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Pharmacy Access to Syringes among Injecting Drug Users: Follow-Up Findings from Hartford, Connecticut

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SYNOPSIS

Objective. To break the link between drug use and the human immunodeficiency virus (HIV), in 1992 the state of Connecticut rescinded a 14-year ban on pharmacy sales of syringes without a physician's prescription. In 1993, the Centers for Disease Control and Prevention (CDC) evaluated the impact of the new legislation on access to syringes among injecting drug users (IDUs) and found an initial pattern of expanded access. However, it also found that some pharmacies, after negative experiences with IDU customers, reverted to requiring a prescription. This chapter reports findings from a four-year follow-up study of current IDU access to over-the-counter (OTC) pharmacy syringes in Hartford, Connecticut.

Methods. Through structured interviews, brief telephone interviews, and mailed surveys, data on nonprescription syringe sale practices were collected on 27 pharmacies, including 18 of the 21 pharmacies in Hartford and nine from pharmacies in contiguous towns, during June and July 1997. Interview data on pharmacy syringe purchase from two samples of IDUs, a group of out-of-treatment injectors recruited through street outreach, and a sample of users of the Hartford Needle Exchange Program, also are reported.

Results. The study found that, while market trends as well as negative experiences have further limited pharmacy availability of

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nonprescription syringes, pharmacies remain an important source of sterile syringes for IDUs. However, the distribution of access is not even; in some areas of the city it is much easier to purchase nonprescription syringes than in others. All of the seven pharmacies located on the north end of Hartford reported that they had a policy of selling OTC syringes, whereas only six (54.5%) of the 11 pharmacies located on the south end have such a policy. Overt racial discrimination was not found to be a barrier to OTC access to syringes.

Conclusions. To further decrease acquired immunodeficiency syndrome (AIDS) risk among IDUs, there is a need for public education to counter empirically unsupported stereotypes about IDUs that diminish their access to health care and AIDS prevention resources and services. In states or cities where pharmacy sale of nonprescription syringes is illegal, policy makers should examine the benefits of removing existing barriers to sterile syringe acquisition. In cases in which pharmacy sale of nonprescription syringes is legal, local health departments should implement educational programs to inform pharmacy staff and management about the critically important role low-cost (or cost-free), sterile syringe access can play in HIV prevention.

The acquired immunodeficiency syndrome (AIDS) epidemic produced a number of notable changes in social attitudes, public behaviors, and social policies, including recognition that illicit drug laws may be consequential barriers to AIDS prevention among drug users.^{1,2} In the era before the AIDS epidemic, many states defined syringes as drug paraphernalia when used or intended for use in illicit drug injection. Nine states also adopted laws that require a doctor's prescription to legally buy syringes from a pharmacy.³ Even in states without prescription laws, many pharmacists require customers to show identification, sign a log book, or present a prescription, prerequisites that lower the likelihood that injecting drug users (IDUs) will acquire sterile syringes legally in a pharmacy.⁴ Louisiana does not have a prescription law, for example, but a recent study shows that the majority of pharmacists in New Orleans require a prescription before they will sell a syringe.⁵ These practices have important implications for human immunodeficiency virus (HIV) prevention. As Gostin observes:

Nationwide, pharmacists retain considerable discretion in deciding whether, and to whom, to sell syringes. Some pharmacists sell to all buyers; others refuse to sell to purchasers who demonstrate visible signs of injection drug use or who cannot offer a plausible medical justification; still others refuse sales for apparently discriminatory or capricious reasons. Pharmacist discretion yields wide variation in the willingness to sell to IDUs. Biases against, for example, racial minorities, young people, and homeless people potentially limit opportunities for pharmacy customers to purchase syringes.⁶

