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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Secretary

Office of Public Health and Science
Office of International and Refugee Health

Memorandum

Date: April 3, 1998

To: International Health Representatives, Area Leads and Participants
7th Health Committee Meeting

From: Director, OIRH

Subject: Final Report from the 7th GCC Health Committee and
10th Gore-Chernomyrdin Commission -- March 5-10.

Thank you all for your continued participation in and support of Gore-Chernomyrdin Health Committee activities. The recent 7th meeting of the Health Committee demonstrated that our efforts have begun to produce real, tangible results; none of which would have been possible without your tireless efforts. A copy of the joint report and related summaries resulting from this meeting are attached.

I am also including a copy of NIDA's report on its meeting in St. Petersburg on Infectious Disease and Substance Abuse.

It is too soon to know how the changes in the Russian Government will affect the continuation of the "U.S.-Russian Joint Commission on Economic and Technical Cooperation," the formal title of the Gore-Chernmomyrdin Commission. But, we doubt it will have any significant impact on our program of cooperation in health. As you may know, we have had a US-USSR and then US-Russia Health Agreement in place for over 25 years. The current agreement between HHS and the Russian Ministry of Health and Russian Academy of Medical Sciences expires 14 January 1999. So far, there are reasonable prospects that acting Minister of Health Dmitrieva will be reinstated and we will know better in the months to come. And, we have been encouraged by the Vice President's office to keep up our efforts with Russia in a "business as usual" manner.

Linda A. Vogel

Attachments:

- Press Release, 10th Gore-Chernomyrdin Commission Meeting
- News Summary, Washington Post March 14, 1998
- Joint Report of the 7th Health Committee Meeting, Signed by Secretary Shalala and Minister Dmitrieva, March 5, 1998, with Appendices
- Prevention of HIV & Other Infectious Diseases Among Drug Abusers, NIDA 10/97

Area Leads and Participants (in alphabetic order):

Joseph Autry III
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration
Department of Health and Human Services

Robert Baldwin
Office of Global Health
Centers for Disease Control and Prevention

Victor Barnes
Centers for Disease Control and Prevention

Camille Barry
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Department of Health and Human Services

Walter Batts
Office of International Affairs
Food and Drug Administration

Stephen Blount
Office of Global Health
Centers for Disease Control and Prevention

Laurie Boeder
Department of Health and Human Services

Victor Boguslavsky
American International Health Alliance

Olga Borisova
Environment, Science and Technology Section
United States Embassy, Moscow

Philip Budashewitz
Executive Secretariat
Department of Health and Human Services

Valerie Bullerdick
International Trade Administration
Department of Commerce

Joseph Carra
Office of Pollution Prevention and Toxics
Environmental Protection Agency

Constance Carrino
Health and Population Division
United States Agency for International Development/Russia

Nancy Carter-Foster
Emerging and Infectious Diseases
Bureau of Oceans and International Environmental and Scientific Affairs
Department of State

Nelba R. Chavez
Substance Abuse and Mental Health Administration
Department of Health and Human Services

Gary Christopherson
Department of Defense

Jordan Cohen
Association of American Medical Colleges

Lawrence Cohen
Office for the New Independent States
Department of State

David Delozier
DHLS
National Center for Environmental Health
Centers for Disease Control and Prevention

Douglas Ebner
United States Information Agency

John Eisenberg
Agency for Health Care Policy and Research

Elaine C. Esber
Center for Biologics Evaluation and Research
Food and Drug Administration

Abby Gardner
Soros Foundation

Helene Gayle
National Center for HIV, STDs and Tuberculosis Prevention
Centers for Disease Control and Prevention

Carol Gleich
Area Health Education Center and Special Programs Branch
Health Resources and Services Administration

Enoch Gordis
National Institute on Alcohol Abuse and Alcoholism
National Institutes of Health

Jeff Gren
Office of Microelectronic, Medical Equipment and Instrumentation
Department of Commerce

Donald Harbick
Program Director, NIS
American International Health Alliance

Peter Hartsock
Community Research Branch
Division of Epidemiologic and Prevention Research
National Institute for Drug Abuse
National Institutes for Health

Ruth Hegyli
National Heart Lung and Blood Institute
National Institutes of Health

James Heiby
G/PHN/HN/PSR
United States Agency for International Development

David Hohman
Office of International Affairs
Department of Health and Human Services

Paul Holmes
ENI/DGSR/HRHA
United States Agency for International Development

Richard J. Jackson
National Center for Environmental Health
Centers for Disease Control and Prevention

Stuart Keitz
International Trade Administration
Department of Commerce

Lloyd Kolbe
Adolescent and School Health Division
Centers for Disease Control and Prevention

