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Issues - Needle Exchange [2]

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\$1 million offered for needle exchange

NEW YORK — Financier George Soros says he will donate \$1 million to buy clean hypodermic needles for drug addicts nationwide who risk contracting AIDS.

Mr. Soros challenged government leaders to "respect the scientific evidence" that needle-exchange programs curb the spread of HIV, the virus that causes AIDS.

Mr. Soros said in an interview with the New York Times that he will give his new gift to the Tides Foundation, a San Francisco-based grants program that will distribute the money to needle-exchange programs around the country.

Mr. Soros said he does not support legalizing drugs, but since they are practically impossible to outlaw, he proposed trying to reduce the harm that drug users cause themselves.

Washington Times 8/18/97

MONDAY, AUGUST 18, 1997 B3

Wall Street Journal

Soros to Donate \$1 Million For Needle Exchanges

NEW YORK (AP)—Billionaire George Soros said he will donate \$1 million to purchase clean hypodermic needles for drug addicts nationwide who risk contracting AIDS.

The financier challenged government leaders to "respect the scientific evidence" that needle-exchange programs curb the spread of HIV, the virus that causes AIDS. Such programs "are scientifically proven to save lives, do not encourage drug use, and are supported by a majority of the American public," Mr. Soros said in a statement.

Critics of Mr. Soros have said his programs encourage drug use.

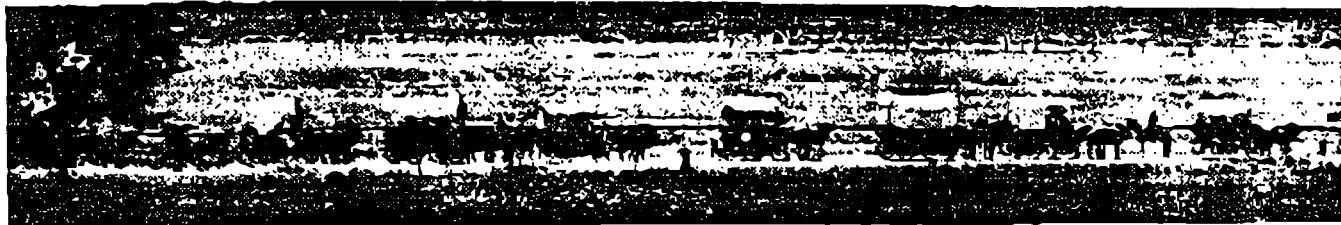
The federal Centers for Disease Control and Prevention estimates that intravenous-drug users, their sex partners and newborn children account for over one-third of new cases of HIV infection.

Mr. Soros said he will give his new gift to the Tides Foundation, a San Francisco-based grants program that will distribute the money to needle-exchange programs around the country.

Last year, Mr. Soros funded ballot initiatives to legalize the medicinal use of marijuana, measures that were approved by voters in California and Arizona.

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The Mormon wagon train passes Chimney Rock near Bayard, Neb., which for Mormons signaled the halfway point to Great Salt Lake.

"Promised Land" far from the mobs that killed their prophet and drove them out of Illinois. They settled in the Great Salt Lake Valley—then remote Mexican territory—where they multiplied and prospered and built up the Church of Jesus Christ of Latter-day Saints.

Now this once-persecuted sect is one of the world's fastest growing faiths, claiming 9.5 million members worldwide, and thousands this summer are retracing the Mormons' formative exodus. Some are short-timers who bring their families for a weekend escapade, but about 350

people intend to trek the entire 1,100 miles in three months, finishing with a triumphant arrival July 22 in Salt Lake City. At least half are non-Mormon frontier buffs out for adventure. But many are Latter-day Saints on a pilgrimage hoping
See MORMONS, A16, Col. 1



BY J. ANNA WILAS—THE WASHINGTON POST

percent of the program's needles are returned to the Needle Exchange. More than 1,600 addicts participate.

At the D.C. Needle Exchange, A Rush to Curb Spread of AIDS

Members of Mobile Unit Offer Addicts a Trade-Off

By Julie Makinen
Washington Post Staff Writer

A dozen heroin addicts are pacing outside the RV at Seventh and H streets in Northeast Washington, desperate for a fix. Inside, Michael Pryor and his crew scramble to open shop.

"Just one more minute, man!" Pryor shouts as he grabs a box of needles. He pulls out a large plastic bag filled with hundreds of cookers—small metal caps in which to mix the drug with water and heat it before injection. "Okay, okay! Here we go!"

He flings open the door, and the morning rush is on at the D.C. Needle Exchange, a \$200,000 city-funded effort run by the Whitman-Walker Clinic that was

launched this spring to curb the transmission of HIV.

Three addicts pile into the vehicle and start unloading their caches of used syringes. "Ten, 20, 28," counts one man, tossing the bloody implements into a red plastic biohazardous waste container. He gets 28 clean ones in return, plus small bottles of bleach and water and a packet including a cooker, a band-aid and an alcohol swab. "Thanks," he offers quickly, darting out to the street. Another man steps in.

By 4:30 p.m., after visiting three sites, Pryor, the program's director, and his two assistants will have handed out nearly 2,000 needles to about 75 addicts—a clientele that includes not only the homeless and unemployed but also teenagers and

See NEEDLES, A14, Col. 1

ing to Snuff Out the Tobacco Culture

try Gambles It Can Survive Efforts to Stop Smoking's Seduction

By Marc Fisher and John Schwartz
Washington Post Staff Writers

challenge is monumental—the dismantling of a \$150 billion industry using money, media and medicine, anti-smoking efforts to undo the work of centuries of literature and Hollywood and Madison Avenue, to sever the automatic connection between a kiss and a column of smoke, between a shout of rebellion and a lick of a butt.

The tobacco industry is willing to bet \$368.5 billion that

links so deeply embedded in the collective consciousness simply cannot be broken.

Friday's massive settlement between the tobacco industry and state attorneys general, though far from final, may turn out to be "the most historic public health achievement in history," as Mississippi Attorney General Michael Moore called it. But anti-tobacco activists, cigarette makers, and historians of the habit say such hyperbole is premature: The future of the cigarette is largely shrouded in smoke.

From former surgeon general C. Everett Koop to historian Richard Kluger, those who have studied the



More Than 1,600 Addicts Participate in Mobile D.C. Needle Exchange

NEEDLES, From A1

senior citizens, parents with children in low and full-time workers.

Over and over, Pryor and his crew explain how to clean the syringes to avoid contracting HIV if they share the needles. They refer users to drug treatment programs. And they offer free oral HIV tests, funded by a recent \$72,000 grant from the Elizabeth Taylor Foundation.

It's a front-line attack on the transmission of HIV in a city where intravenous drug use is blamed for a third of the 4,000 AIDS cases in the last four years and for more than half of the AIDS cases among women during that time, according to the D.C. Agency for HIV/AIDS.

More than 1,600 addicts participate in the four-day-a-week program, and about 90 percent of the needles get returned. It has attracted far more people than participated in a restrictive city-run experiment begun in 1992 that was scrapped after reaching only 58 addicts in two years in a city with an estimated 16,000 intravenous drug users.

Although the needle exchange is legal, clients still are at risk for drug possession arrests. But police say it is not feasible to follow individual exchange clients and wait for them to commit a drug offense. Instead, they focus their enforcement efforts on dealers.

Nonetheless, according to Pryor, police sometimes harass participants and occasionally give the mobile unit a hard time. (Police say they would investigate complaints lodged against any officer.) Meanwhile, some residents complain that the program promotes drug use in their neighborhoods. And for poor addicts who want treatment, beds are scarce.

It helps, then, that Pryor—who ran a smaller, privately funded version of the needle exchange before city money came through—harbors no illusions about his mission. Although he publishes the storybook successes—an addict avoids HIV, gets clean and stops that way—he knows those are far and far between. Most days, accomplishment has to be assessed with a simple question: What would happen if he wasn't out here?

"I don't show up, they are going to use drugs" without clean needles, Pryor says emphatically. "My goal is to get out here, prevent as much damage as possible ... and perhaps give them a way out."

About 10:30 a.m. on a Monday, a well-dressed woman approaches the RV. She looks left, looks right and boards.



Vera Lindsey, left, working for the D.C. Needle Exchange, trades new syringes for used ones and explains how to clean them to a man who identified himself as Elijah.

ties. According to records kept by Whitman-Walker, more than 10 percent of the program's clients are employed full time—including several with the city's Department of Public Works; others are crane operators, construction workers, customer service representatives. Countless others used to work—before their addictions took over their lives.

That's what happened to Victoria Gay, 39, who's next on the RV. A 22-year addict, she's been homeless for six or seven years. Her hands are huge and puffy, her arms, back and neck scarred from thousands of needle hits. Years ago, after her veins collapsed from so many injections, she started skin-popping—injecting under the skin. The practice left her with open wounds that have grown into nozing ulcers.

"It's heartbreaking, what I've done to myself," she says.

expenses if they had started a needle exchange program 10 years ago.

Studies of needle exchanges elsewhere have found that they do not promote increased use of illegal drugs. They also have found that they slow the spread of certain sexually transmitted diseases.

However, Pryor doesn't look to medical-journal studies to judge the effectiveness of needle exchanges; he looks to the drug scene itself. Donning an apron that identifies him as a health outreach worker in case he runs into the police, Pryor strides across the street and down an alley pungent with the smell of urine.

He enters a small, abandoned two-story apartment building on Seventh Street known as an "oil joint," where many of his clients inject, or "oil." Trash is strewn around the lower-level units. Muffled voices float down the grimy staircase.

ing unsafe needles. But "Skinny," a 48-year-old man who regularly exchanges needles, explains:

"People are very scared of AIDS. They see the effects," he says. "It's terrifying, up close and personal. People in this area are very aware of this program. Now there is no excuse to use dirty needles."

Watching Pryor's rapport with the addicts, it's hard to believe that six years ago, he was working at the Patent and Trademark Office. But when he lost his job there, his life took a distinct turn into what seems his calling: health education.

Pryor, 44, wound up working with several community-based organizations, handing out condoms, teaching people about AIDS. He volunteered at the Washington Free Clinic and worked with the KORA Institute, a group that does drug treatment and

the strip where the drugs are," Ennis says with frustration as he pulls the RV up to stop two: a place known as Needle Park near H.D. Woodson Senior High School in Northeast Washington.

A man named Mike is waiting with a plastic fishbowl-like container that once held Tootsie Rolls in a store. Now, it's brimming with 200 needles from the drug house he runs.

"My girl(friend) wants me to quit," explains Mike, 45, who says he's been in treatment more times than he can remember. "In the meantime ... we're all trying to live. You can't make one mistake."

As he leaves, a man and a girl on a pink bicycle with training wheels come through the park. He pulls on the handlebars, rolling her almost up to the RV. A friend of his, who has just exchanged needles, slips a clean one in the back pocket of the man's jeans. Father and daughter roll off down the leafy path and disappear around the bend.

"The kids know," Pryor says, his fingers stroking his chin. "Something's not right with daddy."

The RV is on the move again, to the last stop of the day, the parking lot of Tracks, a nightclub near the Navy Yard, at First and M streets SE.

George, a newcomer in a black and white shirt, is the last customer of the day. Pryor is trying to get him to answer the basic enrollment questions, but George's eyelids keep drooping.

"How often do you use?" Pryor asks. "Two to five times a day? More?"

George's eyes are closed. Pryor pauses for a minute, chuckles and resumes.

"Would it be safe to say you had some today?"

"Uh-huh," George says, breaking into a grin.

Everyone laughs, and George wakes up a bit. Pryor gives him a card and a fast spiel on how to clean his needles. There's no talk of treatment. Even with the card and the special stickers on the needles, it'll be a miracle if he remembers he was at the RV.

"Okay, man, have a good day," Pryor says. "See you next week."

FOR MORE INFORMATION

To read a collection of Post stories and original documents showing the extent of drug addiction in the region, click on the above symbol on the front page of The Post's Web site at www.washingtonpost.com

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About 10:30 a.m. on a Monday, a distressed woman approaches the RV. She looks left, looks right and cries aloud.

As a first-timer, she must answer a questions to enroll and receive a card that will entitle her to exchange needles. First name? Do you live in your own home?

"What kind of work do you do?" Reggie Ennis, 38, one of the needle exchange workers.

"Social worker," the woman answers.

The woman, Ennis learns, is injecting heroin two to five times a day, having started three years ago. She lives the RV with her starter kit of needles and cleaning supplies. Pryor wants to have a detailed talk with her about treatment, while she still has health insurance and before she gets HIV, if she hasn't already. But she exits quickly, saying she has to get back to the office.

Her rush is to go get high and then go back to work," Pryor says as the woman disappears into an alley where addicts often shoot up.

The social worker is by no means the only addict with 9-to-5 responsibility.

According to records kept by Whitman-Walker, more than 10 percent of the program's clients are employed full time—including several with the city's Department of Public Works; others are crane operators, construction workers, customer service representatives. Countless others used to work—before their addictions took over their lives.

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"It's heartbreaking, what I've done to myself," she says. She credits Pryor with saving her life after he found her gravely ill on the street and took her to a hospital. "Now, I'm trying to take better care."

Before the needle exchange started, if addicts like Gay wanted clean needles, they'd have to buy them on the street for \$1 or \$2 apiece. A hit runs \$10, Pryor says, so rather than spend money on a needle and risk not having enough cash for a fix, they'd share instead.

It has taken years to gain some degree of political acceptance for the idea of giving needles to addicts, and there still is a ban on using federal funds for such programs. After the city's first attempt at needle exchange failed, the D.C. Council in 1994 approved the new program, which took three years to begin.

A study released in March put a price tag on the delays, saying D.C. health officials could have prevented as many as 650 AIDS cases and saved as much as \$36 million in medical

expenses if they had started a needle exchange program 10 years ago.

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Upstairs, the rooms are shockingly clean. The floors are swept; fast-food wrappers are gathered in a grocery bag. A half-dozen men are hanging out, some getting ready to inject, others sitting in drug-induced stupors.

"Just came by to check up on you guys," Pryor says to the men, who welcome him like a friend. Poking his head into the room's closet, Pryor breaks into a smile at what he sees: Bottles of bleach and water for cleaning needles are arranged neatly on the shelf. Several more half-used bottles sit on a nearby window ledge and atop a milk-crate table where a man is mixing a cocktail of cocaine and heroin.

"I'm impressed!" Pryor says without a hint of irony. "You guys are using this stuff, huh?"

"Yes sir," says one man, gesturing proudly to the shelf.

It seems a crazy contradiction—people who ravage their bodies with drugs taking precautions against us-

ing unsafe needles. But "Skinny," a 48-year-old man who regularly exchanges needles, explains:

"People are very scared of AIDS. They see the effects," he says. "It's terrifying, up close and personal. People in this area are very aware of this program. Now there is no excuse to use dirty needles."

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AIDS-prevention work in D.C. neighborhoods.

In August, when some private groups put up money for a needle exchange, Pryor ran the program out of the trunk of his car with KOBA employee Vera Lindsey, 31. Soon, they stepped up to a rented van. When the city funding kicked in, Ennis joined the crew, and the program expanded to the RV.