Studies of pharmacy sales of nonprescription syringes (NPS) are limited, particularly in the United States. A mailed questionnaire to 15 pharmacies in New Haven, Connecticut (with follow-up phone calls and in-store visits) found that four had policies against the sale of NPS. In each case, pharmacists cited negative experiences with IDUs as the reason for such policies. Among the other 11 pharmacies, nine provided estimates of their sales of NPS. These data suggest that pharmacies in New Haven sell about twice as many syringes as are exchanged by the New Haven syringe exchange program.⁷ Outside of the United States, studies of pharmacist attitudes toward the sale of NPS reveal hesitation. Pharmacists voice concern about the negative impact on pharmacy business and

public image.⁸ In their study of pharmacists in England and Wales, Glanz and colleagues found that the majority believed that the presence of IDUs in their stores would result in higher rates of shoplifting and loss of other customers.⁹ A study by Tasi and colleagues in Australia produced similar results.¹⁰ At a public workshop organized by the Panel on Needle Exchange and Bleach Distribution Programs of the National Research Council, representatives of the National Association of Chain Drug Stores and the American Pharmaceutical Association expressed these and related concerns, although the latter stressed the important role pharmacists can play in preventing HIV through the sale of NPS.⁴ In terms of actual practices, a Canadian study examining community pharmacies found that one-third refused to sell NPS for nontherapeutic reasons.¹¹ Another Canadian study, an assessment of a pilot project to sell and recover NPS in Montreal pharmacies, found that high price, inconsistent sales practices, and multi-syringe packaging were important barriers to NPS access.¹²

In May 1992 the Connecticut state legislature passed several laws intended to reduce opportunities for HIV exposure through injection drug use. The new policies included a rescission of a 14-year state ban on the sale of NPS. Pharmacies were allowed to sell up to 10 syringes at a time without a prescription. Given the national significance of this new policy, the Centers for Disease Control and Prevention (CDC) initiated a study of its impact on HIV risk.

The CDC study included a statewide telephone survey in Connecticut that recruited a stratified random sample of pharmacies in two types of locations: the five largest cities in the state (Hartford, New Haven, Bridgeport, Stamford, and Waterbury) and all other locations. The sample consisted of 163 of Connecticut's 697 pharmacies, including 80 of the 129 in the five largest cities and 83 of the 568 in all other locations.¹³ The survey asked managing pharmacists questions about the pharmacy's ownership, presence of IDUs in the pharmacy's neighborhood, whether there had been negative incidents associated with the sale of NPS, and an estimated number of NPS sold in a normal week at the time of the November 1993 telephone survey. The CDC found that, whereas 83% of the pharmacies in the five largest Connecticut cities were selling NPS in July 1992, only 73% were doing so in November 1993. The study also compared the sale of NPS in the highest drug use neighborhoods of Hartford with the sale of NPS in Wethersfield, a middle- and upper-middle-class suburban community situated on the southern periphery of Hartford.

The CDC found 25 pharmacies operating in Hartford. Whereas eight pharmacies in the high-drug-use neighborhoods began to sell NPS in July 1992, only five were doing so by June 1993. Conversely, all seven pharmacies in Wethersfield that began to sell NPS in July 1992 were still doing so a year later. The primary reported cause for the decline in the number of pharmacies selling NPS in Hartford and other Connecticut cities was negative incidents with IDUs. Valleroy and colleagues report that 26 (19%) of the 139 pharmacy managers interviewed statewide reported negative incidents:

Twenty-one (33%) in the five largest cities and five (7%) from all other locations reported negative incidents (33% vs. 7% [$X^2 = 15.5$; $P < 0.0001$]). When asked to explain, these 26 pharmacy managers reported a total of 37 incidents, ranging in seriousness from having to fill orders for 50-cent nonprescription syringes at busy times to being attacked with a syringe by an IDU.¹³

Nonetheless, the CDC concluded that the "new Connecticut laws increased IDU access to sterile syringes in Connecticut, especially in areas where drug use was prevalent."¹³

In June and July 1997, the Hispanic Health Council, a community-based health research institute, initiated a follow-up study to assess changes over the past four years in pharmacy access to NPS in Hartford and in several towns in the wider metropolitan area. The primary goals of this follow-up study were to determine the number and percentage of pharmacies that sell NPS, the distribution of these pharmacies in the greater Hartford area, the cost and packaging of syringes (sold as single syringes or in packages of 10 or more), pharmacy policies and practices regarding syringe sale, pharmacy experiences with the new policy, and the influence of racial discrimination on the sale of syringes.

