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AIDS RESEARCH

American Foundation for AIDS Research
120 Wall Street, 13th Floor, New York, NY 10005-3902
t: 212. 806 1600, f: 212. 806 1601

September 29, 2000

Ms. Sandra L. Thurman
Presidential Envoy for AIDS Cooperation
736 Jackson Place
Washington, DC 20503

FAX: (202) 456-2439

Dear Sandy,

Hope you are well. It was great to see you at the Marie Claire event. In spite of your incredible schedule, you always look terrific!

The American Foundation for AIDS Research (amfAR) holds its annual World AIDS symposium and luncheon at the United Nations on November 30. This year, the focus of our symposium is South and Southeast Asia. Our working title is," ***The HIV/AIDS Pandemic: South and Southeast Asia Standing at the Precipice."***

We are inviting you to moderate a panel on this subject during the morning program. We are inviting five expert speakers to join this panel, all experienced with the epidemic in this portion of the world. We have also invited Peter Piot to be a member of this panel to maintain a global/UNAIDS perspective. We know you will be the ideal moderator for this panel because of your knowledge and experience with the epidemic, and your media savvy and diplomacy skills will help highlight salient points to the audience.

Secretary of State Madeline Albright has been invited to open amfAR's symposium program. After the Secretary's remarks, we would ask you, as our moderator, to convene the assembled panel of experts and lead them through a discussion that would highlight the issues surrounding HIV/AIDS in South and Southeast Asia. We expect the panel to convene at approximately 10:45 and run through 11:45.

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The audience targeted for this symposium would include AIDS professionals, concerned business leaders, philanthropic leaders, leading educators and academics, the international health community, select United Nations staff and amfAR donors. The audience would also include invited international, national, local and community media.

At the conclusion of the morning's symposium, we would begin our annual luncheon at the United Nations. This year we have invited Ambassador Holbrooke and Sharon Stone, Chairman of amfAR's Campaign for AIDS Research to be the luncheon speakers.

The press will be advised of photo opportunities at both the beginning and end of the symposium and at the beginning and end of our luncheon. We hope you could extend your day to join us for the luncheon and the photo opportunities. Of course, we would advise your staff of press interest and coordinate any interviews in advance.

amfAR would be honored to have you join us on this special day, and, of course, your participation would be greatly appreciated by both Dr. Krim and Jerry Radwin.

I look forward to hearing from you and do hope you can join us.

Sincerely,

Deborah C. Hernan
Vice President

cc: Jerome J. Radwin,
Chief Executive Officer

COPY

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American Foundation for AIDS Research
120 Wall Street, 13th Floor, New York, NY 10005-3902
t: 212. 806 1600, f: 212. 806 1601

October 21, 1999

4160 6284 27/26

The Honorable Edward M. Kennedy
SR-315 Russell Senate Office Building
Washington, DC 20510-2101

Dear Senator Kennedy:

Because of your long-standing support of just and compassionate AIDS-related public policies, as well as your grasp of the complex issues involved in battling this worldwide epidemic, I am pleased to extend to you, on behalf of Dr. Mathilde Krim and the Board of Directors of amfAR, an invitation to participate as a guest speaker and panelist for an important amfAR symposium in observance of World AIDS Day on November 30, 1999. The purpose of this symposium, to be held from 9:00 AM to 12:00 Noon at the United Nations, is to explore the impact of the global AIDS epidemic on businesses and national economies and, in turn, the effect of business practices and social and economic policies on the evolution of the epidemic. Your expertise will greatly enrich this important dialogue.

Our panel currently includes Dr. David Bloom, Professor of Economics and Demography at Harvard University, and Dr. Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS). amfAR has also invited (Sir)Dr. George Alleyne, Director of the Pan American Health Organization (PAHO); John Corizine, former CEO of Goldman Sachs; Amartya Sen, 1998 Nobel laureate in economics;and Eduardo Doryan, Vice President of Human Development at the World Bank; [your colleague, Senator Orrin Hatch]; as well as other outstanding leaders in business, social policy, and world health to participate on this distinguished panel. Ted Koppel, the venerated newscaster and host of ABC's *Nightline* has graciously agreed to serve as host and moderator for the symposium.

The program will be followed by a special VIP luncheon featuring Sharon Stone, Chairman of amfAR's Campaign for AIDS Research, as guest speaker. amfAR has also invited former South African President Nelson Mandela to address this gathering. Later that evening, amfAR will also present a gala benefit dinner and concert, *Seasons of Hope*, honoring Quincy Jones, Sharon Stone, and Robin Williams at Pier SIXTY at Chelsea Piers. You are most cordially invited to attend both events as the special guest of amfAR's Chairman, Dr. Mathilde Krim.