But while their program has grown, treatment services for the city's addicts are becoming more limited: For those without Medicaid or private insurance, D.C. General Hospital has 20 beds for addicts with multiple maladies. The city's Addiction Prevention and Recovery Administration has a 35-bed detoxification program on the hospital grounds. Most patients stay less than 10 days.

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Sandy -
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Los Angeles Times

November 3, 1997, Monday, Home Edition

SECTION: Part A; Page 3; Metro Desk

LENGTH: 1172 words

HEADLINE: CALIFORNIA AND THE WEST;
GORE LOOKS TO GAYS FOR SUPPORT;
POLITICS: VICE PRESIDENT HAS BEEN REGARDED AS COMMUNITY'S TRUE FRIEND IN WHITE
HOUSE. NOW HE NEEDS HELP SHORING UP CANDIDACY.

BYLINE: MARK Z. BARABAK, TIMES POLITICAL WRITER

BODY:

When Vice President Al Gore sat down to breakfast recently with a small circle of California advisors, the conversation covered the length and breadth of the state.

Over cheese omelets and fresh fruit, a group including former cabinet secretary Henry Cisneros, former White House spokeswoman Dee Dee Myers and former Los Angeles Rep. Mel Levine offered their thoughts on fund-raising, California's changing demographics and how--and where--Gore should spend his time in the state.

Not once during the 90-minute conversation did Gore mention what turned out to be the singular event of his recent Southern California visit: his enlistment in the nation's culture wars.

By extolling the lesbian sitcom character "Ellen" in a speech to a Hollywood audience the next day, Gore reignited the on-again, off-again political debate over entertainment ratings versus social responsibility. The reason the subject never came up at the Century City breakfast was the simple fact that the vice president apparently had no idea his comments would have such impact.

"It was never meant to be a driving point of his speech," said one participant at the breakfast, describing Gore and his political advisors as stunned by the coast-to-coast headlines generated by the vice presidential embrace of "Ellen."

His supportive remarks were evidently aimed at a much narrower and calculated audience: the nation's gay and lesbian activists, a group the vice president has been carefully cultivating for years.

From virtually the moment he took office, Gore has established himself as the best friend gays and lesbians have in the White House. Now, in his time of political need, the vice president is turning to the gay community and other segments of the Democratic Party base--blacks, labor, environmentalists--to help restore some of the luster dimmed by his ties to the ongoing White House fund-raising scandals.

Los Angeles Times, November 3, 1997

"Al Gore is no longer so inevitable as the Democratic nominee in 2000," said political analyst Sherry Bebitch Jeffe. "So he's got to go to work nailing down the support he needs from crucial Democratic constituencies before he can even start thinking about moving to the middle."

But winning gay and lesbian support is not as simple as delivering a supportive speech, despite what Gore's allies might hope or his critics--crying pander--have suggested.

*

The Clinton administration's uneven record on issues of concern to gays and lesbians, from same sex-marriage to the status of gays in the military, has complicated Gore's courtship, making every overture important--and politically treacherous, as the "Ellen" controversy suggests.

"In 1992, it was the Sally Field syndrome: 'They like us, they like us!' " said longtime gay political activist David Mixner, recalling the heady feeling in gay circles at being wooed by presidential candidate Bill Clinton. "As we approach 2000, merely being liked, merely being courted isn't going to cut it."

On Saturday, Clinton is due to shatter a barrier of sorts when he speaks in Washington at the annual dinner of the Human Rights Campaign, the nation's largest gay and lesbian political organization. Clinton's appearance will be a presidential first and an important symbolic gesture.

But that show of support aside, Clinton's relations with the gay community have been rocky from the start of his administration.

Soon after talking office, the president backed off his pledge to ban discrimination against gays in the military. Eventually he settled for the current "don't ask, don't tell" policy, which many in the gay community consider worse than the old way of doing business.

Although the president has won plaudits for appointing openly gay men and women to significant positions, other actions have provoked outrage--none more so than his support for legislation forbidding federal recognition of same-sex marriages, which he signed last year at the height of his hug-the-center reelection campaign.

"The administration has more failures at this point than successes," said Jeff Sheehy, president of the Harvey Milk Lesbian, Gay, Bisexual Democratic Club in San Francisco. "There's a recognition we're much further than we've ever been. But the president has never really stepped up to the plate and produced anything of any significance that will extend beyond the life of his presidency."

Throughout his time in office, Gore has been seen as the gay community's true friend in the administration, whether hosting political activists at a Christmas party at his home, presiding over a White House reception for gays and lesbians or carrying messages from gay supporters to the president.

Los Angeles Times, November 3, 1997

Occasionally, those things the vice president has not done or said have been seen as equally, if not more, significant.

"The fact he never spoke in favor of the Defense of Marriage Act"--banning federal recognition of same-sex marriages--"was, I think, a subtle sign of his own sense of that issue," said Eric Bauman, president of the Stonewall Democratic Club in Los Angeles and founder of Gays and Lesbians for Gore 2000.

But others suggest that it has been difficult to know where--and whether--Gore differs with Clinton on issues of concern like gays in the military, same-sex marriage, medicinal use of marijuana and ~~needle exchanges~~ to prevent the spread of AIDS.

"Gore has been a team player . . . which makes it really frustrating from our perspective to take his measure as presidential timber," said Steve Martin, West Hollywood's mayor pro tem. "On some of these issues, it's clearly a mystery how he would stand."

As the campaign unfolds, Gore's positions will inevitably become more clear. In the meantime, even as he hews to the administration line, activists say the vice president has notably increased his visibility in the gay community over the past six months--if only to keep ahead of his potential Democratic rivals.

*

House Majority Leader Dick Gephardt (D-Mo.), who has his own friends in the gay community, has also been working to build support for a possible presidential run, through stepped-up phone calls and appearances at benefits and fund-raisers. Sens. John Kerry (D-Mass.), Bob Kerrey (D-Neb.) and Paul Wellstone (D-Minn.), three other potential candidates, have also been making overtures to prominent gay leaders.

Activists consider the overtures a sign of the gay community's growing sophistication and political maturation.

"We've got a long way to go and the gay community is certainly not interested in putting itself in anyone's corner at this point," said West Hollywood's Martin. He described activists as "a little older, a little wiser after being burned" in the wake of the wholehearted embrace of Clinton.

"As 2000 approaches, the vice president's going to have to speak out more and more, as are his competitors," Martin said. "The gay and lesbian community could play an important role in picking the next Democratic nominee. You can't do that if you're gotten on the cheap."

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November 2, 1997, Sunday, ALL EDITIONS

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SERIES: CRUMBLLED EMPIRE, SHATTERED HEALTH. One in a series.

HEADLINE: CRUMBLLED EMPIRE, SHATTERED HEALTH / THE DRUG EXPLOSION / AN EPIDEMIC
OF ABUSE, DISEASE IS DEVASTATING REGION'S YOUTH

BYLINE: By Laurie Garrett. STAFF CORRESPONDENT

DATELINE: ODESSA, UKRAINE

BODY:

ODESSA, UKRAINE It's Monday night at 7, and Artur is ready to "walk the thread" through this city's prime narcotics neighborhood, Palermo. The plan is to score enough opium poppy straw, and the necessary solvents, to cook up a batch of "chornie" for himself and, perhaps, for his buddy, Oleg.

To "walk the thread," the two men must first trek across a broad field that cuts Palermo off from the city. The field, littered with syringes that crunch underfoot no matter where you walk, is used 24 hours a day by hundreds of addicts who can't wait to inject their drugs, sharing needles in small groups huddled on the bare ground. Then, the men must wind their way through the dangerous alleyways that zigzag between concrete fortresses surrounded by steel walls with hand-sized holes used to quickly, anonymously, exchange money for drugs.

It is an area, city officials say, inhabited by an estimated 10,000 Gypsies and their "slaves," addicted adolescents who work as runners and testers for nothing more than a daily hit of narcotics.

This night, Artur and Oleg swiftly walk the thread to the concrete mansion of Luba, a middle-aged woman who is dressed in the shiny, multicolored clothing favored in the neighborhood. They make their deal and, with dried poppy plants in hand, return quickly to Oleg's apartment, which he shares with his mother and grandmother.

There, Artur grinds the poppy into powder in the kitchen, as Oleg sits in the living room, talking with his mother, Svetlana, and a reporter. He tells them he is no longer an addict, and promises his mother that he will not inject the drugs with Artur. "If I slip down again," the university graduate says, "I want to die."

But Svetlana is not convinced.

Oleg has already lost a good job and a wife because of the drugs, she tells the reporter, adding, "If you have an intelligent son, you really grieve when he becomes a drug addict." Her voice breaks on the word "narkoman," Russian for drug addict.

Newsday (New York, NY), November 2, 1997

Throughout the former Soviet Union, young men and women - starting as early as age 8 - are sniffing, gulping, smoking and injecting themselves with narcotics at levels unprecedented in the region's history, a crisis reaching such huge proportions it is the single largest concern for public health advocates. A major contributor to exploding levels of associated diseases such as HIV, hepatitis, cardiovascular disease and depression, it has spiked levels of violence and suicide and is helping to rip apart the fabric of family life.

"What we face is unprecedented, colossal," Dr. N.F. Gerasimenko of the Russian Academy of Medical Sciences told the Russian legislature in May.

In the communist days, Soviet-dominated cities from Kamchatka to Berlin had narcology hospitals that functioned as punitive, forced-treatment centers for users who were either snared by police, or who had gone to other hospitals suffering from hepatitis or overdose, said Dr. Oleg Zykov, a Moscow-based substance abuse expert. "And if somebody was arrested a second time in the process," he said, "they were automatically sent to prison."

But in 1991, the rules changed, Zykov said. When the Soviet system fell, many hospitals and prisons were closed due to a lack of funds and the end of the repressive system that supported them. And those whose job it was to fight the war against drugs, and deal with its victims, were suddenly adrift in a world in which criminal gangs are virtually unchecked, where borders are insecure, medical resources scarce or non-existent, and addicts face dramatically higher risks than their American counterparts.

Indeed, experts say this drug explosion is so new and has grown so quickly that everyone - the gangster who smuggles it, the pusher who sells it, and even the young addict who uses it - is improvising, making every traditional target of existing health programs, and old-fashioned law enforcement, unpredictable.

An examination by Newsday of more than 20 cities in five formerly communist countries supports that conclusion. It found that illegal narcotics and amphetamines are purchased easily and openly by individuals of any age.

In Moscow, Dutch physician Murdo Biji, of the volunteer group Doctors Without Borders, has labored for more than a year with young drug addicts, trying to understand the step-by-step process that has facilitated passage of the human immunodeficiency virus and several types of hepatitis viruses into the young adult community.

The problem, he says, is that the government - including both its health care establishment and police - has no clue as to the shape of the current epidemic, or where it may be headed.

"There is no research done here," he says, noting that police don't know how many addicts are out there, what they're using, why they got involved in the first place, and what it will take to get them off the addiction treadmill.

And the anecdotal evidence is both confusing and frightening, he says, pointing to weekend addiction that probably involves a majority of Moscow's 14- to 18-year-olds, an extraordinarily naive group who generally do not believe they are addicted or face health risks.

Newsday (New York, NY), November 2, 1997

"It is the '70s here," Biji says, noting that ex-Soviet youngsters today are taking drugs with the same carefree attitude western youth exhibited 25 years earlier, before the age of AIDS.

He thinks this group would respond well to organized peer education programs, or to drug counselors trained to help occasional users, public health outreach programs common in other societies. Unfortunately, he says, Russians have no expertise in running such programs and are distrustful of them. Where they exist, he said, they are largely European funded and inspired, and have little support from either the public-health establishment or the police.

Beyond the part-timers, Biji said, is another subset of teens and young adults who have graduated to full-time abuse, injecting poppy straw extracts, heroin, amphetamines, or a Polish-invented mixture of drugs called compote. Though this group is much harder to influence, they need to be made more aware of the problems inherent in shared needles and sloppy preparation, Biji said.

In discussions with scores of addicts in the region during the past year, Newsday found that virtually all share needles, even when an individual has a separate supply. What the full-time users need, Biji said, are programs that provide acceptable alternatives such as methadone, a heroin substitute that can help ratchet down addiction, and sterile syringes, which can reduce associated diseases.

But methadone is banned in Russia. And while there are some needle exchange programs funded by outside agencies, such as Doctors Without Borders and UN AIDS, they are frowned upon by much of the narcology establishment, who argue that they encourage drug use.

"The official narcology service is very arrogant," said Dr. Zdenek Jezek, the UN AIDS representative in Moscow. "They think this outbreak of drug use is due to changes in legislation."

Evgeny, 22, a former professional soccer player in Estonia, began at his friends' urgings, he says, using chornie and amphetamines to dull the pain from several injuries. The practice landed him in Tallinn's Merimetse Hospital this summer with dual hepatitis B and C infections.

"I never shared needles. I use my own," Evgeny insisted. "But maybe the drugs were contaminated. I've heard that some people sample the drugs and put their own blood in it."

In fact, the manufacture and use of these drugs often involves exposure to blood, Newsday found.

In Odessa, for example, dealers who make huge batches of chornie test the potency of the drug on so-called "slaves," addicts who work in exchange for drugs. The "slaves" dip their needles into these batches, often plunging down on the syringe before pulling up a sample. In this way, the "slaves" pass their viruses into the larger brew.

In Moscow, Biji has documented cases in which some Moscow addicts, who don't have acetic anhydride on hand to home-brew chornie, inject their own blood into the pot to replace the missing chemical. Dr. Grigory Latyshev of St. Petersburg said he's found many cases in which addicts use their own blood to "flush out"

Newsday (New York, NY), November 2, 1997

tiny bits of narcotics left in syringes used by other addicts and the original cooking pot. They then inject it back into their own bodies, along with any diseases carried within the group.

These practices, experts say, go directly to the lack of education among regular users, a deficit Newsday found clearly evident in the region.

"I was very addicted to chornie," said 16-year-old Anatoly, who was in Moscow's Narcology Hospital No.17, suffering a severe case of hepatitis C, which is likely to cause cirrhosis and, possibly, liver cancer over the coming years of his adult life. "I think I got it the illness because of Gypsy magic."

While such comments are worrisome, some in the international health community say it is more frightening that youngsters like Anatoly seem to be such a mystery to officials responsible within government for preventing epidemics, and to law enforcement intent on stopping drug use.

Today, Zykov says, "The official narcology is going through a severe crisis . . . The narcology service in 1991 had a choice: to lobby for repressive forms of alcohol and drug addiction control, or to look at other models." They opted for the former, he said, and continue to seek dramatic funding increases to expand their hospitals at a time of economic shortfalls. They also are seeking a return to a past system that puts education and safe needle dispersal at risk.

Many police say they are overwhelmed by the drug abuse explosion, and the huge amount of money that supports it.

Dozens of interviews throughout the region ended with the characteristic shrug when police were asked why they allowed drug sales to continue openly on the streets of their cities. They often cited the lack of resources, manpower and willingness among their leaders to take on such a battle.

In Moscow's Pushkin Square subway station, two uniformed officers toting Kalishnykov rifles strolled through a heroin sale while a Newsday reporter stood nearby. They obviously saw what was going on, but took no action. "They don't care," a drug addict said. "They see this every night."

Additionally, users and dealers suggest rampant corruption is a main reason for police inaction.

