distributing safer crack use kits in early 2005.[142]

In addition, because working agreements can be informal, police and NSPs might not share a common understanding of the content of those agreements; even where there is a common understanding, police practices may not always be consistent with the agreements. Although reports of arrests and charges for possession of syringes alone are rare, some police officers have reportedly seized syringes from program participants.[143] Reports of police officers smashing crack pipes are common across the country.[144] In Ottawa, where relations between police and NSPs are particularly strained due to the crack pipe controversy, NSP clients have been charged for possession of inhalation equipment obtained from NSPs, even though the legal basis for such charges is highly dubious.[145]

In Montréal, relations with police are often similarly strained. Tacit agreements between the police and CACTUS-Montréal did not prevent police from parking outside the NSP for long periods of time and even entering the building. According to CACTUS-Montréal's executive director, the increased police presence around the NSP formed part of a general push on the part of the police to target marginalized and street-involved people as a response to community pressures.[146]

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[137] Personal communication with MacKinnon, supra note 41; Personal communication with Walsh, supra note 56. Personal communication with Fairburn, *supra* note 56; Personal communication with Taylor, supra note 64. Personal communication with J. Luce, Director of Prevention Services, AIDS Committee of London, 30 June 2006.

[138] C. Weeks, "Council keeps crack pipe program: Bevan's protests go up in smoke after showdown with health officer," *The Ottawa Citizen* 22 April 2005.

[139] See Canadian AIDS Society and Canadian HIV/AIDS Legal Network, Media Release: Safe crack kits important for health of drug users: AIDS Groups, 31 March 2005. Available via www.aidslaw.ca

[140] Crack pipe program survives review, *CBC News,* 6 June 2005.

[141] Personal communication with Lavigne, *supra* note 130.

[142] Personal communication with D. Bailey, Director, Mainline Nova Scotia, 11 January 2007.

[143] Ibid.; Personal communication with Taylor, supra note 64.

[144] E.g., T. Appleby, "New police strategy designed to blanket high-violence areas," *Globe and Mail*, Feb 13, 2006. See also Canadian HIV/AIDS Legal Network, "Letter to Toronto Police Chief William Blair re: Report of police destroying crack pipes", Toronto, 13 February, 2006. (available via www.aidslaw.ca/drugpolicy.)

[145] Personal communication with Lavigne, *supra* note 130.

[146] Personal communication with M. Tonnelier, Executive Director, CACTUS-Montréal, 24 July 2006.

Judicially created barriers: conditions of release

Probation, parole, and bail conditions may include a requirement that an offender not engage in a number of activities that might affect his or her access to NSP. For example, people may be prohibited from entering a particular area of the city, known as a "red zone" or a "no-go zone." These tend to be areas where drugs can be obtained. They also tend to be the areas where NSPs operate. Conditions of release might also include requirements not to be in possession of drug paraphernalia. In St. Catharines, Ontario, for example, a number of NSP clients reportedly had conditions of release placed on them that included no-go zones and prohibitions on possession of drug paraphernalia. Police informed these clients that they would be in breach of these conditions even if they were found in possession of sterile, unused syringes.[147]

In *R. v. Reid,* the Provincial Court of British Columbia refused to impose a red-zone condition prohibiting the accused from entering Victoria's downtown, in part because it would hinder his access to necessary health services. Judge Gove summarized the testimony of an NSP worker at the sentencing hearing:

> Her evidence was that a significant number of The Needle Exchange [*sic*] clients are subject to the "red zone" condition and frequently tell her that they have to enter the "red zone" because most of the services that they need are there. They run in and out of The Needle Exchange in the middle of the "red zone" saying that they have been "red zoned" and cannot hang around. They feel that they either have to breach the "red zone", not get the services that they need or move to another city.[148]

Although one bail supervisor and probation officer at the trial testified that he had given permission to a number of individuals to enter the "red zone" to use its NSP, the NSP worker thought it was unlikely that most people would admit to using the service to their probation officer because it would indicate that they were using illegal drugs.[149]

Suboptimal program design

Needle and syringe programs are not always designed to maximize access for those who would use the programs. Although there are relatively few studies that examine program design factors,[150] restricted hours, site locations, limits on numbers of syringes distributed, and age restrictions have been identified as potential barriers to NSP access. The only Canadian study that comprehensively addresses program design barriers to access is a 2002 Vancouver study in which Wood et al. asked subjects who had used injection drugs in the previous six months whether they had difficulty getting to sterile injection equipment when they needed it, and if so, why.[151] Similar studies outside Canada, however, have identified many of the same barriers as the Vancouver study, and are discussed in this section.

Operating hours

The most frequently cited reason for difficult access to syringes in the Vancouver study was that the fixed-site needle program was closed when respondents needed clean syringes.[152] In that study, respondents were classified into three groups, depending on how they acquired most of their needles. Of the 69 participants who

[147] Personal communication with R. Thompson, StreetWorks Coordinator, AIDS Niagara, 18 November 2005.

[148] [1999] B.C.J. No. 1603 (B.C. Prov. Ct.) at 27–28.

[149] Ibid. at 29.

[150] Burris et al., *supra* note 84 at 862. A.H. Kral and R.N. Bluthenthal, "What is it about needle and syringe programmes that make them effective for preventing HIV transmission?" *International Journal of Drug Policy* 14 (2003): 361–363.

[151] Wood et al., *supra* note 23.

[152] Ibid. at 99.

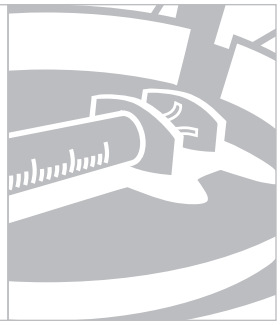
acquired most of their needles from a fixed-site NSP and reported difficulty obtaining syringes, 49 (71%) cited the NSP being closed as a reason for having difficulty accessing clean syringes.[153]

The authors considered that restricted hours may have been a function of community concerns or funding limitations:

> One way to appease community concerns has been to offer restricted hours of service. The operating hours of the Downtown Eastside's large fixed site exchange were from 8:00 a.m. to 8:00 p.m. during the study period. Although it may be perceived that these hours help to prevent drug users coming into the area of the exchange during the evening, the present study identified restricted operating hours as a primary reason for difficulty accessing needles among all groups, even when the exchange vans continue to operate. Similarly, funding limitations may also force exchanges to provide only limited hours of operation. In Vancouver, during the emergence of the HIV epidemic, budgetary restrictions resulted in limiting the services of the mobile exchange vans.[154]

In a comparable study in Sydney, Australia, Treloar and Cao asked people who use drugs but never or infrequently used NSPs to comment on a list of 16 perceived barriers to access to NSPs.[155] Operating hours were the second most frequently reported perceived barrier in that study, with 57% of infrequent NSP users reporting operating hours as a barrier to access.[156]

[R]estricted operating hours act as a barrier to access to services across Canada.



Consistent with these two studies, interviews with key informants for this project indicate that restricted operating hours act as a barrier to access to services across Canada. Particularly outside major urban centres, NSP service after hours is rare. Needle and syringe programs in Prince Edward Island, the Northwest Territories, Manitoba and New Brunswick are open only during weekday business hours. In other parts of Canada, evening services are sometimes available some evenings a week, but only in major urban centres. For example, in Whitehorse a van distributes syringes only two nights a week.[157] Newfoundland and Labrador's only NSP is open weekdays from 8 a.m. to 4 p.m. and on Thursday evenings.[158]

Location and coverage

Inadequate NSP coverage is likely be a critical determinant of syringe sharing.[159] In most countries, including Canada, NSPs tend to be established in large cities where people who use drugs are most highly concentrated.

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[153] Ibid.

[154] Ibid.

[155] Treloar and Cao, "Barriers to use of Needle and Syringe Programmes in a high drug area of Sydney, New South Wales," *International Journal of Drug Policy* 16 (2005): 308–315

[156] Ibid. at 310.

[157] Personal communication with C. Hemsley, Communicable Disease Officer, Yukon Health and Social services, 20 June 2006.

[158] Personal communication with Walsh, *supra* note 56.