The symposium will consist of a series of presentations and moderated discussions examining the interplay between health, business, and the economy and will begin to construct a framework for creative thinking about corporate sector involvement in the AIDS epidemic and the formation of public-private partnerships. amfAR's invited audience, including Fortune 500 CEOs, business leaders, national economists and

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t: 212. 806 1600, f: 212. 806 1601

financial analysts, representatives from UN member nations, financial and health science journalists, foundation program officers, academics, and scientists will have an opportunity to submit questions for discussion by the panel.

A white paper covering the scope and broadly articulating the focus of amfAR's symposium is being prepared by panelists Dr. David Bloom and Dr. Allan Rosenfield, Dean of the Mailman School of Public Health at Columbia University. Should you agree to accept amfAR's invitation to participate in the symposium, an abstract of this paper will be sent to you as a background source for your presentation, and the full paper will be forwarded to you by November 15. This background paper will also be circulated in advance of the symposium to amfAR's invited guests in order to help facilitate the preparation of questions for the panel.

amfAR anticipates excellent press coverage for this symposium, not only because television, radio, newspapers, and periodicals will be eager for AIDS-related information to publish on World AIDS Day (December 1), but also because amfAR's program is one of the first to take an in depth look at the business and economic aspects of the epidemic. amfAR's public relations representatives will be securing special coverage of these issues in the editorial pages of major newspapers, as well as in financial print and media outlets, in order to help familiarize the broader public, especially in the business and financial sectors, with these issues. In addition, the symposium presentations and panel discussions will be transcribed and published in scholarly journals. Through these efforts, your remarks and those of your fellow panelists would certainly reach a very large and interested audience and would help stimulate others to think creatively about how we can join together to find lasting solutions for the AIDS epidemic.

My colleagues and I hope that you will find it possible to accept our invitation. We strongly feel that the social and ethical business responsibilities in this area are compelling and that the economic impact of the AIDS epidemic is something businesses cannot afford to overlook. Your thoughts and perspective would greatly enhance this crucial debate, and your presence would certainly add great distinction to our program. Of course, amfAR would be pleased to handle all arrangements for your travel and accommodations.

Thank you for your kind consideration of this request. I will take the liberty of following up on this letter with a telephone call. I look forward to discussing amfAR's symposium with you in further detail.

Sincerely,

Jeffrey J. Radwin
Executive Vice President
CEO

D-AMFAR

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American Foundation for AIDS Research
120 Wall Street, 13th Floor, New York, NY 10005-3902
t: 212. 806 1600, f: 212. 806 1601

November 5, 1999

Dear Colleague:

I am pleased to send you the enclosed two-year Annual Report, which describes amfAR's programs and key accomplishments in the areas of research, education, prevention, and public policy. We are particularly proud to highlight the work of several recent amfAR grantees, who have achieved notable breakthroughs in both AIDS vaccine research and studies of immune system restoration.

As you know, a vaccine will be the ultimate HIV prevention tool, and the enclosed report features a special article on the challenges that must be overcome in order to design a safe and effective AIDS vaccine, as well as the contributions that amfAR-supported researchers have made toward this critical goal.

You are a valued partner in our efforts to accelerate the pace of AIDS research and achieve new breakthroughs that will help people with HIV/AIDS live longer, healthier lives, and ultimately, prevent HIV infection altogether.

Thank you for your efforts.

Sincerely yours,

Jerome J. Radwin
Executive Vice President and
Chief Executive Officer

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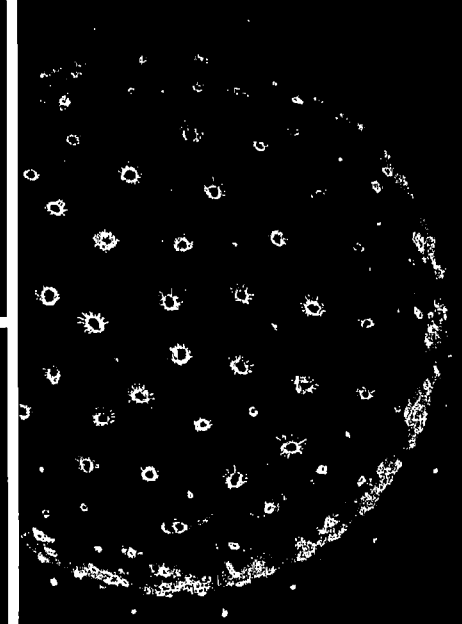

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ANNUAL REPORT | 1998–1999

AMERICAN FOUNDATION FOR AIDS RESEARCH

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AIDS RESEARCH

American Foundation for AIDS Research
public policy office
1828 L Street, N.W., Suite 802
Washington, D.C. 20036
ph: 202 331-8600
fax: 202 331-8606

FACSIMILE COVER SHEET

DATE: 10/13

TO: SANDY

FROM: X **Jane Silver**

Total # of Pages:
(Includes Cover)

Message: Needle exchange info I sent to Dan M. or Deborah VZ or both. Thanks for all your help!