In addition to findings from this study, we report related data from two other studies funded by the National Institute on Drug Abuse (NIDA) that assessed AIDS risk among IDUs in Hartford. Both of these studies—Project COPE II and the Hartford Needle Exchange Evaluation Project (HNEX)—collected self-report information from IDUs on the use of pharmacies to purchase syringes.¹⁴⁻¹⁶ Focus on Hartford is of special interest because of the sociodemographic, drug use, and HIV epidemiological characteristics of the city. Hartford, the capital of Connecticut, like many "rust-belt" cities, has a falling population that is now less than 140,000. The eighth poorest moderate-sized city in the United States, Hartford has an ethnic composition that is 36% African American and West Indian, 31% Latino (primarily Puerto Rican), and 31% white. On the basis of drug treatment admissions

and prior field research, we estimate that there are 7000 to 10,000 IDUs in Hartford.¹⁷ The AIDS annual rate in the city per 100,000 population is 37.1, placing it among the 50 cities with the highest rates in the country. CDC data indicate that slightly less than three-fifths of all AIDS cases in Hartford are in IDUs compared with about one-third nationally.¹⁸ These data confirm the importance of implementing and assessing the effectiveness of AIDS prevention approaches in this city.

METHODS

In our follow-up study, we solicited personal interviews with the attending pharmacists at all Hartford pharmacies, as well as several pharmacies on the suburban periphery of the city where Hartford IDUs also might attempt to buy NPS. We identified pharmacies by consulting the 1997–1998 Hartford Area Yellow Pages. The phone directory showed 21 pharmacies in Hartford proper (one of which shut down during our study) and numerous pharmacies in the surrounding suburbs. Our interview posed questions about the prevalence of IDUs in the neighborhood, policies and practices regarding syringe sale, reasons for not selling NPS, the packaging of NPS, and the perceived role of the pharmacist in HIV prevention.

Of the 18 Hartford attending pharmacists approached for face-to-face interviews, 14 (77.8%) agreed to participate. Two additional pharmacists from Hartford filled out and mailed back surveys that contained the same questions as the interview. In the case of two of the Hartford pharmacies in which interviews were not granted or surveys were not completed, we conducted an abbreviated telephone interview concerning the availability of NPS without a prescription. Three of the attending pharmacists working at the local affiliates of a major pharmaceutical chain declined participation because of corporate policy. A letter requesting participation did not receive a response from the designated corporate officer. Of the 12 attending pharmacists approached for interviews in contiguous towns (in pharmacies located within five blocks of the Hartford city line), data were collected for nine stores (75%). One additional pharmacist agreed to mail in a survey but failed to do so despite reminders. In the remainder of this chapter, findings from face-to-face interviews, telephone interviews, and surveys are aggregated for purposes of analysis. A total of 27 pharmacies—18 from Hartford and nine from surrounding towns—make up the sample for this study.

To assess whether racial discrimination played a role in the availability of NPS, an African American research assistant (who is a former IDU) attempted to buy single

syringes from attending pharmacists who had stated in personal interviews that they sell OTC syringes. The research assistant recorded his assessment of the reaction of the pharmacist and the price charged for the syringes.

As noted, we report relevant data from two other projects as well. The first of these, Project COPE II, was a study of out-of-treatment IDUs and crack cocaine users recruited through street outreach in selected Hartford neighborhoods. Between 1992 and 1997, 1299 participants were enrolled in the project, 850 of whom were IDUs. At intake, we interviewed participants concerning their risk and risk avoidance behaviors, including the purchase of syringes from pharmacies. The other project, the HNEP, conducted intake and follow-up interviews with 1165 new HNEP clients enrolled between 1993 and 1997. These individuals were asked about their use of pharmacies in accessing clean syringes.

RESULTS

All but one of the pharmacists affiliated with Hartford pharmacies stated that there were many IDUs living in the neighborhoods near their stores. In contrast, pharmacists affiliated with stores on the periphery of Hartford sometimes were uncertain about the presence of IDUs in the local neighborhood. Ironically, the one Hartford pharmacist who stated that he did not know whether there were many IDUs in the surrounding neighborhood worked in a store that is in an area that our ethnographic research indicates is one of the highest drug use areas in the city.