[159] See S.A. Strathdee and D. Vlahov, "The effectiveness of needle exchange programs: A review of the science and policy," *AIDScience* 16, 1 (2001): 1–33.

Both the Vancouver and Sydney studies were conducted in high drug-use areas in cities, and even within those cities, distance from NSPs was cited as an important barrier. In Vancouver, Wood et al. found that people frequently cited missing the mobile syringe-distribution van and being out of the area where NSPs operate as reasons for difficult access to clean needles.[160] The authors observed, even in the study's urban setting, that "[g]iven the concentration of the NEP's services [in the Downtown Eastside, with limited services available in neighbouring areas and municipalities], it is not surprising that being away from locations where needle exchange is available was associated with difficulty accessing needles."[161] In Treloar's and Cao's Sydney study, NSPs being too far away was the most commonly cited barrier to access to syringe programs among infrequent NSP.[162] A New York City study similarly found that people who lived closer to NSPs were more likely to use them and less likely to share needles.[163]

There is a lack of scientific research in Canada on the extent to which distance from NSPs hinders access among people who live outside urban settings. However, there is evidence that illegal drug use takes place throughout urban and rural areas in Canada,[164] and that people who use drugs are unlikely to travel far for the sole purpose of obtaining clean injection equipment.[165] A report conducted through a Nova Scotia NSP revealed that substantial numbers of people who use drugs existed in small towns in rural communities in southern and southwestern Nova Scotia. Interviews conducted for the report revealed that participants had limited access to harm reduction services and little awareness of the risks of sharing drug equipment other than needles and syringes.[166]

Where the resources exist, many programs deliver equipment for free to people who live away from fixed sites. However, there are practical limits to how far program staff can travel. Secondary distribution (i.e., through intermediaries who obtain syringes from NSP sites) can also be used to overcome location barriers. However, NSPs in Prince Edward Island[167] and various northwestern Ontario communities[168] have reported difficulty finding an intermediary to meet clients who are unable to reach a fixed site.[169] Secondary distributors need to have the resources, both financial and personal, to travel between communities where they live and cities where NSPs are located. In addition, in some cases police have interfered, arrested, stopped, harassed or taken syringes away from secondary distributors.[170]

Distribution of needles and syringes through pharmacies and through health clinics could arguably alleviate concerns about reaching people living outside urban centres. Indeed, in some places in Canada, such as the Northwest Territories and the Yukon, needles and syringes can only be obtained at health clinics, the offices of regional public health authorities (known in Canada as "public health units") and pharmacies.[171] But people who use drugs in small communities may be reluctant to ask for syringes at pharmacies, health

[160] See *supra* note 23.

[161] Ibid. at 100.

[162] *Supra* note 155.

[163] R. Rockwell et al., "Geographic proximity, policy and utilization of syringe exchange programmes," *AIDS Care* 11, 4 (1999): 437–442.

[164] Wood et al., *supra* note 23 at 100.

[165] S. Hutchinson et al., "Factors associated with injecting risk behaviour among serial community-wide samples of injecting drug users in Glasgow 1990–1994: Implications for control and prevention of blood-borne viruses," *Addiction* 95 (2000), 931–940; Rockwell et al., *supra* note 163.

[166] Mainline Needle Exchange, *Unsafe and safer practices among injection drug users in DHA 1, 2, 3*, 2005.

[167] Personal communication with MacKinnon, *supra* note 41.

[168] Northwestern Health Unit, *Program Evaluation Report,* 2005, on file.

[169] Ibid. at 9.

[170] Human Rights Watch, *Injecting Reason: Human rights and HIV prevention for injecting drug users — California: A case study.* September 2003.

[171] Personal communication with White, *supra* note 47; personal communication with Hemsley, *supra* note 157.

clinics, and public health units where they are well known.[172] Even under conditions of anonymity, people may be uncomfortable requesting syringes in pharmacies and in health clinics. Moreover, as discussed below, pharmacists' refusal to sell syringes is a frequently cited barrier to access to clean needles. Finally, a specialized NSP or a community agency that offers various services for people who use drugs may be better at attracting some clients and building relationships with them. This may explain why, for example, nearly 90% of syringes distributed through Quebec's NSPs are distributed through 69 community agencies, despite the fact that free injection equipment can be obtained at over 200 local health clinics, over 200 pharmacies, and 40 hospitals.[173]

Treloar and Cao reported that among non-NSP users surveyed, 46.1% reported that they did not use NSPs because they did not know about them.[174] Similarly, 22% of the respondents in a study on pharmacy syringe acquisition in Anchorage, Alaska reported not obtaining syringes at pharmacies out of "lack of appropriate skills and knowledge," which included not only being too embarrassed to ask a pharmacist but also "not knowing that they could."[175] Two years after New York State law was amended to provide for pharmacy sales of syringes without a prescription, only half of the people who inject drugs who participated in a study were aware that they could purchase syringes in pharmacies, and knowledge of other modes of acquisition from other legal sources was not widespread.[176]

The lack of awareness of NSPs may be related in part to a desire on the part of some programs to "keep a low profile" in order to avoid community opposition. It can also be traced to funding concerns: NSPs may not have the money to promote their services, or may not wish to promote their services if they do not have the capacity to serve more clients. For example, the AIDS Committee of Newfoundland and Labrador (ACNL) secured funding for its NSP for the first time in 2005. In 2003, before it received its funding, 180 syringes were distributed. After a provincial needs assessment was conducted and provincial funding was given for ACNL to promote the service, distribution rose to 5604 in 2005.[177]

One-for-one exchange and distribution caps

There is debate among NSP operators, politicians, program funders, and community members about whether to impose restrictions on the number of syringes that can be distributed to any one program user per visit. In other words, there is disagreement over whether programs ought to operate with strict one-for-one exchange policies, caps on the number of syringes distributed per visit, need-based distribution, or some combination thereof.[178] Stricter exchange policies may result in fewer contaminated needles being discarded in public places.[179] They may also bring marginalized people who use drugs into more regular contact with NSP personnel who may be the only health service providers they meet.[180] However, such polices may be problematic, especially for frequent injectors such as cocaine injectors, who tend to require multiple injections

[172] D.G. Fisher et al., "Injection drug users' use of pharmacies for purchasing needles in Anchorage, Alaska," *International Journal of Drug Policy* 14 (2000): 381–387; Personal communication with White, Ibid.

[173] *Supra* note 48.

[174] *Supra* note 155 at 310.

[175] Fisher et al., *supra* note 172 at 385.

[176] Deren et al., *supra* note 98 at 377.

[177] Personal communication with Walsh, *supra* note 56.

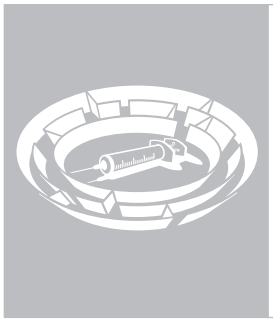
[178] See S. Bray et al., "Doffing the cap: Increasing syringe availability by law but not in practice, Connecticut, 1999," *International Journal of Drug Policy* 12, 3 (2001): 221–235; A.H. Kral et al., "Injection risk behaviour among clients of syringe exchange programs with different syringe dispensation policies," *JAIDS* 37, 2 (2004): 1307–1312.

[179] Spittal et al. state, however: "While it is plausible that distribution programmes that are note exchange-based could lead to more discarded needles in the community, we know of no study demonstrating this to be the case." P.M. Spittal et al., "How otherwise dedicated AIDS prevention workers came to support state-sponsored shortage of clean syringes in Vancouver, Canada," *International Journal of Drug Policy* 15 (2003): 36–35 at 42.

[180] Ibid. at 38.

in a short period of time, in contrast to those who consistently inject heroin and generally require two to four daily injections to avoid withdrawal symptoms[181]

Strict one-for-one syringe dispensation policies tend to lead to more reuse of syringes, though quantitative studies conducted to date have not definitively answered whether they result in more sharing. Kral et al. compared rates of sharing and reuse of injection equipment among clients of 23 California NSPs with different syringe dispensation policies — one-for-one exchange policies, "one-for-one-plus" policies (under which clients are given a few more syringes than they turn in), and unlimited distribution policies.[182] The researchers found that clients of programs requiring one-for-one exchange were more likely to reuse injection equipment than those with a "one-for-one plus" policy or an unlimited distribution policy. However, there was no reported difference in syringe-sharing rates among all groups.[183]



The rationale underlying one-for-one policies is that they will help ensure that used syringes are discarded safely.