The Facts about Montreal and Vancouver

NEW STUDIES FIND NO EVIDENCE THAT NEEDLE EXCHANGE PROGRAMS LEAD TO HIV TRANSMISSION

THE RESEARCH DATA

In two new studies published this year, researchers in both Montreal and Vancouver found no causal association between HIV transmission and the needle exchange programs (NEP) in those cities.

The new findings answer concerns raised by some about the effectiveness of needle exchange programs as an HIV prevention strategy. According to the authors of earlier studies on injection drug users in the two cities, it is a misrepresentation of their research to claim the studies as evidence that NEPs have failed to reduce the spread of HIV and may have even worsened the problem. This new research provides further scientific evidence to refute these claims.

WHAT DO THE NEW STUDIES TELL US?

Vancouver: No evidence that the local NEP is causally associated with HIV transmission. In addition, some statistically significant decrease in risk behavior after enrolling in the NEP was found. This is especially important because NEPs attract higher risk IDUs, providing a window of opportunity to access these difficult-to-reach individuals.

Montreal: No association was found between attendance at the NEP and HIV seroconversion among current IDUs.

WHAT DID THE EARLIER STUDIES TELL US?

Neither of the first two studies was designed to evaluate the effectiveness of the NEPs. Rather, both studies followed injection drug users over a period of time and found that the users of the NEPs in Montreal and Vancouver had higher rates of HIV infection than non-users. There are several reasons for the higher rates of infection. Those who participated in these NEPs practiced the riskiest behaviors. Those who didn't participate in the NEPs often didn't need free needles because they could afford to buy new syringes in pharmacies and were also less likely to engage in other risky behavior. In addition, cocaine injection is a major source of HIV transmission in these cities and some users inject up to 40 times a day. Each city would need approximately 10 million clean needles a year, far above the number available through the NEPs, to prevent the re-use of syringes.

In their original paper, the Vancouver researchers wrote, "In fact, without the presence of an active [needle exchange program] that was implemented early, [the rate of new HIV infection] among [drug injectors] in Vancouver may have been much higher, much earlier."

NEW DATA SUPPORTS EFFECTIVENESS OF NEPS

The new research on NEPs in Montreal and Vancouver provides additional scientific evidence supporting NEPs.

Bruneau J, Lachance N, Lamothe F, et al. Changes in HIV Seroconversion Rates of IDUs Attending Needle Exchange Programs (NEP) in Montreal: The SaintLuc Cohort. Abstract, Canadian Journal of Infectious Diseases, Supplement May 1999.

Bruneau J, Lamothe F, Franco E, 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 1997.

Schechter M, Strathdee S, Cornelisse P, et al. Do needle exchange programmes increase the spread of HIV among injection drug users?: an investigation of the Vancouver outbreak. AIDS 1999.

Strathdee S, Patrick D, Currie S, et al. Needle Exchange is not Enough: Lessons from the Vancouver Injecting Drug Use Study. AIDS 1997.

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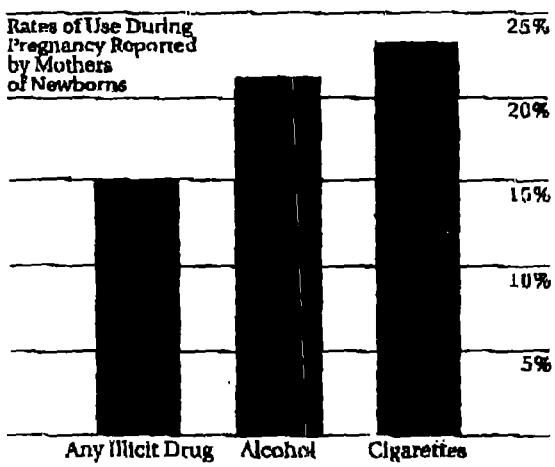
D.C., according to the Metropolitan Washington Council of Governments. The figures are consistent with a U.S. General Accounting Office report, which found that parental alcohol and other drug abuse contributes to 78 percent of foster care cases nationwide.

Washington's expenditures for alcohol and other drug-related foster care cases range from $11 million to $24 million annually. Children in the foster care system are also at increased risk for later drug use and delinquency.

Impact of Drugs on Newborns. One in seven pregnant women admitted for delivery at city hospitals in 1992 tested positive for illicit drugs, according to NIDA's *Washington, D.C., Metropolitan Area Drug Study*. Based on self-reports, nearly 15 percent of new mothers reported using illicit drugs during their pregnancy, 21 percent reported drinking alcohol, and 23 percent reported smoking cigarettes.

Drug Use Common During Pregnancy in D.C.



Washington, D.C. Metropolitan Area Drug Study, National Institute on Drug Abuse, 1995

The study found that babies of women who smoked during pregnancy were four times more likely to be low birth weight than the babies of mothers who did not smoke. Rates of low birth weight also increased for babies whose mothers used alcohol and other drugs during pregnancy.

