

FOIA MARKER

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Series/Staff Member:

Subseries:

OA/ID Number: 19394

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Folder Title:

Correspondence - SLT - Incoming - 7/97 [Folder 3] [1]

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Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. letters	AIDS researcher re: Personal cure to AIDS (Personal) (8 pages)	00/00/1997	b(6)
001b. envelope	re: AIDS researcher (Personal) (1 page)	07/12/1997	b(6)
002. letters	AIDS researcher re: Personal cure to AIDS (Personal) (4 pages)	07/00/1997	b(6)

COLLECTION:

Clinton Presidential Records
National AIDS Policy Office

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Correspondence - SLT - Incoming - 7/97 [Folder 3] [1]

2018-0764-F

jm2047

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

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- b(1) National security classified information [(b)(1) of the FOIA]
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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001b. envelope	re: AIDS researcher (Personal) (1 page)	07/12/1997	b(6)

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Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G-3833

Date Rcvd: 7-15-97

From: Brian T. Warden

Staff Action:

Reviewed By Sandy: _____ Reviewed By: _____

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

To Support Staff: _____

Date of Response: 10/14/97

n:\corresli

76549-7W

310 McPherson

FT Leavenworth, KS 66037

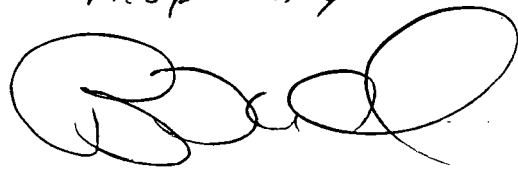
July 6, 1997

Director Sandy Thurman
Office of National AIDS Policy
750 17th St. NW Ste 600
Washington, DC 20503

Dear Sandy Thurman:

I am interested in your decision about the vacancies on the President's Advisory Council. I am extremely interested in filling one of the openings. Please let me know. Thank you!

Respectfully

A handwritten signature in dark ink, appearing to read "Brian T. Warden". The signature is stylized with large, flowing loops and a prominent initial "B".

Brian T. Warden

31 July 97

Dear Sandy,

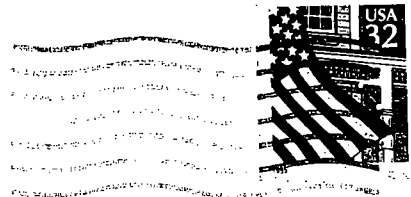
It was absolutely excellent if you to
squeeze another interview in during your last
trip to Atlanta. You are a clear and compelling
voice in the often chaotic and cacophonous
sound of fools, fools and other "Jurassic Park"
-esque characters we are forced to endure.
But the cause is vital and I hope, one
day, we get a chance to work together.

Do you think you could arrange
lunch for us with the President? It would
make my year.

Yours, Robert Morris
#525-8006

SI paper written on

Robert Morris
802 Ashland Ave.
Atlanta, GA
30307



Sandy Thurman
808 17th Street, N.W.
8th Floor
Washington, D.C.

20006



Memorandum

7-14-97

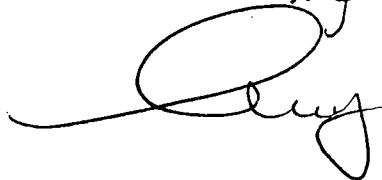
Sandy.

AMY W. SLEMMER

I thought that Thursday's meeting was very helpful, and am encouraged by all of the subsequent action.

I will be up on the Hill today and tomorrow handling out copies of Mothers - Voices Needle Exchange paper.

Thanks for all of your help. I'll see you tomorrow for the Prevention Meeting -



MOTHERS' VOICES

United to end AIDS®

July 11, 1997



Ms. Sandra Thurman
Director
Office of National AIDS Policy
808 17th Street, N.W.
Suite 800
Washington, D.C. 20503

no response needed (TS)

Dear Sandy,

I appreciate the time that you took yesterday to discuss issues surrounding the current ban against the use of federal funding for needle exchange programs. The meeting was both instructive and disturbing. It was helpful to hear your commitment to preserving Secretary Shalala's authority, and disturbing that you could not commit to exercising that authority.

Ann Kurth,
Executive Director

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IN MEMORIAM

Elizabeth Glaser
Don Hall
Flo Spierer

We concur wholeheartedly with the community representatives who expressed outrage at the lack of progress toward a comprehensive plan for implementing the Secretary's waiver. Mothers' Voices believes that the Secretary should act immediately, and should expect a negative reaction from conservatives on Capitol Hill. If a proper roll out plan is arranged, this backlash could be minimized. The Secretary has science behind her as well as the support of the affected community, prominent health organizations, not the least of which is the American Medical Association, the U.S. Conference of Mayors and many major newspapers which have endorsed the lifting of the ban as an effective HIV prevention tool.

Enclosed is a copy of the paper that Mothers' Voices has been distributing on Capitol Hill. It outlines the debate and provides summary talking points in favor of lifting the ban. Mothers' Voices will continue to work diligently to protect Secretary Shalala's authority to exercise the waiver, as we try to educate both the skeptical and potentially dangerous opponents about the need for and effectiveness of needle exchange programs.

I appreciate your efforts, and hope that you will keep tens of thousands of people who stand to benefit from needle exchange programs in mind as you proceed with your decision making process about whether or not the Secretary should exercise her authority. Conservative scientific estimates are that 33 people a day become HIV infected due to transmission through dirty needles. These represent not only needless infections but missed opportunities to provide treatment to injection drug users.

Sincerely,

Amy Whitcomb Slemmer
Legislative Consultant

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Suite 701
New York, NY 10036

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EMAIL: ASLEMMER@AOL.COM



MOTHERS' VOICES

United to end AIDS®

MOTHERS' VOICES REPORT

**Needle Exchange: An Effective Weapon in
Our HIV Prevention Arsenal**

July 1997

Mothers' Voices ■ 165 West 46th Street, Suite 701 ■ New York, NY 10036
telephone 212.730.2777 ■ *facsimile* 212.730.4378 ■ *internet* <http://www.mvoices.org>

MOTHERS' VOICES REPORT

NEEDLE EXCHANGE: An Effective Weapon in our HIV Prevention Arsenal

INTRODUCTION:

New AIDS treatments provide improved chances for long-term survival, and renewed hope for an ultimate cure. During this time of optimism, though, we must not lose sight of the need to continue to aggressively prevent the spread of AIDS. While the new drug combination therapies offer hope to those living with HIV (the virus that causes AIDS), we must remember that these medicines have not prevented one infection.

The public is increasingly familiar with many standard HIV prevention options. Education about the need for safer sex, including condom availability, seems to reach at least a portion of the intended audience, and healthcare workers know to practice universal precautions to avoid viral transmission.

However, one very important weapon in our prevention arsenal *that has been proven to work* remains stigmatized: i.e., providing access to clean needles to reduce the transmission of HIV when dirty needles are shared by injecting drug users. Even though the epidemic has been fueled by exposure to dirty needles, Congress has actually *prohibited* needle exchange programs from receiving federal funding. Without access to these funds, only a handful of such programs (around 100 or so) exist, operating on an ad-hoc basis with piecemeal funding, in an attempt by these communities to stem the tide of local HIV infection.

Because needle/syringe exchange programs have proven effective, there is now a growing call for a national strategy to increase the availability of these programs to reach more areas of the country. Citing an "urgent public health need," the American Medical Association recently called for a change in laws to allow injecting drug users to possess and have easy access to clean hypodermic needles. The AMA voted to work with Congress to develop legislation to revoke the nine-year-old ban on federal funding for needle exchange programs and to urge state medical groups to initiate state bills to relax their state's drug paraphernalia laws.¹

OVERVIEW:

Currently, the fastest growing cause of HIV transmission is injecting drug use (IDU), which is increasing at twice the rate of infections among gay men. The virus is spread through blood to blood contact among drug users who share dirty needles. HIV is then passed on to the sexual partners (many of whom are not injecting drug users themselves), or to their newborns via perinatal transmission (mother to baby). **It is estimated that one-third of all current HIV infections are due, either directly or indirectly, to injecting drug use.**

¹ Seelye, KQ. A.M.A. backs drug-user needle exchanges. *New York Times* 6/27/97: A15.

Researchers have found that nearly 10,000 HIV infections in the United States could have been prevented between 1987 and 1995 if needle exchange programs had been more widely available.²

As public health officials know, people who are addicted to drugs spread the virus because they have no access to clean needles or syringes, and because they are unaware of their HIV status. Surveys have found that injecting drug users are concerned about contracting HIV, but legal and other barriers to clean needles keep them from taking the necessary precautions to prevent transmission of the virus.

Mothers' Voices believes that access to clean needles can significantly reduce HIV infections among injecting drug users, their sex partners and children. We believe that well designed needle exchange programs enable substance users to avoid HIV infection, and provide encouragement to enroll in drug treatment programs and vital links to other important health services.

Thus, we support lifting the ban on federal funding for needle exchange programs³ and revoking or modifying state prescription and paraphernalia laws that limit access to sterile syringes.⁴

FACTS:

- One-third of all new HIV infections are attributable to injecting drug users and their sexual partners. Sixty-three percent of all AIDS cases among women are related to sharing needles and syringes for the injection of drugs or to sex with an injecting drug user; and 58 percent of all pediatric AIDS cases are due to the mother's use of injecting drugs or sex with an injecting drug user. Over one-half of all AIDS-related deaths for African-Americans and Latinos are injection-related.
- The lifetime cost of treating 25,500 cases of needle/syringe sharing related AIDS (the number treated in 1995) was more than \$3 billion. If the federal ban on needle exchange funding continues to the turn of the century, the United States will have failed to prevent 11,000 cases of AIDS at a cost of at least \$1.3 billion for medical care.
- **Needle exchange programs work.** Seven federally supported studies have concluded that needle exchange programs are an effective means of slowing the rate of HIV transmission, without increasing drug use.⁵ After instituting their needle exchange program, New Haven, Connecticut found an estimated 33% reduction in the rate of new HIV infections among their target population.

² Lurie P & Drucker E. *Lancet* 3/3/97

³ Federal law currently prohibits funding needle exchange until "the Surgeon General of the United States [determines] that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs."

⁴ Ten states and the District of Columbia prohibit the purchase of a syringe without a prescription. Paraphernalia laws exist in 46 states and the District of Columbia precluding the possession or distribution of syringes except for "legitimate medical purposes."

⁵ The National Commission on AIDS, 1991; University of California, 1993; The Centers for Disease Control, 1993; The National Academy of Sciences 1995; General Accounting Office, 1993; and Office of Technology Assessment, 1995; NIH Consensus Document on HIV Prevention Strategies, 1997.

- **Needle exchange programs do not increase the incidence of drug abuse.** A study of a San Francisco based needle exchange program found that the rate of daily injections was actually decreased among program participants.
- **Needle exchange programs provide a point of access** for injecting drug users into a broader range of healthcare services including drug treatment, AIDS education and traditional medical care. Most cities have long waiting lists of drug treatment services. In Seattle, Washington eight of ten participants who requested vouchers entered into addiction treatment programs.
- **Needle exchange programs are an inexpensive way to prevent HIV infection.** The median cost of running a needle exchange program is \$169,000, which breaks down to approximately \$0.71 to \$1.63 per syringe distributed. The lifetime cost of treating a person with AIDS is estimated to be approximately \$119,000.

FEDERAL FUNDING, LOCAL DESIGN:

Needle exchange programs cannot begin to solve the problems of those addicted to drugs, nor the larger constellation of problems faced in poor and disenfranchised communities. However, when properly designed and with community support, such programs can have a major impact on reducing HIV transmission among injecting drug users, thus creating an opportunity for many to live long enough to overcome their drug addiction.

One critical element necessary for the success of these programs is local planning and authority over the design of the needle exchange efforts. Mayors and local health officials who have encouraged the creation of needle exchange coalitions have found that cooperative efforts with the local affected population and the community at large have been critically important to the success of these programs. Local autonomy provides health officials with the opportunity to tailor their programs to the specific concerns and conditions of their community.

The ban against the use of federal money for needle exchange programs has been a barrier to increasing the number of local programs in existence. Public health and elected officials report that the federal ban has had a chilling effect on creating new programs. While these programs have proven to be effective, local officials interested in implementing needle exchange programs point to the lack of federal leadership and support as a primary impediment to initiating their own local efforts.

Thus far, the ban against the use of federal funding for needle exchange programs has been motivated by politics. Elected officials and Administration appointees are concerned about being seen as supporting the habits of injecting drug users. But studies have shown that a majority of the American public actually support needle exchange programs -- one recent survey from the Kaiser Family Foundation reveals that 55 percent of 1,000 voters surveyed were either strongly or somewhat in favor of needle-exchange programs to prevent the spread of HIV.⁶ Leaders from the Centers for Disease Control and the National Institutes of Health, numerous national public health organizations, drug treatment programs, law enforcement officials, religious leaders,

⁶ Reuters. Most US voters favor needle exchange. 6/13/97

and organizations involved in the daily battle to prevent the spread of AIDS, support funding needle exchange programs.