Respondents in the 2002 Vancouver study by Wood et al. did not cite distribution restrictions as a barrier to NSP access. This is not surprising as NSPs in Vancouver had moved toward unlimited distribution policies by the time of the study. However, an earlier ethnographic study by Spittal et al. revealed that when NSP dispensation policies required one-for-one exchange, there was demand for injection equipment when users did not have any to exchange; as a result, sterile syringes were being denied to those who needed them.[184] Although the one-for-one policy was formally in place, NSP staff, recognizing that there are various legitimate reasons why a client might not have any equipment to return, developed a system to distribute syringes when clients did not have any to return. Staff and clients referred to equipment distributed to clients who did not have any to exchange as "loaners," presumably to underscore that the client was expected to return them. Program staff retained discretion whether to distribute "loaners," and clients who were well known to NSP staff and trusted by them might receive an increase in the number of "loaners" that they permitted. Despite the official one-for-one dispensation policy, 5–10% of syringes distributed to clients were distributed as "loaners." Spittal et al. observed, however, that because the "loaner" system was subjective and based on established relationships, it did not respond to the needs of new injectors or those new to the community. The greatest deficiency in the "loaning" system, however, according to Spittal and colleagues, appeared to be the "severe constraints that agents feel are placed upon them by the programme . . . It was clear that agents felt compelled to limit 'loaners' to below 10% of their totals."[185] People who inject more frequently (such as cocaine injectors) have been found to be more likely to borrow needles from other people,[186] which could mean a need for easier access to higher numbers of needles. Spittal et al. explained:

[181] M.W. Tyndall et al., "Intensive injection cocaine use as the primary risk factor in the Vancouver HIV-1 epidemic," *AIDS* 17, 6 (2003): 887–892.

[182] Kral et al., *supra* note 178.

[183] Ibid. at 1311–1312.

[184] Spittal et al., *supra* note 179.

[185] Ibid. at 42.

[186] S.A. Strathdee et al., "Social determinants predict needle sharing behaviour among drug users in Vancouver, Canada," *Addiction* 92, 1 (1997): 1339–1347; E. Wood et al., "Factors associated with persistent high risk syringe sharing in the presence of an established needle exchange program," *AIDS* 16, 6 (2002): 941–943.

> Injectable cocaine and heroin addictions are characterized by the urgent need to inject frequently on a cocaine binge, and to inject immediately in case of severe heroin withdrawal . . . Essentially, the current [one-for-one] exchange policy has ensured that there will continue to be a shortage of sterile injection equipment on the streets of Vancouver. Exchange agents became part of a punitive system that immediately sets up adversarial relationships between exchange agents and clients, rather than allowing them to spend their time building productive relationships with their target populations or engaging in service that responds to client need.[187]

The rationale underlying one-for-one policies is that they will help ensure that used syringes are discarded safely. These authors question whether it is worthwhile, in public health terms, to link issues of access and distribution to issues of recovery if one-for-one policies lead to increased transmission of blood-borne pathogens overall.[188] In other words, the public health harm of such a restrictive approach may outweigh the intended benefits of requiring people to return syringes in order to obtain new ones, particularly when there are other ways of ensuring safe disposal, such as ensuring availability of sharps containers.

Some NSPs also place a cap on the number of syringes that can be distributed per visit, regardless of how many the client has brought in for exchange.[189] In Hawaii, NSP began in 1990 with a one-for-one exchange policy and a cap of three syringes per visit. The cap was increased to 25 in 1993, and removed altogether in 1996. The one-for-one exchange policy was maintained throughout. Clients of the Hawaiian NSPs shared injection equipment less frequently as the cap was increased and then removed. HIV prevalence rates also declined.[190] In contrast, a study by Heimer et al. in Hartford, Connecticut, found that raising the cap on syringe distribution — first from 5 to 10 and then from 10 to30 — did not affect injection-related risk.[191] The authors posited this may have been because staff members were reluctant to adopt the new policy, or because people in Hartford might have had difficulty collecting many syringes for exchange.[192] These authors further suggested that merely increasing the cap and making more syringes available may be insufficient where there are other barriers to access, including police harassment, a lack of other services to enhance NSP effectiveness (such as counselling and information), and the structure and operation of the program,[193] including the one-for-one exchange requirement.

Needle and syringe programs in Canada for the most part no longer have strict one-for-one exchange policies and do not have strict caps. Indeed, Ontario's best practice recommendations describes one-for-one exchange policies as "outdated," directing NSPs to distribute sufficient equipment to allow clients to achieve the ideal public health objective of using a new sterile syringe for each injection.[194] In British Columbia, needle recovery is no longer tracked, in an effort to shift from an "exchange" to a "distribution" model.[195]

However, even though no programs in Canada reported *rigid* adherence to one-for-one exchange policies, many NSPs in Canada continue to see it as their role to *encourage* clients to return their injection equipment

[187] Spittal et al., *supra* note 179 at 42–43.

[188] Ibid. at 43.

[189] See ibid. at 37; Kral and Bluthenthal, *supra* note 150.

[190] R.L. Vogt et al., "Hawaii's statewide syringe exchange program," *American Journal of Public Health* 88 (1998): 1403–1404.

[191] R. Heimer et al., "Effects of increasing syringes availability on syringe exchange use of HIV risk Connecticut 1990–2001," *Journal of Urban Health* 79, 4 (2002): 556–570.

[192] Bluthenthal et al., *supra* note 91at 1144.

[193] Heimer et al., *supra* note 191 at 568–569.

[194] *Supra* note 54 at 78.

[195] Personal communication with Mooney, *supra* note 56.

for safe disposal via the NSP.[196] This is a laudable objective, as long as encouragement is done in ways that do not compromise the primary goal of ensuring the use of new, sterile equipment for each injection. However, there remains a concern that, depending on the nature and extent of encouragement, insufficient needles may be distributed. For example, some program guidelines continue to allow staff the discretion to impose caps on the number of syringes distributed to clients who regularly fail to return used syringes.[197] Needle exchange protocols in P.E.I. recommend that a maximum of five syringes be provided to a client who has no used ones available for exchange.[198] Bulk distribution should be particularly encouraged where clients are distributing syringes among those who do not have ready access to NSP. As the Ontario best practice recommendations state: "Providing clients with the number of needles they request is more likely to achieve the goal of reducing transmission of bloodborne pathogens and meet the recommendation for a new sterile needle for each injection."[199]

Age restrictions

In Canada, NSPs do not tend to have specific policies limiting the age of program clients. However, provincial laws require service providers to inform provincial children's aid services where there is reason to believe a child is in need of protection.[200] Service providers tend to treat evidence of injection drug use as warranting reporting under such provincial laws. NSP staff in Ontario and Alberta have indicated that youth uptake of services is small as a result.[201]

In some cases, however, age restrictions in connection with harm reduction have been imposed as a matter of policy. As discussed above, in Ottawa, safer crack use kits are not to be distributed to people under 18 years old. This policy results from a compromise negotiated between public health officials and the Ottawa police chief in 2005, after they clashed over the introduction of the kits in the city's harm reduction program. The city's medical officer of health, who had pushed for the introduction of safer crack use kits in response to sharply rising HCV rates,[202] reluctantly agreed to the police chief's demand to enforce the age restriction. A City of Ottawa harm reduction officer expressed concern that the age limit creates an additional barrier to services for youth.[203]

There is no public health rationale for denying sterile injection equipment to people based on their age. Needle and syringe programs are equally effective at preventing the transmission of blood-borne pathogens among younger people, and the evidence indicates that NSPs do not promote drug use among adolescents.[204] As David Roy has stated, "it would be unwise and ethically dubious to [deny access to] a needle exchange programme

[196] Personal communication with Fairburn, supra note 56; *PEI needle exchange protocol guidelines*, on file, (stating "every attempt is made to exchange the same number of used needles/syringes for new needles/syringes" and "[i]t should be explained to the patient that used needles/syringes are expected to be returned under the provisions of the program and that they are expected to bring in their used needles/syringes at the time of their next exchange.") Personal communication with A. Sherstobitoff, ANKORS, Harm Reduction/Mobile Needle Exchange Coordinator, 17 January 2007.

