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Improving the Health of People Who Inject Drugs Through COVID-19–Related Policies

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The COVID-19 pandemic, with its multiplicative harms, has wreaked havoc across the world: illness, pain, death, supply shortages, unemployment, school interruptions, and more. However, this pandemic also ushered in new societal norms and health policies that present opportunities to improve the quality of life for those who survive the pandemic. For example, thematic qualitative analyses revealed that some people report positive changes resulting from COVID-19–related policies, such as increased access to work-from-home options and improvements to health literacy.[1]

In addition, the COVID-19 pandemic created local public health states of emergencies, which allowed for the creation of legislation that sought to increase access to prevention, harm reduction, and treatment programs,[2-4] all of which can improve the health of people who inject drugs (PWID). Harm reduction centers, even throughout the pandemic, continue to offer much more than sterile syringes. Many programs provide on-site wound care treatment, counseling, housing supports, food, and access or referrals to buprenorphine or methadone.[5] Thus, the precedents set by COVID-19 policies provide an opportunity to create sustained programmatic and policy-level success for the fields of harm reduction and public health.

The health of PWID is at an important juncture that necessitates evidence-based interventions, as drug overdose death rates are at an all-time high.[6] Simultaneously, injection-related bloodborne infections such as HIV are on the rise.[7,8] As a result, the fields of harm reduction and health care must promote and use evidence-based policies and practices to ensure the health and engagement of PWID. Decades of evidence demonstrate that syringe service programs (SSPs) limit harms and promote health, through preventing transmission of viral infections such as HIV and hepatitis C, abscesses, skin and soft-tissue infections, and endocarditis, and provide other health benefits.[9,10] To this end, more than 450 SSPs in the United States self-report to the North American Syringe Exchange Network.[11]

We assert that harm reduction programs and strategies must include steady and ample access to sterile syringes and equipment to meet the needs of PWID, who should have access to a sterile, new syringe for each injection. As recommended by the Centers for Disease Control and Prevention, needs-based strategies operate through supplying people with the number of syringes they state they need for a period of time.[12] This need is based on many factors, including the frequency of one's drug use, one's social network, and financial or transportation concerns.[13] Thus, 89% of SSPs in the United States surveyed by the 2019 Dave Purchase Memorial survey permitted more than simply one-for-one exchange, which requires 1 used syringe to be exchanged for access to 1 new sterile syringe.[14]

However, in many parts of the United States, this cost-effective and efficacious infection prevention intervention is either unavailable or inefficient because of restrictive policies that are not based on evidence.[11,15-17] Some localities still use the antiquated one-for-one exchange scheme.[11,18] In addition, some local or state regulators further limit syringe access or efficiency by requiring local law enforcement approval, zoning restrictions, or direct limits on syringe dispensing.[19] The 2014-2015 HIV and hepatitis C virus epidemics in Scott County, Indiana, provide a historical example of how such barriers (eg, imposing limited operational hours for SSP locations) interfere with programmatic success and positive outcomes for PWID.[20]

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Recent examples of limitations on syringe services have had a detrimental effect on potential positive outcomes. Take into consideration West Virginia, where a restrictive licensure process for harm reduction programs went into effect in July 2021. This regulation (ie, Senate Bill 334) stipulated that all SSPs have a goal of one-for-one syringe exchange.[21] While the one-for-one model is not exactly mandated, programs that have achieved licensure are not giving out syringes on a needs-based manner as they were before the current regulation passed.[21] For example, to meet the one-to-one goal, programs may weigh syringes brought in by program clients to estimate how many syringes that participant can have in return.[18] Many harm reduction advocates argue this bill was based on the notable one-for-one program in Charleston, West Virginia, where participants were given 30 syringes at a time.[22-24] However, this program is the only SSP in the United States that uses barcoded stickers attached to syringes with industrial adhesive that track back to individual participants. Ultimately, many participants never return to the program.[25] These statewide limitations have serious consequences. In Kanawha County, West Virginia, a concerning rise in new HIV cases was primarily among PWID who lacked access to sterile syringes.[26]

In addition, in Maine, the governor issued Executive Order 27 in March 2020, at the beginning of the COVID-19 pandemic.[27] This policy change allowed for expansion of mobile SSPs, mail delivery of drug equipment, increased geographic reach from a single exact street location to county-level certification at all hours, and also eliminated the one-for-one exchange stipulation. These temporary changes, particularly the elimination of the one-for-one exchange, increased access to harm reduction services for people statewide.[28] In Maine, with support from many local and national harm reduction advocates, a new rule exists that allows up to 100 syringes per client if they do not have syringes to exchange.[29] Under the precedent of COVID-19–related policies, Maine is now inching toward harm reduction policies that are evidence based and effective, although more work needs to be done to truly meet the needs of PWID. For example, legislation focused on community drug-checking programs or access to safe supply is currently being advocated for as well.[30,31]

With record levels of injection drug use–associated infections such as acute hepatitis C virus infection and rising rates of serious infections such as infective endocarditis, the relaxation of policies is critically important. Without mail delivery or needs-based programs, people living in rural areas such as Maine and West Virginia often have to travel long distances to access services, sometimes reporting traveling 100 miles round trip.[28] If people are unable to routinely access sterile syringes because of restrictive policies, they are often forced to make the difficult decision to reuse their equipment and are subsequently at risk for infectious complications.[32,33] Particularly when COVID-19 hospitalizations surge and hospitals are at capacity and short-staffed, minimizing hospitalizations for injection drug use–associated complications should be a priority.

Policy makers must take into consideration the layered epidemics of HIV, hepatitis C, overdose, and now COVID-19 when making evidence-based policies to address these intertwined health issues. With new variants only worsening the prevalence of COVID-19 infection, evidence-based syringe service provision must be enacted to improve the health and well-being of PWID.[34] Moving forward, it is imperative that, as a medical and public health community, we support advocacy efforts to improve the health and safety of PWID as well as expanded federal support for SSPs and other harm reduction services.

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