There is bipartisan support from elected officials, as well. In June 1997 the United States Conference of Mayors approved a bipartisan resolution urging immediate elimination of the current restriction on the use of federal funds for needle exchange. Legislators in California, Rhode Island, and Minnesota recently have passed bills supporting needle exchange programs.

Finally, the scientific evidence is in. The National Institutes of Health HIV Prevention Consensus report published in February 1997 found that needle exchange programs cause a 30 percent or greater reduction in HIV in injecting drug users and increase the likelihood that IDUs will enter drug treatment programs. The NIH found that needle exchange *does not* increase drug use or encourage non-drug users, especially youth, to use drugs; and does not lead to an increase in used needles discarded in public spaces.

CONCLUSION:

Needle exchange programs are a critical part of comprehensive HIV prevention. A commitment of funds and resources must be dedicated to these programs so that they will include additional services such as drug treatment programs and healthcare services that make effective intervention for the injecting drug user community possible.

Currently, all statutory conditions for lifting the ban have been met. In 1996 U.S. Secretary of Health and Human Services Shalala herself declared that these programs have been shown to reduce the rate of new HIV infections, and in 1997 she declared that needle exchange programs are "an effective component of a comprehensive strategy to prevent HIV and other blood borne infectious diseases."

The decision to lift the ban should be considered on the merits as a sound public health strategy.

The Clinton administration must exercise its ability to waive the ban, and the members of Congress must stand by Secretary Shalala's decision to do so.

Every day the ban is in place is a day when new HIV infections will be spread -- unnecessarily -- to at least 33 American men, women, and children.



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telephone 212.730.2777 ■ facsimile 212.730.4378 ■ internet <http://www.mvoices.org>

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TO: AIDS Action Family & Friends
FROM: Daniel Zingale *DZ*
Claudia Dawn French *CD*
DATE: July 16, 1997
RE: Great News!

no response needed TS

The national attention on our Monday State of AIDS Forum paid off in Tuesday's Appropriations Subcommittees. Our message: Investments in AIDS programs are directly connected to a decline in deaths. The result: \$258 million increase for AIDS programs.

AIDS Action made headline news around the country yesterday. The lead story? AIDS Action's national State of AIDS Forum where The Centers for Disease Control and Prevention chose to release the latest figures on AIDS in this country and where people with AIDS and leaders in the AIDS community presented the larger picture of what these figures represent ... "the need for a concerted national effort to remedy the inequities that exist in access to Federal HIV prevention programs and health care services, inequities which significantly contribute to the spread of HIV."

Crowded into the National Press Club were 13 television crews including every single national network. C-SPAN carried the Forum live and replayed it during prime-time last evening. Representatives from every major daily newspaper in the nation attended and yesterday the story was in every major outlet around the country – The Washington Post, The New York Times (enclosed), The Boston Globe, The Des Moines Register, The Houston Globe, The Chicago Tribune, The Los Angeles Times, etc. All Wire Services carried the story and it made the international desk. All on-line news forums carried the story all day.

1875
Connecticut Ave NW
Suite 700
Washington DC
20009
Fax 202 986 1345
Tel 202 986 1300

The energy and excitement around this event has been exhilarating. It just goes to show that AIDS Action, with the support of its members – concerned citizens, people with AIDS, community-based organizations, corporate and foundation leaders – can truly make a difference in the lives of people with HIV and AIDS. This has been a remarkable victory for us all.

A special thank you to Dr. Bernard Salick & Bentley Health Care, Inc. for underwriting the State of AIDS Forum and to Whitman-Walker Clinic for hosting the event.

Clinton Presidential Records Digital Records Marker

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This marker identifies the place of an oversized document(s). Given our digitization capabilities, we are sometimes unable to adequately scan such large documents. The title from the original document is indicated below.

Oversized documents have not been scanned in their entirety for the purpose of digitization. To see the documents please contact or visit the Clinton Presidential Library's Research Room.

"All the News
That's Fit to Print"

The New York Times

VOL. CXLVI . . . No. 50,854

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TUESDAY, JULY 15, 1997

ONE DOLLAR

Washington Final

Washington and Baltimore: Hazy, hot, humid. High 99. Tonight, steamy. Low 76. Tomorrow, hazy, humid, not as hot. Widely separated thunderstorms. High 94. Details are on page D19.



Ozler Muhammad/The New York Times



Ozler Muhammad/The New York Times



James Estrin/The New York Times

The Midday Sun Was Too Much

New Yorkers used any means at hand yesterday to shield their baked brows from the sun as temperatures rose into the mid-90's.

Mir Astronaut's Heart Ills Cast Doubt on Repair Effort

By MICHAEL R. GORDON

MOSCOW, July 14 — Just days after good luck charms, he has still had to

O. J. Simpson House Brings \$2.6 Million

After a public auction with two bidders that lasted only three minutes, O. J. Simpson became just an

AIDS Deaths Drop 19% in U.S., In Part From Newer Treatment

*Decline Is Attributed to
Better Medical Care
and Newer Drugs*

By LAWRENCE K. ALTMAN

WASHINGTON, July 14 — AIDS deaths continue to decline in the United States and the trend is expected to go on, Federal health officials said here today.

The number of deaths dropped 19 percent, to 30,700 from 37,900, in the first nine months of 1996, compared with the same period of 1995. Among women, the number of deaths dropped for the first time.

The overall decline was attributed to greater access to medical care and to development of newer drug therapies for both the AIDS virus and for the myriad opportunistic infections that can occur as fatal complications of AIDS, itself a potentially fatal disease.

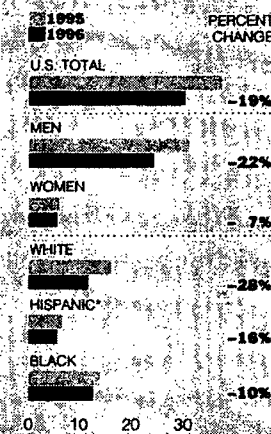
Worldwide, AIDS cases and deaths are on the increase, and experts have said that the combination drug therapies that have helped reduce deaths in the United States are unlikely to have a similar impact in the regions of Africa and Asia where the disease is growing. The cost and difficulty of administering the therapies are barriers to their effective use in poor countries.

The decline in the United States began before the first protease inhibitor drug was marketed in December 1995, said Dr. Helene Gayle, who heads the AIDS programs of the Centers for Disease Control and Prevention, in Atlanta.

Dr. Gayle and advocates for people with AIDS said they were heartened by the good news because some public health officials had suggested that improvements reported earlier by New York City and the disease centers were due to incomplete reporting or statistical quirks.

"We have entered a new era in the H.I.V. epidemic, both in terms of

Estimated number of AIDS-related deaths from January to September. In thousands:



*May be of any race.

Source: Centers for Disease Control and Prevention

The New York Times

BOSNIAN SERB GETS 20-YEAR SENTENCE

*In The Hague, a Tribunal Judge
Cites 'Sadistic' War Crimes*

THE HAGUE, July 14 (Reuters) — The United Nations war crimes tribunal sentenced a Bosnian Serb to a 20-year prison term today for his part in an "ethnic cleansing" campaign against Muslim civilians during the Bosnian war, in 1992.

Dusan Tadic, 41, a former police reservist and bar owner, was sen-

THE DOLLAR SOARS AS EUROPE DOUBTS ITS CURRENCY PLAN

HIGHEST LEVEL IN 6 YEARS

*Increase Reflects Skepticism
on 1999 Start for the Euro
— Fears on Yen Eased*

By EDMUND L. ANDREWS

FRANKFURT, July 14 — Defying the efforts of policy makers on both sides of the Atlantic to restrain the strength of the American currency, the dollar surged in value today against most major European currencies, reaching its highest level in six years against the German mark and the French franc.

The rise reflects the dollar's expanding role as a haven for currency traders skeptical over the future of the euro, the new single European currency that is supposed to start replacing several national denominations here in 1999.

With the dollar buying nearly 1.8 German marks and more than 6 French francs, it is now worth about 10 percent more than it was in early February, when American and European finance ministers declared that the United States currency had already climbed enough and was due for a pause.

By contrast, however, the dollar has moved in the other direction against the Japanese yen, helping to alleviate fears in Washington that a weaker yen will only aggravate the gaping American trade deficit with Japan by making Japanese exports cheaper in world markets.

After soaring against the yen for more than a year, the dollar has slipped back in recent months from its high point of 127 yen in April to about 114 today. For the Clinton Administration, led by Treasury Secre-

The Washington Post

TUESDAY, JULY 15, 1997

Death Rate From AIDS Drops Again

Improved Treatments Are Credited in Trend

By Susan Okie
Washington Post Staff Writer

U.S. AIDS deaths fell by 19 percent during the first nine months of 1996 compared with the same period of 1995, indicating that the decline in deaths from the epidemic first reported earlier this year has accelerated, federal officials said yesterday.

The drop in deaths, which health officials attribute in large measure to the effect of new, more effective AIDS treatments, is greater for men than for women and greater for whites than for blacks or Hispanics, but some decrease is showing up in all groups, the officials said.

"All of this is extremely good news and means we have to intensify our efforts at prevention and improve access to treatment," Helene Gayle, director of the National Center for HIV, STD and TB Prevention at the federal Centers for Disease Control and Prevention, told reporters at a conference sponsored by AIDS Action, a coalition of community-based AIDS organizations.

The decline in deaths is partly caused by a "slowing of the epidemic," meaning that the number of Americans diagnosed with AIDS each year is increasing much more slowly

See AIDS, A6, Col. 1

Death Rate From AIDS Continues Decline

AIDS, From A1

than during the 1980s, Gayle said. The reason is unclear. It could be because fewer people are becoming infected due to changes in behavior, but the CDC has no national program that tracks the number of Americans infected with the virus. Alternatively, it could be because better treatments are slowing the rate at which infected people develop full-blown AIDS.

The reduction in AIDS deaths also partly reflects advances in treatment that predated the approval of the protease inhibitors, the most effective group of antiviral drugs currently available. Gayle said a further decline in deaths is likely. "Thus far we don't think the full effect of the protease inhibitors has kicked in," she said.

The new mortality figures show that from January to September 1996, 30,700 Americans died because of AIDS. That was 19 percent less than the number—37,900—who died during the first nine months of 1995.

Last February, a similar CDC analysis of deaths during the first six months of 1996 showed a 13 percent decrease compared with the previous year—the first downturn since the epidemic began in the early 1980s. The new figures show that deaths have continued to decline, at a greater rate.

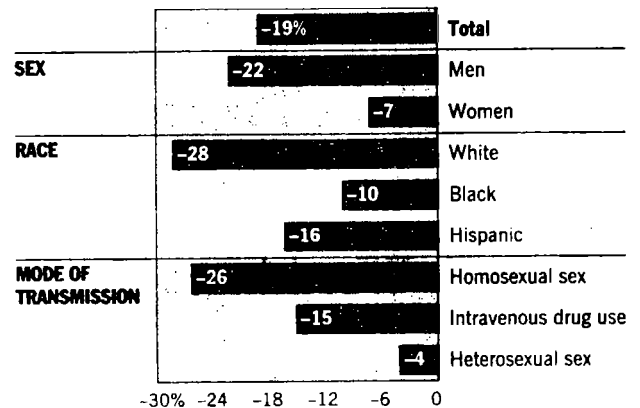
The new figures also show for the first time that deaths decreased by 7 percent for women with AIDS and by 4 percent for people who acquired the virus through heterosexual intercourse. Earlier data had not indicated a reduction in the death rate for those two groups, which make up an increasing proportion of AIDS cases. Women accounted for 20 percent of reported AIDS cases in 1996, compared with 7 percent in 1985.

The reduction in AIDS deaths was greatest for whites—28 percent. It was 16 percent for Hispanics and 10 percent for blacks. "The good news thus is continuing in all categories, but not equally," Gayle said.

The drop in deaths means the number of people living with AIDS is growing by about 10 percent per year, Gayle said. That is because people who are infected with the virus continue to become sick but are surviving longer. Between 150,000 and 180,000 Americans are thought to be taking the new three-drug treatments known as triple therapy.

FEWER AIDS DEATHS

PERCENTAGE CHANGE IN U.S. AIDS DEATHS, 1995-1996 (FIRST NINE MONTHS)



SOURCE: Centers for Disease Control and Prevention

THE WASHINGTON POST

AIDS deaths have also declined locally. In Virginia, there were 628 AIDS deaths reported in 1996, a 30 percent decrease from the 1995 total of 901, said Susan S. Pollard of the state health department. In Maryland, there were 1,168 reported AIDS deaths in 1996, according to Tori Leonard of the state department of health and mental hygiene. That was 20 percent below the 1995 total of 1,456 deaths. Mortality figures for the District were not available yesterday.

Last year, only seven residents died in housing facilities operated by the District-based Whitman-Walker Clinic for HIV-infected people, compared with 18 deaths in 1995, said a clinic spokesman. About 70 people live in the facilities, which have had a waiting list since April 1996. New medical patients now must wait about two weeks before being seen by a doctor, and clinic social workers have no openings for new clients.

Jim Graham, the clinic's executive director, said that despite the increased workload, morale at the clinic has improved. "The old reality was a death sentence for HIV," he said. "We like the new reality even though the new reality has a lot of challenges."