Table 1 indicates that pharmacies within Hartford were much more likely to have a policy of allowing their attending pharmacists to sell syringes without a prescription than were those on the periphery of the city. Thirteen of the 18 (72.2%) pharmacies in Hartford allowed the sale of NPS. One of these was the pharmacy that closed during the course of our research, thereby even further diminishing the number of Hartford pharmacies that sell NPS. Indeed, four of the Hartford pharmacies listed in the Yellow Pages directory released in April 1997 were no longer in business by July 1997. Only five (55.6%) of the nine pharmacies sampled on the periphery of Hartford allowed the sale of NPS.

Some stores both in Hartford and on its periphery give discretion to their attending pharmacists to either follow or ignore store policy regarding the sale of NPS. Of the attending pharmacists in our Hartford sample who are permitted by store policy to sell NPS, all but one actually do. The attending pharmacist at a store situated in the heart of the Latino community said that he sells syringes

only with a prescription, even though store policy permits sales without a prescription. He suspected that most, if not all, of the other attending pharmacists who work the day shift also have chosen to sell syringes only with a prescription. A telephone spot check revealed that one of the attending pharmacists on the evening shift also has opted to sell syringes only with a prescription.

Although the managing pharmacist at a health clinic in the northern side of Hartford said that she was willing to sell syringes without a prescription, she had never had such a request from a customer during the 18 months that she had worked in the clinic's pharmacy. In the racial discrimination assessment of this clinic, we found that neither a pharmacy assistant nor a "floating" pharmacist (assigned from another store) on duty at the time that the project research assistant attempted to purchase syringes knew the pharmacy's policy on the sale of NPS. The attending pharmacist decided to sell a syringe for 25 cents, a price considerably below the selling price at other Hartford pharmacies.

Table 2 compares the practices of attending pharmacists from the north and south sides of Hartford. All of the seven pharmacies located in the north end reported that they had a policy of selling NPS, whereas only six (54.5%) of the 11 pharmacies located in the south end have such a policy. This distribution is of note because African Americans and West Indians are concentrated in various north end neighborhoods, whereas Latinos primarily live in several south end neighborhoods. Latino IDUs, as a result, may have less access to pharmacy

syringes, putting them potentially at greater risk for use of an infected street syringe.

Table 3 illustrates the distribution of pharmacies selling syringes without a prescription with respect to packaging. Hartford pharmacies that sell NPS are more likely to sell syringes both in packets of 10 or singly than are pharmacies on the periphery of Hartford. Only one store on the periphery of Hartford was found to sell singles. Four out of the five Hartford pharmacies that sell single NPS are located on the north end. Our study found a wide price range for packets of 10 but a relatively narrow range for single syringes. The mean reported cost of single syringes was 52 cents, the maximum cost was 65 cents, and the minimum cost was 25 cents. The mean reported cost for packets of 10 was \$3.84, the maximum was \$6.54, and the minimum cost was \$2.19. The two pharmacies charging the most for packets of 10 were both situated in small, nonchain, independent stores in Hartford's north end. A spot check by the project's research assistant revealed that a north end pharmacy that reported charging 65 cents for a syringe during the survey charged him 79 cents. A few pharmacists expressed a willingness to sell single NPS if they were individually packaged and pharmacy staff did not have to break open a pack of 10 for this purpose. However, most who currently sell NPS in packs of 10 expressed reluctance to sell single OTC syringes even under the most optimum circumstances because they are a low-price item that takes time to sell. Two pharmacists in Hartford and one on the periphery of Hartford indicated that IDUs have attempted to return

Table 1. Policy on NPS sale in Hartford-area pharmacies

Area	Sell without a prescription		Sell only with a prescription		Total	
	Number	Percent	Number	Percent	Number	Percent
Hartford	13	72.2	5	27.8	18	100
Periphery	5	55.6	4	44.4	9	100
Total	18	66.7	9	33.3	27	100

Table 2. Sale of NPS in Hartford pharmacies by neighborhood

Area	Sell without a prescription		Sell only with a prescription		Total	
	Number	Percent	Number	Percent	Number	Percent
North end	7	100	0	0	7	100
South end	6	54.5	5	45.4	11	100
Total	13	72.2	5	27.7	18	100

used syringes at their stores, suggesting that these individuals assumed that pharmacies act like the syringe exchange program.