"We always know in advance when a real raid is going to be made," laughed one St. Petersburg dealer. "The only people who get arrested are us addicts," says Alex, 17, in Moscow, whose father was a former KGB official. "The cops pick us up sometimes, beat us, take our money and watches and jackets and dump us back on the streets."

While it's difficult to determine if police corruption is as widespread as most suggest, the World Bank cited law enforcement and judicial corruption in its latest annual report as a key factor holding back development of the former Soviet states. World Bank surveys suggest more than half of business and criminal justice negotiations involve bribes.

And the gangsters who control the drug trade are slowly moving the young addict populations from cheap poppy straw to the more lucrative heroin market, experts say.

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"Heroin use, which is already 30 percent of all drug use in the country, is still on the upswing," said psychiatrist Pavel Bem, who is one of Eastern Europe's leading experts on drug abuse and chair of the Czech government's anti-drug commission.

Bem said there are two main problems for governments in the region: The ready availability of drugs and the low cost. "The weakening of our border controls and our police forces" have contributed to these factors, he said.

Additionally, he said, the gangsters who supply the drugs have been good students of capitalism, "holding their prices way down at introductory levels" in order to reach the largest number of people in an ailing economy.

In Moscow, which has the third highest cost of living among the world's major cities, a daily supply of high-grade heroin averages \$17. The same quality drug would cost two to three times as much in New York.

And the gap is wider elsewhere in the region, according to interviews with users, dealers, health experts and police. High-grade heroin sells for \$10 a dose in Odessa, for instance, and a low-grade poppy straw is available for \$6.

The cheapest high is vint, an extract of ephedrine allergy pills that are chemically oxidized to ephedrone, a powerful hallucinogen. In Moscow, vint costs about \$3 for a daily dose, and is frequently sold by elderly women who supplement pensions by getting free pills from the government for "allergies," then making vint in their kitchens.

One of the principle selling spots for vint in Moscow, witnessed repeatedly by Newsday, is Lubyanka Square, directly across from the headquarters of the Russian police known formerly as the KGB.

In the old days, many Russians said, alcohol and violence were the main problems seen among people in their mid-20s or older. But now, this one-two punch from the past is merging with the growing epidemic of drug use by teens and young adults to create a potentially cataclysmic situation.

In Russia, for example, arrests for drug-related crimes among teens have doubled since 1991. And health professionals say drug abuse is also a major contributor to the sharp rise in suicides among teens in the region.

Today, the path to self-destruction can start very young and continue through an often short lifetime, experts say.

"Do you sniff glue often?" 10-year-old Arsen is asked after a reporter finds him and 13-year-old Yosha filling a plastic bag with model-airplane glue in a shopping mall in downtown Novosibirsk, Siberia's largest city.

"Yes, I like it!" the boy answers, covering his face with the bag, and inhaling.

Psychologist Anna Terentjeva, of the Moscow-based drug group NAN, which stands for "No to Alcoholism and Drug Addiction," says drug use is becoming rampant in ever younger communities. She and her staff have just completed surveys in Moscow colleges, she said, that reveal a startling 100 percent of the students have tried drugs, while half say they use heroin, other narcotics or

Newsday (New York, NY), November 2, 1997

amphetamines regularly.

But the drug use upsurge is most pronounced, experts say, in industrial areas built, for the most part, during or immediately after World War II, as the Soviet Union built itself into a superpower.

Millions moved to these cities during the 1960s and '70s, mostly voluntarily. The pay was good and Moscow gave its top industrial centers highest priority for shipments of fresh food, new clothing, televisions and consumer products. In times of great scarcity for the rest of the Soviet Union, workers in Novosibirsk, Nor'ilsk, Kemerovo or Narva had tomatoes in February.

But with the collapse of the Soviet Union has come a tough transitional economy in which the industries of the past have closed.

In Estonia, the Russians built a heavy-industry complex in the old medieval village of Narva, near Russia's northwestern border. Prior to 1991, Narva was prosperous. Now nearly all the cement, textile and metal factories are closed and 39 percent of the people are unemployed.

"Democracy is good, but it's better when you have something for young people to do," moans Narva's Deputy Mayor Viktor Veevo. The Estonian-born Russian estimates that 3,000 people in Narva between the ages of 14 and 25 are drug addicts, or about one out of every five residents. "I'm trying to set up things for them to do," he shrugs. "You know, democracy equivalents of the Young Pioneers and Komsomol."

Which seems laughable to Ramon, 23, recovering in Narva's infectious disease hospital from dual infection with hepatitis B and C, acquired after six months of shooting poppy straw. The unemployed, divorced father of a 2-year-old girl started using drugs because "everybody does. It used to be alcohol; now it's drugs."

But, no one told him drugs could hurt your health, or that shared needles could spread hepatitis. Ramon vows he will find a job when he recovers, but that's a tough prospect for a former Russian, now that the Estonian government has passed laws requiring Estonian language skills to gain citizenship, and citizenship papers to attain employment.

"He will never stop," clucks nurse Irina Odnolko. "They never do. I say to them, Why don't you do something with yourself?' And they say, Life is already gray. There's no point.' "

The incidence of hepatitis B and C is up 400 percent in Narva since 1992, said Dr. Olev Silland, the director of that city's hospital, and his guess is there's as many as 10,000 IV drug users in the city, or one of every eight residents.

In more affluent Prague and Moscow, different dynamics are at play, says the psychiatrist, Bem.

"If you look at young teens today," Bem said, "to build a career and to be valuable to society, it means you have to fulfill a lot of very difficult tasks. And a lot of young people say, We cannot do it! We cannot fulfill this demand. We are not counted.' It's senseless. They have no sense of grounding."

Newsday (New York, NY), November 2, 1997

Under the fashionable Arbat shopping district in Moscow, 17-year-old Alex and his teenage buddies laugh loudly as a drunk man in his 30s mistakenly tries to enter the subway through an exit turnstyle, and collapses with a moan. "Only fools drink bad vodka," the young drug addict tells his friends.

Later, in a nearby restaurant, the teenagers - who admit they are heroin addicts - explain themselves in terms that echo Bem's comments.

Alex, the youth whose father works for the KGB, describes how he graduated from vint to chornie, and finally to heroin when he was 16. He insists, and Vlad agrees, that "80 percent of teens 14 to 18 use drugs now. And the other 20 percent have at least tried it."

The two teens met in the hospital, where they were being treated for hepatitis C infections. They say they know there are risks, but they are willing to take them. "I just don't think about them," Alex says. "I prefer a short, bright life to a boring one. The only thing I'm scared of is an overdose."

Back in Odessa, meanwhile, Oleg continues trying to comfort his anxious mother, while Artur cooks their ground poppy straw in a succession of highly flammable, putrid chemicals that include acetone and paint thinner. Often the first interaction such young drug users have with the health care system is on the burn wards after kitchen explosions.

After three hours of shopping, grinding and cooking, Artur reveals a saucepan containing about four tablespoons of a smelly, dark brown concoction. He draws half of it up into his 20cc syringe, while the other half awaits Oleg's attention. Then, the two men make eye contact, pause, and - as promised - empty both the syringe and the pan into the sink.

For one night, they are no longer addicts stuck in a system that seems determined to defeat them. For one night at least, Oleg has kept his promise.
TOMORROW: The Plague of Alcohol

GRAPHIC: Newsday Photos by Viorel Florescu- 1) Field of lost dreams. People use this field near the Ukraine village of Palermo to shoot drugs. The field is littered with syringes, and is used 24 hours a day by hundreds of addicts who are unable to wait until they're behind closed doors to inject their drugs. 2) The preparation. Artur cooks ground poppy straw while his friend Oleg rolls up his sleeve, even as Oleg promises his mother they won't use the drug.> 3) Newsday Cover Photo by Viorel Florescu- A field near Odessa, Ukraine, used 24 hours a day by addicts to inject just-purchased drugs (Bulldog edition)

LANGUAGE: English

LOAD-DATE: November 2, 1997

5TH STORY of Level 1 printed in FULL format.

Copyright 1997 The Washington Post
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November 02, 1997, Sunday, Final Edition

SECTION: OP-ED; Pg. C06; LETTERS TO THE EDITOR

LENGTH: 233 words

HEADLINE: 'A Brick for a Brain'

BODY:

In his vitriolic and intemperate attack on North Carolina Sen. Jesse Helms [op-ed, Sept. 18], Richard Cohen steps out of bounds, debases the currency of rational discourse and in the process sullies his reputation as a thoughtful journalist.

Mr. Cohen says that Jesse Helms is "a man with a brick for a brain" and is also "cruel" because he's against medicinal use of marijuana and needle exchanges for drug addicts. Unfortunately for Mr. Cohen, the only brick that lands squarely here is the one he administers to his own head for writing such churlish insults. Mr. Helms is a senator who stands for election on the basis of his positions on issues; these happen to be his positions, and in them he's joined by tens of millions of Americans.

Was it a "brick-brained" senator who initiated and then carried through in a masterful legislative stroke the most important postwar reform of our turgid foreign policy bureaucracy? Does the chairman adequately employ his "brick" when dealing with treaties and countless other presidential nominations that have passed through his committee? Does Mr. Cohen suppose that Madeleine Albright thinks his brain to be a "brick" as she works with him on such complex policy matters as NATO expansion, which Mr. Helms has signaled that he supports?

RICHARD V. ALLEN

Washington

The writer was national security adviser to President Reagan.

LANGUAGE: ENGLISH

LOAD-DATE: November 02, 1997

6TH STORY of Level 1 printed in FULL format.

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October 31, 1997; Friday 15:32 Eastern Time

SECTION: Washington - general news

LENGTH: 615 words

HEADLINE: Testing Issue Stalls Spending Bill

BYLINE: ROBERT GREENE

DATELINE: WASHINGTON

BODY:

The last-minute breakup of a compromise left House Republicans struggling Friday for a way to appease both opponents and backers of national reading and math tests.

The political battle over the top item on President Clinton's education agenda threatens a 1998 appropriations bill that provides increases for medical research, including AIDS and breast cancer, college student aid, other school aid and Head Start.

House and Senate conservatives revolted Thursday against a testing compromise that was part of the \$80.2 billion spending bill agreed to by negotiators from both parties.

The rebellion forced House leaders to put the bill on hold. An emergency meeting of House Republicans produced no immediate results.

"The issue is not resolved," said Rep. John Boehner of Ohio, chairman of the House Republican Conference. "There's a regrouping going on trying to find some common ground."

Conservatives argued that the deal gives in to the president by allowing continued development and field trials of the tests of fourth-grade reading and eighth-grade math.

The White House also criticized Thursday's deal as unacceptable because it would let Congress decide in future legislation whether the voluntary, standardized tests will actually be given. Democratic allies in the Senate promised to block the deal if it reaches the floor.

Lawmakers were floating several possible changes. But the Republican and Democratic leaders of the Senate and House Appropriations committees cautioned any changes could topple the delicate compromise they reached on a variety of issues, including needle exchanges for illegal drug users.

"This has been an extraordinarily difficult bill to construct," said Sen. Arlen Specter, R-Pa.

Authors of the compromise noted that it included education increases, including a raise in individual Pell Grants from \$2,700 to \$3,000; \$900 more

AP Online, October 31, 1997

for the National Institutes of Health; \$375 million more for Head Start; \$5.3 million more for breast and cervical cancer screening; \$18 million more for AIDS prevention.

'All of this is in jeopardy if people don't understand that we have to compromise on this issue,' said Sen. Tom Harkin of Iowa, top Democrat on the Senate Appropriations Committee.

Clinton says the tests are needed so parents can see how their children and schools are doing in two core subjects at two critical times, against a fixed standard.

Opponents argue that such tests would lead to a national curriculum and a loss of local control over education. Black and Hispanic groups argue the tests could be used to further discriminate against students from poor backgrounds and schools, and those with limited English.

On another front, Senate backers of legislation creating tax-advantaged education savings accounts failed Friday to push the measure to a vote over Democratic opposition.

The bill, sponsored by Sens. Paul Coverdell, R-Ga., and Robert Torricelli, D-N.J., would let families contribute up to \$2,500 per year for the private or public elementary and secondary school costs of each child, with interest accumulating tax-free. A 56-41 vote to limit debate fell four votes shy of the 60 needed.

But behind the scenes, the two sides were negotiating a compromise that would allow Democrats to offer amendments, including possibly one giving tax breaks for money put in prepaid college tuition plans.

The senators also said they would meet Wednesday to discuss their bill with President Clinton, who until now has threatened to veto it.

'I am convinced that given that opportunity, we can reach agreement with President Clinton,' Torricelli said. The House has already passed it.

LANGUAGE: ENGLISH

LOAD-DATE: October 31, 1997

8TH STORY of Level 1 printed in FULL format.

The Associated Press

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October 31, 1997, Friday, PM cycle

SECTION: Washington Dateline

LENGTH: 680 words

HEADLINE: House Republicans battle among selves over testing

BYLINE: By ROBERT GREENE, AP Education Writer

DATELINE: WASHINGTON

BODY:

A feud among House Republicans is blocking agreement over what to do about national reading and math tests sought by President Clinton.

An emergency House GOP meeting today failed to produce a settlement. "The issue is not resolved," said Rep. John Boehner, R-Ohio, chairman of the House Republican Conference. "There's a regrouping going on, trying to find some common ground."

House and Senate negotiators trying to push through an \$ 80.2 billion spending measure thought they had a deal Thursday.

But the bipartisan agreement within the House and Senate Appropriations committees broke down when conservatives said Republican leaders gave Clinton too much on the tests.

The White House also called the deal unacceptable because it only allows the tests to be developed and given on a limited, trial basis and only after further congressional approval. Senate Democrats promised a filibuster on the spending bill.

House Republican leaders, concerned about the rebels in their own party, told negotiators to consider changing the bill today. It provides money for the Education, Labor and Health and Human Services departments for the year that started Oct. 1.

One compromise being discussed would block further development of the reading and math tests unless Congress authorized them in other legislation or three-quarters of the governors asked for the tests.

Rep. Frank Riggs, R-Calif., a member of the House Education and Workforce Committee, said that would address worries among conservatives over federal meddling in education. He said it also could ease administration concerns about having the tests blocked by Congress.

Capitol Hill sources, speaking on condition of anonymity, said Thursday that House Speaker Newt Gingrich reprimanded Rep. Bob Livingston, R-La., chairman

The Associated Press, October 31, 1997

of the House Appropriations Committee, over his handling of the issue.

A House Republican aide said the GOP leadership had never agreed to the testing compromise.

House negotiators were eager to finish work on the overdue spending bill and were less committed to the fight over national testing. They had to work with their counterparts from the Senate, which has agreed to testing if it is controlled by a congressionally created board instead of by the Education Department.

The young conservatives revolted, joined by a senior member, Rep. Bill Goodling, R-Pa., chairman of the Education and Workforce Committee.

"Once again, our leadership is running from a fight with the president," said Rep. Lindsey Graham, R-S.C., a freshman conservative who persuaded the leaders to reopen the spending bill. The rebels said leaders were afraid of being blamed for shutting down parts of the government if Clinton vetoes the bill.

House opposition to the tests had been solid, with 295 members voting last month to block federal spending for them.

Goodling considers the tests to be a waste of money, because people already know which students and schools are doing poorly. Other opponents say the tests duplicate existing ones and could lead to a "national school board" dictating a national curriculum.