The use of the new drug combinations has dramatically changed the demands that the AIDS epidemic is placing on the health care system. In New York state, for example, inpatient

hospital expenditures paid by insurance companies or by the state health department for people with AIDS fell from about \$1.1 billion in 1994 to \$900 million in 1996, said Victoria Sharp, director of the AIDS Center at New York's St. Luke's-Roosevelt Hospital.

Over the same period, outpatient visits and drug costs for AIDS patients rose steeply, she said, but expenditures by insurers and the state health department in those categories increased by only about \$10 million. Outpatient care "is dramatically underfunded," Sharp said. "All this exciting new therapy is there, but you clearly have to have access to competent physicians in order to truly have access to this therapy."

The cost of standard therapy with three antiviral drugs is between \$10,000 and \$12,000 per year. Sharp said doctors in the outpatient AIDS clinic at her hospital need to spend an average of 40 minutes with each patient, compared with about 20 minutes five years ago.

Representatives of AIDS organizations argued that the federal Medicaid program should be expanded to cover HIV-infected people whose incomes are near the poverty level, so that they can afford the drugs that are likely to slow the progression of their disease. Currently, HIV-infected individuals cannot qualify for Medicaid until they have full-blown AIDS.

AIDS Deaths Drop Further, U.S. Reports

By MARLENE CIMONS
TIMES STAFF WRITER

WASHINGTON—AIDS deaths fell 19% over a nine-month period last year compared with the same period in 1995, accelerating a decline reported earlier this year, federal health officials said Monday.

Although the figures were considered encouraging, they continued to reflect disparities among various groups. The sharpest decrease was among white men, while the number of deaths fell less among women, minorities and poor people, who may lack access to the powerful and expensive new generation of AIDS drugs.

"We have entered a new era in the HIV epidemic, both in terms of treatment and prevention," said Dr. Helene Gayle, director of the national center for HIV, STD and TB prevention at the Centers for Disease Control and Prevention in Atlanta.

The estimated number of deaths from the disease from January to September of last year was 30,700, down from 37,900 during the same nine months of 1995, according to CDC statistics.

The greatest successes in reducing the incidence of AIDS have been seen in gay and bisexual men. Gayle said, however, that at least 40,000 new infections are occurring annually and that "much work is left to be done."

Please see AIDS, A9

AIDS: Bigger Decline in Death Count

Continued from A1

Heterosexual transmission is the fastest growing mode, the CDC said. Heterosexually transmitted cases are increasing by 15% to 20% annually, compared with an increase of 5% or less among gay men and intravenous drug users, the CDC reported.

The decline in deaths is an acceleration of a trend first reported in February, when health officials said AIDS deaths had dropped 13% during the first six months of 1996, compared with the same period in 1995. That was the first recorded drop since the initial reports of the epidemic in 1981.

"Dramatic progress has been made in preventing new infections and in slowing the progression of disease for those infected," said Gayle, whose remarks were made at a forum sponsored by the AIDS Action Council, a Washington-based lobbying and education group.

Health officials said the continuing decline is linked closely to two factors: new drug combination therapies—which include protease inhibitors, a powerful new class of

antiviral drugs—and increased resources devoted to treatment and prevention.

Public health officials have noted repeatedly, however, that the drugs do not work for all infected individuals and not everyone can get them. They can cost about \$15,000 a year, a sum out of the reach of many whose insurance does not pay for the treatment or who are not eligible for public assistance.

"Social safety nets are collapsing," Doug Nelson, executive director of the AIDS Resource Center of Wisconsin, said at the AIDS forum.

He said health programs in Milwaukee that serve the indigent have closed and he predicted that changes to state welfare programs "will further limit access to financial assistance for low-income individuals... our most difficult challenge today and in the years ahead will be to assure access to health care as HIV treatment costs go up, and social safety nets come down."

In addition, global health officials have been disappointed that the

new drugs, so successful in this country, are unavailable or unaffordable to AIDS sufferers overseas, particularly in developing countries.

"As we continue to work to develop better treatment options, we must not lose sight of the fact that preventing HIV infection is the only way to reduce the burden of this disease," Gayle said.

The biggest decline in deaths in this country was recorded among men, with the number falling 22%. Deaths among women dropped only 7%. Still, this was the first time a mortality decrease among women with AIDS was reported.

Similar death-rate disparities exist among racial and ethnic groups. Deaths among whites dropped 28%, compared with 10% among African Americans and 16% among Latinos.

"As the CDC data indicate, the fact remains that there is not equal access to the continuum of care people with HIV/AIDS require to stay alive and healthy," said Daniel Zingale, executive director of AIDS Action Council. "AIDS continues to ravage communities of color and

women—populations which represent the fast growing groups of new AIDS cases."

The statistics, while encouraging, nevertheless "underscore the need for a concerted national effort to remedy the inequities that exist in access to federal HIV prevention programs and health care services—inequities which significantly contribute to the spread of HIV," he added.

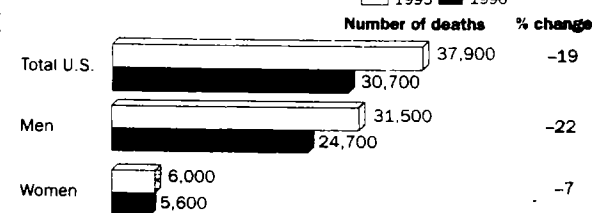
In Los Angeles, health officials have not broken down the local AIDS data in the same way that the CDC has analyzed national death rates, but the trend is much the same.

The number of AIDS deaths reported to the county in the first six months of this year was down 56%, compared with the same period last year, from 1,345 to 586, said Dr. Paul Simon, a medical epidemiologist with the Los Angeles County Department of Health Services. He said there was no readily available data on local racial or ethnic trends in AIDS mortality.

He attributed much of the decline to improved treatments, such as the combination drug therapies. "What

Drop in AIDS Deaths

Deaths from AIDS are declining—19% during the first nine months of 1996—with white men accounting for most of the change, the government announced



Source: Centers for Disease Control and Prevention

Los Angeles Times

it suggests is that it's more important than ever for a person at risk of HIV infection to seek out an HIV test" and get treatment, he said.

"It's wonderful news," the director of education for AIDS Project Los Angeles, Lee Klosinski, said of the new national figures. But he said there was evidence that not all groups in Los Angeles were benefiting equally from the treatment advances.

Research by the advocacy group on 6,000 Los Angeles County people with AIDS showed that

"African American and Latino people are much less likely to know about combination therapy, much less likely to be on it and much less likely to be offered it than their Caucasian counterparts," he said.

"It's wonderful that these drugs have such a powerful effect," Klosinski said, "and it's a tremendous challenge to get information and access to these drugs to people of color."

Times staff writer Terence Monmaney in Los Angeles contributed to this story.

THE WHITE HOUSE

WASHINGTON

July 7, 1997

MEMORANDUM FOR SANDRA THURMAN

FROM: JODIE R. TORKELSON
ASSISTANT TO THE PRESIDENT FOR
MANAGEMENT AND ADMINISTRATION

SUBJECT: Request for Newsclips

I am happy to approve your request for daily newsclips. However, please understand that the newsclips are normally distributed to Assistants and Deputy Assistants to the President. In offices with a number of Special Assistants to the President, one copy is distributed and shared among those Special Assistants.

Due to the cost of these newsclips (over \$1,000 per year), we must limit their distribution to these senior staff. As a result, we cannot provide newsclips to other members of your staff.

Thank you.

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. letters	AIDS researcher re: Personal cure to AIDS (Personal) (4 pages)	07/00/1997	b(6)

COLLECTION:

Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 19394

FOLDER TITLE:

Correspondence - SLT - Incoming - 7/97 [Folder 3] [1]

2018-0764-F

jm2047

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
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- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G 3829

Date Rcvd: 7-14-92

From: Letter to The President from
Lyone Gates, City of Cincinnati

Staff Action:

Reviewed By Sandy: _____ Reviewed By: _____

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

See G3598

To Support Staff: _____

Date of Response: _____

n:\corresli

City of Cincinnati



Tyrone K. Yates
Vice Mayor

City Hall Room 352
801 Plum Street
Cincinnati, Ohio 45202
Phone (513) 352-3643
Fax (513) 352-1517
E-Mail: Tyrone.Yates@cincncl.rcc.org

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Projects

City Planning Commission

March 5, 1997

President Bill Clinton
The White House
Washington D.C. 20500

Dear Mr. President:

Every credible piece of scientific evidence cries out for your leadership and courage on the value of needle exchange programs to help stem the tide of men, women, and children becoming infected with HIV/AIDS.

I have been advocating a needle exchange program for the City of Cincinnati for several years. Moral arguments are getting tied up in scientific and medical questions. The inner cities of America are being ravaged by a failure to adopt such programs. Could I suggest a White House Conference on the subject? Or a major public address or executive action favoring needle exchange programs?

Every life impacted by HIV/AIDS is a part of our great national potential squandered without need. You have said our country "doesn't have a person to waste." Please consider the question of federal executive action authorizing the approval of needle exchange programs as a public health emergency or authorize the office of the Surgeon General of the United States to do so. Minority communities are especially hard hit Mr. President, and it is estimated that 80% of the next 125,000 U.S. HIV/AIDS cases will belong to minority groups. Please act now in the long term public health interests of the United States.

I wish you the best in your careful consideration of this important matter.

Sincerely,

Tyrone K. Yates
Vice Mayor



Equal Opportunity Employer

cc: Vice President Al Gore
Senator John Glenn
Senator Edward M. Kennedy
Congresswoman Marcy Kaptur
Congressman Charles Rangel
Congressman Louis Stokes
Ms. Mary Frances Berry, Chairperson, U.S. Commission on Civil Rights
Mr. Franklin Raines, President, Office of Management & Budget
~~X~~ Honorable Alexis M. Herman, Assistant to the President
Dr. David Satcher, Director, Centers for Disease Control
Mr. Eddie Williams, President, The Joint Center for Political & Econ. Studies
Mayor Roxanne Qualls, City of Cincinnati
Mayor Dennis Archer, City of Detroit
Mayor Willie Brown, City of San Francisco
Mayor Bill Campbell, City of Atlanta
Mayor Richard M. Daley, City of Chicago
Mayor Michael White, City of Cleveland
Mr. J. Thomas Cochran, Executive Director, The U.S. Conference of Mayors
Vernon Jordan, Esq., National Underground Railroad Freedom Center
Reverend Dr. Otis Moss, National Underground Railroad Freedom Center
Reverend Fred Shuttlesworth, Southern Christian Leadership Conf., Gtr Cincinnati
Honorable Nathaniel Jones, Judge, U.S. Court of Appeals, Sixth Circuit
Mrs. Carole Rigaud
Mr. & Mrs. Calvin H. Conliffe
Mr. & Mrs. Paul Wyly
Dr. & Mrs. John H. Coleman

Office of
National AIDS Policy

Correspondence Routing Slip

FILE

Tracking Number: 63881

Date Rcvd: 7-31-97

From: Ann Kurth

Mother's Voices

Staff Action:

Reviewed By Eric: _____ Reviewed By: _____

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

no response needed - (TS)

To Support Staff: _____

Date of Response: _____

MOTHERS' VOICES

United to end AIDS® July 28, 1997



Sir Richard Sykes
Chief Executive Officer
Glaxo Wellcome, Inc.
Lansdowne House, Berkeley Square
London W1X6BQ
United Kingdom

Dear Sir Sykes:

Mothers' Voices, an United States non-profit organization representing tens of thousands of HIV educator and advocate mothers, supporters, and consumers, calls on you to take swift action regarding expanded access to, and accelerated FDA approval of, GW 1592 (abacavir).

As you know, expanded access programs historically have provided experimental anti-HIV drugs to tens of thousands of individuals with HIV who have failed all other approved therapies. Bristol Myers-Squibb's first ddI expanded access program, for example, made the drug available to 35,000 enrollees. Other drugs for which expanded access programs have been instituted include ddC (Hoffmann-LaRoche), 3TC (Glaxo Wellcome), Nevirapine (Boehringer Ingelheim) and Indinavir (Merck).

We in the HIV community remain confounded and unconvinced by your company's insistence that only around 2,000 expanded access slots be made available for abacavir in 1997. At the last conference call hosted by your community relations department, there seemed to be regression even on this paltry figure, with the community being told that now these slots will be made available only at the rate of two enrollees per week! This despite the fact that it is conservatively estimated that there are tens of thousands of individuals in the United States alone -- to say nothing of the global epidemic -- who have failed all existing anti-HIV therapies and have no other treatment option except for 1592, and who would benefit immensely from immediate access.

We are perplexed about why Glaxo Wellcome is willing to risk public media exposure to accusations of foot-dragging in making this drug available to patients who need it and to the general market for commercial distribution. City Councils in San Francisco and New York already have endorsed statements condemning your company's delays, and major stockholders such as the New York State Commonwealth Retirement Fund, also are sending you the consistent message that it is good corporate policy for Glaxo Wellcome, after more than *nine years* of development, to bring this drug to market.