The cost of neonatal intensive care for low birth weight newborns ranges from $25,000 to $35,000 per child. Approximately 14 percent of babies born in the District are low birth weight (1,187 in 1996), and at least 20 percent of them have been exposed to alcohol, tobacco or other drugs before birth. Caring for these infants costs the city at least $5.9 million each year.

Like many cities, the District does not track the number of babies born with fetal alcohol syndrome (FAS), a birth defect that is commonly overlooked and underestimated nationwide. A single FAS case costs about $1.4 million over a lifetime.

HIV and AIDS

Key Findings

- One in three AIDS cases in Washington is linked to drug use.
- Among those living with AIDS in Washington, drug-related cases cost more than $10 million each year for health care alone.
- Despite these alarming figures, Congress has prohibited the city from using locally-raised revenues for needle exchange programs which have been shown to reduce HIV infections among addicts without increasing drug use.
- Alcohol and other drug use place Washington's high percentage of sexually active teens at greater risk for HIV infection.

Prevalence. The eighth leading cause of death nationally, AIDS, which disproportionately affects drug users, is the third leading killer in Washington. The city's AIDS death rate is more than seven times the national average (120 per 100,000 compared to 16 per 100,000).[11]

[11] AIDS is the leading cause of death among city residents aged 30 to 44, accounting for 46 percent of all deaths. In addition to the more than 5,000 people in the city living with AIDS, an estimated 10,000-12,000 other residents have HIV (the virus which causes AIDS). The District is expected to begin tracking HIV cases in 1999 in order to meet new CDC guidelines.

A growing percentage of the city's AIDS cases are the result of injection drug use (IDU). By the end of 1997, 36 percent of AIDS cases in the city were linked to IDU, compared to 24 percent in 1993. The drug-related AIDS cases diagnosed in 1997 will generate lifetime health care costs exceeding $34 million dollars.

African Americans constitute nearly all (97 percent) of the AIDS cases diagnosed among injection drug users between 1994 and 1997. In populations with unusually high rates of drug use (e.g., the homeless, criminal offenders, young adults), the risk of contracting AIDS is greater.

Drug-related cases among those living with AIDS in the District generate at least $10.4 million in health care costs annually.

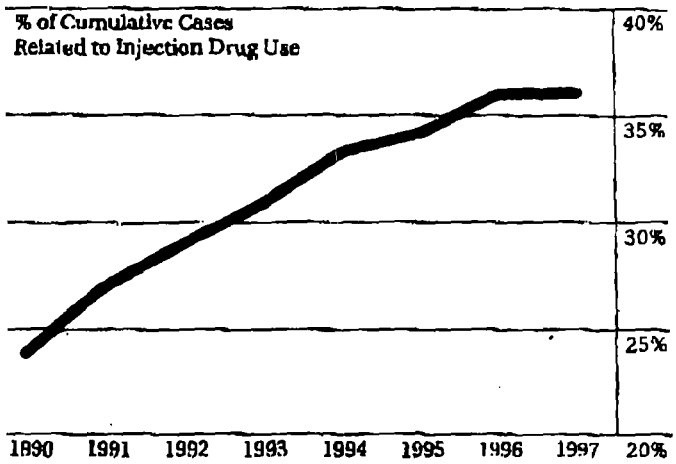
AIDS Prevention Through Needle Exchange. Beginning in 1996, the D.C. government funded a needle exchange program run by the Whitman-Walker Clinic, a community-based provider of AIDS services. The program, which reached an estimated 3,000 injection drug users, reduced needle sharing among participants by two-thirds.

Since October 1998, Congress has prohibited the city from using local funds for needle exchange programs. The ban also prohibits any federally funded organization from operating a needle exchange program in the city, even if the program is financed strictly with private funds. As a result, Whitman-Walker's $220,000 needle exchange program closed, although a fiscal impact study found that failing to provide needle exchange would cost the city $8.3 million annually.

In October 1998, Whitman-Walker and local health advocates formed Prevention Works, Inc., a privately funded organization to operate a local needle exchange program. The program, licensed by the D.C. Health Department, began operating in December 1998. Its future will depend on sustained financial support from the private sector.

AIDS Risks for Youth. Alcohol and other drug use can lower inhibitions and lead to high-risk behavior, including reduced condom use. Although 91 percent of Washington's teenagers report being taught about HIV and AIDS in school, and 73 percent say a parent or other adult family member has discussed the topic with them, a high percentage are still at risk for AIDS.

D.C. AIDS Cases Increasingly Linked to Drug Use



D.C. Administration for HIV/AIDS

A majority of teens in the city are sexually active (53 percent vs. 35 percent nationally). While 68 percent of those who are sexually active say they use condoms, in 1997, 21 percent of city teenagers reported using alcohol or other drugs at the time of their last intercourse; this drug use decreases the likelihood of condom use. Teens in Washington are also three times more likely than teens nationwide to have intercourse before age 13 (21 percent vs. 7 percent) and more than twice as likely to have at least four sexual partners (38 percent vs. 16 percent)—factors which also increase their risk for contracting HIV.

