

Needle Exchange: The Moral Framework for a Global Problem

By MARY JO IOZZIO, Ph.D.

The Roman Catholic Diocese of Albany, with its Office of Catholic Charities, has initiated a needle-exchange program, Project Safe Point, to provide free, sterile needles and syringes to intravenous drug users as an extension of the Catholic mission to serve those who are poor and vulnerable.

Unfortunately, the Diocese of Albany remains alone in its all-out support of needle exchange. But needle-exchange programs reach to the core of the critical efforts of Catholic-sponsored health care and parish-based health clinics to provide preventive compassionate care responses to HIV and other blood-borne infections. As a number of Catholic scholars have recognized, with Fr. Jon Fuller, SJ, MD, and Fr. James Keenan, SJ, at the lead, needle-exchange programs can reduce infection rates in urban and near-urban drug undergrounds that keep contaminated paraphernalia in circulation among injecting drug users.¹

The need to supply safe needles is critical and a Catholic response imperative. For these reasons — that Albany stands alone, these programs are effective and they bring Jesus' healing mission and inclusive love — other such programs should find greater support and do likewise soon.

Needle exchange helps protect individuals from blood-borne infections like HIV, AIDS and hepatitis by getting used syringes off the streets, thus reducing the potential for drug users to share a contaminated needle. These programs allow a person who injects drugs to bring back his or her



No Room for Complacency in the Face of HIV and AIDS

used needle and/or syringe and receive free, sterile replacements. Because the exchange is made in person, it offers health care workers an opportunity to engage people who inject drugs in counseling for health, HIV prevention and treatment referral.

Despite these positive benefits, some persist in thinking that needle exchanges foster the use of illicit drugs among populations unworthy of our help.

There is no scientific or sociological evidence that making sterile syringes and needles available through needle exchange encourages or increases illicit drug use. Moreover, no person is unworthy of our concern and help.

Just as there is no room for racism, sexism, heterosexism or

ableism (dehumanizing thinking about people with disabilities) in the house that Christ built, there is no room for marginalizing or complacency regarding our sisters and brothers who, for whatever reason, are vulnerable to HIV, AIDS and other blood-borne infection through the use and reuse of contaminated paraphernalia. Complacency makes excuses for ignoring people in need, yet Christ commanded another way: to be with and for those who are vulnerable, hungry, home-

less, imprisoned, sick.

The United Nations Joint Program on HIV/AIDS (UNAIDS) estimates that at the end of 2009, more than 33 million people around the world were living with HIV.² The Centers for Disease Control and Prevention (CDC) estimates more than 1 million Americans are living with the virus, though 21 percent of them don't know they are infected. An estimated 50,000 Americans are infected each year, 12 percent of whom are intravenous drug users and most likely acquired the disease through shared needles, syringes or other equipment used to prepare illicit drugs for injection — a mode of transmission that is entirely preventable.³

STAGGERING COSTS

Though UNAIDS reports new HIV/AIDS infections are decreasing, as are AIDS-related deaths, thanks to antiretroviral drugs, safer sex practices and better care, services and support, the diagnosis remains tragic. HIV/AIDS and its complications killed 1.8 million people worldwide in 2009, according to UNAIDS, and the CDC says about 18,000 people die from AIDS every year in the U.S., for there still is no cure. The diagnosis often portends a dramatically shortened life, social exclusion, stigma and the suspicion of having infected others.

As a communicable disease, HIV falls within the boundaries of Catholic social teaching on justice, the common good and solidarity with those who are poor. Those with firsthand experience caring for HIV/AIDS patients in hospitals, clinics, home health agencies, outreach programs and community centers put prevention of the disease at or near the top of their priority list.

In 2009, their cause got a boost. Since 1988, there had been a ban on federal funding for harm-reduction programs that include syringe exchange and counseling services for injecting drug users. The ongoing lobbying work of the Interfaith Drug Policy Initiative and the Drug Policy Alliance, along with a March 3, 2008, forum they sponsored at the U.S. Capitol for congressional health staffers, helped spur a reappraisal. In December 2009, Congress decided to turn over to local public health or law enforcement agencies the power to halt federal funding of any needle-exchange program they deem to be taking place in an “inappropriate” location. Since then, Delaware has become the first state to sign needle-exchange

programs into law.

Many public agencies cheered this Congressional action as one that, among other programs, could save thousands from hepatitis, HIV and other blood-borne infections especially in urban areas, which are disproportionately affected by the incidence of injecting drug use and the presence of HIV in that population. In Baltimore alone, one study found the second-highest rate of injecting drug use in the United States, at 162 per 10,000, and the 11th-highest rate of HIV among this population.⁴

You may be wondering, “Why should I care?” My first response is, “Why not?” After all, isn't that where the burden of proof lies for a people called to love one another? Here, a significant change in policy signals a new appreciation for the ways in which a fairly straightforward initiative can save thousands from life-threatening, blood-borne infection. Albany's Project Safe Point is just such an initiative, one that can be duplicated anywhere in the country.