John Langenbrunner
The World Bank

James LeDuc
National Center for Infectious Disease
Centers for Disease Control and Prevention

Alan I. Leshner, Ph.D.
National Institute on Drug Abuse
National Institutes of Health

Dawn Liberi
United States Agency for International Development

Sandra McCormick
Gundersen Lutheran (La Crosse, Wisconsin)

Srdjan Matic
Open Society Institute

Robert E. McCarthy
Office of East European and NIS Affairs
United States Information Agency

Mary Ann Micka
Health Reform and Humanitarian Assistance Division
Europe and Newly Independent States
United States Agency for International Development

Dayton Miller
Nutritional Biochemistry Branch
National Center for Environmental Health
Centers for Disease Control and Prevention

Ambassador Richard Morningstar
Department of State

Ellis Mottur
Department of Commerce

Peggy Murray
International Research and Training Program
National Institute on Alcohol Abuse and Alcoholism
National Institutes of Health

M. Patricia Needle
International Program
National Institute on Drug Abuse
National Institutes of Health

David Nicholas
Center for Human Services
United States Agency for International Development

William Nitze
Environmental Protection Agency

Gary Norris
Chemical Biological Warfare and International Affairs
Office of the Assistant Secretary of Defense for Health Affairs
Department of Defense

Sam Notzon
National Center for Health Statistics
Centers for Disease Control and Prevention

Richard J. O'Brien
Research and Evaluation Branch
Division of Tuberculosis Elimination
National Center for HIV, STDs and Tuberculosis Prevention
Centers for Disease Control and Prevention

Deborah Queenan
Agency for Health Care Policy and Research
Department of Health and Human Services

Juan Ramos
Office of Prevention
National Institute for Mental Health
National Institutes for Health

Darrel Regier
Division of Epidemiology and Services Research
National Institute for Mental Health
National Institutes for Health

Carol Rubin
Environmental Exposures and Health Effects Section
National Center for Envrionmental Health
Centers for Disease Control and Prevention

James Sayers
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration
Department of Health and Human Services

Steven Sawmelle
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration
Department of Health and Human Services

Philip Schambra
Fogarty International Center
National Institutes of Health

Anna Shakarishvili
Division of Adolescent and School Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

Ambassador Sally Shelton-Colby
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

Jim Smith
American International Health Alliance

Linda Staheli
Division of International Relations
Fogarty International Center
National Institutes of Health

Richard Tarplin
Department of Health and Human Services

Natalie Tomitch
Division of International Relations
Fogarty International Center
National Institutes of Health

Frank Vinicor
Diabetes Translation Division
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

Lewis Weinstein
Public Health Resources Institute

Karl Western
National Institute for Allergy and Infectious Diseases
National Institutes for Health

Marian Willinger
National Institute for Child Health and Human Development
National Institutes for Health

International Health Representatives not listed above (in alphabetic order):

Stanley Bendet
Administration for Children and Families

Robert Bernstein
United States Agency for International Development

Georgia Buggs
Office of Minority Health

Marla Bush
Administration on Aging

Faye Calhoun
National Institute on Alcohol Abuse and Alcoholism

Bruce Chelikowky
Indian Health Services

John Paul Clark
United States Agency for International Development

Jarrett Clinton
Department of Health and Human Services

Barbara Cohen
Department of Health and Human Services

Carol Dabbs
United States Agency for International Development

Elaine Daniels
Office of HIV/AIDS Policy

Jonathan Davis
Department of State

Winston Dean
Office of the Surgeon General

George Dines
Health Resources and Services Administration

Kathleen Downs
United States Agency for International Development

Robert Emrey
United States Agency for International Development

Phyllis Gestrin
United States Agency for International Development

Dale Gibb
United States Agency for International Development

Eric Goosby
Office of HIV/AIDS Policy

Miryam Granthon
Office of Disease Prevention and Health Promotion

Sheila Harley
Substance Abuse and Mental Health Services Administration

Kathleen Hastings
Food and Drug Administration

Suzanne Haynes
Office of Women's Health

Robert Knouss
Office of Emergency Preparedeness

Carolyn Beth Mazzella
Office of the Surgeon General

Jocelyn Mendelsohn
Office of the General Counsel

Jay Merchant
Health Care Financing Administration

Linda Myers
Office of Disease Prevention and Health Promotion

Stuart Nightingale
Food and Drug Adminstration

Norman Prince
Program Support Services

Joy Riggs-Perla
United States Agency for International Development

Alex Ross
United States Agency for International Development

Kenneth Secord
United States Agency for International Development

Sandy Thurman
National AIDS Program Office

Craig Vanderwagen
Indian Health Services

Pamela Wolf
United States Agency for International Development

HIVNEWSLINE

REPORTING RECENT ADVANCES IN THE DIAGNOSIS AND TREATMENT OF PATIENTS WITH HIV INFECTION

EDITOR-IN-CHIEF

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Director, AIDS Program
San Francisco General Hospital