Syringe Exchange in the United States, 1996: A National Profile

Denise Paone, EdD, Jessica Clark, BA, Qiuhu Shi, PhD, David Purchase, and Don C. Des Jarlais, PhD

ABSTRACT

Objectives. This paper provides 1996 information on the status of US syringe exchange programs and compares these findings with data from our 1994 survey.

Methods. In November 1996, questionnaires were mailed to 101 syringe exchange programs. Program directors were contacted to conduct telephone interviews based on the mailed questionnaires. Data collected included numbers of syringes exchanged, syringe exchange program operations, legal status, and services offered.

Results. Eighty-seven programs participated in the survey. A total of 46 (53%) were legal, 20 (23%) were illegal but tolerated, and 21 (24%) were illegal-underground. Since 1994, there has been a 54% increase in the number of cities and a 38% increase in the number of states with syringe exchange programs. Eighty-four programs reported exchanging approximately 14 million syringes, a 75% increase from 1994. Syringe exchange programs also provided a variety of other services and supplies, and legal programs were more likely than illegal ones to provide these services.

Conclusion. Despite continued lack of federal funding, syringe exchange programs expanded in terms of the number of syringes exchanged, the geographic distribution of programs, and the range of services offered. (*Am J Public Health.* 1999; 89:43–46)

The primary goal of syringe exchange programs is to reduce HIV transmission associated with drug injection by providing sterile syringes in exchange for used, potentially contaminated syringes. Data from the Centers for Disease Control and Prevention indicate that approximately one-third (36%) of AIDS cases in the United States are directly or indirectly associated with injecting drug use.[1] Moreover, 50% of new HIV infections are occurring among injection drug users.[2] Despite these numbers and the data documenting the efficacy of syringe exchange programs, no federal funding is available for syringe exchange.[3–5] Even without federal support, however, syringe exchange programs in the United States continue to expand both in number and in terms of geographic area.

This report summarizes a survey of US syringe exchange programs' activities during 1996 and compares the findings with those from a similar 1994 survey.

Methods

In November 1996, the Beth Israel Medical Center in New York City, in collaboration with the North American Syringe Exchange Network (NASEN), mailed questionnaires to the directors of 101 syringe exchange programs in the United States that were known to NASEN. The survey instrument included a series of open-ended and closed-ended questions. Subsequently, program directors were contacted by Beth Israel Medical Center research staff to conduct structured telephone interviews based on the mailed questionnaires. Directors were given the option to keep their program's data confidential. Affiliation with NASEN provides several advantages: (1) no cost for membership, (2) provision of operating supplies, (3) informal network of support, (4) important national information, and (5) a yearly national convention that offers scholarships for syringe exchange programs that cannot afford the costs of sending representatives. NASEN maintains strict confidentiality for its members, and we have assumed that the vast majority of syringe exchange programs in the United States are affiliated with NASEN and were therefore included on our mailing list. Although some small programs, or those administered by private individuals, may have gone unnoticed, it is very unlikely that any programs exchanging large numbers of syringes per year would not be known to NASEN.

The survey data we have collected include the number of syringes exchanged during 1996 and information about the syringe exchange programs' operations, legal status, and services offered. A shorter and much more limited analysis of these data was reported in June 1997 in *Morbidity and Mortality Weekly Report (MMWR)*.[6] We now present a more detailed analysis that includes the associations between program size and services provided, program costs, geographic location, and funding sources.

Programs were categorized according to their legal status. "Legal" programs operated in states that did not have a prescription law (a law requiring a prescription to purchase a hypodermic syringe) or that had an exemption to the state law allowing the program to

Denise Paone, Jessica Clark, Qiuhu Shi, and Don C. Des Jarlais are with the Beth Israel Medical Center, New York, NY. David Purchase is with the North American Syringe Exchange Network, Tacoma, Wash.

Correspondence and requests for reprints should be sent to Denise Paone, EdD, Beth Israel Medical Center, Chemical Dependency Institute, 1st Ave and 16th St, New York, NY 10003 (e-mail: dpaone@ix.netcom.com).

This paper was accepted May 22, 1998.

operate. "Illegal but tolerated" programs operated in states that had a prescription law but had received a formal vote of support or approval from a local elected body. "Illegal-underground" programs operated in states that had a prescription law and no formal support from local officials.

For programs that operated multiple sites and/or satellite programs, only the parent program was surveyed and provided data for all of its dependent subsidiaries. All programs considered new in 1995 or 1996 were distinct programs, not simply new sites for already established programs.