AN ETHICS WIN-WIN

Needle-exchange programs like Safe Point accomplish at least two positive objectives in one act, a win-win in ethics: They protect injecting drug-users from infection, thus they protect the drug users' sexual partners and needle-sharers (and *their* sexual partners and needle sharers).

It is easy to find other reasons to care in the examples Jesus provides in the parables of the lost (coin, sheep and man-child) and in his attention to those deemed by the authorities as outcast

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(lepers, sinners and those possessed). But if altruism is insufficient grounds for supporting needle-exchange programs, perhaps the cost savings will be persuasive.

Needle-exchange programs help prevent HIV infection for a cost of between \$4,000 and \$12,000 per injecting drug user annually. Treating an injecting drug user for HIV costs about \$190,000 per year, according to the CDC.⁵

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An earlier cost-effectiveness analysis projecting potential savings for a hypothetical cohort of 1 million intravenous drug users concluded that, if needle-exchange programs were available, those programs could have prevented 12,350 cases of HIV infection and AIDS in the U.S. during 1998, saving millions of dollars in treatment costs.⁶

I am not alone among Catholic scholars in support of and arguing for such programs. As early as 1998, Fuller and Keenan publicly advocated for needle-exchange programs as one response among others to stave off HIV infection. Fuller applied the casuist principle of cooperation to the moral conundrum accompanying what seems to be avoidance of illicit drug use by attending to ways of thwarting the present crisis (exceptional crises, like that posed by HIV, require exceptional responses).

At the annual meetings of the Society of Christian Ethics, Keenan educated the community of scholars about HIV and AIDS prevention until, at its January 2000 meeting, the membership “resolved that the Society of Christian Ethics publicly endorses and encourages the development of needle exchange programs in the United States which: are established with the support of local communities; are one-for-one exchange programs, which do not increase the number of needles in circulation; [and] provide linkages to medical care, detoxification and drug treatment.” The basis of the resolution rests in the faith traditions of Judaism, Christianity and Islam following the justice commands of God in Leviticus and Deuteronomy, particularly in their injunctions to care for the widow, the orphan and the sojourner in their midst. Both Fuller and Keenan also argued for this and other prevention methods in the 2002 collection, *Catholic Ethicists on HIV/AIDS Prevention*.

Today, we recognize that this command extends to all people who are vulnerable, especially those without voice (and therefore without power), and it enjoins those with voices that may be heard to bring their concerns to the public arena for a response.

A MATTER OF COMMON GOOD

In the Catholic tradition we refer to these com-

mands by making a preferential option for those who are poor and vulnerable — for our purposes here, injecting drug users and their friends.

Arguing likewise, Fr. Jorge J. Ferrer, SJ, Christopher Vogt, Anna Kasafi Perkins and Emily Reimer-Barry have written — using casuistry, hospitality, a reappraisal of suffering and the common good — that our Catholic tradition can stand with other denominations and faith traditions, the CDC, the Office of the Surgeon General, the Institute of Medicine and the American Medical Association in support of needle-exchange programs.

I, too, have found that the Catholic interest in health care extends to support of needle exchange as a harm reduction strategy.⁷

The position of these theologian ethicists and their medical counterparts rests on the ethical demands of justice to both prevent harm and protect the innocent — surely the foundation of all our laws and rooted firmly in the common good. Persons who inject drugs and those who are related to them either as co-users, sex partners, parents, friends or children deserve the equal protections of the law to reduce and/or remove the potential harms of risk-to-life through needle exchange; that is, preventable hepatitis B and hepatitis C, HIV and other blood-borne infections. To not respond or to forget that the Body of Christ has AIDS is to betray complacency in the face of human suffering.

COMPLACENCE IS IMMORAL

The reality of HIV/AIDS has moved away from being a priority concern for many in the industrialized world. Clearly, there have been great

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strides in HIV and AIDS treatment, but the problem of ongoing, preventable infection has not been resolved.

Sadly, the work of Caritas Internationalis, an international confederation of Catholic relief, development and social service organizations, and UNAIDS is neither sufficiently representative of what should be our concern nor sufficiently effective. Neither the Catholic arm of charity nor the UN has received the support they need to make needle-exchange programs readily available to the world’s vulnerable populations. HIV has not been eradicated and new infections are

reported each year. These international efforts deserve our recognition and intentional support.

To persist in doing nothing betrays complacency in the face of others' suffering. Do we, members of a faith tradition that advocates the corporal works of mercy, really want to ignore our sisters' and brothers' vulnerability to infection? Are any of us in a position to declare that some are guilty of a moral transgression and therefore deserving of merciless complacency?

When HIV/AIDS falls off the radar of those who live comfortably, I wonder what else or who else fell off too.

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NOTES

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