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Associate Professor
Division of Infectious Diseases
Department of Medicine
University of Alabama
Birmingham, AL

CATHERINE M. WILFERT, M.D.
Professor
Division of Infectious Diseases
Department of Pediatrics
Duke University Medical Center
Durham, NC

EXECUTIVE EDITOR

EDWIN BAYRD

14 April 1998

Sandra Thurman, Director
Office of National AIDS Policy
808 17th Street, N.W.
8th Floor
Washington, D.C. 20006

Dear Ms. Thurman:

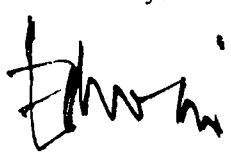
Living with HIV means living with stress. There is the stress of remembering to take all of one's medications every day. There is the stress of monitoring one's health status on a daily basis and one's response to therapy on a month-to-month basis. For some, there is the added stress of having to conceal the fact that they are living with HIV. And for all infected individuals, there is the unending, unabating stress of *not knowing*. Not knowing if a cough is actually PCP. Not knowing if an antiretroviral regimen is actually working. Not knowing what is coming next, and what form it will take, and how bad it will be, and how long it will last.

Stress may be an inevitable result of living with HIV disease, but that does not mean it is untreatable. If stress merely produced headaches, gastrointestinal upset, sleep disturbances, malaise, and depression—all of which are, in fact, classic symptoms of severe stress—we would want to treat it, simply to alleviate such symptoms and enhance the quality of life of people with HIV. But we now know that sustained stress also erodes immune function and hastens the onset of frank AIDS. This knowledge gives us an added incentive to treat stress just as aggressively as we treat viremia in seropositive individuals.

The enclosed issues of *HIV Newsline* and *AIDS Care* focus on aspects of stress management. Dr. Jeffrey M. Leiphart, who is the Director of HIV Prevention Services for the UCSF AIDS Health Project—and who founded one of the most successful comprehensive stress-reduction programs developed specifically for seropositive individuals—has contributed lead articles to both publications. He has also suggested a number of germane, practical, and realistic ways in which primary care providers and patients alike can reduce the stress that is a fact of life for people living with HIV. You will find Dr. Leiphart's recommendations in the PULL OUT AND SAVE sections of both publications.

On another note altogether, Paul and I call your attention to the editorial that Dawn Averitt contributed to the April issue of *AIDS Care*. It is a particularly compassionate—and clear-eyed—assessment of the recent Conference on Retroviruses, as seen from the viewpoint of those most affected by recent advances in the diagnosis and treatment of HIV infection—the patients themselves.

Cordially,



Edwin Bayrd
Executive Editor

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AIDS Care

Volume 2, Issue 2 • April 1998

DEDICATED TO IMPROVING THE QUALITY OF LIFE OF ALL PEOPLE LIVING WITH HIV

Highlights of the 5th Conference on Retroviruses and Opportunistic Infections

What are the newest developments in the treatment of HIV? How will these advances affect you? An advocate for people living with HIV provides a full report

DAWN AVERITT

Learning to Take It Easy

A simple program of stress-reduction that can improve your outlook—and your CD4 count

JEFFREY M. LEIPHART, PH.D.

NEWSLINE... NEWSLINE...

Makers of two protease inhibitors okay twice-daily dosing... New two-month TB prophylaxis regimen is as effective as yearlong therapy... A six-drug regimen proves to be surprisingly effective in heavily pretreated patients... Addition of leukemia drug to anti-HIV therapy shows promise... Adding a protease inhibitor to your antiretroviral regimen may reverse dementia... Cavities can promote the development of oral thrush...

Plus: WHAT THIS MEANS FOR YOU: HIV experts tell you, in clear, concise language, what impact these developments are likely to have on your day-to-day life.

What You Can Do to Reduce the Level of Stress in Your Life

Practical advice on how to cope with the tension and turmoil that are inevitable aspects of living with HIV

JEFFREY M. LEIPHART, PH.D.

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HIV NEWSLINE

REPORTING RECENT ADVANCES IN THE DIAGNOSIS AND TREATMENT OF PATIENTS WITH HIV INFECTION

Volume 4, Issue 2 • April 1998

OPTIMAL MEDICAL MANAGEMENT page 27

Coping with Stress

It *is* possible to assess—and ameliorate—
this aspect of living with HIV infection

JEFFREY M. LEIPHART, PH.D.

NEWSLINE page 34

NEWSLINE...NEWSLINE...NEWSLINE...NEWSLINE...