Programs were also categorized according to their size. Small programs exchanged fewer than 10 000 syringes per year, medium programs exchanged between 10 000 and 55 000 syringes per year, large programs exchanged between 55 001 and 499 999 syringes per year, and extra large programs exchanged 500 000 or more syringes per year.

We examined the data to determine the relation between program size and number of syringes exchanged. Eighty-four programs reported exchanging nearly 14 million syringes (3 programs did not provide data). Of these 84 programs, 73 were open for more than 12 months, 3 were open for between 9 and 12 months, and 8 were open for less than 9 months. Thus, 11 programs were in a start-up phase of operations, which is an atypical period in any organization, and the number of syringes they exchanged in the calendar year may be underestimated.

Programs were questioned about "secondary exchange," which was defined as participants' providing syringes to people who do not attend syringe exchange programs themselves and which includes participants' exchanging used syringes for new ones, giving syringes away, bartering with syringes, and/or selling syringes to other users. For some programs, secondary exchange accounts for a large proportion of the total number of syringes exchanged. Ethnographic data indicate that many people do not go to an exchange because they fear the stigma associated with using a syringe exchange program. Programs were also questioned about funding for "syringe disposal." This question was designed to determine whether the programs had funding specifically designated in their budget for collecting and disposing of syringes according to designated methods for the disposal of biohazardous waste. Finally, programs were questioned about operational difficulties experienced during the past year. Responses included "lack of resources" (insufficient funds for the operation of syringe exchange) and "staff shortages" (not mutually exclusive categories).

TABLE 1—Number of US Syringe Exchange Programs and Syringes Exchanged, by Size of Program, 1996 (n = 84[a])

Size of Program	Programs No.	Programs (%)	Syringes Exchanged No.	Syringes Exchanged (%)
<10 000	23	(27)	84 737	(<1)
10 000–55 000	27	(32)	810 247	(6)
55 001–499 999	24	(29)	3 658 060	(26)
≥500 000	10	(12[b])	9 407 628	(67)
Total	84	(100)	13 940 672	(100)

[a]Three programs did not report the number of syringes exchanged.
[b]These 10 programs were located in New York City (2), Seattle, Tacoma, Philadelphia, Chicago, Bridgeport, Oakland, San Francisco, and Los Angeles.

Descriptive statistics (frequencies, mean, standard deviation, median, and range) were generated for all study variables. Bivariate analyses were conducted by using the χ^2 test, Fisher exact test, and student t test. Significance was reported at $P < .05$.

Results

Of the 101 programs contacted, 87 participated in this survey, providing an 86% response rate, slightly lower than the 88% response rate in 1994.[7] Almost all of the programs that did not participate were small and/or underground. Of those that did participate, 51 began operating before 1995, 22 in 1995, and 14 in 1996. These 87 syringe exchange programs reported operating in 71 cities in 28 states and 1 territory; 44 of the programs were located in 4 states (California, 17; Washington, 11; New York, 10; and Connecticut, 6). In 8 cities, at least 2 programs reported operating. In comparison, in 1994, 60 syringe exchange programs reported operating in 46 cities and in 21 states.

The 10 programs in New York represent 3 of the 5 boroughs—Manhattan, Brooklyn, and the Bronx. To date, there are no known syringe exchange programs in either Staten Island or Queens.

Of the 87 programs that participated in this study, 3 did not provide information about the number of syringes exchanged. The remaining 84 reported exchanging approximately 14 million syringes (median: 36 017 syringes per syringe exchange program). In comparison, approximately 8 million syringes were exchanged by 55 programs in 1994 (median: 39 014). Although the overall number of syringes exchanged increased from 1994 to 1996, the median decreased because of an increased number of small programs in 1996.

The 10 most active programs—those that exchanged 500 000 or more syringes—accounted for approximately 9.4 million (67%) of all syringes exchanged. As in 1994, the San Francisco syringe exchange program reported exchanging the largest number of syringes (approximately 1.5 million) in 1996. In comparison, the 23 small programs—those exchanging fewer than 10 000 syringes—exchanged fewer than 1% of the total number of syringes (Table 1). These small programs exchanged a mean of 2815 syringes in 1996 and operated on a mean annual budget of $19 643 (median: $5000) compared with a mean budget of $245 334 (median: $255 000) for all programs.

In addition to exchanging syringes, the programs provided other risk reduction supplies and services. All 87 (100%) provided IDUs with information about safer injection techniques and/or use of bleach to disinfect injection equipment. All but 3 (97%) reported referring clients to substance-abuse treatment programs and providing instruction in the use of condoms and dental dams to prevent sexual transmission of HIV and other sexually transmitted diseases, and 70 (80%) reported offering education on sexually transmitted disease prevention. The 3 programs that did not refer participants to drug treatment were illegal-underground programs and may have been limited by budgetary or staffing constraints. Various health services were also offered by many programs (Table 2).