More than 150 prominent U.S. AIDS organizations and individuals endorsed a consensus statement in Fall 1996 calling for the immediate implementation of an

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Suite 701
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telephone
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212.730.4378
internet
<http://www.mvoices.org>

expanded access program for 1592. The consensus statement was presented to the company formally in January, 1997. Your company waited until Spring 1997 to announce a program to provide 1592 to 2,000 individuals with AIDS worldwide in 1997. The company now suggests that in 1998, it will only be able to offer 1592 to approximately 5,400 additional individuals in the United States. The number of individuals being offered access to 1592 is extraordinarily small compared to expanded access programs instituted for other AIDS drugs.

Glaxo Wellcome claims that production difficulties and concerns for safety have caused it to limit access programs for 1592. Yet your company has known for a significant amount of time that this compound has very potent activity against HIV. Glaxo has also heard calls for access to this drug from community leaders for more than a year. These two factors should have given the company time and cause to scale up production to meet the critical need for this drug.

Safety has also been mentioned as an excuse for Glaxo's delays; and safety is truly a concern with any new drug. However, early studies suggest that 1592 may be one of the safest and most easily tolerated anti-HIV drugs developed so far. In addition, expanded access programs were designed for individuals who had failed all other treatment regimens and therefore were more desperately in need of new therapies and more willing to take educated risks about these therapies. Moreover, companies developing anti-HIV drugs receive substantial benefit from accelerated approval regulations instituted by the Food and Drug Administration. These regulations significantly reduce the time period and expense required for obtaining FDA licensing of anti-HIV therapies.

By failing to institute an expanded access program which provides 1592 to all patients who have failed existing anti-HIV therapies, Glaxo Wellcome is seriously jeopardizing the lives and the health and well-being of tens of thousands of HIV-infected individuals worldwide.

As the leadership for your company, we call on you and Mr. Ingram to take action now on expanding adequate access to 1592, and to applying for accelerated FDA approval no later than March 1998. We look forward to seeing this commitment in writing and articulated to the HIV community very shortly.

Please feel free to contact our office at 212 - 730 - 2777.

Sincerely,



Ann Kurth, MPH, MSN, RN
Executive Director

cc: Robert Ingram
Mothers' Voices National Board
1592 Access Coalition
Sandra Thurman, Director National HIV Policy Office

MOTHERS' VOICES

United to end AIDS®



July 28, 1997

Mr. Robert Ingram
Chief Executive Officer
Glaxo Wellcome, Inc.
5 Moore Drive
Research Triangle, NC 27709

Dear Mr. Ingram:

Mothers' Voices, a national non-profit organization representing tens of thousands of HIV educator and advocate mothers, supporters, and consumers, calls on you to take swift action regarding expanded access to, and accelerated FDA approval of, GW 1592 (abacavir).

As you know, expanded access programs historically have provided experimental anti-HIV drugs to tens of thousands of individuals with HIV who have failed all other approved therapies. Bristol Myers-Squibb's first ddI expanded access program, for example, made the drug available to 35,000 enrollees. Other drugs for which expanded access programs have been instituted include ddC (Hoffmann-LaRoche), 3TC (Glaxo Wellcome), Nevirapine (Boehringer Ingelheim) and Indinavir (Merck).

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We are perplexed about why Glaxo Wellcome is willing to risk public media exposure to accusations of foot-dragging in making this drug available to patients who need it and to the general market for commercial distribution. City Councils in San Francisco and New York already have endorsed statements condemning your company's delays, and major stockholders such as the New York State Commonwealth Retirement Fund, also are sending you the consistent message that it is good corporate policy for Glaxo Wellcome, after more than *nine years* of development, to bring this drug to market.

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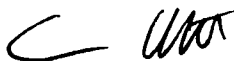
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As the leadership for your company, we call on you and Sir Richard Sykes to take action now on expanding adequate access to 1592, and to applying for accelerated FDA approval no later than March 1998. We look forward to seeing this commitment in writing and articulated to the HIV community very shortly.

Please feel free to contact our office at 212 - 730 - 2777.

Sincerely,



Ann Kurth, MPH, MSN, RN
Executive Director

cc: Sir Richard Sykes
Mothers' Voices National Board
1592 Access Coalition
Sandra Thurman, Director National HIV Policy Office

Office of
National AIDS Policy

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Correspondence Routing Slip

Tracking Number: G3878

Date Rcvd: 7-29-97

From: Elena M. Aivarado
Mujeres Unidas Pro Salud

Staff Action:

Reviewed By Eric: _____ Reviewed By: _____

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

no response needed (TS)

To Support Staff: _____

Date of Response: _____

MUJERES UNIDAS PRO SALUD



**LATINAS: PARTNERS FOR
HEALTH**

National Project Director
Elena M. Alvarado

July 21, 1997

Ms. Sandra Thurman
Coordinator
National AIDS Policy Office
750 17th St., NW, #1060
Washington, DC 20502

Dear Sandra:

The National Latina Health Network (NLHN) is applying for funding under a CDC cooperative agreement, (Announcement 765), entitled "National Program to Prevent HIV Infection and Other Priority Health Problems Among Large Populations of Youths in High-Risk Situations".

In the past, the National AIDS Policy Office has kept us abreast of educational materials, public health announcements, health information and resources available to share with our Network nationwide. We would like to continue to maintain and expand upon such opportunities as they become available with your agency. The Latinas: Partners for Health project has recently incorporated as a national 501 (c)(3) volunteer-based organization. While under the auspices of HDI Projects, (the National Hispanic Education and Communications Projects) the Latinas: Partners for Health Network outgrew its work and visibility to focus on public health issues affecting Latinas and their families. The outgrowth of the project is a natural progression of the goals and objectives set forth by the national advisory council of the Latinas: Partners for Health. This will allow us to address other critical health issues and concerns facing Latinas and their families.

The purpose of the awards are intended to strengthen the capacity of national non-governmental organizations to assist national, State, and local efforts to prevent HIV infection and other priority health problems among large populations of youth in high-risk situations. The Network has been involved with HIV prevention education over the last seven years and has showcased *TAPP for Latinas* at six town meetings held throughout the country.

If funded, NLHN will utilize its TAPP for Latinas (Teatro AIDS Prevention Project) curricula along with other resources and marketing materials and provide technical assistance and training to local community organizations, continuation schools, women-focused groups, etc in the use of TAPP as a peer-education model. Our main goal is to inform and educate young Latinas about choices they make regarding their sexual health. Our target population is young Latinas, 16-24 years. The program will be carried out over a five-year period. We are hoping to work in 10 states during the project period utilizing our existing Network which spans six U.S. regions including Puerto Rico..

To better utilize and maximize use of existing national and federal resources which can provide access to technical information, information sharing of materials and other health resources to our Network, we are requesting a letter of support to this effect.

Enclosed you will find a sample letter of support. **We would appreciate receiving your letter by no later than Wednesday, July 30. Please send support letters to Peggie Edwards in the enclosed self-addressed stamped envelope or fax to (202) 337-9635.**

Your continued support is very much appreciated. In the meantime if you have any questions, please feel free to contact me at (202) 337-9633.

Sincerely,



Elena M. Alvarado
National Director

Enclosure: Sample Letter of Support
 NLHN Mission Statement
 Latinas: Partners for Health Snapshot

SAMPLE SUPPORT LETTER

For Federal Agencies

DUE DATE: Wednesday, July 30, 1997

Elena M. Alvarado
National Director
National Latina Health Network
1000 Thomas Jefferson St., N.W., #310
Washington, DC 20007

Dear Ms. Alvarado:

We are pleased to support your application for a CDC Cooperative Agreement, Announcement 765 for "National Programs to Prevent HIV Infection and Other Priority Health Problems among Large Populations of Youth in High-Risk Situations". The National Latina Health Network's proposed "Teatro AIDS Prevention Program (*TAPP*) *for Latinas*" is an important project in which we will be more than happy to collaborate.

Given the increasing incidence of HIV/AIDS among Latinos, *TAPP for Latinas* is particularly an innovative approach to peer education. The use of theater as a form of peer education has proven itself to be highly effective as a teaching tool among Hispanic/Latinos. Targeting communities of color for youth in high-risk situations is critical to combating HIV/AIDS.

(Your federal agency) proposes to collaborate with the National Latina Health Network in providing education materials, health information and technical resources to their project.

Please let us know if we can be of further assistance to you.

Sincerely,



National LATINA Health Network

Mission Statement

The mission of the National Latina Health Network (NLHN) is to address critical public health concerns affecting Latinas and their families nationwide by promoting leadership, advocacy, community health partnerships and initiatives that impact social health policy.

Organizational Goals

The organizational goals are the following:

- To strengthen, support and involve networks of Latina leaders in developing leadership constituency in the field of public health.
- To build local/national community health partnerships in enhancing the quality of life of Latinas and their families.

Objectives

- To serve in leadership positions to raise awareness about public health concerns in the Latino community.
- To foster partnership-building by linking grassroots health leaders with the public and private sectors.
- To share resources and strategies to combat public health problems in our communities.
- To provide a mechanism for public health leaders to work with Latina leaders in communities to address public health concerns.



LATINAS: Partners for Health Network

Snapshot

WHAT IS THE ELC

The Education Leadership Council (ELC) is a national advisory council of 30 Latino women leaders concerned with and involved in public health. Through a grassroots initiative, the ELC has mobilized into the "**Latinas: Partners for Health**," a network of over 1200 women. Network members are found in every region of the United States, including Puerto Rico.

WHO WE ARE

The ELC Network is composed of professionals concerned with and involved in public health planning, education, outreach and evaluation. Members include service providers, medical doctors, business owners, media specialists, researchers, nurses, clinic directors and other allied health professionals.

WHAT WE DO

The ELC network works to:

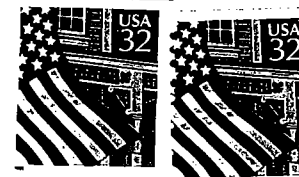
- Foster partnership-building by linking grassroots health leaders with the public and private sectors.
- Share resources and strategies to combat public health problems in our communities.
- Provide a mechanism for public health leaders to work with Latino leaders in communities to address public health concerns.
- Serve as a spokesperson to raise awareness about public health concerns in the Latino community.

WHAT RESOURCES DO WE PROVIDE

- ◆ ***The Latina AIDS Action Plan*** - Guidelines for public health strategies, including prevention and education, care and treatment, research, legal and ethical issues.
- ◆ ***The HIV/AIDS Media Action Guide*** - A health communications media planning and promotion guide providing technical assistance to community leaders, with support from the CDC and the American Red Cross. The guide takes the reader step-by-step through a complete public relations program.
- ◆ ***Latinas: Partners for Health Newsletter*** - A quarterly publication intended to promote resource-sharing and foster community partnerships and collaborations.
- ◆ ***Public Service Announcements*** - Thirty-second spot announcements produced and distributed in 16 English and Spanish-language public service announcements (PSAs) targeting Hispanic youth and adults. Well-known celebrities Edward Olmos, SaFire, Elizabeth Peña, Willie Colon, Cult Jam and others are among those who donated their time for PSAs that combine popular music and hard hitting prevention messages including testimonials from HIV positive individuals.
- ◆ ***Latinas: Partners for Health Directory*** - The guide is a valuable resource for public health officials at the federal, state and local levels on seeking partners for public health initiatives. It also provides contacts for data exchange on successful prevention approaches, outreach strategies, expertise and resource sharing. The Directory is distributed to state and local health departments, policy makers at all levels of government, national AIDS and health-related groups, colleges and universities and womens' groups.
- ◆ ***Latinas: Partners for Health HIV/AIDS Partnership Plan*** - This document is a compilation of action items and policy recommendations developed to address specific state and regional concerns regarding HIV/AIDS. It is intended as a reference tool for policy makers, health educators, community leaders and public and private sector groups interested in sound and effective HIV/AIDS policies and programs.
- ◆ ***TAPP for Latinas (Teatro AIDS Prevention Program)*** - A two-track national and local HIV/AIDS bilingual health communications and marketing program utilizing peer-education via the use of Latino theater. This Info-drama is being organized through a series of town meetings in six U.S. urban centers targeting young Hispanic women 16-25 years to take personal responsibility for and make informed decisions regarding their sexual health. The prevention message will be carried via electronic and print media coverage for maximum reach and impact.

The ELC-Latinas: Partners for Health Network, formerly a project of the National Hispanic Education and Communications Projects (HDI Projects) has evolved into a national 501 (c)(3) volunteer-based organization, now known as the National Latina Health Network.

OUR NEW ADDRESS
HDI Projects
1000 Thomas Jefferson St, N.W. Ste. 310
Washington, DC 20007
Tel (202) 337-9633
Fax (202) 337-9635



HDI Latinas Partners for Health
1000 Thomas Jefferson Street, NW
Suite 310
Washington, DC 20007

ATTENTION: PEGGIE EDWARDS

PLEASE FAX YOUR LETTERS TO (202) 337-9635: AATN: Peggie
THAN MAIL THE HARD COPIES.

Thanking you in advance for all your cooperation.