[197] *PEI needle exchange protocol guidelines*, Ibid.

[198] Ibid.

[199] *Supra* note 54 at 78.

[200] See, e.g., *Ontario's Child and Family Services Act*, R.S.O. 1990, c, C-11, s. 72(1).

[201] Personal communication with Lavigne, *supra* note 130. Personal Communication with Luce, *supra* note 137.

[202] D. Tencer, "Hep-C called 'runaway' problem among city's illegal drug users: medical officer defends expanded paraphernalia plan". Ottawa Citizen, 09 Oct 2004.

[203] Personal communication with Lavigne, *supra* note 130.

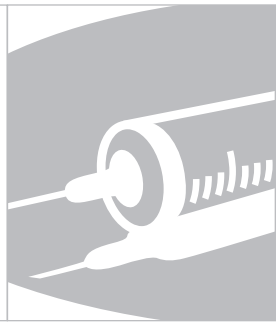
[204] Marx et al., *supra* note 11.

when this is the immediately needed protective intervention."[205] Moreover, young people have an equal right to access to tools for prevention of disease and other health services, making this a matter of human rights.[206]

Setting and atmosphere

People may not participate in NSPs if they find the setting and atmosphere of facilities unappealing or stigmatizing. In 2002, Strike et al. interviewed staff and managers of all NSPs in Ontario, as well as all government officials, as part of an ethnographic study. They found that "clients are said to be hesitant to attend fixed sites at public health units because these locations are perceived to be too 'clinical' and/or too governmental'."[207] Further, NSPs based in AIDS service organizations were sometimes perceived as "too 'gay-oriented' or HIV-related."[208] In light of these barriers, Strike et al. reported, three NSPs located in public health units relocated their fixed sites closer to the core drug-using areas of the city or changed the physical layout of fixed sites (e.g., created a separate entrance) to increase access for clients and reduce interaction with agency staff and clients of other parts of the health unit. However, care must be taken to ensure that such measures reflect best human rights practices, since they risk creating further stigma and limiting access to care by separating NSP clients from other clients of community service organizations. Nonetheless, it is important that services be provided in facilities that people who use drugs feel comfortable using.

Inappropriate attitudes and practices on the part of pharmacists, whether **directed at all people who use drugs or only some groups, can stigmatize** clientele and discourage acquisition.



Being refused syringes or treated poorly at pharmacies

Some pharmacists refuse to sell syringes to people whom they suspect of injecting illegal drugs. In one Vancouver study, being refused syringes at pharmacies was common among people who used drugs regardless of their primary source of injection equipment (e.g., fixed-site NSP, NSP van, or pharmacy). Among people who sought sterile injection equipment primarily from pharmacies, being refused syringes was the main barrier cited,[209] meaning their source was not a reliable one. Inappropriate attitudes and practices on the part of pharmacists, whether directed at all people who use drugs or only some groups, can stigmatize clientele and discourage acquisition.[210] A study in New York, San Francisco and Dayton, Ohio found that 12% of pharmacists refused to sell syringes to African-Americans.[211] On the other hand, surveys of pharmacists

[205] D. Roy, "Access to sterile needles for young people under the age of 14: an ethical analysis," *Canadian HIV/AIDS Policy & Law Newsletter* 2,3 (1996): 4.

[206] Convention on the Rights of the Child, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989) Article 24 (f). ICESCR, *supra* note 26 art. 12; UN Committee on the Rights of the Child, General Comment 3: HIV/AIDS and the Rights of the Child: CRC/GC/2003/ (2003).

[207] C.J. Strike et al., "Needle exchange programs: delivery and access issues," *Canadian Journal of Public Health* 93,5 (2002): 339–343.

[208] Ibid.

[209] Wood et al., *supra* note 23 at 100.

[210] A.A. Gleghorn et al., "Pharmacists' attitudes about pharmacy sale of needles/syringes and needle exchange programs in a city without needle/syringe prescription laws," *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* 18, 1 (1998): S89–S93.

[211] P. Lurie et al., *supra* note 55.

in Canada and England have suggested that pharmacists could, with adequate training and support, play an important public health role by providing NSPs and related services.[212]

In Canada, pharmacy sales are legal, and professional regulatory bodies have encouraged pharmacists to sell syringes openly.[213] Nonetheless, pharmacists generally retain discretion regarding whether to sell syringes and whether to display them openly or behind the counter. The policy of the Ontario College of Pharmacists for example, is that "the placement of needles and syringes and their sale is left to the professional judgment of the pharmacist. Although the college has encouraged pharmacists to sell syringes to anyone requesting them, the matter is left to the professional judgment of the individual pharmacist."[214] Quebec has a program whereby pharmacies, especially those in less urban areas, act as NSP sites and display a logo to indicate that the pharmacy provides injection equipment for sale or distribution.[215]

There are reports from across Canada of pharmacists refusing to sell syringes to people who use drugs. In Newfoundland and Labrador, for example, some pharmacists have begun requiring prescriptions for needle purchases.[216] The Ontario College of Pharmacists has reported that "the sale of syringes by pharmacists continues to be a contentious issue for the pharmacy profession. Complaints concerning the way customers have been treated when requesting such products continue to be brought forth."[217]

Failure to meet program clients' preferences regarding mode of distribution

A number of studies suggest that having several means of providing syringes may contribute to the goals of sterile syringe programs. The design and implementation of needle and syringe programs should be tailored to local needs,[218] and multiple sources of syringes may maximize the access of people who inject drugs to clean injection equipment.[219] Equipment can be distributed through fixed-site programs, from mobile units, in pharmacies, or in vending machines (although in Canada injection equipment is not distributed through vending machines).[220] Programs can be peer-run, government-administered or administered by a community-based organization. Sometimes people who use drugs will obtain needles through secondary distribution (i.e., the practice of NSP clients distributing injection equipment to other people who use drugs).[221]

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[212] J. Sheridan et al., "Pharmacy-based needle exchange (PBNX) schemes in Southeast England: A survey of service providers," *Addiction* 95 (2000): 1551–1560; T. Myers et al., "Community pharmacist perspectives on HIV/AIDS and interventions for injection drug users in Canada," *AIDS Care* 10, 6 (1998) 689–700.

[213] Myers et al., ibid. at 691 ("at the time of this study, three of ten provincial pharmacy regulatory bodies encouraged the open display of needles and syringes to allow for customer self-selection.")

[214] Ontario College of Pharmacists, "Close-up on complaints—committee decisions—syringes" (1995) available via www.ocpinfo.com.

[215] Myers et al., *supra* note 212.

[216] Personal communication with Walsh, *supra* note 56.

[217] Ontario College of Pharmacists, *supra* note 214.

[218] Bastos and Strathdee, *supra* note 12.

[219] See W.T. Ciaffa et al., "Practices surrounding syringe acquisition and disposal: Effects of syringe exchange programmes from different Brazilian regions: The AjUDE-Brasil II project," *International Journal of Drug Policy* 14, 5/6 (2003): 365–371 at 369. (Noting that even in settings with minimal barriers to NSP access, pharmacies remain an important source of sterile syringes.); Lurie et al., *supra* note 55.

[220] For a description of some different types of NSP, see D.C. Des Jarlais, "Structural interventions to reduce HIV transmission among injecting drug users," *AIDS* 14, 1 (2000): S41–S46.

[221] M.W. Tyndall et al., "Satellite needle distribution among injection drug users: policy and practice in two Canadian cities," *JAIDS* 31, 1 (2002): 98–105; J-P.C. Grund et al., "Reaching the unreached: Targeting hidden IDU populations with clean needles via known user groups," *Journal of Psychoactive Drugs* 24, 1 (1992): 41–47; J.D. Rich et al., "Strategies to improve access to sterile syringes for injection drug users," *AIDS Readers* 12, 12 (2002): 527–535; T.W. Valente et al., "Satellite exchange in the Baltimore needle exchange program," *Public Health Reports* 113, S1 (1998): 90–96.