Initial therapy with d4T or 3TC appears to confer survival benefit... Prophylaxis for common OIs *is* cost-effective, and so is maximally suppressive antiretroviral therapy... Clarithromycin plus ethambutol is the most efficacious therapy for MAC... Administering hydroxyurea with ddI increases intracellular concentrations and facilitates activation of this nucleoside... Clarithromycin and rifabutin appear to be protective against cryptosporidiosis... Nevirapine plus two nucleosides exerts durable effect: Sustained benefits seen after two years of combination therapy... New data on workplace exposure to HIV: ZDV prophylaxis reduces risk of infection by 81%...

Plus: More news from the 5th Conference on Retroviruses and Opportunistic Infections:
A three-nucleoside combination offers an alternative
to protease inhibitor-containing regimens...
Efavirenz plus indinavir dramatically reduces viral load...
Further confirmation of the efficacy of triple-combination therapy...

PULL OUT AND SAVE page 43

How You Can Help Your Patients Reduce the Level of Stress in Their Lives

Practical recommendations for healthcare professionals who
provide continuing care to patients with HIV disease

JEFFREY M. LEIPHART, PH.D.

COMING IN HIV NEWSLINE page 48

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

April 10, 1998

The Honorable Sandy Thurman
Director
White House Office of National AIDS Policy
808 17th St., NW, 8th Floor
Washington, DC 20503

Dear Ms. Thurman: Sandy

Wanted to let you know of a meeting yesterday between Director McCaffrey and Erskine Bowles to discuss needle exchange policy. Other participants included Rahm Emanuel and Bruce Reed. Mr. Bowles stated that he was keeping the President abreast of the ongoing discussion of this issue, to include providing him copies of recent correspondence between ONDCP and the AIDS Policy Office.

In summary, the concerns the Director has with moving forward on needle exchange at this time are as follows:

- **The science is uncertain.** It would be imprudent to take a key policy step on the basis of yet uncertain and insufficient evidence.

- **The public health risks outweigh benefits.** Each day, over 8,000 young people will try an illegal drug for the first time. Heroin use rates are up among youth. While perhaps eight persons contract HIV directly or indirectly from dirty needles, 352 start using heroin each day, and more than 4,000 die each year from heroin/morphine-related causes (the number one drug-related cause of death). Even assuming that needle exchange programs can further accelerate the already declining rate of HIV transmission, the risk that such programs might encourage a higher rate of heroin use clearly outweighs any potential benefit.

- **Treatment should be our priority.** Our fundamental moral obligation is to provide treatment for those addicted to drugs. Needle exchange programs should not be funded instead of treatment.

- **Federal dollars are not required.** State and local governments and the private sector can already fund NEPs.

- **Federal support of NEPs may undercut AIDS research, prevention and treatment.** If federal funds are allocated to NEPs, those who oppose AIDS research, treatment and prevention programs may argue why provide millions of federal dollars for these HIV/AIDS programs when the answer lies in a twenty-cents needle?

- **Federal support of NEPs may undermine other drug-control programs.** The use of taxpayer dollars to support needle exchange programs is a lightning rod issue. The President's *National Drug Control Strategy* is increasingly gaining support and making a difference. An Administration decision to alter course on NEPs and spend federal monies to buy drug paraphernalia could seriously undermine our ability to continue to carry out effective drug policies that enjoy bipartisan support.

- **Supporting NEPs will send the wrong message to our children.** By handing out needles we encourage drug use. Such a message would be inconsistent with the tenor of our national youth-oriented anti-drug campaign.

- **NEPs place disadvantaged neighborhoods at greater risk.** NEPs are normally located in impoverished neighborhoods. These programs attract addicts from surrounding areas and result in a concentration of criminal activity.

The bottom line is that General McCaffrey believes we should provide the President the opportunity to listen to the considered viewpoints of his Drug Policy Council before a decision is made to support needle exchange programs with federal funds.

Sincerely,

James R. McDonough
Director, Strategy

Enlosure
Vancouver Needle Exchange
Trip Report

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

April 6, 1998

INFORMATION
MEMORANDUM FOR THE DIRECTOR

THROUGH: **THE DEPUTY DIRECTOR**

FROM: **STRATEGY (D.B. DES ROCHES)**

SUBJECT: Vancouver Needle Exchange Trip Report

1. **PURPOSE:** To provide you with field observations on needle exchange and drug abuse in Vancouver, Canada.

2. **GENERAL:** You had directed that Dr. Adger and I visit the Vancouver Needle Exchange in light of the high incidence of HIV among needle exchange participants and the skyrocketing death rate due to drug overdose in Vancouver. Jane Sanville of ODR joined the trip because of her expertise in the field of AIDS. We spoke with law enforcement and public health officials, as well as with the scientists who studied the needle exchange and those who run the needle exchange. (Trip Schedule at TAB 1). Our visit to the U.S. Customs and Border Patrol at Blaine raised separate issues, which will be reported under separate cover.