PEGGIE EDWARDS

Office of
National AIDS Policy

Correspondence Routing Slip

FILE COPY

Tracking Number: 63877

Date Rcvd: 7/28/97

From: Donald Van Giesen

Staff Action:

Reviewed By Sandy: _____ Reviewed By: _____

Assigned To: _____

RCVD: _____ DONE: TS 8/25

Recommendations/Instructions:

Response sent
Forward copies of attachments to me and DM

To Support Staff: _____

Date of Response: _____

n:\corresli

August 25, 1997

Donald I. Van Giesen, MD
864 Second Street
Santa Rosa, CA 95404

Dear Dr. Van Giesen:

Thank you for sending along a copy of the AMA's recent resolution on needle exchange. I appreciate your efforts to support a public policy stance on this issue that is based on science, not on politics.

As for your comments on legislative strategy, I would suggest that you talk to Jan Silver at American Foundation for AIDS Research (AmFAR). She can be reached at (202) 331-8600. I've already let her know that you might be calling.

Again, thank you for all of the work that you are doing to bring an end to this epidemic. Please pass along my regards to Kris and Holly!

Very truly yours,

Sandra L. Thurman
Director, Office of National AIDS Policy

Donald I. Van Giesen, M.D., F.A.C.S.

A Medical Corporation
Adult & Pediatric Urology

864 Second Street
Santa Rosa, California, 95404
Telephone (707) 544-7611

July 23, 1997

Ms Sandra Thurman, Director
Office of AIDS Policy
The White House
Washington, D.C.

Dear Sandy:

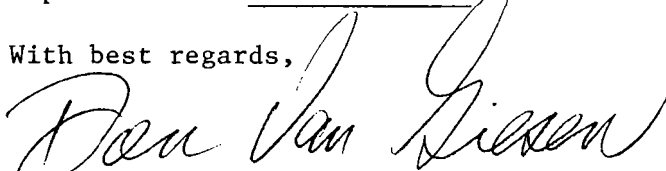
RE: AMA meeting and passage of my resolution on Needle Exchange
Programs: We did it!!

Now I'll push AMA to get moving on legislation. Hopefully I can get
Pete Stark to sponsor/author. Any thoughts or suggestions?

Kris and Holly are at Lake Tahoe with the President and Vice President
this weekend. They're taking the V.P. on a hike. Also, Kris and Holly
are engaged!

I am mailing more information, including the Reference Committee
report and the New York Times article.

With best regards,


Donald I. Van Giesen, M.D.

A Pulitzer Prize-winning newspaper

THE Press DEMOCRAT



A New York Times Company

Santa Rosa, California

Michael J. Parman, Publisher
Bruce W. Kyse, Executive Editor
Robert L. Swofford, Managing Editor
Peter Golis, Editorial Director

EDITORIALS

One more chance

Last month, the American Medical Association joined a chorus of health professionals in calling for laws to allow needle exchange programs to help prevent the spread of AIDS. The U.S. Conference of Mayors adopted a similar resolution in a bipartisan vote.

But California Gov. Pete Wilson has been a steadfast foe of needle exchange programs, regularly vetoing bills on the subject passed by the Legislature. Opponents say the programs promote drug use, although numerous studies have shown no evidence of that.

The Legislature is trying again to give the governor the chance to do the right thing. SB 885 would set up two-year pilot programs in Long Beach, Los Angeles, San Francisco and San Jose to study

needle exchange programs.

Given the studies that have already been done, the bill might be criticized as a too-timid step. But at least it would be a step in a humane direction, toward saving lives.

Intravenous drug users now account for the highest rates of new HIV infection, and more than one-third of all new AIDS cases nationwide. The AMA said that if the federal ban against needle exchange programs continues through 2000, the United States would have failed to prevent up to 11,000 cases of AIDS, many among sexual partners of drug users and their children.

The evidence in support of needle exchange programs keeps growing. The Legislature should pass these bills until the governor recognizes that.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:
(A-97)

Introduced by: California Delegation

Subject: Needle and Syringe Exchange Programs

Referred to:

-
- 1 Whereas, in recognizing the urgent need to reduce the spread of HIV and other infections
2 such as bacterial endocarditis and hepatitis B and C among injection drug users (IDUs), the
3 American Medical Association in 1994 (Policy 95.958) stated it "encourages needle
4 exchange programs (NEPs)"; and
5
6 Whereas, one of the most basic public health axioms in vector-borne disease is that to stop the
7 transmission of the disease you have to eliminate the vector, i.e., in this case, contaminated
8 syringes and needles; and
9
10 Whereas, the modification of the drug paraphernalia laws in Connecticut, allowing IDUs to
11 obtain their syringes from sterile sources, has led to a 39% decrease in syringe sharing; and
12
13 Whereas, if the 1988 ban on federal funding of NEPs continues, up to 11,000 preventable
14 HIV infections, including heterosexual partners and their unborn children, could occur by the
15 year 2000 at a cost of up to \$630,000,000, mostly at public expense; and
16
17 Whereas, to lift the funding ban, federal law requires that the NEPs be shown to (1) reduce
18 the transmission of HIV infection, and (2) not lead to increased illicit injection drug use; and
19
20 Whereas, during the past six years, seven (7) independently federally-funded studies have
21 reported that BOTH of these requirements had been met, and five of these study groups have
22 recommended revoking the existing federal funding ban, which to date has NOT been done;
23 and
24
25 Whereas, most of these groups also recommended the revocation and/or modification of state
26 laws that restrict IDUs' ability to possess syringes; and
27
28 Whereas, funded sterile syringe exchange programs and pharmacy sales of sterile syringes
29 are equally important in HIV transmission prevention, and often offer the only venues for
30 counseling on drug education and referrals to drug treatment programs; therefore be it

1 RESOLVED, That as an urgent public health need, the AMA initiate and support legislation
2 revoking the 1988 U.S. government ban on funding for needle exchange programs for
3 injection drug users (IDUs); and be it further
4

5 RESOLVED, That the AMA strongly encourage state medical associations to initiate state
6 legislation modifying drug paraphernalia laws, so that injection drug users (IDUs) can legally
7 purchase and possess syringes.

Fiscal Note:.

REPORT of

Reference Committee D, Page 12

1 Testimony on Resolution 425 was uniformly favorable. It was thought that wider dissemination of
2 the FDA's hotline would be beneficial, which is why the suggested change was made.

- 3
4 (15) COUNCIL ON SCIENTIFIC AFFAIRS REPORT 8 - THE
5 REDUCTION OF MEDICAL AND PUBLIC HEALTH
6 CONSEQUENCES OF DRUG ABUSE
7 RESOLUTION 408 - PROHIBITION OF ILLICIT DRUGS
8 RESOLUTION 419 - WAR ON DRUGS
9 RESOLUTION 426 - LEGALIZATION OF NEEDLE EXCHANGE
10 PROGRAMS AND PURCHASE AND POSSESSION OF
11 NEEDLES AND SYRINGES
12 * RESOLUTION 435 - NEEDLE AND SYRINGE EXCHANGE
13 PROGRAMS

} excellent -
included

14 15 RECOMMENDATION A:

16
17 Mr. Speaker, your Reference Committee recommends that
18 Recommendation 3 of Council on Scientific Affairs Report 8 be
19 amended by insertion and deletion on page 12, lines 35-41 to read as
20 follows:
21

- 22 3. That the AMA encourage the expansion of opioid maintenance
23 programs so that opioid maintenance therapy can be available
24 to any individual who applies and for whom the treatment is
25 suitable. Training must be available so that an adequate
26 number of physicians is prepared to provide treatment.
27 Program regulations should be modified strengthened so that
28 treatment is driven by patient needs, ~~and~~ medical judgement
29 and drug rehabilitation concerns. Treatment goals should
30 acknowledge the benefits of abstinence from drug use, or
31 degrees of relative use reduction.
32

33 RECOMMENDATION B:

34
35 Mr. Speaker, your Reference Committee recommends that
36 Recommendation 4 of Council on Scientific Affairs Report 8 be
37 amended by insertion and deletion on page 12, lines 43-45, and page 13,
38 lines 1-2, to read as follows:
39

- 40 4. That the AMA encourage the extensive application of needle
41 and syringe exchange and distribution programs and the
42 consideration of modified, less modification of restrictive laws
43 and regulations concerning the sale and possession of needles
44 and syringes to maximize the availability of sterile syringes and
45 needles, while ensuring continued reimbursement ~~for medically~~
46 ~~necessary~~ for medically necessary needles and syringes. The
47 need for such programs and modification of laws and
48 regulations is urgent, considering the contribution of injection
49 drug use to the epidemic of HIV infection.

1 RECOMMENDATION C:

2
3 Mr. Speaker, your Reference Committee recommends that
4 Recommendation 5 of Council on Scientific Affairs Report 8 be
5 amended by insertion on page 13, lines 4-7, to read as follows:
6

- 7 5. That the AMA encourage the undertaking of comprehensive
8 research into the potential effects, both positive and adverse, of
9 relaxing existing drug prohibitions and controls and, that, until
10 the findings of such research can be adequately be assessed, the
11 AMA reaffirm its opposition to drug legalization, with a report
12 back on the status of such research at the Interim Meeting of
13 1998.
14

15 RECOMMENDATION D:

16
17 Mr. Speaker, your Reference Committee recommends that a new
18 Recommendation 6 be added to Council on Scientific Affairs Report 8
19 on page 13 following line 7 to read as follows:
20

- 21 6. That ~~the AMA initiate and support legislation~~ revoking the 1988
22 federal ban on funding for needle exchange programs for
23 injecting drug users.
24

25 *my* RECOMMENDATION E:
26 *RESO-*
27 *lution*

28 Mr. Speaker, your Reference Committee recommends that a new
29 Recommendation 7 be added to Council on Scientific Affairs Report 8
30 on page 13 to read as follows:

- 31 * 7. That the AMA strongly encourage state medical associations to
32 initiate state legislation modifying drug paraphernalia laws so
33 that injection drug users can legally purchase and possess
34 needles and syringes.
35

36 RECOMMENDATION F:

37
38 Mr. Speaker, your Reference Committee recommends that the
39 recommendations in Council on Scientific Affairs Report 8 be adopted
40 as amended in lieu of Resolution 409 (I-95), Resolution 422 (I-95),
41 Resolution 405 (I-96) and Resolutions 408, 419, 426 and 435 and the
42 remainder of the report filed.
43

44 Report 8 of the Council on Scientific affairs reviews the scientific literature on harm reduction and
45 drug addiction and defines harm reduction as practices employed to reduce the medical or public
46 health consequences of drug abuse. Current policy is reviewed, and the goals and criticisms of harm
47 reduction strategies are addressed. The report recommends that comprehensive research be
48 undertaken on the potential effects—both positive and negative—of relaxing existing laws. The
49 report further recommends that the AMA reaffirm its opposition to drug legalization.

Resolution 408 would have our AMA review the risks and benefits of the prohibition of currently illicit drugs.

Resolution 419 asks our AMA to collect, review, and evaluate all available data and studies regarding the potential decriminalization of drugs and their impact on the health status of Americans, as well as the medical value, if any, of currently illicit drugs.

Resolution 426 would have our AMA study the impact of legalization of the purchase and possession of needles and syringes without a prescription.

Resolution 435 asks for AMA support of legislation revoking bans on federal funding of needle exchange laws as well as medical society support for laws relaxing controls on needle purchase and possession.

Considerable and passionate testimony was heard on issues related to drug abuse and efforts to decrease the adverse effects that illicit drugs have in our country. The report of the Council on Scientific Affairs was well received and highly praised for its quality and thoroughness. Most speakers favored the Council's report over the resolutions, although some significant issues suggested by the resolutions were incorporated into the report's recommendations with the concurrence of the Council. Some speakers felt the distinction between methadone maintenance and drug treatment should have been stronger, but your Reference Committee was persuaded by the otherwise overwhelmingly positive testimony.

Testimony was also heard on the need to distribute the report widely, possibly distributing it with a forthcoming report from a national commission later this fall. A number of speakers also expressed a desire that the House be kept informed as the literature on alternative approaches to the drug problem develops.

(16) COUNCIL ON SCIENTIFIC AFFAIRS REPORT 1 - GUIDE TO
CLINICAL PREVENTIVE SERVICES, SECOND EDITION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 of Council on Scientific Affairs Report 1 be amended by insertion on page 3, line 29 to read as follows:

2. That the AMA continue to encourage the adoption of practice guidelines as they are developed based on the best scientific evidence and methodology available.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Scientific Affairs Report 1 be adopted as amended in lieu of substitute Resolution 411 (A-96) and the remainder of the report filed.

National Repo

The New York Times

A.M.A. Backs Drug-U

By KATHARINE Q. SEELYE

Lenon Wilson, a longtime heroin addict in Chicago with puffy scars the size of leeches on his arms, climbed into an unmarked silver van and unfurled a paper bag concealing 28 dirty hypodermic needles.

"If the van wasn't here, I'd use the same needle three, four, five times, even when it's dirty and has bacteria running through it, and then I'd use somebody else's when I couldn't use mine anymore," said Mr. Wilson, known as Smoky, as he scooped up 33 clean needles in exchange for his 28. The volunteers for the Chicago Recovery Alliance at this mobile van in Harvey, Ill., 25 miles from downtown Chicago, like to give out a bonus of five to their regulars.