Clinton says the standardized tests in fourth-grade reading and eighth-grade math are necessary because none of the existing widely given commercial tests has built-in standards.

Livingston said Goodling should have been happy that his committee would have final say over the tests.

But Goodling said he would have gotten jurisdiction too late to do any good.

Millions of dollars would have been spent and the tests would be available, he said. There is no limit, Goodling said, to how many states would get the tests under a pilot program.

Before the dispute over testing erupted, negotiators had agreed on another difficult issue: needle exchanges to protect users of illegal drugs against AIDS.

The agreement would prohibit the Health and Human Services Department from supporting such exchanges until March 31, 1998. The House had originally passed on outright ban.

The moratorium would allow time for the writers of anti-drug legislation to deal with the issue.

LANGUAGE: ENGLISH

LOAD-DATE: October 31, 1997

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Health Line

October 31, 1997

SECTION: POLITICS & POLICY

LENGTH: 159 words

HEADLINE: NEEDLE EXCHANGES: CONGRESS DEADLOCKED OVER BAN

BODY:

A House-Senate conference committee was unable to come to an agreement yesterday over provisions in the Health and Human Services spending bill that would allow federal funding for needle-exchange programs. Congress Daily reports that House GOP leaders refused to back down from a provision that would require a "six-month moratorium on needle exchanges for drug addicts in an effort to give authorizing committees time to settle the issue." House Republicans said they were unsure whether "they could pass the bill without the moratorium language." Senate conferees said, however, that they had "compromised on other issues" and refused to agree to the moratorium. Conferees were scheduled to meet late yesterday to discuss the issue again (10/30). A Harris Poll released yesterday finds broad support among Americans for lifting the federal ban on needle exchange programs (see related story).

LANGUAGE: ENGLISH

LOAD-DATE: October 31, 1997

10TH STORY of Level 1 printed in FULL format.

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Health Line

October 31, 1997

SECTION: SURVEYS AND POLLS

LENGTH: 1230 words

HEADLINE: NEEDLE EXCHANGES: HARRIS POLL FINDS BROAD SUPPORT

BODY:

According to a new Harris Poll commissioned by the Lindesmith Center, 71% of Americans believe that the ban on federal funding for needle-exchange programs should be lifted so that decisions on how to use federal funding for HIV prevention programs can be made by states and local governments. The survey found that support for lifting the ban crossed party lines. Seventy-two percent of Republicans, 70% of Democrats and 74% of independents agreed that states and cities should be allowed to make decisions concerning the funding of needle exchanges. In addition, 69% of people opposed to needle exchanges still believe that the ban on federal funding for the programs should be lifted. When respondents were first asked whether they favor or oppose needle exchanges, 44% were in favor and 42% were opposed. After being told which groups support and oppose needle exchanges, 50% of respondents said that they support the programs, while 45% said they were opposed. The poll surveyed 1,003 American adults by phone from October 15 through October 19; the margin of error is plus or minus 3%. Congress is currently debating whether to lift restrictions on the use of federal funds for needle-exchange programs (see related story).

LINDESMITH CENTER?

The Lindesmith Center is a drug policy research institute that concentrates on broadening the public debate over drug issues. The center is a project of the Open Society Institute, the foundation created by philanthropist George Soros (Lindesmith Center release, 10/30). Soros has helped fund campaigns to legalize the medical use of marijuana. [Click here for related stories.](#)

LANGUAGE: ENGLISH

LOAD-DATE: October 31, 1997

Needles

**STATEMENT BY CONGRESSWOMAN ELEANOR HOLMES NORTON
PROTESTING CONGRESSIONAL AND ADMINISTRATION REFUSAL TO ALLOW
NEEDLE EXCHANGE PROGRAMS
CONGRESSIONAL BLACK CAUCUS PRESS CONFERENCE**

APRIL 24, 1998

We, who are African American Members of Congress, we of the Congressional Black Caucus, have every reason to be angry--and we are. Many Americans most at risk for AIDS, disproportionately black and Hispanic, have been callously and needlessly condemned to death. The refusal to fund needle exchange programs is a death sentence because we now know for sure that needle exchange has extraordinary life saving effects. In barring needle exchange, the forces of ignorance and political expediency within the Congress and the administration have won--for now.

Those led by Barry McCaffrey, the drug czar, who has little to show for his futile efforts, have triumphed over HHS Secretary Donna Shalala and the entire medical and scientific community. Yet we now have conclusive evidence that the one-for-one exchange of clean for dirty needle can markedly reduce the runaway spread of AIDS among black and Hispanic men, women and children.

All the studies tell the same life saving story. Among them are six federally funded investigations including the National Academy of Sciences (1995), the Centers for Disease Control (1995) and the GAO (1993). Needle exchange programs reduce HIV infections by at least one third and risk behavior by 80 percent. These same studies show that needle exchange programs neither increase nor promote drug use.

In the face of this compelling evidence, General Barry McCaffney has used brutal tactics within the Administration to subvert a decision to fund needle exchange programs that he must have learned in wars with real enemies. We put him on notice that he has now made a new enemy. He has started a new war with us, and we intend to fight back. If all that the General can bring to his drug war is the frenetic effort he has waged to stop what works, he should resign. I call for his resignation both because he has been ineffective in quelling the upsurge of deadly drugs and because his death dealing battle against needle exchange, steeped in ignorance, must not be tolerated in a federal official.

The AIDS epidemic among African Americans is one of the reasons the Congressional Black Caucus has made the drug menace our top priority. AIDS is the leading killer of black and Latino men and women, ages 25 to 44. More than half these deaths are needle-related. More than one third of all AIDS cases are needle drug users, their partners, and kids. Two thirds of AIDS in women and 50 percent of AIDS in children come from needle or needle chain transmissions. When General McCaffrey declares war on needles, the prisoners he takes are

people of color. The lives he sacrifices are the lives of people we represent.

Nor do we come only out of compassion. Needle drug users often are desperate people who prey upon people in communities where they live in order to finance their habits. We strongly believe they must be punished for crimes against the people we also represent. We know, however, that needle exchange programs offer the only way to reach many of these addicts and to get them into treatment. We also believe that needle exchange should not be done in isolation but that needle exchange should be part of comprehensive programs that include prevention and treatment.

The "compromise" to allow needle exchange with no funding is a sham and an insult. More than 50 cities already are using needle exchange. They do not need permission. They need help. It is the vital federal funding that is missing. Here in the nation's capital the Whitman Walker Clinic and other private efforts were exchanging 4,000 needles a week in 1997. Even during its financial crisis the city decided that \$200,000 in funding annually at 10 cents a needle was minuscule compared with \$120,000, the average lifetime cost of care for HIV infected/AIDS individual.

We will not stand for demagoging an issue of life and death for our community, whether from within the administration or on the floor of Congress. We know whose lives are at stake when needles are forbidden. AIDS is increasing more rapidly among drug users than any other group, and blacks are four times more likely to die from needle-injected AIDS than from a drug overdose.

General McCaffrey complained that needle exchange sends the wrong message. We get his "drop dead" message to our community loud and clear. Unless he is willing to reconsider and acknowledge the overwhelming scientific evidence, I hope he gets my message to leave the administration and take his destructive tactics with him. We call upon the President to respond to the evidence and save lives. We call upon the administration to respond to the American people, two thirds of whom support needle exchange.

The law says that needle exchange is barred unless the HHS Secretary "determines that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs." That condition has been more than met.

sarah
Did this ever go
out?

de

Anthony J. Vallelunga
213-Schoolhouse Road
Albany, N.Y. 12203-5906

Dear Mr. Vallelunga:

Thank you for the information regarding your patent on a single-use syringe. I have been aware of the existence of such a device for some time and know of its potential for reducing HIV transmission in intravenous drug use populations. This Administration believes that needle exchange, as part of a comprehensive HIV prevention strategy, can be an effective weapon in preventing new HIV infections. The President stated that needle exchange programs should be a local decision and thus has not allowed the use of federal funds for this activity.

While this Office may not endorse specific products such as the single-use syringe, I remain supportive of innovations which are shown have the potential to stem the spread of AIDS.

Sincerely,

Sandra L. Thurman
Director
Office of National AIDS Policy

Todd -
please send them
Sandy's letter on
this topic.
Thanks. Sarah
X 65514

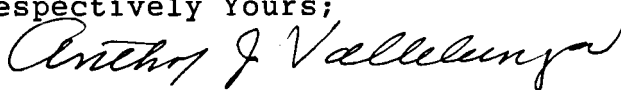
M's Sandy Thurman
Director Of National Aids Policy
White House
Washington, D.C. 205-10-8025.

Anthony J. Vallelunga
213-Schoolhouse Road
Albany N.Y. 12203-5906

Dear M's Thurman;
I have just saw your interview on C.B.S. News regarding
Needle Exchanges Programs. And its the truth. Needle exchange
programs don't want any preventative methods because the
funding would dry up, more importantly jobs would be gone.

I have been fighting this battle for over 6 years. I have
been granted 3 patents prevention Syringes. Allow me to come
to Washington. Give me 30 minutes of your time. Let me
demonstrate my syringe and prove right before your eyes
that put into the right hands this preventive syringe can
save millions of lives. Cut the percentage of Aids Via
Intravenous Usage to no less than 99%. I worked with former
Lt Gov Hanley. Unfortunately for me Me did not regain
office. Look who Am I? A 73 year old man that has dedicate
over 6 years of my life to solving this problem. Now that I
have nobody wants to listen. I am only asking that you allow
me at my expense to spend a 30 minutes with you, Needle
exchanges don't want them. Syringe manufactures don't want
to spend million tooling up when they already control the
market. Allow me to show you this. Then how it can be
accomplished will be resolved. You first have to know that
such a device exist. It Does. Am I asking too much? please
allow an old poor man to help save lives. Let it be our
legacy to the world to prevent the spread of Aid and all
contagious diseases via A Needle. Please reply. I have Patents
and F.D.A. Sanctions. WE can lift a few eye brows and save
lives, doing it. You may not be Madam Currie, But you could be
Madam Sandy.

Respectively Yours;



Anthony J. Vallelunga

P.S. Enclosed please find Patents, F.D.A REPORT, BILL #
2915 never got out of committee. Why? At that time there was
no Syringe that would meet the requirements of the Health
care institutions. Even my first needle was one that
prevented reuse, but did not fill all Medical Standards. I
have actually, Syringes that work, that will prevent the
spread of any contagious disease passed on by syringes.
May I come and demonstrate them to you? What have you got to
loose only $\frac{1}{2}$ hour of time.

This Bill Died because there was no syringe to meet all aspects of medicine. Ours Does

102D CONGRESS
1ST SESSION

H. R. 2951

To prohibit the use of Federal funds for syringes and needles that are not nonreusable, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 18, 1991

Mr. KENNEDY introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To prohibit the use of Federal funds for syringes and needles that are not nonreusable, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SECTION 1. SHORT TITLE.

4 "This Act may be cited as the "Federal Safe Syringe
5 and Needle Promotion Act of 1991".

6 SEC. 2. FINDINGS; PURPOSE.

7 (a) FINDINGS.—Congress finds that—

8 (1) the transmission of blood-borne diseases
9 such as AIDS and hepatitis B occurs in a chain
10 from person to person, and accidental or deliberate



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

DEC - 6 1995

Food and Drug Administration
9200 Corporate Boulevard
Rockville MD 20850

Mr. Thomas E. Farari
Director of Medical Affairs
Unique Management Enterprises, Incorporated
209 Schoolhouse Road
Albany, New York 12203-5956

Never been able to raise
money to market

Re: K950245
Trade Name: Unique Needle
Regulatory Class: II
Product Code: FMF
Dated: September 7, 1995
Received: September 11, 1995

Dear Mr. Farari:

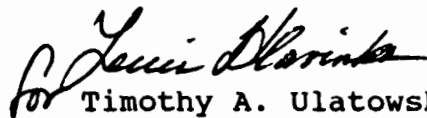
We have reviewed your Section 510(k) notification of intent to market the device referenced above and we have determined the device is substantially equivalent to devices marketed in interstate commerce prior to May 28, 1976, the enactment date of the Medical Device Amendments or to devices that have been reclassified in accordance with the provisions of the Federal Food, Drug, and Cosmetic Act (Act). You may, therefore, market the device, subject to the general controls provisions of the Act. The general controls provisions of the Act include requirements for annual registration, listing of devices, good manufacturing practice, labeling, and prohibitions against misbranding and adulteration.

If your device is classified (see above) into either class II (Special Controls) or class III (Premarket Approval) it may be subject to such additional controls. Existing major regulations affecting your device can be found in the Code of Federal Regulations, Title 21, Parts 800 to 895. A substantially equivalent determination assumes compliance with the Good Manufacturing Practice for Medical Devices: General (GMP) regulation (21 CFR Part 820) and that, through periodic GMP inspections, FDA will verify such assumptions. Failure to comply with the GMP regulation may result in regulatory action. In addition, the Food and Drug Administration (FDA) may publish further announcements concerning your device in the Federal Register. Please note: this response to your premarket notification submission does not affect any obligation you might have under sections 531 through 542 of the Act for devices under the Electronic Product Radiation Control provisions, or other Federal Laws or Regulations.

Page 2 - Mr. Farari

This letter immediately will allow you to begin marketing your device as described in your 510(k) premarket notification. An FDA finding of substantial equivalence of your device to a legally marketed predicate device results in a classification for your device and permits your device to proceed to the market, but it does not mean that FDA approves your device. Therefore, you may not promote or in any way represent your device or its labeling as being approved by FDA. If you desire specific advice for your device on our labeling regulation (21 CFR Part 801 and additionally 809.10 for in vitro diagnostic devices), promotion, or advertising please contact the Office of Compliance, Promotion and Advertising Policy Staff (HFZ-300) at (301) 594-4639. Other general information on your responsibilities under the Act may be obtained from the Division of Small Manufacturers Assistance at their toll free number (800) 638-2041 or at (301) 443-6597.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "Timothy A. Ulatowski", is written over the typed name.

Timothy A. Ulatowski
Acting Director
Pilot Division
Office of Device Evaluation
Center for Devices and
Radiological Health

United States Patent [19]

Vallelunga et al.