3. **OBSERVATIONS -- FACTS:**

A. The Vancouver Needle Exchange Program (NEP) is one of the largest in the world -- it has distributed over 1 million needles annually for the last ten years, and close to 2.5 million needles last year alone.

B. The HIV rates among participants in the NEP is higher than the HIV rate among injecting drug users who do not participate.

C. The death rate due to illegal drugs in Vancouver has skyrocketed since 1988, the year needle exchange was introduced. In 1988, 18 deaths were attributed to drugs: in 1993 200 deaths were attributed to drugs. The Provincial Coroner told us that in March they were averaging more than 10 deaths due to drugs per week, and were on pace for 600 deaths province-wide in 1998 -- mostly in Vancouver.

D. With the implementation of NAFTA, the Vancouver Port Police was disbanded. Vancouver is the most active Pacific port in North America.

E. The highest rates of property crime in Vancouver are within two blocks of the needle exchange (See maps, TAB 2).

4. **OBSERVATIONS--STATEMENTS:**

A. The single most striking point, which all interviewees stressed, was the ***lack of adequate drug treatment capacity in British Colombia***. The head of the Vancouver -Richmond Health Board stated: "I can have all the needles I want, but they won't give me a single drug treatment bed." Other health care professionals noted the fact that governmental responsibility for drug treatment has been shuffled among various ministries, and has never been a priority.

B. Every interviewee stated that ***the most abused injection drug in Vancouver is cocaine.*** This was cited repeatedly as a major reason for the failure of needle exchange to prevent HIV: cocaine abusers typically inject much more frequently than do heroin abusers.

C. Every interviewee cited the geographic features of the Downtown / Eastside (the major drug abuse area and the location of the needle exchange) as an exacerbating factor. Bounded by railyards and docks on two sides, it is an isolated and distinct area that contains most of the serious injection drug abuse and the drug trade, as well as associated prostitution and property crime. The area has a large number of single residence occupancy hotels, which all said contributed to the "massing effect" of addicts.

D. Every interviewee said that the average age of IV drug users has decreased in recent years.

E. Every interviewee save the Coroner pointed to the lack of turnstiles on the skytrain (elevated light rail system) as an aggravating factor, as it increased ingress for the destitute to the Downtown/Eastside area from other parts of the city.

F. The Vancouver Police interviewees stated that they had been called by other interviewees and asked what they were going to say.

G. The Director of the NEP stated that "it is ridiculous to propose that we hand out 10 million needles a year." 10 million is the number he estimated would be required to accommodate the injecting cocaine users in Vancouver with one needle per injection.

H. Jane Sanville noted that the primary investigator of the needle exchange study had been urged to suppress her research at professional conferences because it had the potential of casting a negative light on NEPs.

I. Every interviewee stated that the primary reasons for the increase in drug abuse was the available supply of cheap drugs, and that the needle exchange had either no effect or a marginal effect on overall drug abuse.

J. The Vancouver Police stated that there are inadequate drug treatment beds in the criminal justice system. Court mandated treatment is not a reality.

K. The Vancouver Police stated that there was a 24 hour drug market and similar open drug injection activity in the area immediately adjacent to the needle exchange. During a drive-

around with a detective from the Vancouver Drug Squad, we observed multiple instances of drug users injecting and purchasing drugs. A one block long alley typically had three or four people injecting, preparing to inject or moving from injecting drugs. While walking around the area, we frequently encountered discarded syringe wrappers and protective tips.

4. **OBSERVATIONS-- REPORTER NOTES:**

A. Everyone save the police clearly wanted needle exchange to be a success (the police seemed to feel it was a facilitator for drug use, but officially supported it), and felt that the failure of needle exchange to stop the spread of HIV was due to three factors:

1). The NEP was set up for heroin users: the prevalence of cocaine injection (which is much more frequent) meant that the NEP would be inadequate.

2). Vancouver suffers from a "nutbowl effect" -- the homeless, migrants, counter-culture types and disaffected, at-risk personalities tend to migrate there from around the country. Everyone pointed to social policies in other Canadian provinces, especially Alberta, which encouraged socially marginal people to move to British Colombia (by providing bus tickets).

3). Vancouver was on the trailing edge of the AIDS epidemic: some stated that the NEP was founded just as AIDS began to surge. It was frequently asserted that "it would have been much worse without NEP." (*Note -- it might be interesting to evaluate other NEPs in this light -- generally, NEPs in America were established on the trailing edge of the epidemic. Any claimed reduction in HIV incidence might be attributable to the normal course of the disease*).