"You get a better hit with a clean needle, and it leaves less of a scar," Mr. Wilson said. "It's more hygienic all the way around."

It was people like Mr. Wilson that the American Medical Association had in mind yesterday when it joined a growing chorus of voices and called for a change in laws to allow intravenous drug users easier access to clean needles to help block the spread of H.I.V., the virus that causes AIDS.

More than one-third of all new AIDS cases in the nation are caused by contaminated needles or sex with drug users. And drug users now account for the highest rates of new H.I.V. infection — at nearly twice that of homosexual men.

The medical association had previously "encouraged" needle-exchange programs, in which addicts turn in dirty needles in exchange for clean ones. But yesterday, citing an "urgent public health need," it was broader and more emphatic. The association's policy-making House of Delegates, meeting in Chicago, voted overwhelmingly to work with members of Congress to initiate legislation revoking the 1988 ban on Federal financing for needle-exchange programs and to encourage state medi-

cal societies strongly to initiate state legislation relaxing drug paraphernalia laws so users can legally buy and possess needles.

"There is more and more evidence that the advantages of needle exchange outweigh the disadvantages," Dr. Nancy Dickey, chairman of the board of trustees and president-elect of the medical association, which represents half the nation's doctors, said in an interview. "We're addressing a public health epidemic."

The association said that if the ban continued to the year 2000, the United States would have failed to prevent up to 11,000 cases of AIDS, including those among heterosexual partners of drug users and their children, at a cost of up to \$630 million for medical treatment.

Public health professionals applauded the association, saying that its action, combined with a similar bipartisan resolution from the United States Conference of Mayors earlier this week, could increase pressure on the politically sensitive Clinton Administration and a reluctant conservative Congress to reverse the Federal ban on financing needle-exchange programs.

In San Francisco, Roslyn Allison, project director at the AIDS Foundation H.I.V. Prevention Project, the nation's largest needle-exchange program, said of the medical association's decision, "It sends a message to other agencies that still view this as a dark and sinister practice."

Outside, Allison, a 26-year-old prostitute with bruises on her arms, said the clean needles were safe. Referring to the bad needles she used until recently, she said: "Women would get clogged, broken and it was pretty common for people to pass them around."

Dr. Peter Lurie, a researcher at the University of Michigan who is one of the world's foremost experts on needle exchange programs, said the public health benefits of need-



Lloyd DeGrane for The New York Times

The American Medical Association yesterday endorsed needle-exchange programs like this one in Harvey, Ill., south of Chicago.

ional Report

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FRIDAY, JUNE 27, 1997

The New York Times

M.A. Backs Drug-User Needle Exchanges

CHARINE Q. SEELYE

Wilson, a longtime heroin addict in Chicago with puffy scars of leeches on his arms, to an unmarked silver van and a paper bag concealing podermic needles.

"If I wasn't here, I'd use the needle three, four, five times, but it's dirty and has bacteria through it, and then I'd use someone else's when I couldn't use more," said Mr. Wilson, who, smoky, as he scooped up 33 needles in exchange for his 28. He is a member of the Chicago Needle Exchange at this mobile van in the city, 25 miles from downtown Chicago, to give out a bonus of needles to regulars.

"It's a better hit with a clean needle than it leaves less of a scar," said Mr. Wilson. "It's more hygienic and safer."

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The medical association had previously "encouraged" needle-exchange programs, in which addicts exchange dirty needles in exchange for clean ones. But yesterday, citing a public health need, it was more emphatic. The association's policy-making House of Delegates, meeting in Chicago, voted unanimously to work with members of Congress to initiate legislation to repeal the 1988 ban on Federal funding for needle-exchange programs and to encourage state medi-

cal societies strongly to initiate state legislation relaxing drug paraphernalia laws so users can legally buy and possess needles.

"There is more and more evidence that the advantages of needle exchange outweigh the disadvantages," Dr. Nancy Dickey, chairwoman of the board of trustees and president-elect of the medical association, which represents half the nation's doctors, said in an interview. "We're addressing a public health epidemic."

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Dr. Peter Lurie, a researcher at the University of Michigan who is one of the world's foremost experts on needle exchange programs, said the public health benefits of needle

exchange had been evident for years.

"If an infection is spread from person to person by an inanimate object, you can prevent it by removing that object," he said. "This is not rocket science."

But what is obvious to public-health professionals is less clear-cut for politicians. The medical group's action was greeted coolly in Washington, which remains fearful of putting its official imprimatur on something that many perceive as tantamount to promoting drug use.

Some critics see needle exchange

An influential group speaks out to help drug users avoid AIDS.

as a foot in the door toward legalizing drugs. They say that the exchange may help addicts avoid AIDS, but that they may die instead of overdoses. Focusing on needle exchange, they argue, takes attention away from treatment.

Beyond that, while many programs offer condoms to those who arrive for clean needles, critics say the needle exchange ignores the vast number of cases of H.I.V. infection that are transmitted through sex. And addicts still need money for drugs, so clean needles do nothing to reduce robberies or violent crime.

One critic of needle exchange is Representative Charles B. Rangel, a Democrat whose Harlem district is home to some of the worst drug-infestations in urban America. Mr. Rangel said needle exchange is acceptable as part of a drug rehabilitation program, but, "if the budget is just for clean needles, I don't want it."

When Congress prohibited the spending of Federal money for needle exchange, it said the ban could be lifted only when such programs met two conditions: that they be shown to reduce transmission of H.I.V. and not to increase illegal drug use. The medical association came to just that conclusion yesterday.

Previously, numerous studies, including ones by the Federal Centers for Disease Control and Prevention, the National Institutes of Health, the General Accounting Office and the National Academy of Sciences, have generally found that needle exchanges are effective in slowing the spread of H.I.V. and that they have not increased drug use.

But no one in Congress has even tried to lift the ban, and signals from the Clinton Administration, which has the authority to lift the ban, have been cautious.

Dr. David Lewis, director of the Brown University Center for Alcohol and Addiction Studies, said of the mood: "The Administration is scared. If they move to bring the issue up, Congress will be even more strict and make it harder for addicts to obtain clean needles."

Representative Jesse L. Jackson Jr., Democrat of Chicago, who supports needle-exchange, said the "demagoguing" on the issue "sometimes makes it hard for politicians to vote or do the right or healthy thing."

But Gary Bauer, president of the Family Research Council, a conservative group, said the collective mind-set in Congress was so opposed to needle exchange that conservatives felt no need to organize against the issue. "It strikes the average voter in the gut as being against common sense," he said. He said the matter was "untouchable" for Mr. Clinton because drug use had gone up on his watch. "I don't see how this Administration could do anything on this that wouldn't blow up in their face," he said.

REPORT OF THE COUNCIL ON SCIENTIFIC AFFAIRS

CSA Report 8-A-97

Subject: The Reduction of Medical and Public Health Consequences of Drug Abuse
(Resolutions 409 and 422, I-95, and Resolution 405, I-96)

Presented by: Mitchell S. Karlan, MD, Chair

Referred to: Reference Committee D
(Ben P. Owens, MD, Chair)

1 Resolution 416, adopted at the 1994 Interim Meeting as amended by Reference Committee D,
2 asks that the American Medical Association (AMA) support the study of harm reduction for
3 drug addiction, such as treatment on demand, methadone maintenance, sterile needle-exchange,
4 decriminalization of drugs, and peer education and counseling.

5
6 While the report was in development, Resolution 409 (I-95), introduced by the Connecticut,
7 Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont Delegations, and
8 Resolution 422 (I 95), introduced by the Pennsylvania Delegation, were referred to the Board
9 of Trustees. These resolution asked:

10
11 That the AMA support the deregulation of syringes and needles; and
12 That the AMA analyze the relationship between crime with its associated
13 violence and the distribution and use of illicit drugs; and
14 That the AMA study the potential effects of decriminalization of illicit drugs
15 on that relationship.

16
17 Resolution 405 (I-96), introduced by the American Association of Public Health Physicians,
18 was referred to the Board of Trustees. It asked:

19
20 That the American Medical Association recommend that physicians advise IV
21 drug users to (1) stop injecting and using drugs and begin substance abuse
22 treatment, (2) never reuse or "share" syringes, water, or drug preparation
23 equipment, (3) use only sterile syringes obtained from a pharmacy, (4) use a
24 new syringe with each injection, (5) use sterile or clean reliable fresh tap water,
25 (6) clean the injection site prior to injection with alcohol, and (7) safely dispose
26 of syringes after one use; and

27
28 That the AMA urge state and local societies to join with state and local health
29 departments, professional organizations of pharmacists and law enforcement
30 agencies to review the current statutes and regulations that limit the availability
31 of syringes and needles; and

1 That the AMA support the deregulation of syringes through the removal of
2 prescription requirements for syringe purchase, the exclusion of syringes from
3 the drug paraphernalia laws and the removal of regulations which substantially
4 restrict the availability of sterile syringes; and
5

6 That the AMA urge state medical societies and physicians to join with state and
7 local health departments, substance abuse treatment programs, and community
8 groups to advocate for increased availability of substance abuse treatment as an
9 important HIV prevention measure; and
10

11 That the AMA urge state medical societies and physicians to join with state and
12 local health departments, diabetes organizations, the professional organizations
13 of pharmacists and community groups to implement community programs to
14 assure the safe disposal of used syringes and needles.
15

16 Present AMA Policy Relevant to These Issues
17

18 The AMA has stated repeatedly that drug dependencies, including alcoholism, are diseases and
19 that their treatment is a legitimate part of medical practice (Policy 95.983, AMA Policy
20 Compendium). Although illicit drug use is a criminal action, drug addiction is a disease
21 amenable to treatment (Policy 420.970). Government and other public and private
22 organizations are urged to base their policies on the recognition that drug dependencies are
23 diseases (Policy 95.983). The AMA urges federal, state, and local governments to increase
24 funding for drug treatment so that drug abusers can have immediate access to appropriate care,
25 regardless of ability to pay. This is the most important step that can be taken to reduce the
26 spread of human immunodeficiency virus (HIV) infection among intravenous drug abusers
27 (Policy 20.977).
28

29 The AMA continues to monitor trends in HIV transmission among intravenous drug injectors
30 and to "pinpoint effective strategies (including needle-exchange programs)" for control of HIV
31 infection (Policy 20.977). The AMA encourages needle-exchange programs (Policy 95.958).
32

33 The AMA urges the expansion of drug rehabilitation programs (Policy 95.980) and urges
34 Congress to "substantially increase its funding for drug treatment programs" (Policy 95.973).
35 The AMA "encourages the availability of methadone maintenance for persons addicted to
36 opioids" and calls for the removal of federal and state regulations that restrict or inhibit
37 methadone maintenance (Policy 20.966). To help control the spread of HIV infection, the
38 AMA supports the development of interim methadone maintenance clinics, which include
39 appropriate medical services, for persons with opioid dependence awaiting transfer to a full-
40 service clinic (Policy 95.959). The AMA suggests the development of new methadone
41 treatment regulations with a shift of emphasis from administrative process to performance-
42 based standards with greater reliance on the physician's clinical judgment (Policy 95.964). The
43 Council on Scientific Affairs (CSA) produced a report in 1994 on "Methadone Maintenance in
44 Private Practice." This report reaffirms a position of the AMA recommending further
45 evaluation of the use of properly trained practicing physicians as an extension of organized
46 methadone maintenance programs in the management of those patients whose needs for allied

*Not
sure about
give
sterile needles*

services are minimal (called "medical" maintenance). The CSA supported the position that "medical" methadone maintenance may be an effective measure in controlling the spread of infection with HIV and other blood-borne pathogens. *for this I OUs in Treatment*

At the same time, the AMA condemns illicit drug use and encourages physicians to do all in their power to discourage the use of illegal drugs (Policy 95.961). Within that context, the AMA discourages marijuana use (Policy 95.995) and believes that the sale and possession of marijuana should not be legalized (Policy 95.998), but supports the modification of state laws to reduce the severity of penalties for possession of marijuana (Policy 95.995). The AMA opposes drug legalization (Policy 95.981) and the manufacture, sale, and use of drug paraphernalia (Policy 95.989). *... changes?*

Harm Reduction Goals

Harm reduction is a term with disparate meanings and connotations. To an alcoholism treatment professional, it can be a "code word" for controlled drinking, a goal not widely accepted in the medical community. To others, it is synonymous with legalization of marijuana, heroin, cocaine, and other drugs. To still others, it means tailoring treatment to the needs of individual patients to achieve optimal outcomes.

There are some nonmedical users of psychoactive substances who, for any of several reasons, may not be willing or able to cease use at a particular time. For the purposes of this report, harm reduction is defined as those practices that are employed to reduce the medical and/or public health consequences associated with such use.

Harm reduction, in this light, becomes important in cases where prevention fails. It can coexist, and is not incompatible, with a goal of abstinence for a drug-dependent person, or a policy of "zero-tolerance" for society.