Attending pharmacists gave widely varying responses when asked how many NPS they sell in a typical week, either in packets of 10 or as singles. For example, the pharmacist at a south end pharmacy said that he sells "a lot" of packets of 10, but was unable to indicate exactly how many. Similarly, the pharmacist at a north end store located in a neighborhood that is well known for its heavy drug use said that he had "no idea" how many packets of 10 or singles he sells. Other pharmacists were more exact. The pharmacist at one north end store stated that he sells 100 singles and two to three packets of 10 a week, while a pharmacist at a south end store reported that, although he does not sell singles, he sells about 20 packets a week. In contrast to these NPS higher volume locations, the attending pharmacist at a store located in a north end hospital stated that he sells only two or three packets in a month. Whereas most attending pharmacists who sell NPS in stores on the periphery of Hartford reported selling from one packet per month to three packets per week, an attending pharmacist in a store on the periphery of Hartford reported selling 20 packets a week. On the basis of these very rough figures, it appears that Hartford pharmacies sell a few hundred singles and more than 40 packets of 10 NPS per week. Pharmacies on the periphery of Hartford appear to be selling more than 24 packets of 10 per week, but only a small number of

singles in the same timeframe. In sum, we estimate that pharmacies in the greater Hartford area are selling at least 1000 NPS per week. Site visits by members of our research team to shooting galleries in abandoned buildings in Hartford during the last year affirm that in some areas of the city, particularly the north end, NPS use is common based on the regular identification of discarded NPS wrappers littering the floors. For purposes of comparison, it should be noted that the Hartford Needle Exchange Program currently reports exchanging approximately 1000 NPS per week. In sum, our findings suggest that Hartford area pharmacies are significant sources of clean syringes for IDUs.

Findings from Project COPE II and the HNEP support this assertion. Among Project COPE participants, 72% reported that they buy at least some of their syringes from a pharmacy. Of these participants who use pharmacies as a source for sterile syringes, 41% reported that they acquire all of their syringes from pharmacies, and another 10% reported that they buy more than half of the syringes they use from pharmacies. In addition, 34% reported that half of their syringes come from pharmacies. The remainder acquire fewer than half of their syringes from pharmacies. As indicated in Table 4, among HNEP participants enrolled between 1993 and 1997, approximately 68% reported buying syringes from pharmacies. These data sets affirm that pharmacies remain a significant source of clean syringes for IDUs in Hartford. However, as seen in Table 4, the percentage of new participants

Table 3. Differences in packaging of NPS in Hartford-area pharmacies

Area	Sell both packets and singles		Sell only packets		Total	
	Number	Percent	Number	Percent	Number	Percent
Hartford	5	38.4	8	61.5	13	100
Periphery	1	20.0	4	80.0	5	100
Total	6	33.3	12	66.6	18	100

Table 4. Purchase of NPS from pharmacies by new needle exchange participants

	Year of intake interview				Total
	1993	1994	1995	1996	
Did not purchase pharmacy syringes	185 (28.7%)	85 (29.7%)	68 (43.9%)	37 (46.8%)	375 (32.2%)
Purchased pharmacy syringes	460 (71.3%)	201 (70.3%)	87 (56.1%)	42 (53.2%)	790 (67.8%)

in the HNEP who reported purchasing syringes from pharmacies declined from a high of 71% in 1993 to a low of 53% in 1996. This notable drop may well reflect lessening access to pharmacy syringes as a result of the reduction in the number of pharmacies in Hartford and the decision by some pharmacies not to sell NPS. Another factor may be an increasing reliance on the HNEP as a source of new syringes.