US005738655A

[11] Patent Number: 5,738,655

[45] Date of Patent: Apr. 14, 1998

[54] NONREFILLABLE SYRINGE

[76] Inventors: **Anthony J. Vallelunga**, 213 Schoolhouse Rd., Albany, N.Y. 12203; **Thomas E. Ferari**, 7 Mohawk Trail, Queensbury, N.Y. 12804; **James L. Kloss**, 213 Schoolhouse Rd., Albany, N.Y. 12203

[21] Appl. No.: 680,169

[22] Filed: Jul. 15, 1996

[51] Int. Cl.⁶ A61M 5/00

[52] U.S. Cl. 604/110; 604/218; 604/228

[58] Field of Search 604/110, 218, 604/228, 187, 200, 229; 128/919

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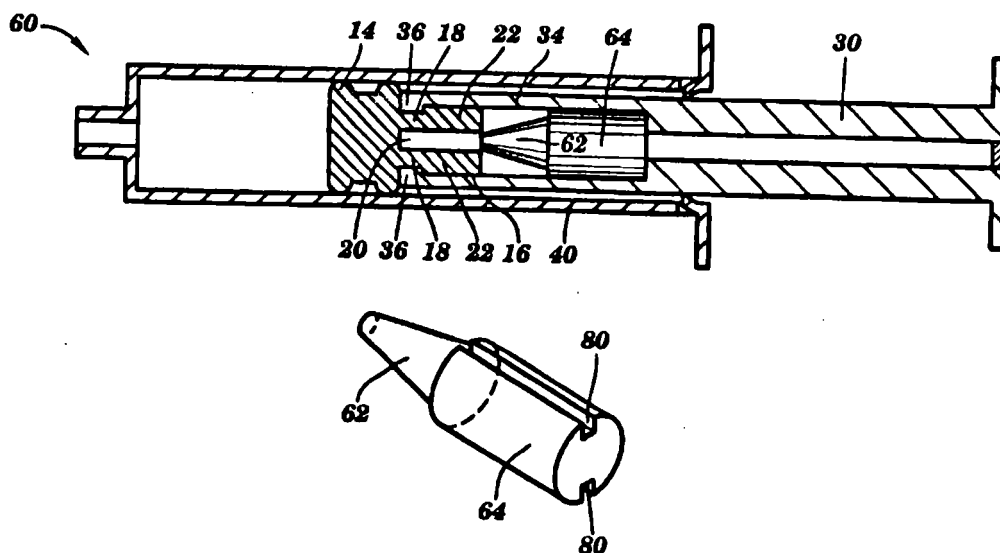
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Primary Examiner—Michael Powell Buiz
Assistant Examiner—Ronald K. Stright, Jr.
Attorney, Agent, or Firm—John A. Merecki

[57] ABSTRACT

A nonrefillable syringe including a unique plunger stem/piston arrangement which is designed to disconnect after an injection has been completed. A piston is removably connected to a plunger stem by a first connecting member and a novel nipple assembly. The first connecting member comprises a plurality of circumferentially spaced arms extending longitudinally away from the piston and forming an interior aperture. The nipple assembly includes a tapered nipple removably matable with the aperture formed by the circumferentially spaced arms of the first connecting member, and a cylindrical carrier for slidably positioning the nipple assembly within a hollow end of the plunger stem. The tapered nipple is gradually forced out of the aperture during use of the syringe. When the tapered nipple is forced completely out of the aperture, the piston disconnects from the plunger stem.

13 Claims, 6 Drawing Sheets



The
United
States
of
America

The Commissioner of Patents
and Trademarks

*Has received an application for a patent
for a new and useful invention. The title
and description of the invention are en-
closed. The requirements of law have
been complied with, and it has been de-
termined that a patent on the invention
shall be granted under the law.*

Therefore, this

United States Patent

*Grants to the person or persons having
title to this patent the right to exclude
others from making, using or selling the
invention throughout the United States
of America for the term of seventeen
years from the date of this patent, sub-
ject to the payment of maintenance fees
as provided by law.*

Michael R. Kirk

Acting Commissioner of Patents and Trademarks

Phyllis A. Huller
Attest



US005215524A

United States Patent [19]

Vallelunga et al.

[11] **Patent Number:** **5,215,524**[45] **Date of Patent:** **Jun. 1, 1993****[54] PLUNGER FOR NON-REUSEABLE SYRINGE**

[76] Inventors: **Anthony J. Vallelunga**, 209 Schoolhouse Rd., Albany, N.Y. 12203-5956; **Paul V. Cacciotti**; **Vincent E. Cacciotti**, both of 9 Morgan Way, Latham, N.Y. 12110

[21] Appl. No.: **978,181**

[22] Filed: **Nov. 17, 1992**

Related U.S. Application Data

[63] Continuation-in-part of Ser. No. 914,196, Jul. 14, 1992, abandoned.

[51] Int. Cl.⁵ **A61M 5/00**

[52] U.S. Cl. **604/110; 604/228; 604/218; 128/919**

[58] Field of Search **604/110, 187, 218, 220, 604/228, 229, 263; 128/919**

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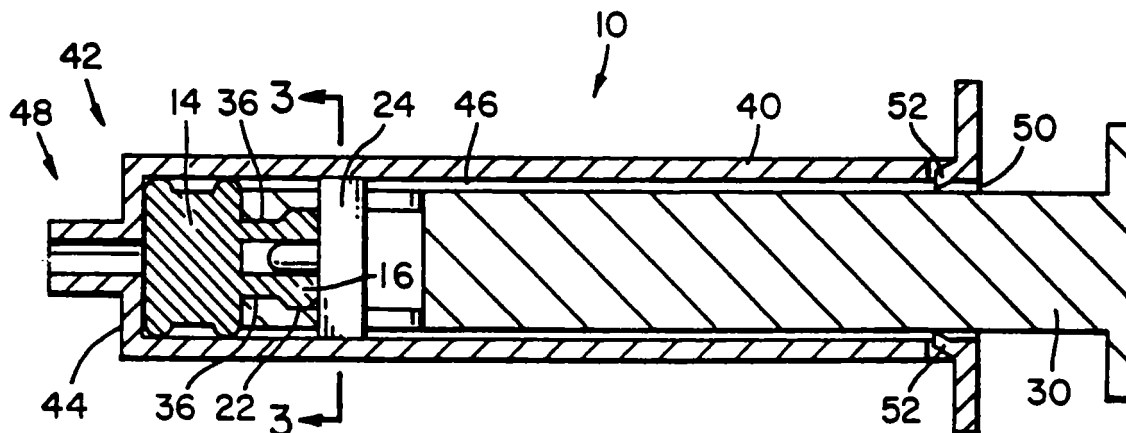
Primary Examiner—C. Fred Rosenbaum

Assistant Examiner—Mark O. Polutta

Attorney, Agent, or Firm—Heslin & Rothenberg

[57] ABSTRACT

A non-reuseable syringe is provided which includes a plunger. The main components of the plunger include a piston and a hollow cylindrical plunger stem. The piston is removably connected to the hollow cylindrical plunger stem by first and second connecting members. The connecting members utilize a nipple mating with an aperture to effect disconnection of the piston from the plunger stem after a single use of the syringe.

7 Claims, 2 Drawing Sheets

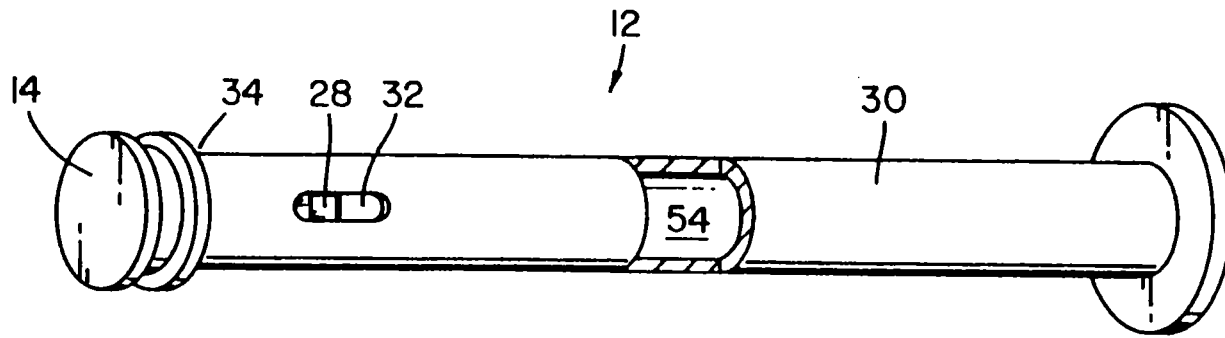


FIG. 1

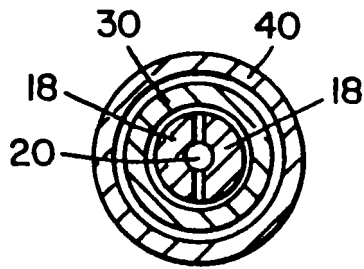


FIG. 6

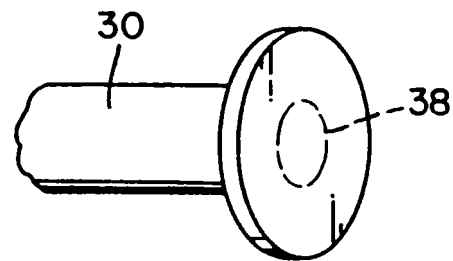


FIG. 4

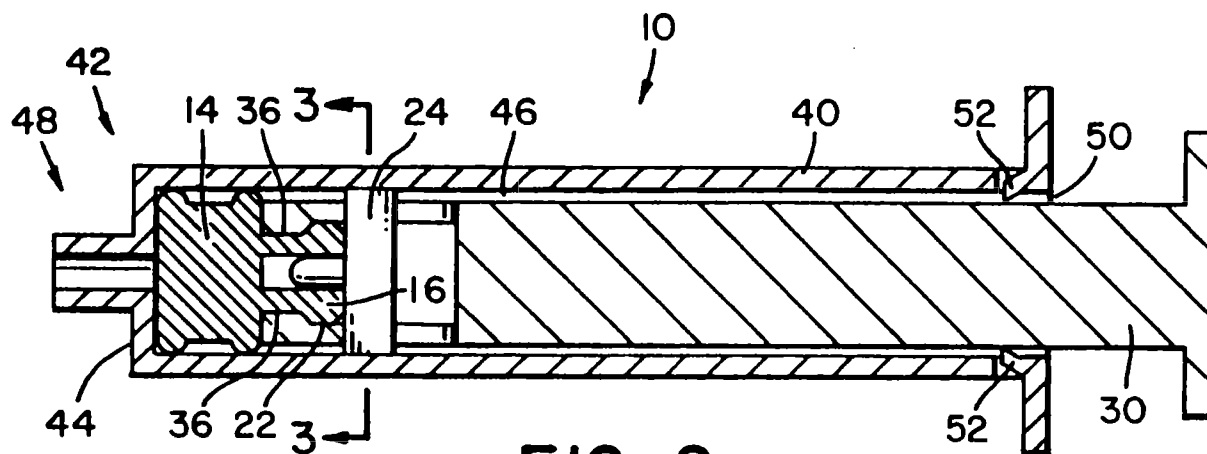


FIG. 2

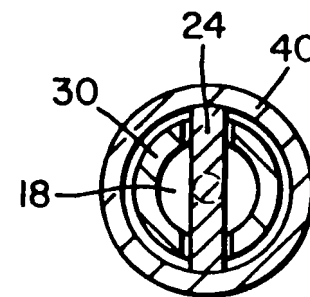


FIG. 3

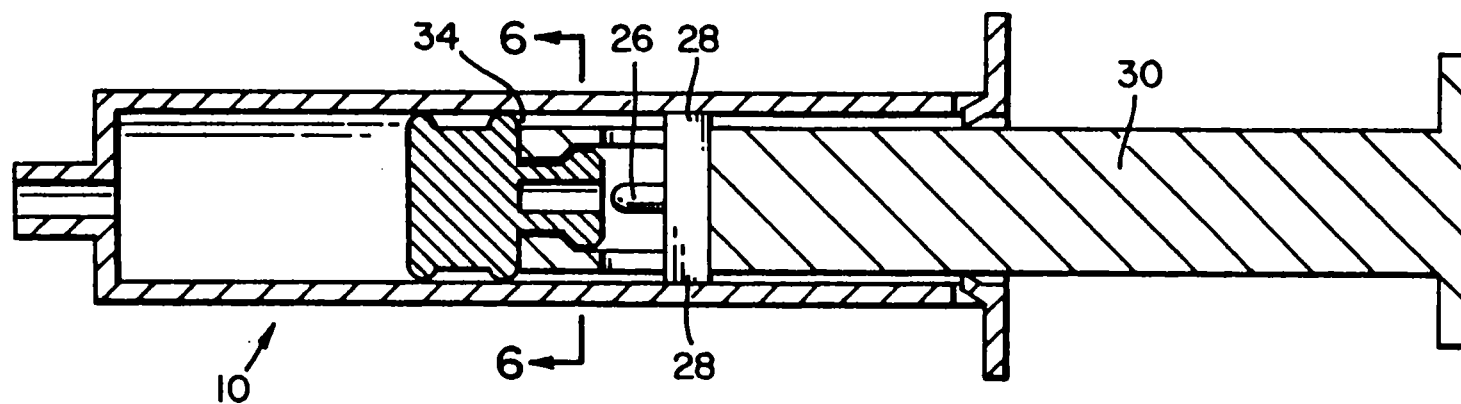


FIG. 5

PLUNGER FOR NON-REUSEABLE SYRINGE

This application is a continuation-in-part of U.S. Ser. No. 914,196, filed Jul. 14, 1992 now abandoned, the contents of which are hereby incorporated by reference into this application.

FIELD OF THE INVENTION

This invention relates in general to a plunger for a non-reuseable syringe, and more particularly to a non-reuseable syringe which is incapable of being used more than once for making an injection. The non-reuseable syringe utilizes a plunger that includes connecting members which disconnect the plunger stem from the plunger piston after insertion of the plunger into the housing of the syringe in order to expel the contents of the syringe.

BACKGROUND OF THE INVENTION

In the United States and throughout the world, the multiple use of hypodermic syringe products which are intended for single use only is instrumental in drug abuse and more particularly in the transfer of contagious diseases. Such contagious diseases include AIDS and hepatitis. The transfer is most prevalent in intravenous drug users who routinely share and reuse syringes, but can also be a problem for the medical community if proper precautions to prevent multiple use of disposable syringes are not followed. Furthermore, the effects of multiple use are a major concern in third world countries where repeated use of syringe products may also be responsible for the spread of many diseases.

Many attempts have been made to remedy this problem. Some early attempted solutions involved destruction of the syringe after use either by using a destructive device or providing a syringe assembly with frangible zones so that the syringe could be rendered inoperable by the application of force. Although many of these devices work quite well, they require the specific intent of the user followed by the actual act to destroy or render the syringe inoperable. None of these devices is effective with a user having the specific intent to reuse the syringe.

Accordingly, there is a need for a non-reuseable syringe which becomes inoperative or incapable of further use automatically without an additional act on the part of the user. This need must be met without preventing the filling or use under normal conditions of the syringe.

Although various types of single use non-reuseable syringes have been proposed, the severity of the AIDS epidemic and the need for solutions to the above problems continuously provide a need for other types of non-reuseable syringes.

SUMMARY OF THE INVENTION

This continuous need is met, and the problems of multiple use of prior syringes overcome, by the plunger for a non-reuseable syringe of the subject invention, as well as by the syringe utilizing such plunger.

The main components of the plunger of the subject invention include a piston and a hollow cylindrical plunger stem. The piston is removably connected to the hollow cylindrical plunger stem by first and second connecting members. The first connecting member is connected longitudinally to the piston and comprises a plurality of circumferentially spaced arms extending

longitudinally away from the piston. The circumferentially spaced arms form an aperture at an interior thereof and are flared at an exterior thereof on an end opposite the connection to the piston. The second connecting member comprises a nipple and a plurality of protrusions extending radially away from the nipple. The nipple is mated with the aperture formed by the circumferentially spaced arms of the first connecting member. The hollow cylindrical plunger stem has a plurality of circumferentially spaced slots extending longitudinally at an open front end thereof, and the open front end of the hollow cylindrical plunger stem encloses the first connecting member and the second connecting member such that the plurality of protrusions of the second connecting member slide within the plurality of slots and are friction fit within the inner diameter of an outer housing.