B. The academics evaluating the NEP and the NEP itself were very close: the principle author of the Vancouver study accompanied us to the NEP and was given a telephone message that had been sent to her there. I did not take this to indicate any unethical behavior, but note merely that human scientists (anthropologists, psychologists, epidemiologists) work with humans, and thus are constantly challenged to maintain the same level of objectivity and detachment from their subjects as mathematicians and physicists.

C. All the ONDCP participants were amazed at the lack of treatment capacity in Vancouver. When we asked interviewees about this, they too were outspoken about inadequate treatment. Apparently, there is a requirement for addicts to abstain for three months prior to entering one of the few treatment spaces. Catch 22 is not just an American invention.

D. The academics who studied the NEP seemed extremely concerned by the increase in HIV among NEP participants, and devoted much of our time together to explaining how NEP frequent users were a much more marginalized and at-risk segment of society than were infrequent NEP users. When asked if there were any studies comparing NEP users and non-NEP users, the study director responded that they had no way to interview non-NEP users.

E. Property crime of all sorts in Vancouver seems to be highest in the areas around the NEP building. This is sort of a chicken-egg thing: it's hard to gauge cause and effect.

F. Public support for needle exchange seemed to exist, but only so long as the NEP was confined to Downtown-Eastside. Expansion of the NEP (by vans) was opposed at a public

meeting on the day of our departure.

G. All interviewees save the police referred to the NEP's efforts to maintain relations with the community, and their efforts to keep discarded needles away from schools, etc. However, in a private interview, an elementary schoolteacher said that children at area schools are not allowed outside at recess for fear of needles. I was unable to verify this statement.

5. **CONCLUSIONS:**

A. **There has been a trade-off between needle exchange and drug treatment**. This is the single most important lesson learned in Vancouver. The trade-off was not explicit, and was probably not deliberate. It may have resulted from normal bureaucratic politics, or the shuffling of responsibilities among ministries. **Nevertheless, it has evolved and is allowed to persist.**

1). Absent any mandate for drug treatment, NEPs will focus on what they can afford and do best--exchange needles.

2). Once the NEP was instituted, there seemed to be no imperative for the establishment or expansion of drug treatment. All interviewees stated that NEP was not a "silver bullet," but reality suggests that it is treated as such.

B. **In the absence of treatment, the potential benefits of needle exchange programs are marginalized for the most at-risk.** The single most common explanation given for the prevalence of HIV among NEP participants was that the NEP participants were at a greater risk than non-NEP participants. Harm reduction believes that by giving addicts the means and knowledge to safely use drugs (i.e. needles), most of the negative effects of drug abuse can be alleviated. Yet this approach still requires that the addict responsibly use the needles he is given; the HIV statistics show that he does not. For an at-risk population paternal approaches which -- as a last resort -- can supplant irresponsible behavior will probably be more effective. **With an at-risk, irresponsible population, without access to drug treatment, needle exchange appears to be nothing more than a facilitator for drug abuse.**

C. **High-purity cocaine and heroin is becoming increasingly prevalent and will pose challenges across the board.** Vancouver is literally swamped with drugs. Large seizures appear to have no effect at the street level. This influx of high-purity heroin and cocaine is a major cause of both the high HIV rates in Vancouver as well as the high death rate. We should examine high-purity drugs as a separate threat, and consider a national initiative along the lines of our methamphetamine initiative.

ENCLOSURES:

TAB 1 Trip Schedule
TAB 2 Crime Maps

March 30, 1998

INFORMATION
MEMORANDUM FOR THE DEPUTY DIRECTOR

FROM: **STRATEGY (D.B. DES ROCHES)**

SUBJECT: Vancouver Trip

1. **PURPOSE:** To provide you with background information for our trip to Vancouver to gather data on needle exchange programs and drug abuse in the city.

2. **GENERAL:** The Vancouver study of needle exchange has produced a number of findings which are of interest: a. HIV rates have increased drastically among those in the program and b. deaths attributable to drug abuse have also increase dramatically. The Director has dispatched us to Vancouver to see the situation on the ground and determine what conclusions may be drawn.

3. **SCHEDULE:**

April 2, 1998

1130	Lunch with Dr. John Blatherwick {(604)775-1866}, Chief of the Vancouver-Richmond Health Board, 3rd Floor, 1060 West 8th Street (near Oak and B'way), Vancouver
1300	Meeting with Steffanie Strathdee {(604) 631-5535} (Principle Investigator of Vancouver Needle Exchange Study) and others, Room 611, St Pauls Hospital, 1081 Burrard Street (@ Davie, Comox entrance) Vancouver.
1500	Tour of Vancouver Needle Exchange with Strathdee.
1600	Mtg with Deputy Chief Brian Maginnis, {(604) 665-3089) Head of Investigations and Narcotics, Vancouver Police Department, 312 Main Street, Vancouver
1700	Tour of vicinity needle exchange and drug purchasing areas with Vancouver PD.