Different needle distribution methods presumably reach different subpopulations. For example, fixed-site NSPs tend to attract an older, male, white, urban group with longer injecting histories.[222] A study of 18–30-year-old people who use drugs in Chicago revealed that very few of them were using the fixed-site needle and syringe program: almost two thirds reported not having used an NSP in the previous six months; and only 13% reported attending an NSP more than once a month on average.[223]

Pharmacies tend to attract a different demographic group than fixed-site programs. In an Anchorage, Alaska study, women, higher-frequency injectors, and higher-income earners were more likely to use pharmacies, as were opioid (as compared to cocaine) injectors.[224] African-Americans were less likely to attempt pharmacy syringe purchase than whites and Native Americans,[225] which is consistent with prior studies in the United States.[226] In Australia, demographic characteristics including age and sex were comparable for people who obtained needles at NSPs and pharmacies, but respondents using NSPs had a higher-risk profile than those who used pharmacies, meaning that they were more likely to have been imprisoned in the previous year, were more frequent injectors, and had injected outdoors more frequently in the previous month.[227] Unlike in Anchorage, pharmacy users were more likely to inject amphetamines.[228] People who purchased syringes in pharmacies in Vancouver were found to have a lower-risk profile than clients at fixed-site or mobile units.[229] In New York, pharmacies were found more likely to be used by those who were younger and those who were white.[230]

Vancouver's peer-run, nighttime NSP was found to reach the highest-risk drug-using population, and was found to be an important addition to existing city-sanctioned daytime NSPs. As discussed, a study in 2003 showed that difficulty obtaining syringes was strongly associated with syringe sharing, and was attributable to the restricted hours of the sanctioned NSP.[231] Due to the difficulty of obtaining syringes at night in Vancouver, VANDU initiated a program of exchanging syringes from a tent in the heart of the city's open drug scene during hours when the fixed-site NSP was closed. The VANDU NSP, unlike the daytime NSPs in the city, had a more flexible trading policy that enabled users to obtain up to 10 "loaners" even if they had no syringes to exchange. When the operators of the city-run program began to question the value of the VANDU site, Wood et al. conducted a study to evaluate the risk profile of the population served by the VANDU NSP and to examine factors associated with acquiring syringes from the VANDU site. They determined that cocaine injection, injecting in public, and requiring help injecting were all associated with obtaining syringes from VANDU's site. Each of these factors had been associated with HIV risk in previous studies.[232] In addition, use of the VANDU site was associated with safe syringe disposal, despite the fact that public drug use and frequent cocaine injection had been associated with unsafe syringe disposal in previous studies.[233] The

[222] K. Khoshnood et al., "'Dropouts' or 'Drop-ins'? Client retention and participation in New Haven's needle exchange program," *Public Health Reports* 110, 462–466; J. D. Rich. et al., "Obstacles to needle exchange participation in Rhode Island, *JAIDS* 21 (1999): 396–400; Treloar and Cao, *supra* note 155 at 309.

[223] S.L. Bailey et al., "The use of needle exchange by young injection drug users," *JAIDS* 34, 1 (2003): 67–70.

[224] Fisher et al, *supra* note 172.

[225] Ibid. at 384–385.

[226] See M. Singer et al., "Changing the environment of AIDS risk: Findings on syringe exchange and pharmacy sale of syringes in Hartford, CT," *Medical Anthropology* 18, 1 (1997): 107–130. (Finding that African Americans and Latinos less likely than whites to use pharmacies.)

[227] H.-H. Thein et al., "Injecting behaviour of injecting drug users at needle and syringe programmes and pharmacies in Australia," *International Journal of Drug Policy* 14, 5 (2003): 425–430.

[228] Ibid. at 427.

[229] C.L. Miller et al., "Risk-taking behaviors among injecting drug users who obtain syringes from pharmacies, fixed sites, and mobile van needle exchanges," *Journal of Urban Health* 79, 2 (2002): 257–265.

[230] Deren et al., *supra* note 98.

[231] Wood et al. (2003), *supra* note 22.

[232] Ibid.

[233] Ibid.

researchers therefore concluded that VANDU, by providing a peer-run, nighttime NSP, was performing a critical function by reaching a specific vulnerable population.

Similarly, a Baltimore study found that a van-based NSP and pharmacy-based NSPs attracted different clienteles.[234] Both offered one-for-one exchange services and were open for similar hours. Riley et al. assessed the differences between first-time participants of each program and found that those who used the van-based NSP were less likely to be African-American, but were more likely to be cocaine injectors, to inject more frequently, and to use needles that had already been used by someone else. The authors concluded that NSPs ought to be diversified in order to meet the various needs of people who inject drugs.[235]

Another Baltimore study examined the extent to which secondary distributors (people who acquire sterile syringes from NSPs or other sources and redistribute them to other people who inject drugs) contribute to NSP effectiveness.[236] Although secondary distributors accounted for only 10% of clients of Baltimore's NSP, they accounted for more than 64% of needles distributed by the NSP. These results indicated that secondary distributors could be expressly targeted with prevention messages and encouraged to bring those messages to the wider community of people who use drugs.

The Sacramento Area Needle Exchange (SANE), an illegal program in which people who have access to an NSP distribute injection equipment to other people who use drugs, was found to serve a more remote clientele and to reach a greater proportion of women than other NSPs.[237] In California, where SANE operated, a doctor's prescription was required to purchase and possess syringes unless a local governing body were to declare a state of emergency and authorize an NSP. At the time of a study by Anderson and colleagues, SANE operated without any such legislative authorization. SANE staff recruited and trained designated needle and syringe distributors who served geographically, economically, professionally or medically defined networks. The program was designed to be able to cover a large geographic region at a lower cost than would be required to establish large numbers of fixed-site NSPs or sufficient mobile service. This approach also presumably reduced the risk that NSP clients would interact with police by having designated distributors deliver the majority of services to clients' locations rather than having clients travel to a fixed site or mobile unit. Finally, it also provided syringes to clients who may not have wanted to or could not use fixed-site programs.

There is some direct evidence that offering more than one mode of syringe acquisition may improve access to clean needles and syringes. In 2003, Fisher et al. found that people who were given the option (under the research project's design) of obtaining syringes from pharmacies, NSPs, or "unsafe sources" such as the street were more likely to get needles from known sterile sources than those who were permitted to use pharmacies and unsafe sources only.[238] They concluded:

> when both pharmacies and [NSPs] are available, some individuals will purchase [needles and syringes] at pharmacies, some will exchange [needles and syringes] at [NSPs], some will do both, and still others will do neither. This study provides the strongest evidence to date that both pharmacies and needle exchanges are needed simultaneously, if the goal is to provide sterile [needles and syringes] to [people who inject drugs].[239]

Of course, each mode of distribution can give rise its own set of concerns. For example, while secondary distribution may extend coverage to the broader community, its recipients typically do not receive the other

[234] E.D. Riley et al., "Comparing new participants of a mobile versus a pharmacy-based needle exchange program," *JAIDS* 24, 1 (2000) 57-61.

[235] Ibid. at 60.

[236] T.W. Valente et al., "Satellite exchange in the Baltimore needle exchange program," *Public Health Reports* 113, S1 (1998): 90–96.

[237] R. Anderson et al., "Delivery syringe exchange through 'satellite exchangers': the Sacramento Area Needle Exchange, USA," *International Journal of Drug Policy* 14 (2003): 461–463.

[238] Fisher et al., *supra* note 172 at 385–6.

[239] Ibid. at 386.

services often found at NSPs, like counselling and referrals to drug treatment programs.[240] Similar concerns could be expressed regarding syringe vending machines.