Addiction treatment that is accessible and responsive to the needs of patients can be a major harm reduction mechanism. Because early treatment is so important to successful outcomes, screening for alcohol and other drug use becomes an effective intervention when used to indicate which individuals should be evaluated for substance use disorders and possible treatment. Screening methods, including laboratory tests, history taking, and administration of questionnaires on substance use, may be applied in a variety of settings, such as emergency rooms, trauma centers, prisons and jails, community agencies, the workplace, etc.

Other interventions designed to reduce harm attendant upon alcohol, nicotine, and other psychoactive drug use may include attempts to:

- Reduce the direct toxicity of drugs or the indirect toxicity caused by co-ingestion of contaminants, including microorganisms;
- Reduce the consequences of drug use on others, e.g., by reducing the likelihood of transmitting HIV infection to sexual partners or the impact of violent criminal behavior on persons unrelated to drug dealing;

- Demarginalize the user and transport his or her life into productive pursuits by lessening the time, effort, and money spent on acquiring drugs.

Techniques for accomplishing these ends might include provision of drugs to persons who are drug dependent; substitution of other drugs for the drugs to which the person is addicted; modification of use patterns and routes of administration; and provision of safer techniques, tools, and locations for drug self-administration. *NEP*

Criticisms of Harm Reduction

Critics of harm reduction approaches to substance abuse point out that harm reduction has "downside" risks, and could actually be harmful in itself.

Some critics take the position that harm reduction is often a poor alternative to prevention. If, for example, a smoker who would otherwise quit smoking, either on his/her own or through treatment, is persuaded to use cigarettes with reduced tar content, the health risks are greater not only for that individual but for those who are subject to passive smoke inhalation. Diminishing harm does not eliminate it.

Even when harm reduction is incorporated into treatment, such as in methadone maintenance for opiate addicts, there have been complaints about diversion of drug supplies for "street" sales to naive users, or charges that maintenance programs perpetuate a two-tiered system of drug-free middle class patients versus drug-dependent underclass patients.^{1,2}

Finally, harm reduction may be opposed because of belief that it "sends the wrong message," especially to young people, raising doubts about the undesirability and dangers of drug use. Indeed, if harm reduction methods are perceived to be readily available as safety nets or damage control, a potential drug user might be less reluctant to experiment with drugs, or, later on, less inclined to seek needed treatment. *Not shown to be true*

Harm Reduction in a Risk-filled World

On the face of it, there appear to be numerous analogies to reducing the harmful consequences of nonmedical drug use, rather than eliminating such use itself. Safety standards, such as traffic rules and automobile speed limits, occupant restraints (seat belts, air bags), shatterproof glass, and anti-lock braking systems, reduce the inherent dangers of automobile travel. The placement of lifeguards at public beaches reduces the likelihood of drowning. The development of protective gear for athletes, the requirement that motorcyclists wear helmets, and the placement of expiration dates on processed foods are harm reduction strategies. Although not without critics, such measures have been widely accepted in American society. They seek not to prohibit potentially dangerous activities, but to alter the conditions under which such activities occur and, thereby, reduce the incidence of negative consequences for individual participants and society as a whole.

There is, however, a logical flaw in equating harm reduction measures for these activities with harm reduction strategies for drug use. Despite their risks, these activities involve socially

1 acceptable, or even necessary, behavior. Because it would be neither desirable nor realistic to
2 attempt to prohibit these activities, harm reduction is the only realistic option. The nonmedical
3 use of drugs, on the other hand, does not constitute socially acceptable behavior and, therefore,
4 it is not undesirable or unrealistic to try to prevent such use.

5 6 Harm Reduction and Drug Use

7
8 Since the early 20th century, harm reduction strategies have become an important part of public
9 policy concerning legal drugs. For medicinal drugs, this includes standards for evaluation and
10 approval, requirements that some drugs be available only by prescription, and use of warning
11 labels on over-the-counter home remedies. While none of these strategies completely
12 eliminates medicine-related harm, they reduce the level of harm to within acceptable limits.

13
14 More recently, harm reduction ideas have influenced approaches to tobacco users. Possible
15 harm reduction interventions with tobacco include behavioral, pharmacological, and public
16 health interventions. Less hazardous products (e.g., low tar and nicotine cigarettes) can be
17 used, nicotine replacement preparations (e.g., gum, patch, nasal spray) can be used, or intake
18 can be reduced (e.g., decrease number of puffs per cigarette or reduce the number of cigarettes
19 smoked per day). (However, see Criticisms of Harm Reduction above.) A growing number of
20 businesses and municipalities confine smoking to specially ventilated areas of buildings or
21 outdoor locations to reduce the amount of second-hand smoke inhaled by nonsmokers.

22
23 Harm reduction also has become part of society's approach to alcohol. Campaigns that
24 encourage the use of "designated drivers" and urge people to "not let friends drive drunk" are
25 clear attempts to lessen the harm of alcohol consumption on individual users and others. These
26 campaigns have been successful because they do not necessarily seek to restrict alcohol
27 consumption but, instead, offer reasonable suggestions for the consumption of alcohol in a less
28 damaging way.

29
30 Outside the United States, harm reduction approaches to the use of "illegal" drugs have gained
31 the support of some politicians and governmental leaders. In the Netherlands, Australia,
32 Germany, England, and Switzerland, harm reduction has become a principle for drug policy
33 formation at local and national levels. This change was driven, in large part, by the acquired
34 immunodeficiency syndrome (AIDS) epidemic and growing awareness that HIV was spreading
35 rapidly among injection drug users and, from them, to the rest of the population. Thus,
36 policies to control the spread of AIDS have been at the heart of the harm reduction movement.
37 However, in recent years, the movement has broadened substantially and now includes
38 strategies for reducing various kinds of drug-related harm, particularly within hard-core addict
39 populations.

40 41 Harm Reduction Through Improved Treatment Outcomes

42
43 A harm reduction approach to drug treatment acknowledges that, just as there is a spectrum of
44 patterns of drug use, there is a range of outcome measures that are reasonable to assess when
45 evaluating the effectiveness of professional treatment services.

Quantity and frequency of substance use--pre- and post-treatment--is but one outcome measure. Abstinence is not an invariable outcome of a given professional intervention, and failure to achieve abstinence should not necessarily be interpreted as treatment failure. Reduction of use and increase in the number of use-free days are both measurable treatment outcomes that can be regarded as beneficial and harm reducing.

Yet, because the vast majority of individuals who meet diagnostic criteria for substance dependence are not able to achieve a state of nonproblematic controlled use of alcohol or other drugs, it is reasonable to recommend a goal of total abstinence to these patients. Many studies have demonstrated substantial success rates for abstinence-based treatment in both inpatient and outpatient settings.

Relapse to drug using often accompanies dropout from treatment. A common reason for ending treatment is the lack of available reimbursement for ongoing services. Only recently have data become available confirming the benefits, if not the necessity, of sustained professional care.

Methadone Maintenance

The most widely implemented harm reduction program in the United States, begun in the late 1960s, is methadone maintenance therapy (MMT). This is a form of drug substitution or maintenance therapy (OMT) for opioid dependence. Another form uses the longer-acting agent levo-alpha-acetyl-methadol (LAAM) instead of methadone. OMT is a specific modality of treatment for opiate dependence, and is highly effective in resolving the signs and symptoms of addiction: e.g., preoccupation with substance procurement and self-administration, loss of control over amount and routes of consumption, and persistent or increasing use despite adverse consequences. The developers of MMT in the United States, Dole and Nyswander, argue that the lives of many chronic heroin injectors could be improved by providing them with "maintenance doses" of a substitute opiate drug.³ The synthetic opioid methadone was chosen because of its relatively good bioavailability when consumed orally and its relatively long persistence in the body. In sufficient doses, once-a-day administration promised to prevent opiate withdrawal, diminish "drug craving," and free heroin users from the necessity of obtaining street drugs. And because of tolerance, methadone clients would not be chronically intoxicated, making it possible for them to live more stable and productive lives.³

Methadone maintenance was expanded in the United States during the 1970s. In subsequent years, numerous evaluation studies have produced evidence of significant positive outcomes. Retention rates have been much higher than those for other treatment modalities, and methadone patients have had lower rates of criminality, arrest, and imprisonment. In addition, even when methadone patients continue using heroin and other illicit drugs, such use is substantially below pre-treatment levels.^{4,5} Another important benefit of methadone patients' decrease in illicit drug consumption is reduced risk for the various adverse health consequences that accompany repeated injection, including HIV infection.⁶

Methadone maintenance soon began spreading from the United States to other countries, with the emergence of the AIDS epidemic encouraging more widespread adoption in Europe and

1 Australia. In fact, outside the United States, methadone maintenance has become an integral
 2 part of treatment and rehabilitation strategies as well as harm reduction strategies, with efforts
 3 to make the programs easily accessible and "user friendly." Heroin users are generally free to
 4 enter and leave programs at will, are not excluded upon evidence of additional drug use, have
 5 input into decisions regarding dosage levels, and can earn "take home" privileges to facilitate
 6 the development of stable work and family lifestyles. While methadone recipients are generally
 7 offered counseling or other therapeutic opportunities, they are not obligated to participate as a
 8 condition of receiving methadone. In addition, methadone is made available in a variety of
 9 ways: through clinics, mobile units that travel to areas where drug users congregate, and
 10 prescription by private physicians. The principle underlying these "low threshold" systems is
 11 to maximize methadone delivery and, thereby, decrease heroin consumption and related
 12 harms.⁷⁻¹¹ To generate further risk reduction, some British programs also have begun to
 13 provide an injectable form of methadone to clients unwilling to consume the drug orally.¹²

14
 15 In contrast, despite the AIDS epidemic, methadone maintenance has become increasingly
 16 restrictive in the United States--with a contraction in the number of programs and
 17 implementation of stricter regulations regarding dosage levels--despite evidence that better
 18 outcomes are often obtained when patients are maintained on higher doses.^{13,14}

19
 20 Although many of the measures instituted abroad might not be appropriate in this country,
 21 reorganization and expansion of methadone services could improve the health and social
 22 functioning of chronic heroin injectors, including those on program waiting lists, those not
 23 amenable to or eligible for standard MMT programs, and those who are patients in AIDS and
 24 tuberculosis clinics. In addition, greater methadone availability can produce positive
 25 consequences for society by reducing drug users' reliance on street drugs, reducing criminality,
 26 and reducing the spread of HIV infection.

27
 28 Consistent with evidence of effectiveness in limited trials,¹⁵ federal regulations prohibiting
 29 methadone prescription for maintenance by physicians outside of formal MMT programs
 30 should be re-evaluated. Research on the "medical" model of maintenance should be supported.
 31 This was the subject of a previous CSA report ("Methadone Maintenance in Private Practice,"
 32 I-94).

33 34 Needle-Exchange

35
 36 Harm reduction among drug injectors should include a recommendation to cease drug use and
 37 the provision of effective treatment. If cessation cannot be achieved, education about the value
 38 of clean needles and syringes and information about needle-exchange can be useful. When
 39 hypodermic needles and syringes are not readily available, intravenous drug users tend to reuse
 40 injection equipment numerous times, and often share it with others. As a consequence, blood-
 41 borne diseases may spread rapidly in populations of drug users. During the past several
 42 decades, epidemics of hepatitis have been attributed to needle-sharing. Since the mid-1980s,
 43 needle-sharing has been responsible for spreading the HIV infection from one drug user to
 44 another, from drug users to their sexual partners and, eventually, from infected mothers to their
 45 neonates.

1 Although a variety of programs have been developed for reducing the spread of HIV infection
 2 among drug injectors, needle-exchange has been one of the most important and effective. In
 3 many countries, the response to reports of escalating HIV prevalence among intravenous drug
 4 users was creation of needle and/or syringe distribution programs, most of them requiring
 5 participants to return dirty needles in exchange for sterile ones. The Netherlands was a leader
 6 in this regard; in fact, because of its early commitment to harm reduction philosophies, needle
 7 exchange was implemented there in the early 1980s, prior to emergence of the AIDS crisis.¹⁶
 8 By the late 1980s, governments in England, Switzerland, Australia, and Germany also had
 9 begun needle-exchange programs and, within a few years, most other European countries had
 10 followed their lead.¹⁷

11
 12 While differing in format and size, needle-exchange programs share a commitment to
 13 maximizing the availability of sterile needles and syringes--offering them at multiple locations,
 14 through storefronts, outreach workers, or mobile vans. In some cities, needles and syringes
 15 are distributed at drug-treatment centers¹⁸ and, in Amsterdam, even police departments have
 16 joined the effort.¹⁹ More recently, "vending machines" that yield a clean syringe if a syringe is
 17 deposited have been placed in high drug-use areas to make clean needles available around the
 18 clock.²⁰ Pharmacists also have been encouraged to sell needles and syringes to drug users and,
 19 in Liverpool, England, some pharmacies operate needle-exchange programs.²¹

20
 21 There is substantial evidence of reduced needle-sharing among regular participants in needle-
 22 exchange programs.^{22,23} More importantly, HIV infection rates among drug users have been
 23 consistently lower in cities with needle-exchange programs--as well as lower in cities that
 24 implemented programs early in the AIDS epidemic, compared with those doing so later.^{24,25}
 25 For example, while the HIV infection rate among injection drug users remained 1% to 2% in
 26 the Scottish city of Glasgow, where a needle-exchange program was quickly established, it
 27 reached 70% in nearby Edinburgh, where the response of government officials was to
 28 implement even more stringent controls over injection equipment.^{26,27} While the intended
 29 purpose of the increased controls was to discourage drug injection, the consequences included
 30 increased needle-sharing and escalating HIV rates.