April 2, 1998

0930 Meeting with Louise Pollock, {(604) 255-3151)Director, Downtown Community Health Center (methadone maintenence, primary drug / HIV treatment facility), 4112 E. Cordova St, Vancouver.

1200 Meeting with USCS SAC, POE Blaine, Washington

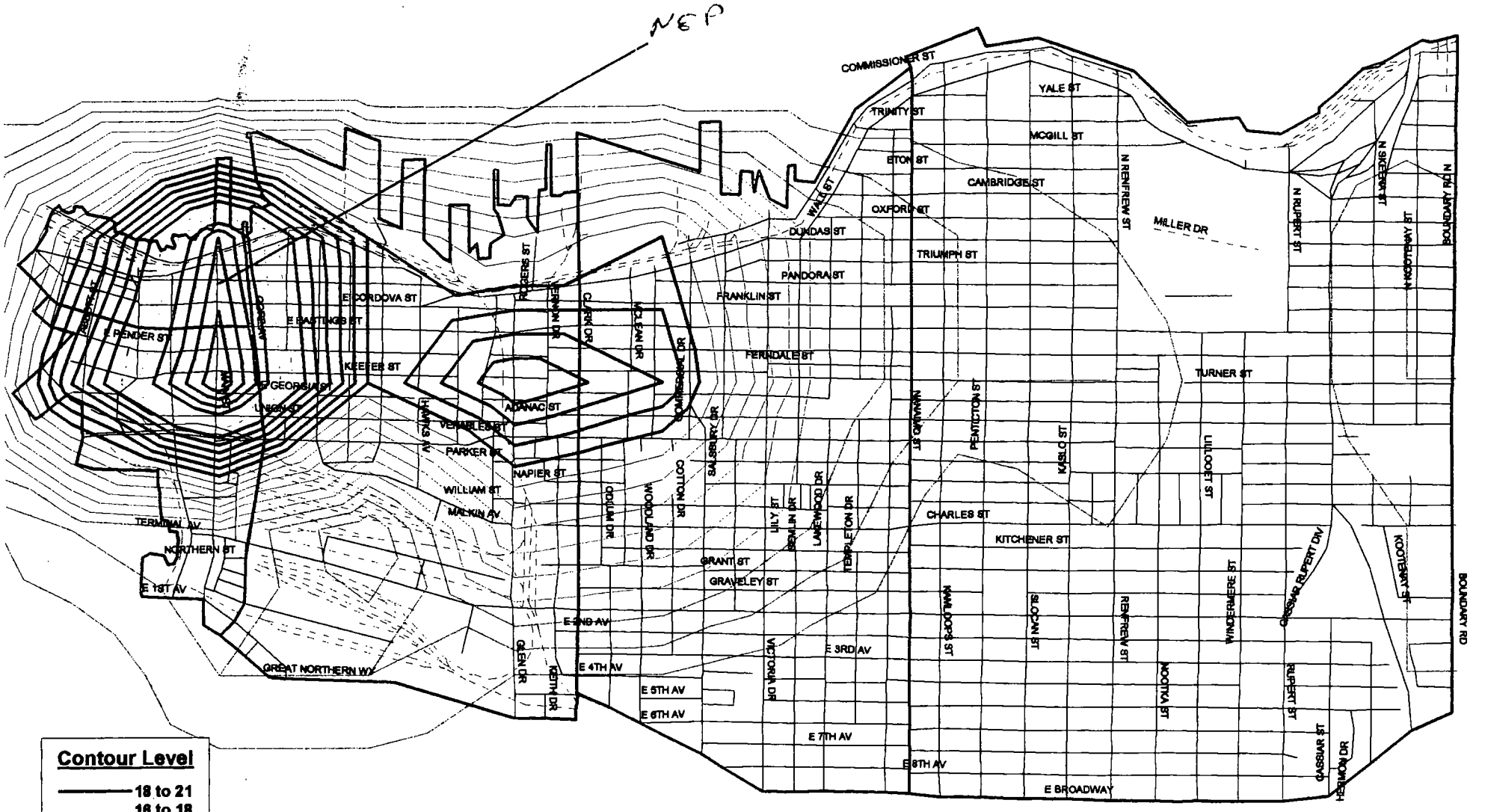
1500 Meeting with BC Provincial Coroner, (604) 660-7739

ENCLOSURES:

TAB A: Vancouver Needle Exchange Study
TAB B: Illicit Drug Statistics for British Colombia
TAB C: Vancouver / Richmond Health Board Paper on Drug Reform

Patrol District Two
Commercial Break & Enter

Mar15th. To Mar 29th., 1998



Contour Level

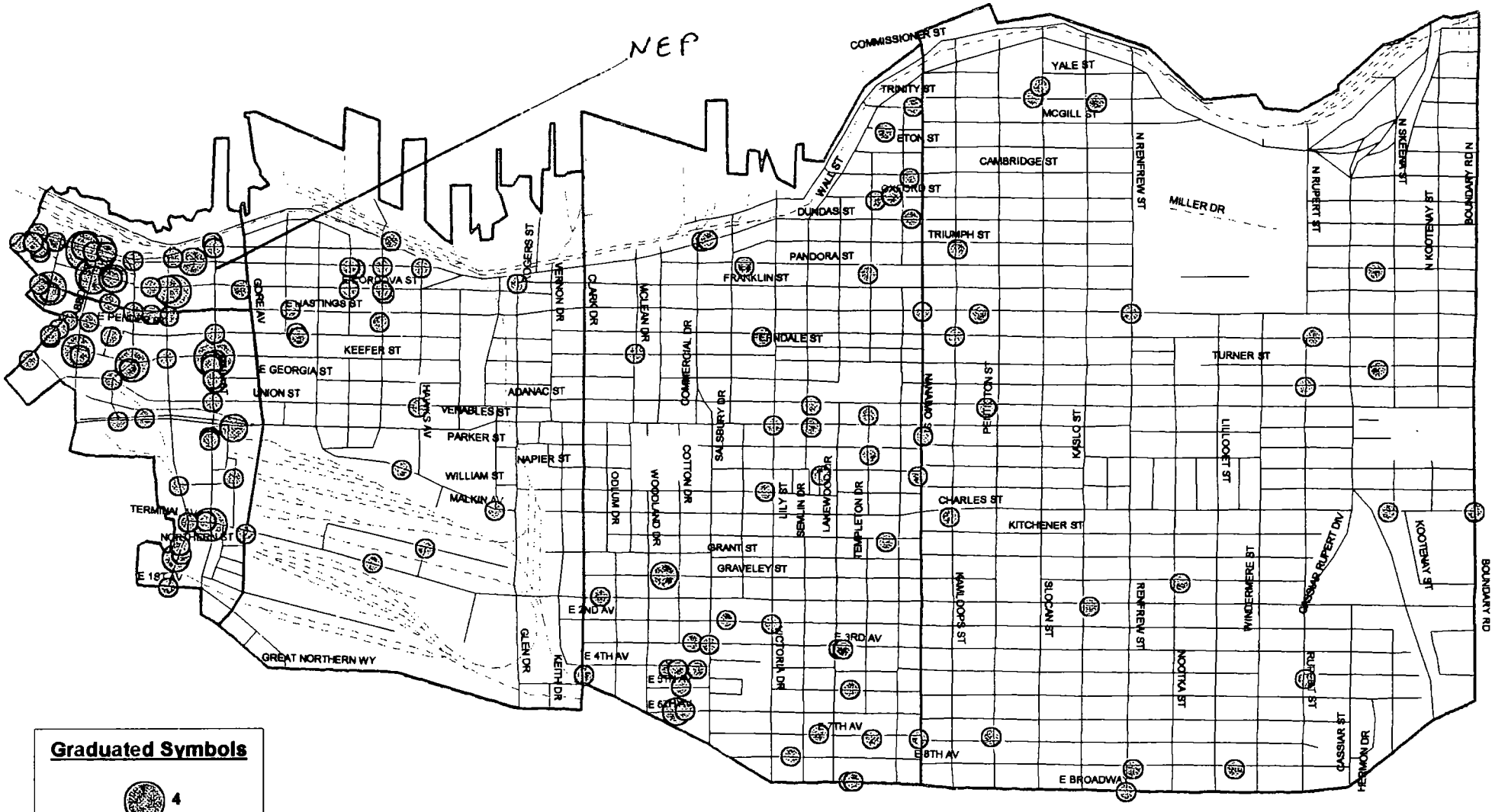
- 18 to 21
- 16 to 18
- 13 to 16
- 10 to 13
- 7 to 10
- 4 to 7
- 1 to 4

55 Incidents In 45 Separate Locations
62 Incidents In Previous 2-Week Map

Vancouver Police Department
Crime Analysis Unit

Patrol District Two
Theft From Auto

Mar15th. To Mar 29th., 1998



Graduated Symbols

4
2
1

182 Incidents In 153 Separate Locations
219 Incidents In Previous 2-Week Map

Vancouver Police Department
Crime Analysis Unit