Stigma and Privacy Concerns

In Treloar's and Cao's 2003 study in Sydney, Australia, concerns about stigma and maintaining anonymity were reported as a barrier to NSP access by two thirds of both groups in the study — those who had ever and those who had never used NSPs. It was the only barrier reported by both groups.[241] Stigma was cited as a major access barrier in the Rhode Island.[242] In Baltimore, people who preferred to obtain syringes from secondary distributors expressed that privacy was one reason for their preference.[243]

A Human Rights Watch report on California quotes an NSP program coordinator speaking of an affluent friend who "somehow can't bring herself" to use the service: "There are injectors in very affluent places in this country. I know one, and she won't come and exchange. We are friends, we work together, and . . . she says 'I can't.' She shares."[244]

There has been no comprehensive study identifying the extent to which stigma and privacy concerns interfere with NSP access in Canada. However, numerous key informants for this project identified it as a major concern, particularly in more remote communities where anonymity is especially difficult to preserve. In Saskatchewan and the Northwest Territories, for example, some individuals have reported that informal secondary exchange is preferred in instances where anonymity is important, such as in small, rural communities where people do not want to be identified as a person who uses drugs by requesting sterile injection equipment or being seen with sharps containers in a health centre in their home community.[245] A needs assessment conducted for a Halifax NSP reported that "many people in the south and southwestern regions of Nova Scotia were very paranoid and feared the community finding out that they were addicts for a number of valid reasons: school-age children, social services, [police]. . ."[246] Clients of an NSP in Nelson, British Columbia have declined to use NSPs for fear that that physicians may cut off legal prescriptions if they learn that the clients are injecting those prescription drugs, contrary to their physician's instructions.[247]

Community resistance, including municipal restrictions

Community attitudes and resistance can make it difficult to establish new NSPs and to expand existing ones. Because people who use drugs and people living with HIV tend to be stigmatized,[248] it can be difficult to maintain support for health services for them, particularly where there are perceived threats to the community. As is the case with many harm reduction measures, community members may believe erroneously that NSPs increase drug use, or may fear that the program will result in increased neighbourhood crime.[249]

In Canada, NSPs have faced difficulties finding a place in communities. Strike's and colleagues' study of NSPs in Ontario reported that each time a new NSP was proposed, proponents had to contend with

[240] Valente et al, *supra* note 221.

[241] *Supra* note 155 at 312.

[242] Rich et al., *supra* note 221.

[243] Voytek et al., *supra* note 221 at 466.

[244] Human Rights Watch, *supra* note 170 at 46.

[245] Personal communication with S. Fairburn, 5 January 2007; personal communication with White, *supra* note 47.

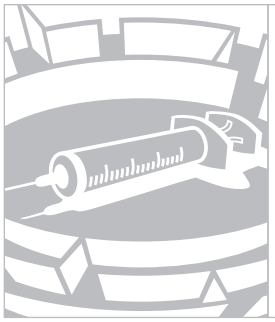
[246] Mainline Needle Exchange Provincial Needs Assessment (2002) on file.

[247] Personal communication with Sherstobitoff, *supra* note 196.

[248] See Strike et al., *supra* note 136 at 262.

[249] See *supra* notes 9–11.

community opposition or skepticism.[250] These authors interviewed coordinators, managers, and workers at all of Ontario's NSPs in order to "explore how [NSP] establish, define and defend their existence within their home communities."[251] They concluded that community stigmatization directed toward NSPs and their clients, and Nimbyism — the "not in my back yard" sentiment — impeded the establishment and functioning of such programs. At initial planning stages, oral and written complaints were made to politicians, public health authorities and newspapers, in which residents portrayed NSPs as a public health hazard. Almost all the programs studied reported having been held accountable for improperly discarded needles in their communities, even though needles might have been improperly discarded before programs were established. Community opponents relied on statistics that there was less than a 100% recovery rate by NSPs to argue inaccurately that NSPs were failing to achieve their public health goal.[252] Some community members expressed concern that NSPs draw drug users and sex trade workers to the neighbourhood. In some instances, residents verbally harassed staff and hit NSP outreach vans with their fists.[253]



Concerns about community opposition have led some NSPs to keep a low **profile; they perceive that a confrontational attitude may increase the visibility of the organization and the potential for opposition . . .**

Zoning laws have been used by city councils to prevent the establishment, maintenance, and functioning of NSPs. In Tacoma, Washington, the joint city/county health department had to sue the city to establish NSPs.[254] In a similar Canadian example, a British Columbia NSP was able to move premises only after a successful lawsuit. The city council in Whalley, British Columbia had "made no secret of its desire to disperse social services out of Whalley as a means of making the area less attractive to drug users and homeless persons."[255] The Surrey HIV/AIDS Centre Society, which operated a non-profit clinic providing an NSP and HIV/AIDS support services, was denied a building permit for construction on the new site when it sought to move to premises a few doors away. The city refused to grant the permit on the ground that the Society was not operating with the correct license, and the Society sought judicial review of this decision.[256] The legal issue in the case was whether the Society could hold a medical office business license, or whether it was required to obtain a community service business license. Under a new bylaw, promulgated within a month before the Society sought its building permit, those seeking community service business licenses, unlike medical office licenses, had to submit a community impact statement as part of the application.

[250] *Supra* note 54.

[251] Ibid. at 263.

[252] Ibid. at 266.

[253] Ibid.

[254] S. G. Sherman and D. Purchase, "Point defiance: A case study of the United States' first public needle exchange in Tacoma, Washington," *International Journal of Drug Policy* 12, 1 (2000): 45–57.

[255] G. Bellett, "Judge approves HIV/AIDS clinic's move in Whalley," *Vancouver Sun*, 17 February, 2006.

[256] *Surrey HIV AIDS Centre Society v. City of Surrey and Murray Dinwoodie*. Supreme Court of British Columbia, 15 February 2006, Vancouver, Docket L052209; G. Betteridge, "B.C. Court gives go-ahead to non-profit needle exchange and drop-in." *HIV/AIDS Policy and Law Review* 11, 2/3 (2006): 41.

The executive director of the Surrey North Community Health Centre within which the Society operated said that obtaining community approval for controversial social programs would be "impossible."[257] He said that "[e]veryone would agree that they are needed, but not in their backyard."[258] The British Columbia Supreme Court found that the Society was providing medical services and therefore could qualify for a medical service business license, which, unlike a community service organization, did not require a community impact statement. It also held that the Health Centre could not be refused a medical service business license simply on the basis that it was a non-profit society.[259] By classifying the Health Centre as a medical business, the Court avoided answering the question of whether it was lawful for the municipality to require businesses classified as community service organizations to submit community impact statements.

Similarly, CACTUS-Montréal, a community-based NSP, was nearly prevented from moving to its new premises because of community opposition and zoning bylaws targeting community organizations. Since its inception in 1989, CACTUS-Montréal's NSP had been operating from cramped conditions near a bus station. The program sought to move to a site near a health clinic in a high-traffic area that would allow for greater anonymity. By June 2004, CACTUS and the Montréal borough of Ville-Marie had agreed on the ideal site, and CACTUS had secured the federal funding needed for the move. Public consultations by CACTUS revealed little opposition to the plan.

Nonetheless, in August 2004, borough Councillor Robert Laramée cancelled the move, stating that area residents and business owners had contacted him voicing concerns about the project.[260] The Université du Québec à Montréal (UQÀM) had also reportedly expressed an interest in the space and was pressuring the municipality.[261] By December of the same year, a further obstacle to the move was created by the passage of a municipal bylaw that would require community organizations serving marginalized populations to go through a community approval process in order to build or move to new facilities. After a period of significant political tension and uncertainty around the issue, and under a newly elected municipal government, a public hearing was held to discuss the move. Representatives from the police and UQÀM attended. The new municipal government finally approved the move shortly after the meeting.[262]

Concerns about community opposition have led some NSPs to keep a low profile; they perceive that a confrontational attitude may increase the visibility of the organization and the potential for opposition, and that it may be impossible for them to change community attitudes.[263] In order to cope with community opposition, one NSP in Ontario moved its fixed site to another location that it believed was less accessible to clients.[264] Another negotiated a compromise with the local community that required mobile units to maintain a certain distance from schools and daycare centres when delivering services.[265] (Despite observing the rule, workers reported objection by community members when the van stopped at a red light near forbidden stopping places.) As discussed earlier, in order to appease the police chief, the Ottawa NSP agreed not to distribute safer crack use kits to people under 18.