To accomplish the non-reuseable feature of the syringe which includes the plunger of the subject invention, an open front end of the plunger stem is constricted on an interior thereof such that the interior snugly mates with the flared exterior of the circumferentially spaced arms when the nipple is inserted into the aperture formed by the interior thereof.

When the piston which is located at the front end of the plunger is inserted into the rear end of a hollow cylindrical housing of a syringe unit, the wall and the piston form a sealed cavity (with the cylindrical housing side wall) for containing a liquid within the interior of the hollow cylindrical housing.

Prior to use, and preferably during manufacturing, the nipple is mated with the aperture. When the nipple is mated with the aperture, the second connecting member is positioned toward the front of the slots in the plunger stem. This allows the entire plunger unit to be drawn back for filling of the syringe, because in this configuration, the interior constricted portion of the hollow cylindrical plunger stem exerts pressure on the circumferentially spaced arms. However, the nipple counteracts such pressure and prevents flexion of the arms inward. Therefore, the piston, plunger stem, and first and second connecting members operate as a single unit.

However, after use or after the plunger has been withdrawn and then pushed forward in any way, the nipple is forced from the aperture as the protrusions on the second connecting member slide to the rear of the slots in the plunger stem. Any subsequent attempt to draw back the plunger to fill the syringe with fluid results in the interior constricted portion of the hollow cylindrical plunger stem exerting pressure on the circumferentially spaced arms. Since the nipple no longer counteracts such pressure, the arms flex inward and the hollow cylindrical plunger stem passes over the first connecting member. Thus, the plunger stem and second connecting member are disconnected from the piston and the first connecting member. Accordingly, the syringe is incapable of being refilled because the piston must be withdrawn to create the vacuum for filling the syringe and to create the cavity for holding the liquid within the syringe.

The resulting non-reuseable single use syringe can thus be used to prevent multiple use of syringes, such as disposable hypodermic syringes. This is accomplished by providing the piston/syringe as discussed in further detail below.

BRIEF DESCRIPTION OF THE FIGURES

These and other objects, features and advantages of this invention will be evident from the following detailed description of preferred embodiments when read in conjunction with the accompanying drawings in which:

FIG. 1 is a partially cut away isometric view of a plunger which is one embodiment of the subject invention;

FIG. 2 is a side view of a non-reuseable syringe including the plunger shown in FIG. 1, shown prior to withdrawal of the plunger to fill the syringe;

FIG. 3 is a cross sectional view of the non-reuseable syringe shown in FIG. 2;

FIG. 4 is a partial isometric view of the rear end of the plunger shown in FIG. 1;

FIG. 5 is a side view of the non-reuseable syringe of FIG. 2 indicating the position of the syringe elements during insertion of the plunger into the hollow cylindrical housing; and

FIG. 6 is a cross sectional view of the non-reuseable syringe shown in FIG. 5.

DETAILED DESCRIPTION OF THE INVENTION

The main components of one preferred embodiment of the subject invention are depicted in FIGS. 1-6. As shown in FIGS. 1 and 4, the plunger 12 comprises a hollow cylindrical plunger stem 30 closed at its rear end 38. At the front end 34 of the plunger stem a piston 14 provides a liquid sealing means. The closed rear end 38 and the piston 14 form an interior 54 of the plunger 12. Toward the front end 34 of the plunger 12, slots 32 extend longitudinally around the circumference of the plunger stem.

The plunger stem 30 is connected to the piston 14 by a first connecting member 16 and a second connecting member 24. As shown in FIGS. 2 and 6, the first connecting member 16 is connected longitudinally to the piston 14, or may be integral therewith, and comprises a plurality of circumferentially spaced arms 18 extending longitudinally away from the piston 14. The arms 18 form an aperture 20 at their interior, the purpose of which is discussed in further detail below. At the exterior end 22 of the arms away from the connection to the piston, the arms are flared. The aperture 20 is mated with a nipple 26 which is part of the second connecting member 24. The second connecting member 24 also includes a plurality of protrusions 28 which extend radially away from the nipple 26 to form a friction fit within the inner diameter of an outer housing (see below) and also slideably fit within the slots 32 of the plunger stem 30. This is best shown in FIGS. 2 and 3. The interior surface at the front end of the plunger stem forms a constricted end 36, such that the front end 34 of the plunger stem 30 snugly fits against the arms 18 of the first connecting member 16. The flared end 22 of the first connecting member mates with the constricted end 36 of the interior of the plunger stem 30 (see FIG. 2).

The plunger 12 is snugly inserted into a hollow cylindrical housing 40 of a syringe 10 (see FIGS. 2 and 5). The hollow cylindrical housing 40 is closed at its front end 42 by a wall 44, to which a needle can be mounted via a mounting means 48. Syringe needles are generally marketed with a plastic-type bracket on one end thereof. This plastic-type bracket mounts to the mounting means 48. The bracket may snugly slide over the

mounting means 48, or the mounting means could be provided with grooves into which corresponding ridges on the bracket are twisted. Various means for connecting syringe needles are known in the art and can thus be used in the subject invention to mount a needle to the mounting means. A needle so mounted in the wall 44 is in fluid communication with the interior 46 (see FIG. 2) of the housing 40.

In order to prevent tampering with the connecting members in an attempt to reuse the syringe, removal of the plunger 12 is prevented by one-way flanges 52 at the rear end 50 of the housing 40. These flexible flanges are angled so that insertion of the plunger is possible but removal is not possible due to the contact of the protrusions 28 of the second connecting member 24 with the flanges 52. When the flanges extend into the interior of the housing, the diameter of the second connecting member 24, which is friction fit within the housing 40, is such that it cannot pass through the housing at the position of the flanges.

Having described one embodiment of the plunger and non-reuseable syringe of the subject invention, its use is best illustrated in FIGS. 2 and 5. As shown in FIG. 2, the initial position of the elements of the syringe 10 prior to withdrawal (so as to fill the syringe) are illustrated. The plunger 12 is fully inserted into hollow cylindrical housing 40, so that the piston 14 is adjacent the wall 44 at the front end 42 of the housing 40. The nipple 26 is mated with the aperture 20 and the protrusions 28 are positioned slideably within and toward the front of the slots 32. A cross section illustrating the position of the syringe elements taken through the second connecting member is shown in FIG. 3. In this position, the nipple 26 prevents withdrawal of the plunger stem 30 without simultaneous withdrawal of the piston 14. This is because withdrawal of the plunger stem 30 causes the constricted front end 36 of the plunger stem 30 to exert a rearward force on the flared ends 22 of the first connecting member's arms 18. The nipple 26 prevents the arms 18 from flexing inward in response to this force. Accordingly, the entire plunger 12 unit is pulled rearward in one motion, so as to fill the syringe.

Upon injection or any forward motion of the plunger stem 30, as shown in FIG. 5, the second connecting member 24 slides to the rear of the slots 32 and the nipple 26 is no longer mated with the aperture 20. FIG. 6 illustrates a cross section of the syringe at the position of the flared ends of the arms at this point of an injection stroke. Any subsequent rearward movement of the plunger stem therefore results in another rearward force on the flared ends of the first connecting member's arms. The removal of the nipple allows the arms to flex inward, allowing the constricted end of the plunger stem to pass thereby. The plunger stem and second connecting member are thus withdrawn, but the piston and first connecting member remain within the housing and no longer operate in conjunction with the plunger stem. As should be readily apparent, the syringe is then incapable of being used again because movement of the piston is necessary to create the vacuum for filling of the syringe.

It should be readily apparent to those skilled in the art that any suitable materials, such as plastic and rubber, can be utilized for the various syringe elements.

The syringe which includes the plunger as described above is assembled as follows. The piston 14 and the first connecting member 16 are positioned at the front

end 42 of the hollow cylindrical housing 40. The second connecting member 24 is positioned within the slots 32 of the hollow cylindrical plunger stem 30. At this point, the rear end 38 of the plunger stem 30 is not closed or sealed, but remains hollow (see broken lines on FIG. 4). The hollow cylindrical plunger stem 30, with the second connecting member 24 positioned within the slots 32, is snugly inserted into the hollow cylindrical housing 40 until the second connecting member 24 contacts the first connecting member 16 at the front of the hollow cylindrical housing 40. A rigid device, such as a wire or even a pencil-like member, is inserted into the hollow center 54 of the plunger stem 30 to exert a forward force on the second connecting member 24. This causes the nipple 26 of the second connecting member 24 to mate with the aperture 20 of the first connecting member 16. The rigid device is then removed from the center of the plunger stem, and the rear end 38 of the plunger stem is sealed or closed by suitable means. For example, a plastic plug may be inserted or injected, or a cap can be permanently applied to the end of the plunger stem. The end is permanently sealed so that future tampering with the second connecting member is not possible. This prevents the syringe from being "reset", i.e. forcing the second connecting member forward to mate the nipple with the aperture. After the end of the plunger stem is sealed, the syringe is ready for use.

Accordingly, after a single use the syringe of the subject invention cannot be used again because the plunger stem separates from the piston. This prevents subsequent filling with liquid.

The subject invention thus provides a method of preventing multiple use of a syringe comprising the steps of: selecting the single use syringe of the subject invention as disclosed above; drawing a liquid into the single use syringe; and dispensing the liquid from the single use syringe. When the liquid has been dispensed from the single use syringe, the syringe cannot again be used to draw a liquid into the syringe due to the separation of the piston from the plunger stem upon any subsequent withdrawal of the plunger body.

Although preferred embodiments have been depicted and described in detail herein, it will be apparent to those skilled in the relevant art that various modifications, additions, substitutions and the like can be made without departing from the spirit of the invention and these are therefore considered to be within the scope of the invention as defined in the following claims.

What is claimed is:

1. A plunger for a single use syringe comprising:

a piston;

a first connecting member connected longitudinally to said piston, said first connecting member comprising a plurality of circumferentially spaced arms extending longitudinally away from said piston, said circumferentially spaced arms forming an aperture at an interior thereof and said circumferentially spaced arms flared at an exterior thereof on an end opposite said connection to said piston;

a second connecting member comprising a nipple and a plurality of protrusions extending radially away from said nipple, said nipple mated with said aperture; and

a hollow cylindrical plunger stem having a plurality of circumferentially spaced slots extending longitudinally at an open front end thereof, said open front end of said hollow cylindrical plunger stem enclosing

said first connecting member and said second connecting member such that said plurality of protrusions of said second connecting member slide within said plurality of slots, and said open front end of said plunger stem constricted on an interior thereof such that said interior snugly mates with said flared exterior of said circumferentially spaced arms when said nipple is inserted into said aperture formed by said interior thereof.

2. The plunger of claim 1 wherein a rear end of said hollow cylindrical plunger stem is closed.

3. The plunger of claim 1 wherein said first connecting member is integral with said piston.

4. A single use syringe comprising:

a hollow cylindrical housing closed at its front end by a wall so as to form an interior thereof;

means for mounting a needle in said wall, wherein when said needle is mounted in said wall, said needle is in fluid communication with the interior of said hollow cylindrical housing; and

a plunger comprising: 1) a piston; 2) a first connecting member connected longitudinally to said piston, said first connecting member comprising a plurality of circumferentially spaced arms extending longitudinally away from said piston, said circumferentially spaced arms forming an aperture at an interior thereof and said circumferentially spaced arms flared at an exterior thereof on an end opposite said connection to said piston; 3) a second connecting member comprising a nipple and a plurality of protrusions extending radially away from said nipple, said nipple mated with said aperture; and 4) a hollow cylindrical plunger stem having a plurality of circumferentially spaced slots extending longitudinally at an open front end thereof, said open front end of said hollow cylindrical plunger stem enclosing said first connecting member and said second connecting member such that said plurality of protrusions of said second connecting member slide within said plurality of slots, and said open front end of said plunger stem constricted on an interior thereof such that said interior snugly mates with said flared exterior of said circumferentially spaced arms when said nipple is inserted into said aperture formed by said interior thereof;

said piston of said plunger snugly inserted into an open rear end of said hollow cylindrical housing and slideable within said hollow cylindrical housing, and said radial extension of said plurality of protrusions contacting the interior of said hollow cylindrical housing such that said second connecting member friction fits within said interior of said hollow cylindrical housing.

5. The syringe of claim 4 further comprising a locking member at the open rear end of said hollow cylindrical housing, said locking member comprising a flexible one-way flange, wherein when said flange is extended into the interior of said hollow cylindrical housing, said second connecting member is incapable of passing within the diameter of said hollow cylindrical housing at a position at which said flange is extended.

6. The syringe of claim 5 wherein said flexible one-way flange comprises one or more tabs integral with said hollow cylindrical housing.

7. A method of preventing multiple use of a syringe which method comprises the steps of:

selecting the single use syringe of claim 4 for dispensing a liquid therefrom;

positioning said nipple within said aperture and drawing a liquid into said single use syringe, wherein said drawing comprises drawing said plunger away from said front end of said hollow cylindrical housing and thereby causing said protrusions to position at a forward end of said slots; and
dispensing the liquid from the single use syringe, wherein said dispensing comprises pushing said plunger toward said front end of said hollow cylindrical housing and thereby causing said protrusions to position at a rearward end of said slots thereby removing said nipple from said aperture; wherein

when said liquid has been dispensed from said single use syringe, said syringe cannot again be used to draw a liquid into said syringe due to the removal of said nipple from said aperture, such that subsequent drawing of said plunger causes said constricted interior on the front end of said plunger stem to compress said flared exterior of said circumferentially spaced arms, thereby disengaging said plunger stem from said piston and said first connecting member.

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[54] **ASPIRATING NON-REUSEABLE SYRINGE**

[76] **Inventors:** Anthony J. Vallelunga, 209
Schoolhouse Rd., Albany, N.Y.
12203-5956; Paul V. Cacciotti;
Vincent E. Cacciotti, both of 9
Morgan Way, Latham, N.Y. 12110

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[52] **U.S. Cl.:** 604/110; 604/218;
604/228

[58] **Field of Search:** 604/110, 187, 218, 220,
604/228

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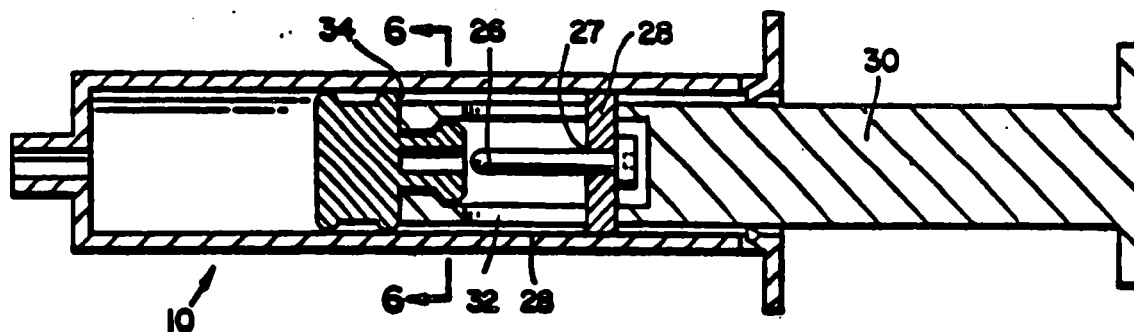
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Primary Examiner—John D. Yaako
Attorney, Agent, or Firm—Healin & Rothenberg

[57] **ABSTRACT**

An aspirating non-reuseable syringe is provided which includes a plunger. The main components of the plunger include a piston and a cylindrical plunger stem. The piston is removably connected to the cylindrical plunger stem by first, second, and third connecting members. The connecting members utilize a nipple mating with one aperture and sliding within another aperture to effect aspiration as well as disconnection of the piston from the plunger stem after a single use of the syringe.