A direct association was found between program size and the provision of services other than syringe exchange. The 10 extra-large programs reported offering, on average, 4.70 services; the 24 large programs offered an average of 3.29 services; the 27 medium programs offered an average of 1.93 services; and the 23 smallest programs reported offering an average of 1.91 services.

In 1996, 46 (53%) syringe exchange programs were legal, 20 (23%) were illegal but tolerated, and 21 (24%) were illegal-underground. Legal status was further examined to assess association with delivery of services (Table 3). Legal programs were

more likely to offer on-site HIV counseling and testing and tuberculosis skin testing than were illegal programs. Operations also differed with regard to legal status. Legal programs were less likely than illegal ones to conduct secondary exchange and more likely to have formal agreements with drug treatment providers. Finally, legal programs were less likely than illegal programs to report lack of resources or staff shortages as problems encountered over the last year.

The primary source of funding reported by 45% of programs was their state government, whereas 33% reported their local government, and 15% reported private foundations. No programs received federal funding for exchange operations, reflecting current federal law restrictions.[4]

Programs reported their annual syringe exchange budget, and the cost per syringe for each program was calculated. Program size was correlated with cost per syringe exchanged, and larger programs showed a lower cost per syringe. The average cost per syringe exchanged for extra-large programs was $0.25; for large programs, $0.98; and for medium programs, $1.43. The mean cost for all 3 categories was $1.07. This relationship remained stable when programs were stratified by legal status. We did not calculate the cost for the small programs because nearly all of these programs reported being open for less than a year, which is likely to be an atypical period.

TABLE 2—On-Site Health Services at US Syringe Exchange Programs, 1996[a]

Type of Service	Offering Service No.	(%)
HIV counseling and testing	37	(43)
Primary health care	15	(17)
Tuberculosis skin testing	22	(25)
Sexually transmitted disease	16	(18)

[a]n = 87.

Discussion

Several limitations to this study must be noted. Because the definition of "legal" status did not include an account of local drug paraphernalia laws, legal barriers to syringe exchange programs may have been underestimated. Drug paraphernalia laws may affect a program's effectiveness, even in the presence of "waivers" or prescription laws, by making the carrying of syringes by participants an offense liable to prosecution.

Syringe exchange program activity, overall, may have been underestimated, because not all operational programs are known to NASEN and not all NASEN members participated in the survey. However, as discussed in the methods section, it is very unlikely that programs exchanging large numbers of syringes per year would go unknown to NASEN.

In addition, data presented in this report were self-reported by program directors, and our cost constraints precluded making site visits. Finally, although we report on referrals to various health services and to drug treatment, because of confidentiality laws and funding limitations, very few programs tracked the proportion of clients who did in fact use the services to which they were referred.

Despite a lack of federal funding for the operation of syringe exchange in the United States, the number of syringes exchanged increased by 75% between 1994 and 1996, and the number of cities and states operating syringe exchange programs also increased. More than half the states (29) had at least one syringe exchange program in 1996, located in 71 cities, reflecting a 54% increase in the number of cities. The 36 new programs that began operating since 1994 were geographically dispersed (i.e., 3 opened in the Northwest, 3 in the Southwest, 10 in the Midwest, 7 in the Southeast, and 13 in the Northeast).

Although the data indicate that syringe exchange programs are complex service organizations that provide more than "clean needles," programs that have full legal status share several differing but important operational characteristics. Similar to the results of our 1994 survey, legal programs were more likely to offer certain on-site services and referrals, to have an age minimum for participants, to have formal agreements with drug treatment providers, and to receive funding for syringe disposal. The 3 programs that did not make referrals to drug treatment were illegal-underground. The illegal status of programs suggests more difficulty in raising funds, resulting in a lack of resources and in staff shortages. More important, illegal status may hinder the ability of programs to exchange enough syringes to significantly affect the injection practices of a community with many injection drug users.

In a recent study, Des Jarlais et al.[3] compared HIV incidence among injection drug users participating in legal syringe exchange programs in New York City with HIV incidence among nonparticipants (who did not have legal access to sterile syringes). The study found that use of legal syringe exchange programs provides a strong (adjusted odds ratio of 0.3) individual-level protective effect against HIV infection.

This survey provides important information on the state of syringe exchange in the United States. In addition to providing important public health services, syringe exchange programs clearly serve as centers for the dissemination of education and HIV-prevention supplies. Secondary exchange of syringes was widely reported and appears to be an important mechanism for the distribution of sterile injection equipment to those injection drug users unable to obtain syringes directly from an exchange. Interestingly, illegal programs were more likely to allow secondary exchange, which may be associated with being less regulated, than officially sanctioned programs. Despite the

TABLE 3—Services Offered and Operational Issues, by Legal Status, for US Syringe Exchange Programs, 1996