One way of managing political opposition is to try to bring community members on board. Public opinion regarding NSPs has been found to be very malleable. Responses to public opinion polls on NSPs have been

[257] Bellett, *supra* note 255.

[258] Ibid.

[259] *Surrey HIV AIDS Centre Society*, *supra* note 256.

[260] T. Lindeman, "Needling exchange: Cactus and the borough accuse each other of endangering the community organization's future," *Montreal Mirror*, 10–16 March 2005.

[261] Ibid.

[262] Personal communication with Tonnelier, *supra* note 146.

[263] Strike et al., *supra* note 54 at 267.

[264] Ibid. at 268.

[265] Ibid.

shown to be particularly sensitive to the wording of the questions. In 14 different polls conducted from 1987 to 2000, support for NSPs ranged from 29% to 66%. Polls conducted by public health organizations indicated more support than polls conducted by organizations with a "family values perspective," and polls that referred to clients as "drug addicts" were less likely to garner support than those that avoided loaded terms or provided health information to respondents.[266]

A number of different strategies to foster community support for NSPs were discussed in the study by Strike et al.:

- In a model that is common across the country, community-based NSP founding committees were established in Ontario in order to gather support for programs early. They often included cautiously supportive members and on occasion included vocal opponents such as police officers, members of religious groups or drug abstinence advocates. Many of those who initially opposed NSPs eventually came to support them through these interactions.[267]

- Administering NSPs through public health units under the supervision of the Chief Medical Officer of Health was seen as another strategic manoeuvre because the Minister of Health is likely to be viewed as a responsible public figure.[268]

- NSP workers have also tried to challenge pervasive stigma against people who use drugs and discuss their entitlement to receive health care services in presentations made to media, community members, and parent organizations in order to change attitudes.[269] For example, during community presentations, one worker might ask his audience:

  > How many of you drink three or four times a week? How many of you are hung-over right now? How many of you smoke? How many of you have a coffee in front of you right now?

- Workers also reminded audience members that drug addiction may not always be a choice, and that they or those close to them might be in a position to require harm reduction services.

- Within organizations that provide harm reduction services among other kinds of services, additional efforts have been used to change workers' perceptions of people who use drugs as unworthy clients. For example, where occasional thefts are blamed on NSP clients, workers might normalize theft by pointing out that it occurs in all workplaces, not just NSPs, and pointing out that all workplaces require appropriate security measures. The intention is to shift responsibility for security from the client to the staff.[270]

Others have suggested that NSPs' provision of ancillary services, such as HIV testing and counselling, referrals to health and drug treatment, condom distribution, and health education, may help gain community support.[271]

Insufficient funding

Budgetary issues prevent NSPs from meeting demand in terms of both coverage and service design. In the United States, where federal funding of NSPs remains illegal, limited funding is a serious constraint to optimal

[266] J.S. Vernick et al., "Public opinion about syringe exchange programmes in the USA: An analysis of national surveys," *International Journal of Drug Policy* 14 (2003): 431–435.

[267] Strike et al., *supra* note 54 at 265.

[268] Ibid. at 265.

[269] Ibid. at 269–270.

[270] Ibid. at 270.

[271] Bastos and Strathdee, *supra* note 12; Lurie et al. supra note 55.

service delivery in many settings.[272] There are no such statutory limits on funding NSPs in Canada. As discussed earlier in this paper, governments in Canada generally endorse NSPs, and most NSPs are fully or partially publicly funded. Nonetheless, funding issues often prevent NSPs in Canada from being as effective as they could be.

Most key informants interviewed for this project, especially those working in community-based organizations, indicated that more funding would enable them to operate longer hours, provide some or more mobile services, and provide the full complement of safe injection equipment, including sterile water and cookers.

NSPs are not covered by the *Canada Health Act*,[273] which requires the provinces to meet certain criteria in order to receive federal funding for health care expenditures through the Canada Health and Social Transfer. One such criterion is that provincial health insurance plans be "comprehensive" — but under this Act this simply means that such plans must cover all medically necessary *hospital* and *physician* services,[274] and NSPs are not generally considered either.

In the final report of the Commission on the Future of Health Care in Canada (known as "the Romanow Report") it was recommended that the principle of comprehensiveness under the *Canada Health Act* be expanded to recognize changing definitions of health and health care. Noting that "many [health] services can now be provided outside hospitals and by professionals other than physicians", the Romanow Report suggested:

> [C]omprehensiveness should be retained as a principle, not so much as a description of existing coverage under the *Canada Health Act* but as a continuing goal. It should be redefined to mean that, as financial resources permit and as the health care system changes, the definition of comprehensiveness (and of services insured under provincial plans) should continue to evolve to improve the continuum of care. Immediate changes should be made to expand insured services to include medically necessary diagnostic and home care services. In the longer term, the principle of comprehensiveness should be revisited and updated periodically.[275]

The definition of hospital services under the current Act includes those services geared toward disease prevention.[276] However, there is no principled basis for limiting publicly insured disease-prevention services under the *Canada Health Act* solely to those provided in hospitals or by physicians, particularly as services that help prevent the spread of infectious diseases such as HIV and HCV also help prevent greater pressures on hospital and physician services.

The federal government does occasionally provide project-based funding directly to NSPs, for example through the Public Health Agency of Canada's HCV initiatives.[277] Some funding for harm reduction flows through Canada' Drug Strategy. However, despite the stated aim of Canada's Drug Strategy to "ensure that Canadians can live in a society free of the harms associated with problematic drug use"[278], only $10 million (or 2.6%) of the $368 million spent by the federal government in 2004-2005 to address illicit drugs was directed to harm reduction measures.[279]

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[272] P. Lurie and E. Drucker, "An opportunity lost: HIV infections associated with lack of a national needle exchange programme in the USA," *Lancet* 349, 9052 (1997): 604–608.

[273] R.S.C. 1985, c. C-6.

[274] Ibid. at s.9.

[275] Commission on the Future of Health Care in Canada, *Building on Values: the Future of Health Care in Canada,* 2002 at 62.

[276] Canada Health Act, *supra* note 273, s. 2.

[277] See e.g., www.phac-aspc.gc.ca/hepc/hepatitis_c/funded_projects/0304.htm.

[278] Government of Canada, *Canada's drug strategy: What is it?* in Government of Canada, *supra* note 15.

[279] DeBeck et al., "Canada's renewed drug strategy – an evidence-based review," *HIV/AIDS Policy and Law Review* 2, 3 (2006): 1– 11 at 8.

Thus, under the current system, provinces and territories establish or fund NSPs at their discretion, with few or no incentives from the federal government. Any funding provided through the province or territory would come from each provincial or territorial budget, generally without federal subsidy.

The funding model varies among Canada's provinces and territories. Most have some kind of regional public health authority through which NSPs are established and/or funded. In Quebec, Ontario, British Columbia, Manitoba, the Northwest Territories, and the Yukon, each regional health authority receives a lump-sum budget from the provincial or territorial ministry of health, a portion of which may be allocated to syringe programs depending on the agreement struck between the provincial/territorial and regional authorities. In Saskatchewan and Nova Scotia, some of the provincial funding provided to regional health authorities is expressly earmarked for NSPs. Any supplemental funding must come from the general budgets of regional health authorities.[280] Alberta has a joint community/federal/provincial initiative called the Alberta Community HIV Fund that provides ongoing and project funding to community-based organizations, including for NSPs.[281] Additional funding and supplies, including for NSPs, must be obtained through regional health authorities. Some smaller provinces fund NSPs directly from the general budget of their ministry of health.[282]

The extent to which the provinces exercise control over services offered — and, in particular, the extent to which they encourage or require that NSPs be made available —also varies. In Ontario, ministerial guidelines specifically require local health units to consider whether NSPs are required in the region and if so, to direct funding toward them.[283] However, there is no clear enforcement mechanism to ensure compliance with the guidelines, other than a requirement to report on their implementation, and some regional health authorities continue not to offer NSPs. In most other provinces there is no such legal requirement; regional or provincial health authorities may decide to establish NSPs and pay for them out of their general budget, and decisions to create or expand programs depend on the extent to which local units see a need.