31
 32 In the United States, HIV rates among intravenous drug users are similar to those in
 33 Edinburgh, as high as 70% in some cities.^{28,29} State regulations that require a physician's
 34 prescription for the purchase of needles and syringes prevent drug users from obtaining them at
 35 pharmacies. In addition, in most states, anti-paraphernalia laws make the possession of drug-
 36 administration equipment a criminal offense and, thus, grounds for arrest and imprisonment.
 37 As a consequence, drug users, particularly those who buy drugs on the street, tend not to carry
 38 injection equipment. Instead, they borrow it from others or rent it in communal "shooting
 39 galleries." Indeed, it has been suggested that the strikingly higher prevalence of HIV infection
 40 among African-American and Hispanic drug injectors, compared with Caucasians, may be
 41 largely due to the concentration of minority drug users in the most intensely policed urban
 42 areas.³⁰

43
 44 In the past few years, a few dozen needle-exchange programs have been started in the United
 45 States, but most are small and serve only a fraction of the nation's intravenous drug users.
 46 Federal law continues to prohibit the use of federal money for needle exchange,³¹ despite

evidence that needle availability decreases needle-sharing and HIV transmission and does not increase the number of drug users or the frequency of injection among current users.³² These conclusions are supported not only by European studies, but by the results of a study of approximately 2,900 heroin injectors in Baltimore, Maryland. Included in the sample were 40 diabetic subjects who, because they had identification cards to justify their possession of hypodermic syringes, seldom shared injection equipment with others and had much lower rates of HIV infection. Furthermore, there was no evidence that they injected drugs more frequently or intensely than their non-diabetic counterparts.³²

A thorough review of the impact of foreign and domestic needle-exchange programs was recently conducted by the Institute for Health Policy Studies at the University of California, San Francisco, for the US Centers for Disease Control and Prevention. Although the authors of the report had some reservations about the small amount of data available, at the time, they were unequivocal in their support of making sterile equipment available to injection drug users.³³

Outreach Interventions

Among the earliest organized harm reduction efforts, in response to the AIDS epidemic, were outreach programs in which workers from drug abuse service agencies left their offices and sought to engage injection drug users in local drug scenes, "copping" areas (ie, areas where drugs are purchased), prostitution areas, pool halls, bars, crack houses, and shooting galleries. They offered information on strategies for reducing the risk of HIV transmission to drug users and their sexual partners. In addition, they delivered bleach for disinfecting needles and provided condoms. In Europe and Australia, early outreach work was often tied to needle- and syringe-exchange and distribution efforts. Some American outreach programs also included needle exchange, but these actions were limited, often illegal, and sometimes resulted in criminal prosecution. In some outreach settings, intervention efforts were conducted, in part, to attract users into treatment, but a harm reduction attitude generally prevailed in that abstinence was not demanded and services were not withheld from those who continued to use drugs.³⁴

In 1988, the National Institute on Drug Abuse (NIDA), through its Community Research Branch, began funding outreach projects in approximately 60 inner city sites. These programs provided information about HIV and distributed bleach and condoms at street sites, mobile vans, neighborhood "field stations," and storefronts. These programs often relied on "indigenous leader outreach models." The indigenous leaders are paid, community-based workers, frequently ex-addicts, who can identify and enter networks of injectors.

A major emphasis of the NIDA-funded programs was research. Program personnel attempted to gather systematic information on drug use, needle-sharing exchange, and sexual practices in networks of injection drug users. Not only was this "ethnographic" analysis useful in identifying behaviors associated with a high risk of HIV transmission, but it provided data for the development and modification of interventions. As an example, outreach workers in Chicago, who were providing bleach for needle cleansing in shooting galleries, discovered that there was often no running water and that disinfected needles were potentially being

contaminated by shared rinse water. As a consequence, workers began including bottles of sterile water in the "disinfectant pack" they distributed.³⁵

Outcome evaluation has consistently documented the success of outreach interventions. Essentially all reports confirm that injection drug users reduce risk-laden behaviors when pertinent information and services, such as counseling, are made readily available, and especially when they are offered by peers who are members of drug-using subcultures.³⁶⁻³⁸ For example, drug users often volunteer to aid outreach workers in their efforts by introducing them to other users, facilitating their entrance into unfamiliar communities, helping in the preparation of harm reduction kits, and assisting in the distribution of bleach, clean needles, and information. The principal investigator of the outreach project in Chicago stated:

We have found that as addicts become aware of the threat that AIDS poses, they are quite capable of assimilating a strong sense of social responsibility which can be readily channeled to include an assumed role of prevention advocacy.³⁹

Harm reduction approaches have shown that when injectors and other drug users achieve some stability and normalization, they can become active participants in planning and delivering services.⁴⁰⁻⁴²

Outreach projects can serve as an effective catalyst for risk-reduction behaviors, including a decrease in needle-sharing, an increase in needle disinfection, and an increase in condom use. Policy makers can interact with user populations to obtain information on indigenously developed harm reduction strategies or use information from these populations to inform decision-making. Because of concern over AIDS, heroin users in New York City are increasingly smoking and sniffing the drug instead of injecting it.

Drugs and Violence

The interplay between drugs and violence is complex. However, there is little doubt that drug use and violence in our society are linked. There are regular news accounts of violence and death visited upon participants in drug deals, as well as upon innocent bystanders. The nature of the relationship--the causal order--is not clear. In the aggregate, it is not known whether drugs of abuse facilitate most of this violent behavior, or whether violence-prone individuals are more likely to use or distribute drugs.

Fagan,⁴³ reviewing the links between several drugs and aggression, found variable associations, but little evidence that any drug caused violent behavior. However, drug-seeking behavior can sometimes precipitate violent acts. Marijuana generally produces a euphoric effect and may even reduce violent behavior, although some observers attribute fearfulness and intense aggressive impulses to marijuana use.^{44,45} Opiates induce sedation and are not likely to lead directly to violence.

Cocaine, however, which has intense alerting and activating effects, is often tied to aggressive behavior, and amphetamines, as well as phencyclidine (PCP), have a reputation, among

HIV and other pathogens that frequently results from unsterile drug injection practices and other addictive life-style behavior.

Needle exchange also has been effective in this regard, as demonstrated by extensive programs in Europe and more limited experience recently in this country. Additional efforts to make drug taking less dangerous and injurious are being successfully undertaken by outreach street projects, many of which utilize drug users or former drug users to educate and counsel their peers.

Whether the crime and violence associated with drug taking and procurement could be reduced through liberalization of drug control laws and regulations, without concurrently creating other serious problems for individuals and society, is a question requiring further study.

Harm reduction in all of its aspects should be treated like any other complex medical and public health issue, with a focus on raising empirical questions that can increase our knowledge about effective interventions. Harm reduction strategies are readily amenable to scientific examination.

RECOMMENDATIONS

The Council on Scientific Affairs recommends that the following be adopted in lieu of Resolution 409 (I-95), Resolution 422 (I-95), and Resolution 405 (I-96), and that the remainder of this report be filed:

1. That the AMA encourage national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use.
2. That the AMA encourage policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society.
3. That the AMA encourage the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be modified so that treatment is driven by patient needs and medical judgment. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction.
4. That the AMA encourage the extensive application of needle and syringe distribution programs and the consideration of modified, less restrictive, regulations to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement

W. J. ...
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1 medical personnel and police officers, as agents that precipitate violent attacks and persistent
2 struggling against restraint.

3
4 The AMA has previously considered the role of drugs in family violence and concluded that
5 there is no simple link between the two.⁴⁶

6 7 Drug Decriminalization

8
9 Violence and other crimes associated with drug distribution and procurement often are cited as
10 reasons for re-examining our current restrictions over the production, sale, and possession of
11 most drugs of abuse.

12
13 Those who advocate relaxing or ending drug prohibitions also point to other negative social
14 correlates, such as black markets, corruption of public officials, overloading the criminal
15 justice system, and contraction of civil liberties. They contend that prohibitions drive up the
16 costs of illegal drugs, forcing users to spend large sums of money, which they often obtain by
17 committing crimes. Many times, they say, these drugs are of low quality, inducing users to try
18 more potent forms or more efficient routes of administration.

19
20 While some advocates have called for outright legalization, others have proposed a more
21 modest approach that would retain existing restrictions on production and large-scale
22 distribution, but would decriminalize possession of small amounts for personal use.

23
24 It is not clear what the consequences of any such changes in our present drug control system
25 would be. There might be a decrease in crime, but there might also be an increase in
26 problematic drug use, with a greater number of persons experimenting and becoming addicted,
27 and with supplies perhaps being more readily available to minors. Beyond that, it is possible
28 that any public policy move toward decriminalization would be seen as a move toward
29 legalization, and might be interpreted as sanctioning drug use as acceptable behavior.

30
31 Careful scientific studies of these questions need to be carried out to determine the potential
32 efficacy and desirability of such changes in national policy. The AMA encourages
33 comprehensive research into the potential positive and adverse effects of relaxing existing drug
34 prohibitions and controls. Until these studies can be conducted, the CSA sees no reason to
35 modify current AMA policy concerning drug legalization.

36 37 Conclusions

38
39 Harm reduction may involve various strategies directed toward diminishing the risks of
40 psychoactive drug use. It seeks to identify options that can minimize the adverse effects of
41 drug use on individuals and society. A treatment regimen with the sensitivity and flexibility to
42 cope with the specific needs of an addicted patient and with the discrete nature and severity of
43 the patient's condition is potentially a powerful harm reduction mechanism. In particular,
44 methadone maintenance treatment for opioid-dependent persons can be especially useful not
45 only in helping patients lead more normal and productive lives, but in reducing the spread of

1 for medically necessary needles and syringes. The need for such programs is urgent,
2 considering the contribution of injecting drug use to the epidemic of HIV infection.
3

- 4 5. That the AMA encourage the undertaking of comprehensive research into the potential
5 effects, both positive and adverse, of relaxing existing drug prohibitions and controls
6 and, that, until the findings of such research can be adequately assessed, the AMA
7 reaffirm its opposition to drug legalization.

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Office of
National AIDS Policy

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From: Anne Hughes

Association of Nurses in AIDS Care (ANAC)

Staff Action:

Reviewed By Sandy: _____ Reviewed By: _____

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RCVD: _____ DONE: _____

Recommendations/Instructions:

no response needed (ID)

To Support Staff: _____

Date of Response: _____

ANAC

ASSOCIATION OF
NURSES IN AIDS CARE

July 20, 1997

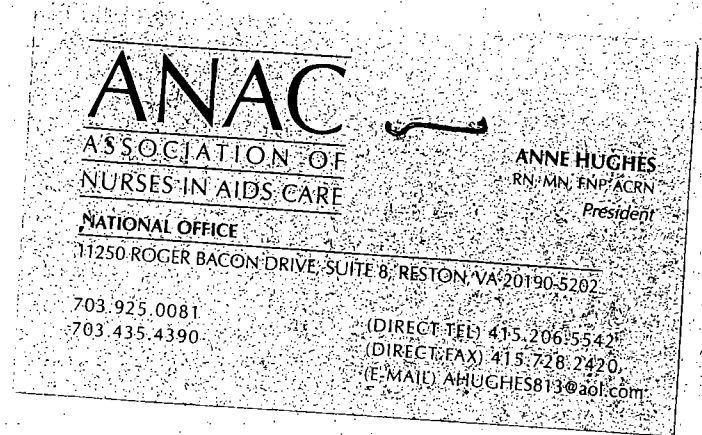
Ms. Sandra Thurman

Director

National Office of AIDS Policy

808- 17th Street, N.W., 8th floor

Washington, D.C. 20006



Dear Ms. Thurman:

Thank you so much for meeting with Dr Inge Corless, Ms. Helen Schietinger and myself on the 10th of July as representatives of the 2,800 members of the Association of Nurses in AIDS Care (ANAC). ANAC is committed to providing your office whatever information and support we are able.

Those topics of special interest to the HIV/AIDS nurses, and to our members, which we discussed during our meeting were: promoting the appointments of HIV/AIDS nursing experts to HIV-related federal commissions; recognizing the role of nurses in assisting patients/families manage the complex demands of HIV disease and its treatment both as case manager and as direct care provider; appreciating the contributions HIV+ health care workers continue to make to the workforce and to society; and last but certainly not least endorsing needle exchange as the most important prevention tool for injecting drug users who are unable to stop their drug use.

We so appreciated your warmth and your hospitality even as you were rushing off to the White House for another meeting. Please know we are all routing for your great success.

Sincerely yours,

Anne Hughes, RN, MN, FNP, ACRN
President, ANAC

PS. I think Richard Sowell was almost embarrassed when I told him we were all enjoying some memorable Sowell moments.