5 Claims, 3 Drawing Sheets



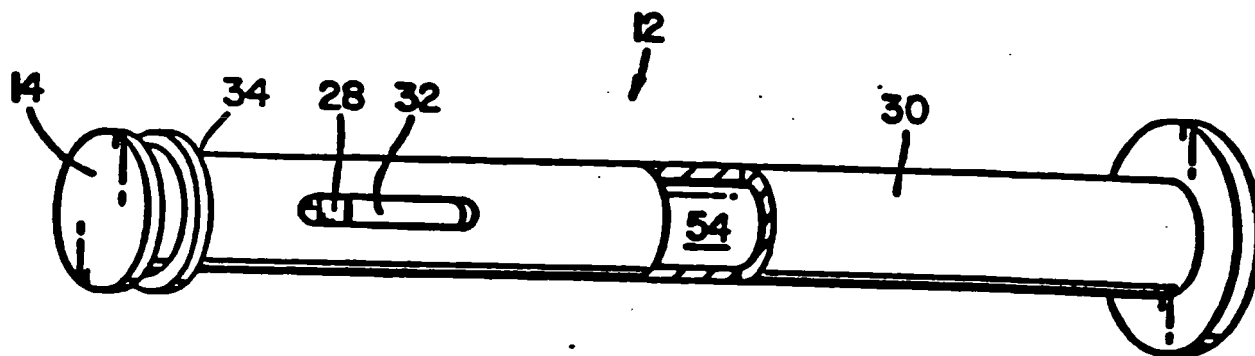


FIG. 1

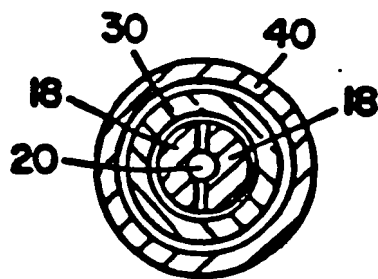


FIG. 6

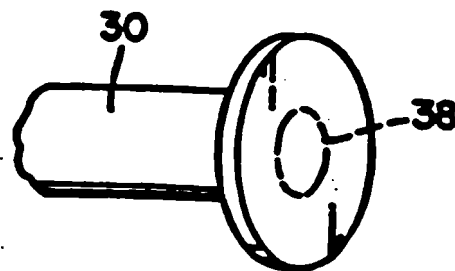


FIG. 4

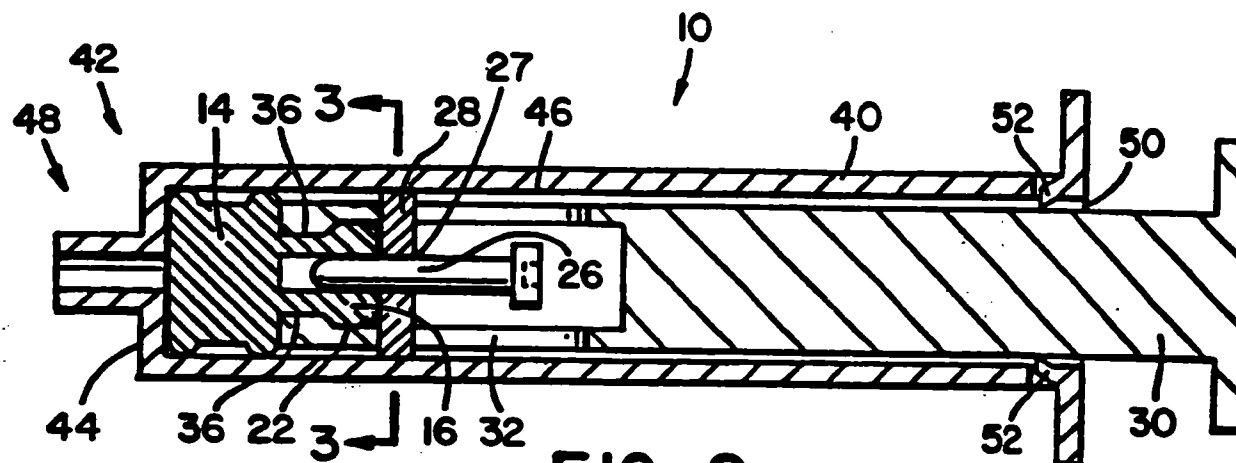


FIG. 2

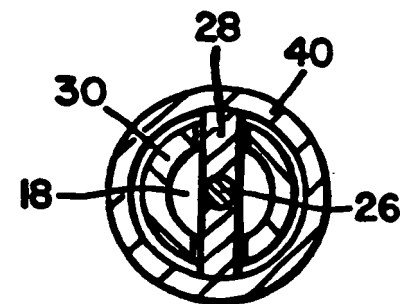


FIG. 3

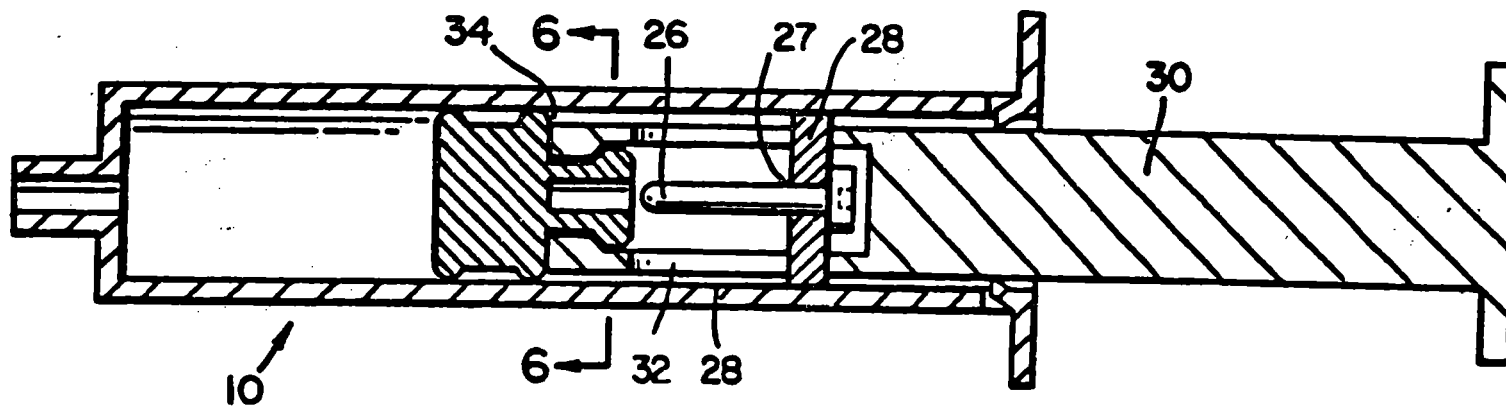


FIG. 5

ASPIRATING NON-REUSEABLE SYRINGE

FIELD OF THE INVENTION

This invention relates in general to a plunger for a non-reuseable syringe, and more particularly to a non-reuseable syringe which is incapable of being used more than once for making an injection and yet is capable of aspirating fluids. The non-reuseable syringe utilizes a plunger that includes three connecting members which disconnect the plunger stem from the plunger piston after insertion of the plunger into the housing of the syringe in order to expel the contents of the syringe.

BACKGROUND OF THE INVENTION

In the United States and throughout the world, the multiple use of hypodermic syringe products which are intended for single use only is instrumental in drug abuse and more particularly in the transfer of contagious diseases. Such contagious diseases include AIDS and hepatitis. The transfer is most prevalent in intravenous drug users who routinely share and reuse syringes, but can also be a problem for the medical community if proper precautions to prevent multiple use of disposable syringes are not followed. Furthermore, the effects of multiple use are a major concern in third world countries where repeated use of syringe products may also be responsible for the spread of many diseases.

Many attempts have been made to remedy this problem. Some early attempted solutions involved destruction of the syringe after use either by using a destructive device or providing a syringe assembly with frangible zones so that the syringe could be rendered inoperable by the application of force. Although many of these devices work quite well, they require the specific intent of the user followed by the actual act to destroy or render the syringe inoperable. None of these devices is effective with a user having the specific intent to reuse the syringe.

Accordingly, there is a need for a non-reuseable syringe which becomes inoperative or incapable of further use automatically without an additional act on the part of the user. Co-owned U.S. Pat. No. 5,215,524, issued Jun. 1, 1993, the contents of which are hereby incorporated by reference, discloses a single use syringe which utilizes a disconnecting plunger stem. This syringe becomes inoperative automatically after a single use.

However, the need for a non-reusable syringe must be met without preventing the filling or use of the syringe under normal conditions. One such use under normal conditions includes the ability to aspirate fluid using the syringe. It is common in the medical community to aspirate fluid during the use of a syringe (i.e., to alternately retract and extend the plunger of the syringe without expelling all contents of the syringe). This ability to aspirate must still be available with a single use syringe, and is not available with the syringe of U.S. Pat. No. 5,215,524.

Although various types of single use non-reuseable syringes have been proposed, the severity of the AIDS epidemic and the need for solutions to the above problems continuously provide a need for other types of non-reuseable syringes, particularly those which also provide for aspiration.

SUMMARY OF THE INVENTION

This continuous need is met, and the problems of multiple use of prior syringes overcome, by the plunger for a non-reuseable syringe of the subject invention, as well as by the syringe utilizing such plunger.

The main components of the plunger of the subject invention include a piston and a cylindrical plunger stem hollow at an open end thereof. The piston is removably connected to the cylindrical plunger stem by first, second, and third connecting members. The first connecting member is connected longitudinally to the piston and extends into the open end of the plunger stem. The first connecting member comprises a plurality of circumferentially spaced arms extending longitudinally away from the piston. The circumferentially spaced arms form a first aperture at an interior thereof and are flared at an exterior thereof on an end opposite the connection to the piston. The second connecting member comprises a plurality of protrusions extending radially away from a second aperture. The third connecting member is a longitudinal nipple slidable within the second aperture and matable with the first aperture formed by the circumferentially spaced arms of the first connecting member. The cylindrical plunger stem has a plurality of circumferentially spaced slots extending longitudinally at an open end thereof, and the open end of the hollow cylindrical plunger stem encloses the first, second and third connecting members such that the plurality of protrusions of the second connecting member slide within the plurality of slots and are friction fit within the inner diameter of an outer housing.

To accomplish the non-reuseable feature of the syringe which includes the plunger of the subject invention, an open end of the plunger stem is constricted on an interior thereof such that the interior snugly mates with the flared exterior of the circumferentially spaced arms when the nipple is inserted into the first aperture formed by the interior thereof.

When the piston which is located at the front end of the plunger is inserted into the rear end of a hollow cylindrical housing of a syringe unit, the wall and the piston form a sealed cavity (with the cylindrical housing side wall) for containing a liquid within the interior of the hollow cylindrical housing.

Prior to use, and preferably during manufacturing, the nipple is mated with the first aperture. When the nipple is mated with the first aperture, the second connecting member is positioned toward the front of the slots in the plunger stem. This allows the entire plunger unit to be drawn back for filling of the syringe, because in this configuration, the interior constricted portion of the cylindrical plunger stem exerts pressure on the circumferentially spaced arms. However, the nipple counteracts such pressure and prevents flexion of the arms inward. Therefore, the piston, plunger stem, and first, second and third connecting members operate as a single unit.

However, the nipple is forced from the first aperture as the protrusions on the second connecting member slide to the rear of the slots in the plunger stem. Any subsequent attempt to draw back the plunger to fill the syringe with fluid results in the interior constricted portion of the cylindrical plunger stem exerting pressure on the circumferentially spaced arms. Since the nipple no longer counteracts such pressure, the arms flex inward and the cylindrical plunger stem passes over the first connecting member. Thus, the plunger stem,

second connecting member, and third connecting member are disconnected from the piston and the first connecting member. Accordingly, the syringe is incapable of being refilled because the piston must be withdrawn to create the vacuum for filling the syringe and to create the cavity for holding the liquid within the syringe.

The resulting non-reuseable single use syringe can thus be used to prevent multiple use of syringes, such as disposable hypodermic syringes. This is accomplished by providing the piston/syringe as discussed in further detail below.

The syringe according to the subject invention is also capable of aspiration due to the use of the sliding third connecting member (the nipple) within the second aperture. The nipple can slide within the aperture a distance equal to the length of the slots before the second connecting member (the plurality of protrusions) contacts the end of the slots and thereby forces the nipple out of the first aperture. Thus, one is able to move the plunger back and forth within the limitations of the slot length without disengaging the plunger stem. This allows for aspiration using the syringe as is also discussed in further detail below.

BRIEF DESCRIPTION OF THE FIGURES

These and other objects, features and advantages of this invention will be evident from the following detailed description of preferred embodiments when read in conjunction with the accompanying drawings in which:

FIG. 1 is a partially cut away isometric view of a plunger which is one embodiment of the subject invention;

FIG. 2 is a side view of a non-reuseable syringe including the plunger shown in FIG. 1, shown prior to withdrawal of the plunger to fill the syringe;

FIG. 3 is a cross sectional view of the non-reuseable syringe shown in FIG. 2;

FIG. 4 is a partial isometric view of the rear end of the plunger shown in FIG. 1;

FIG. 5 is a side view of the non-reuseable syringe of FIG. 2 indicating the position of the syringe elements during insertion of the plunger into the hollow cylindrical housing;

FIG. 6 is a cross sectional view of the non-reuseable syringe shown in FIG. 5; and

FIGS. 7 and 8 are side views of the non-reuseable syringe of FIG. 2 showing the aspiration feature of the syringe accomplished by sliding the nipple within the aperture without disconnecting the nipple from the aperture.

DETAILED DESCRIPTION OF THE INVENTION

The main components of one preferred embodiment of the subject invention are depicted in FIGS. 1-8. As shown in FIGS. 1 and 4, the plunger 12 comprises a cylindrical plunger stem 30 closed at its rear end 38 and hollow at least at the other front end 34. At the front end 34 of the plunger stem 30 a piston 14 provides a liquid sealing means. The closed rear end 38 and the piston 14 form an interior 54 of the plunger 12. Toward the front end 34 of the plunger 12, slots 32 extend longitudinally around the circumference of the plunger stem.

The plunger stem 30 is connected to the piston 14 by a first connecting member 16, a second connecting member (made up of aperture 27 and protrusions 28), and a third connecting member 26. As shown in FIGS.