Strike et al. have observed that the practice of funding NSPs through local health authorities may actually result in insufficient NSP support. Despite Ontario's guidelines, some people working within organizations that provide NSPs continue to view them as "non-core" or "marginal" services that are "outside the agency mandate". Strike et al. report: "While many medical and executive directors support [NSPs], they often face internal opposition to the programs because of fears that diversion of funds to the [NSP] will threaten the viability of other programs perceived to be more important to the organization."[284] Strike et al. also reported concerns on the part of people working within organizations that provide NSPs that such programs serve "undesirable" clients.[285] This kind of reluctance at the level of individual institutions to provide NSPs is further evidence of the way in which stigma operates as a barrier to NSPs, in this case indirectly by influencing funding levels. Specially designated funds for NSPs may make more sense if the services remain stigmatized and therefore likely to be marginalized when it comes to funding decisions made at the regional, local or institutional level.

Many NSPs rely on *ad hoc* or project-based funding from provincial and federal sources. In northern Ontario, eight NSP sites were established in four communities under provincial government direction and with federal project funding from the Public Health Agency of Canada's Hepatitis C Disease Prevention, Community-based Support and Research Program. These sites were established in pharmacies, community-based organizations

[280] Personal communication with Fairburn, *supra* note 56. Personal communication with Bailey, *supra* note 42; Personal communication with D. Mombourquette, Public Health Services, Capital Health, Nova Scotia 15 March 2003.

[281] Personal communication with L. Findlay, Project Manager, Population Health Strategies, Alberta Health and Wellness 5 June 2006.

[282] E.g., New Brunswick (personal communication with J. Le Blanc, Media Relations Coordinator, Health Department, New Brunswick, 6 March 2006), PEI (which receives only free equipment but no funds; personal communication with MacKinnon, *supra* note 41), Newfoundland and Labrador (personal communication with Walsh, *supra* note 56).

[283] See *supra* note 42.

[284] Strike et al., *supra* note 136 at *269*.

[285] Ibid. at 268.

and health clinics. Despite the earmarked federal funding, one health unit identified conflicting time pressures for public health nurses as a challenge,[286] indicating a shortage of resources. Another community reported that lack of financial support led to frustration from neighbouring communities with an identified need whose clients had to travel long distances.[287] Restricted hours, another barrier identified, can also be attributed to insufficient funding.[288]

[286] *Supra* note 168 at 9.

[287] Ibid. at 9.

[288] Ibid.

Conclusion and recommendations

Needle and syringe programs are backed by an overwhelming volume of public health literature and, in principle, benefit from widespread support among health policy-makers. Nonetheless, in Canada, the goal of ensuring that new, sterile injection equipment is used for every injection remains distant.

Evidence from this report reveals that lack of information about whether and how demand for sterile syringes are being met significantly impedes progress toward ensuring access to sterile injection equipment for everyone who needs it. There is little reliable information about the number of people across Canada who use drugs and about which programs are available to serve them. Needs assessments for possible expansion of NSPs are not conducted systematically. Particularly in provinces where NSPs are newer, there are few opportunities for sharing best practices.

Furthermore, the law casts a shadow of criminality over participation in NSPs, despite the fact that they are government-supported health interventions. Provisions in the *Controlled Drugs and Substances Act* and the *Criminal Code* continue to prohibit the possession of used injection equipment, and have been incorrectly interpreted to prohibit possession of some sterile injection equipment, such as cookers and filters, and of safer crack use kits. Police activities that impede access to sterile syringes put the health and lives of people who use drugs at risk and reinforce negative community attitudes without reducing problems associated with drug use and without improving community safety.

Numerous other problems, including funding concerns and difficulty finding appropriate sites for programs, can be traced in some way to community stigmatization of programs associated with drug use and with HIV. In addition, programs may not designed in ways that meet the needs of people who use drugs if members of communities of people who use drugs are not meaningfully involved in the planning and delivery of those services.[289] These barriers are compounded by government failures to adequately fund NSPs.

International human rights law requires Canada to take positive steps to prevent and control epidemic diseases, including HIV/AIDS. This means that Canada must not only refrain from maintaining laws and policies that interfere with people's access to harm reduction measures for disease prevention, but it must work to eliminate existing barriers. Where community attitudes conflict with proven public health approaches, and where the health and dignity of Canadians are at stake, governments must act to change those attitudes.

NSP coverage and funding

- Provincial and territorial governments need to identify explicitly that NSPs are necessary services in every health region. Where they do not already do so, provinces and territories should require that each region regularly assess whether such programs are needed. People who use drugs should be involved in the design of these needs assessments. Enforcement mechanisms are also needed to ensure that needs assessments are in fact conducted and that where services are needed, geographically accessible NSPs are established without undue delay, keeping in mind that NSPs may operate in different ways.

- Stable funding must be guaranteed to all NSPs. Provincial and territorial governments must adequately fund NSPs directly, or, if service decisions are devolved to regional health authorities, must ensure that local pressures do not leave NSPs without sufficient funds. Provinces and territories could make up for shortfalls in funding allocated at the regional level or could legislatively require that public health units adequately fund harm reduction programs including NSPs. Provinces and territories should require public

[289] See R. Jürgens, *"Nothing About Us Without US: Great, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical and Human Rights Imperative*, Canadian HIV/AIDS Legal Network, 2005.

reporting of needs assessments and funding allocation decisions related to those needs assessments, and create effective enforcement measures so that programs or program clients could challenge local failures to provide adequate funding.

- The federal government should expand the Canada Health and Social Transfer to make federal health care funding available not only for hospital and physician services but also health protection and promotion services, including NSPs.
- Federal government funding earmarked for AIDS and HCV and Canada's Drug Strategy should be used to support harm reduction services, including NSPs.

[L]ack of information about whether and how demand for sterile syringes are **being met significantly impedes progress toward ensuring access to sterile** injection equipment for everyone who needs it.

Law and law enforcement

- The definition of a controlled substance in s. 2 of the *Controlled Drugs and Substances Act* should be amended so that it no longer includes items with trace amounts of drugs on them.
- The paraphernalia law in s. 462.2 of the *Criminal Code* should be repealed to ensure that policy-makers, police, NSP staff and NSP clients do not perceive any restrictions from the criminal law on the range of harm reduction equipment that can be distributed.
- Law enforcement and health policy branches of government should ensure that the enforcement of drug laws does not interfere with health policy. Clear, formal policies should be put in place throughout Canada to ensure that police activities not to interfere with NSP effectiveness.
- The Canadian Association of Chiefs of Police should reconsider their stated opposition to harm reduction and should adopt a resolution to encourage police forces to police in ways that do not interfere with harm reduction services.
- Judges should not impose bail, parole or probation conditions that prevent access to harm reduction services. In particular, they should not impose restrictions on carrying drug paraphernalia or designate areas where harm reduction services are offered as "no-go zones."

Program design

- NSPs should have regular, funded opportunities to develop and share best practices.
- Best practices should be determined in genuine consultation with communities of people who inject drugs.

- Programs should be designed with the primary goal of maximizing access to sterile injection equipment. There should be no limits, formal or informal, on the quantity of equipment distributed, types of equipment that can be distributed and the age of clients.
- Sterile injection equipment should be made available from as wide a variety of sources as possible and in conformity with the needs of the local population as determined through regular needs assessments and in consultation with people who use drugs.
- Governments, associations of pharmacists, and pharmacists should work together to ensure that sterile injection equipment is easily accessible in pharmacies.

Stigma and community resistance

- Public health departments should create public education campaigns to reduce stigma associated with NSPs.
- Zoning laws should not be used to create hurdles, such as community approval requirements, for the establishment of NSPs.

These actions should form part of a coordinated Canadian strategy to maximize access to harm reduction services and equipment in wide consultation with people who inject drugs. The public health literature has long been clear that the best way to reduce the spread of HIV/AIDS and hepatitis C among people who inject drugs is to ensure that there is no reason to use non-sterile injection equipment. Canadian governments have in the past expressed their commitment to harm reduction, including NSP, as part of sound public health policy. It is time for all Canadian governments to act on that commitment to ensure the health and dignity of all Canadians.