	Legal[a] No.	(%)	Illegal[b] No.	(%)
HIV counseling and testing	29	(63)	8	(20***)
Tuberculosis skin testing	19	(41)	3	(7***)
Secondary exchange	38	(83)	41	(100***)
Age minimum	23	(50)	10	(24*)
Formal agreements with drug treatment providers	29	(63)	14	(34*)
Specific funding for syringe disposal	18	(39)	8	(20*)
Lack of resources	19	(41)	29	(71***)
Staff shortage	17	(37)	29	(71***)

[a]n = 46.
[b]n = 41.
*P < .05; **P < .01; ***P = .001.

current ban on the use of federal funds for syringe exchange, programs have grown in number, size, and scope. However, the ability to provide large numbers of sterile syringes, as well as referrals and access to services, is clearly associated with legal status. This finding suggests that changes in syringe distribution laws, changes in drug paraphernalia laws, and increased public support and funding for syringe exchange programs would have a significant positive effect on HIV risk behavior. □

Contributors

Dr Paone conceived and developed the idea for the article, wrote the first and subsequent drafts, and discussed the ideas at scientific meetings worldwide. Ms Clark coordinated the project and conducted interviews. Dr Des Jarlais coconceived and codeveloped the idea for the article. Dr Shi managed and analyzed the data and provided statistical expertise. Mr Purchase coordinated various aspects of data collection nationwide through the North A ican Syringe Exchange Network. All authors codeveloped and corefined the intellectual content, contributed to early and final drafts, and provided historical, ethical, and editorial expertise as required.

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References

1. *HIV/AIDS Surveillance*. Atlanta, Ga: Centers for Disease Control and Prevention; 1997;8: 1–39. February 2, 1998.
2. Holmberg SD. The estimated prevalence and incidence of HIV in 96 large US metropolitan areas. *Am J Public Health*. 1996;86:642–654.
3. Des Jarlais DC, Marmor M, Paone D, et al. HIV incidence among injecting drug users in New York City syringe-exchange programmes. *Lancet*. 1996;348:987–991.
4. Normand J, Vlahov D, Moses LE, eds. *Preventing HIV Transmission: The Role of Sterile Needles and Bleach*. Washington, DC: National Academy Press; 1995.
5. Lurie P, Reingold AL, eds. *The Public Health Impact of Needle-Exchange Programs in the United States and Abroad: Summary, Conclusions, and Recommendations*. San Francisco: University of California, San Francisco, Institute for Health Policy Studies; 1993.
6. Centers for Disease Control and Prevention. Syringe exchange programs—United States, 1996. *MMWR Morb Mortal Wkly Rep*. 1997; 46:565–568.
7. Centers for Disease Control and Prevention. Syringe exchange programs in the United States, 1994–1995. *MMWR Morb Mortal Wkly Rep*. 1995;44:684–685, 691.
8. Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act. Pub L No. 102-394, 106 Stat 1827, §514. (October 6, 1993).

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To: Cheryl **From:** Cliff Morrison, Program Director

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Phone: **Pages:** 3

Re: **CC:**

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Cheryl: attached is the ltr. to vice president Gore inviting him to speak at the conference. also, a request for a photo of Sandy for our program.

Thanks, Cliff

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HIV/AIDS at the crossroads
Confronting Critical Issues

January 31, 2000

Al Gore
Office of the Vice President
The White House
Washington, D.C. 20500

Dear Vice President Gore:

On behalf of the Planning Committee for the 12th National HIV/AIDS Update Conference, we would like to invite you to make a short presentation at the opening plenary session of the Conference. The opening plenary session is scheduled for Wednesday, March 15, 2000 from 9:00 – 10:30 a.m. at the Bill Graham Civic Auditorium, San Francisco, California. Mervyn F. Silverman, MD, Conference Director and Chair will moderate the opening plenary session. Other invited speakers include San Francisco Mayor, Willie Brown, California Governor, Gray Davis, Sandra Thurman, Director of the White House Office for AIDS Policy and Mary Fisher, Founder of the Family AIDS Network. The National HIV/AIDS Update Conference is an annual event that attracts approximately 2000 participants from all areas of the country. Participants include physicians, nurses, social workers, counselors, administrators, volunteers, policy makers and people living with HIV disease. This conference is the only one of this kind that is held annually. The theme for the Conference is "HIV/AIDS at the Crossroads: Confronting Critical Issues". I am enclosing a copy of our main announcement for you to review. Should you accept this invitation we would like for you to speak for approximately fifteen minutes and address the issues in any way that you would like. You will find that this is a very "friendly" audience that will be extremely receptive to your comments. If you have any questions, please feel free to contact me directly at 510/645-1245 (fax: 510/645-1246) or e-mail cliffmo@aol.com

I look forward to hearing from you soon.

Sincerely,

Cliff Morrison, Conference Program Director

cc: Sandra Thurman

March 14-17, 2000
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Conference Secretariat
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205 Viger Avenue West
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Canada H2Z 1G2

tel: (514) 874-1998
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