Reported negative incidents associated with the sale of NPS were the main reasons that some pharmacists decided not to continue to sell them. Attending pharmacists at only four of the Hartford stores and one of the stores on the periphery of Hartford reported negative incidents inside or immediately outside of the store. The pharmacist at a south end store decided to discontinue the sale of NPS after a series of incidents, including the refusal of some IDUs to wait their turn in line, the practice of "shooting up" outside the store, and the disposal of used syringes in the store's parking lot dumpster. The attending pharmacist at a Hartford pharmacy reported finding used syringes on the store floor several times and said that one IDU threw his used syringes on the counter for disposal. He also stated that the sale of NPS resulted in the influx of "disreputable types" into the store and increased shoplifting. The attending pharmacist at a store serving a predominantly Latino neighborhood said that several times he or other staff members found disposed syringes on the store shelves. He also cited an incident in which a person threatened both him and another employee with an exposed syringe upon being discovered shoplifting. There was no evidence, however, that the shoplifter purchased this syringe at the store. The attending pharmacist at a store on the periphery of Hartford stated that the store manager decided to stop the sale of NPS upon finding a disposed syringe in the store parking lot. A few attending pharmacists said that they decided not to sell NPS because they heard stories about negative incidents at other stores. Some of the pharmacists who sold NPS stated that they will not sell them to anyone younger than a certain age (such as 16 or 18), an age cohort that is at high risk for contracting HIV as it experiments with drugs.^{19,20} This was the only reason given for not selling NPS.

The racial discrimination assessment component of the study did not reveal any overt signs of discriminatory behavior by personnel at Hartford area pharmacies that sell NPS. The African American research assistant was treated courteously in all of the stores where he attempted to purchase a single syringe, including stores that did not sell singles. All of the stores that reported they sold single NPS sold them to our research assistant without

any notable hesitation or observable negative reaction. Of the pharmacists we interviewed in person, all but one, a young Asian American woman, were white. A young white male pharmacist who worked in a hospital-based pharmacy expressed concern about intercultural communication between pharmacists and IDUs and stated that most pharmacists tend to be conservative in their perception of their customers and in their unwillingness "to go beyond the bench" (to get to know customers and their particular backgrounds, experiences, and needs). In contrast, this pharmacist noted that he felt comfortable with "street people," in large part because of his experiences as a resident in the inner cities of two New England urban areas.

Most of the pharmacists we interviewed reported that their primary role in HIV prevention is that of health education, teaching people about the proper use of condoms, syringes, and home HIV testing kits. However, the tone of the pharmacists' comments suggested the possibility that their customers' class and ethnic differences, particularly customers from inner-city areas, prohibited them from effectively communicating with the customers who are at the greatest risk of HIV infection. The traditional role of the friendly neighborhood pharmacist who is a familiar businessperson in the community is being altered by market forces. The modern pharmacist is often a harried employee whose primary interests are profit making and store efficiency (or rapid customer flow) rather than community public health promotion or customers' personal health concerns. Pharmacists not only fill prescriptions, they also oversee the activities of one or more pharmacy assistants. As we experienced in this study, the pharmacist may not even be permitted to grant an interview to a health researcher because corporate or store policy dictates against it.

DISCUSSION

Our study indicates that four years after the Connecticut state legislature rescinded the ban on OTC sale of syringes, and despite a decline in their number, pharmacies remain a significant source of sterile syringes for IDUs in Hartford. The importance of pharmacies in this regard is enhanced by the fact that they make sterile syringes available in parts of the city and at times of the day (and during weekends) when the HNEP is not operating. However, the 2000 syringes per week supplied by pharmacies and the HNEP together are not adequate to provide even one new syringe per week to all of the estimated 7000 to 10,000 drug injectors in Hartford. If

HIV prevention programs adopted the public health standard of encouraging drug injectors to use a new syringe each time they injected, then, given the COPE II mean injection rate of 33 times per individual per week, Hartford area pharmacies and the HNEP would need to distribute at least 10 times the number of new syringes that they currently supply.¹⁶

In spite of the continued importance of pharmacy provision of sterile syringes to IDUs, we found that pharmacy sales of NPS may have dropped over time, at least in some parts of the city. Moreover, pharmacies located in the towns along Hartford's borders are less likely to sell NPS than those located in the city proper. Various minor incidents at pharmacies within the stores or in their parking lots, or (possibly embellished) stories of incidents at other stores, have prompted some pharmacies to discontinue selling NPS. Within the city, this has been a significant problem in the south end of Hartford, where most of the Latino population in the city resides and where, according to COPE II data, rates of injection are highest. Class and ethnic differences between pharmacists and many IDUs appear to be a factor contributing to the lack of availability of NPS in certain stores both within Hartford and in surrounding towns. However, we did not find open discrimination based on race in the actual sale of NPS to customers.

Mobilizing pharmacies to play a greater role in HIV prevention among IDUs will require overcoming a number of significant barriers. Existing research suggests that these barriers are not peculiar to Hartford or even to the United States; they are firmly rooted in cross-national public attitudes about and images of illicit drug users. Since the turn of the century, when drug use was criminalized, drug users have been portrayed regularly in the media, in government pronouncements, and elsewhere, in ways that isolate them from being included as fellow citizens and community members.²¹⁻²³ As a result, despite abundant research showing a high degree of heterogeneity among drug users (e.g., various studies show that most drug users, including a much broader group than those recruited through street outreach or needle exchange studies, are employed),²⁴⁻²⁶ popular stereotypes depict them as uniformly unhygienic and slovenly; dangerous and lacking self-control; rejecting existing social standards and community values; and willing to commit any behavior, however heinous, to satisfy their craving for drugs. For example, a recent article on drug use in Hartford's only daily newspaper, the Hartford Courant, quotes a city resident as saying, "[They're] out here all night long. The people who sell drugs and those

who use 'em don't seem to care about life at all."²⁷ The ongoing demonization of drug users as the ultimate cause of urban social problems serves as a justification to avoid implementing innovative public health services and policies that could contribute to decreasing routes of HIV transmission. Breaking down such ill-conceived barriers is a fundamental task of effective health promotion and disease prevention.

On the basis of our study of pharmacy policies and practices in NPS sales in Hartford, we offer the following recommendations.

- Public education, including health care provider education, is needed to counter empirically unsupported stereotypes about IDUs that diminish their access to health care, prevention resources, and services. These efforts should stress that IDUs are not morally defective individuals but rather people who suffer from chemical addiction, and who are at high risk for HIV infection and transmission.
- In states and cities where pharmacy sale of NPS is not a legal activity, policy makers should examine the benefits of removing existing legal barriers to sterile syringe acquisition as a public health approach to prevent the transmission of HIV and other blood-borne pathogens. It should be stressed that drug users are not a socially isolated and distinct group (despite continued efforts to depict them as such). It is therefore impossible to ignore the epidemic among drug users and expect that HIV will not diffuse throughout the wider population.
- In states and cities where pharmacy sale of NPS is a legal activity, local health departments should implement educational programs to inform pharmacy staff and pharmacy chains about the important role that the sale of NPS can play in HIV prevention. Emphasizing cultural competency, these programs should attempt to help pharmacists bridge the class and ethnic differences between them and many inner-city IDUs.
- Health departments, in conjunction with community organizations and local syringe exchange programs, should seek avenues by which IDUs can be informed about the importance of avoiding conflict or other incidents during the purchase of NPS at pharmacies. In addition, health departments should produce educational pamphlets (in both English and Spanish)

explaining the proper use of syringes to avoid vein damage and infection.

- In states where OTC purchase of syringes is legal, health departments should strongly urge pharmacies to lower the cost of syringes, whether they are sold individually or in packets. State subsidies could be used to help lower OTC syringe costs. As a means of increasing the immediate access of syringes among individuals with limited resources, pharmacies also should be assisted, through local distribution systems, to sell individually packaged syringes.

- Given pharmacies' wide distribution and extended hours of operation, as well as an apparent willingness of IDUs to use them, city and state health departments should explore opportunities for implementing syringe exchange programs within pharmacies.

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