2 and 6, the first connecting member 16 is connected longitudinally to the piston 14, or may be integral therewith, and comprises a plurality of circumferentially spaced arms 18 extending longitudinally away from the piston 14. The arms 18 form a first aperture 20 at their interior, the purpose of which is discussed in further detail below. At the exterior end 22 of the arms away from the connection to the piston, the arms are flared. The first aperture 20 is mated with the third connecting member, a longitudinal nipple 26. The second connecting member includes a plurality of protrusions 28 which extend radially away from a second aperture 27 to form a friction fit within the inner diameter of an outer housing (see below) and also slideably fit within the slots 32 of the plunger stem 30. This is best shown in FIGS. 2 and 3. The nipple 26 slides within this second aperture 27. The interior surface at the front end of the plunger stem forms a constricted end 36, such that the front end 34 of the plunger stem 30 snugly fits against the arms 18 of the first connecting member 16. The flared end 22 of the first connecting member 16 mates with the constricted end 36 of the interior of the plunger stem 30 (see FIG. 2).

The plunger 12 is snugly inserted into a hollow cylindrical housing 40 of a syringe 10 (see FIGS. 2 and 5). The hollow cylindrical housing 40 is closed at its front end 42 by a wall 44, to which a needle can be mounted via a mounting means 48. Syringe needles are generally marketed with a plastic-type bracket on one end thereof. This plastic-type bracket mounts to the mounting means 48. The bracket may snugly slide over the mounting means 48, or the mounting means could be provided with grooves into which corresponding ridges on the bracket are twisted. Various means for connecting syringe needles are known in the art and can thus be used in the subject invention to mount a needle to the mounting means. A needle so mounted in the wall 44 is in fluid communication with the interior 46 (see FIG. 2) of the housing 40.

In order to prevent tampering with the connecting members in an attempt to reuse the syringe, removal of the plunger 12 is prevented by one-way flanges 52 at the rear end 50 of the housing 40. These flexible flanges are angled so that insertion of the plunger is possible but removal is not possible due to the contact of the protrusions 28 of the second connecting member 24 with the flanges 52. When the flanges extend into the interior of the housing, the diameter of the second connecting member protrusions 28, which are friction fit within the housing 40, is such that the second connecting member cannot pass through the housing at the position of the flanges.

Having described one embodiment of the plunger and non-reuseable syringe of the subject invention, its use is best illustrated in FIGS. 2 and 5, and 7 and 8. As shown in FIG. 2, the initial position of the elements of the syringe 10 prior to withdrawal (so as to fill the syringe) are illustrated. The plunger 12 is fully inserted into hollow cylindrical housing 40, so that the piston 14 is adjacent the wall 44 at the front end 42 of the housing 40. The nipple 26 is mated with the aperture 20 and the protrusions 28 are positioned slideably within and toward the front of the slots 32. A cross section illustrating the position of the syringe elements taken through the second connecting member is shown in FIG. 3. In this position, the nipple 26 prevents withdrawal of the plunger stem 30 without simultaneous withdrawal of the piston 14. This is because withdrawal of the plunger

stem 30 causes the constricted front end 36 of the plunger stem 30 to exert a rearward force on the flared ends 22 of the first connecting member's arms 18. The nipple 26 prevents the arms 18 from flexing inward in response to this force. Accordingly, the entire plunger 12 unit is pulled rearward in one motion, so as to fill the syringe.

Upon forward motion of the plunger stem 30 to an extent greater than the length of the slot 32, as shown in FIG. 5, the second connecting member including the plurality of protrusions 28 slides to the rear of the slots 32 and the nipple 26 is no longer mated with the aperture 20. FIG. 6 illustrates a cross section of the syringe at the position of the flared ends of the arms at this point of an injection stroke. Any subsequent rearward movement of the plunger stem therefore results in another rearward force on the flared ends of the first connecting member's arms. The removal of the nipple allows the arms to flex inward, allowing the constricted end of the plunger stem to pass thereby. The plunger stem, second 20 connecting member, and third connecting member are thus withdrawn, but the piston and first connecting member remain within the housing and no longer operate in conjunction with the plunger stem. As should be readily apparent, the syringe is then incapable of being used again because movement of the piston is necessary to create the vacuum for filling of the syringe.

FIGS. 7 and 8 illustrate the aspiration feature of the subject invention. The syringe (beginning as shown in FIG. 2) plunger stem 30 is withdrawn in the hollow cylindrical housing 40 to the point shown in FIG. 7. The plunger stem 30 is then pushed back into the hollow cylindrical housing 40 to the position shown in FIG. 8. At this point, the nipple 26 remains mated within the first aperture 20 of the first connecting member 16, by sliding within the second aperture 27 of the second connecting member. The plunger stem 30 can be alternately withdrawn and pushed into the hollow cylindrical housing 40 in this fashion for aspiration until the plurality of protrusions 28 of the second connecting member contact the rear of the slots 32. At that time, the second connecting member will pull the nipple 26 out of the first aperture 20 of the first connecting member 16 and render the syringe incapable of further use, as shown in FIG. 5.

Thus, the amount of aspiration possible can be controlled by controlling the length of the slots and the length of the longitudinal nipple. By extending the slot and providing a nipple which can slide within the second connecting member, this aspiration feature is attainable.

It should be readily apparent to those skilled in the art that any suitable materials, such as plastic and rubber, can be utilized for the various syringe elements.

The syringe which includes the plunger as described above is assembled as follows. The piston 14 and the first connecting member 16 are positioned at the front end 42 of the hollow cylindrical housing 40. The third connecting member 26 is positioned in the aperture 27 of the second connecting member, and both members so connected are then positioned within the cylindrical plunger stem 30 so that the protrusions 28 of the second connecting member extend through the slots 32 of the cylindrical plunger stem 30. At this point, the rear end 38 of the plunger stem 30 is not closed or sealed, but remains hollow (see broken lines on FIG. 4). The hollow cylindrical plunger stem 30, with the second and third connecting members positioned within the

plunger stem, is snugly inserted into the hollow cylindrical housing 40 until the third connecting member 26 contacts the first connecting member 16 at the front of the hollow cylindrical housing 40. A rigid device, such as a wire or even a pencil-like member, is inserted into the hollow center 54 of the plunger stem 30 to exert a forward force on the third connecting member 26. This causes the nipple 26 (of the third connecting member) to mate with the first aperture 20 of the first connecting member 16. The rigid device is then removed from the center of the plunger stem, and the rear end 38 of the plunger stem is sealed or closed by suitable means. For example, a plastic plug may be inserted or injected, or a cap can be permanently applied to the end of the plunger stem. The end is permanently sealed so that future tampering with the second and third connecting members is not possible. This prevents the syringe from being "re-set", i.e., by forcing the third connecting member nipple forward to mate with the first aperture. After the end of the plunger stem is sealed, the syringe is ready for use. Accordingly, after any required aspiration and a single dispensing use, the syringe of the subject invention cannot be used again because the plunger stem separates from the piston. This prevents subsequent filling with liquid.

The subject invention thus provides a method of preventing multiple use of a syringe comprising the steps of: selecting the single use syringe of the subject invention as disclosed above; drawing a liquid into the single use syringe; and dispensing the liquid from the single use syringe. When the liquid has been dispensed from the single use syringe, the syringe cannot again be used to draw a liquid into the syringe due to the separation of the piston from the plunger stem upon any subsequent withdrawal of the plunger body. The invention also provides a method of aspirating using a single use syringe by alternately pushing and drawing the plunger without unmating the nipple of the syringe.

Although preferred embodiments have been depicted and described in detail herein, it will be apparent to those skilled in the relevant art that various modifications, additions, substitutions and the like can be made without departing from the spirit of the invention and these are therefore considered to be within the scope of the invention as defined in the following claims.

What is claimed is:

1. A plunger for an aspirating single use syringe comprising:

- a cylindrical plunger stem being hollow at an open end thereof, said plunger stem having a plurality of circumferentially spaced slots extending longitudinally at said open end thereof and being constricted on an interior of said open end thereof;
- a piston attached to said open end of said plunger stem;
- a first connecting member connected to said piston and extending into said open end of said plunger stem, said first connecting member comprising a plurality of circumferentially spaced arms extending longitudinally away from said piston, said circumferentially spaced arms forming a first aperture at an interior thereof and said circumferentially spaced arms flared at an exterior thereof on an end opposite said connection to said piston;
- a second connecting member comprising a plurality of protrusions extending radially away from a second aperture, said second connecting member positioned within said plunger stem so that said plural-

ity of protrusions slide within said plurality of slots; and

- a third connecting member comprising a longitudinal nipple slidable within said second aperture and matable with said first aperture, wherein when said nipple is mated with said first aperture, the flared circumferentially spaced arms of said first connecting member snugly mate with said constricted interior of said plunger stem.
2. The plunger of claim 1 wherein said first connecting member is integral with said piston.
3. An aspirating single use syringe comprising:
a hollow cylindrical housing closed at its front end by a wall so as to form an interior thereof;
means for mounting a needle in said wall, wherein when said needle is mounted in said wall, said needle is in fluid communication with the interior of said hollow cylindrical housing; and
a plunger, said plunger comprising:
a cylindrical plunger stem being hollow at an open end thereof, said plunger stem having a plurality of circumferentially spaced slots extending longitudinally at said open end thereof and being constricted on an interior of said open end thereof;
a piston attached to said open end of said plunger stem;
a first connecting member connected to said piston and extending into said open end of said plunger stem, said first connecting member comprising a plurality of circumferentially spaced arms extending longitudinally away from said piston, said circumferentially spaced arms forming a first aperture at an interior thereof and said circumferentially spaced arms flared at an exterior thereof on an end opposite said connection to said piston;
a second connecting member comprising a plurality of protrusions extending radially away from a second aperture, said second connecting member positioned within said plunger stem so that said plurality of protrusions slide within said plurality of slots; and
a third connecting member comprising a longitudinal nipple slidable within said second aperture and matable with said first aperture, wherein when said nipple is mated with said first aperture, the flared circumferentially spaced arms of said first connecting member snugly mate with said constricted interior of said plunger stem, said piston of said plunger snugly inserted into an open rear end of said hollow cylindrical housing and slidable within said hollow cylindrical housing, and said radial extension of said plurality of protrusions contacting the interior of said hollow cylindrical housing such that said second connecting member friction fits within said interior of said hollow cylindrical housing.

4. A method of preventing multiple use of a syringe which method comprises the steps of:

- selecting the single use syringe of claim 3 for dispensing a liquid therefrom;
positioning said nipple within said first aperture and drawing a liquid into said single use syringe, wherein said drawing comprises drawing said plunger away from said front end of said hollow cylindrical housing, causing said protrusions to position at a forward end of said slots; and
dispensing the liquid from the single use syringe, wherein said dispensing comprises pushing said plunger toward said front end of said hollow cylindrical housing, causing said protrusions to position at a rearward end of said slots thereby removing said nipple from said first aperture; wherein when said liquid has been dispensed from said single use syringe, said syringe cannot again be used to draw a liquid into said syringe due to the removal of said nipple from said first aperture, such that subsequent drawing of said plunger causes said constricted interior on the front end of said plunger stem to compress said flared exterior of said circumferentially spaced arms, thereby disengaging said plunger stem from said piston and said first connecting member.
5. A method of preventing multiple use of an aspirating syringe which method comprises the steps of:
selecting the single use syringe of claim 3 for aspirating and dispensing a liquid therefrom;
positioning said nipple within said first aperture and drawing a liquid into said single use syringe, wherein said drawing comprises drawing said plunger away from said front end of said hollow cylindrical housing, causing said protrusions to position at a forward end of said slots;
alternately pushing said plunger toward said front end of said hollow cylindrical housing and drawing said plunger away from said front end of said hollow cylindrical housing, such that said nipple slides within said second aperture and said protrusions slide within said slots without contacting said rearward end of said slots, thereby aspirating with said single use syringe; and
dispensing the liquid from said single use syringe by pushing said plunger toward said front end of said hollow cylindrical housing and contacting said protrusions with said rearward end of said slots, thereby removing said nipple from said first aperture; wherein when said liquid has been dispensed from said single use syringe, said syringe cannot again be used to draw a liquid into said syringe due to the removal of said nipple from said first aperture, such that subsequent drawing of said plunger causes said constricted interior on the front end of said plunger stem to compress said flared exterior of said circumferentially spaced arms, thereby disengaging said plunger stem from said piston and said first connecting member.
- • • • •



Rensselaer

New York State Center for Advanced Technology in Automation and Robotics
Harry E. Stephanou, Director

23 January 1995

Mr. Tony Valletunga
The Unique-Needle Management Enterprises Inc.
209 Schoolhouse Rd
Albany NY 12203

Dear Tony:

This is to confirm that we have reviewed the design of the "unique needle" concept, and strongly support your plans to proceed with its commercialization. We find your design to be innovative and technically sound. It definitely addresses a very real market need, and has enormous commercial potential.

As per our earlier discussion, the CAT is willing to invest its own discretionary funds to develop a proof-of-concept automated assembly cell for the unique needle. We believe that this will be necessary to clearly demonstrate that it can be manufactured in a cost effective manner.

The NYS Manufacturing Extension Partnership has also expressed interest in participating in this proof-of-concept experiment, and to cost share its expenses with the CAT. A final decision is pending, following a proposal that will include a detailed plan of work and budget.

We are prepared to provide your company with an exclusive license to the use of the automation technology developed in this project. It is our policy to provide preferential treatment to New York State corporations, so the final royalty arrangements will depend on the NYS labor content of the product.

In closing, let me reiterate my excitement about this important project. Your missionary zeal is indeed contagious, and I really look forward to a long and mutually rewarding partnership. Please do not hesitate to contact me if I may be of any assistance.

Very truly yours,

Harry E. Stephanou
Director

c. Mr. Paul Burton, NYS MEP

This report 3 years ago 13% at risk. Your show CBS 18% at Risk
4/25 98 ???????????

INJECTIONS: PLEDGE FOR SAFETY

Background: *UNICEF estimates 500M injections are given annually, and target 97% of these to be safe. This means that 13% are still at risk — 1,300,000 injections/week at risk!*

The Dawn of Truly Safe Injection Practices: The End of Syringe Sharing

A new type of syringe, which destroys itself after one use, is now available, ensuring that the syringe-needle cannot be reused. The cost of the auto-destruct syringe is on a par with conventional disposable syringes, and is up to four times cheaper than the equivalent cost per injection of reusable syringe-needles.

Auto-Destruct Syringes Do The Right Thing Right Every Time

Safe Injection Practice Can Be Ensured. The auto-destruct syringe puts an end to syringe sharing, ensures a clean syringe-needle without relying on the sterilization process or personal discipline, and reduces the cost of injection.

Syringe Sharing Spreads Diseases

The use of unclean or shared syringe-needles among drug users is a major cause of the spread of AIDS and Hepatitis B^{1,2,5}. In New Haven Conn., more than 60% of its reported AIDS cases could be traced to drug injection⁵.

Ineffective Sterilization Jeopardizes Immunization Programs

A recent WHO Western Pacific Regional meeting on Expanded Program on Immunization (EPI) concluded that "incorrect sterilization and injection practices, including those of EPI, remain a major problem for health services in many countries"². This has been reported in every regional meeting since 1980, but few improvements have been made thus far. The trust in immunization programs could soon be jeopardized. A current WHO/UNICEF joint statement⁷ declares "immunization is at risk" and presents pledges for injection safety from 51 countries.

Reusable Syringe Practice is Relatively Complex and Expensive

Often, reusable syringe-needles are mistakenly believed to be cheaper than disposables. A study in Bangladesh revealed that the cost of reusable syringes is four times more per injection than disposable syringes, when sterilization and materials are taken into account.

Correct sterilization also requires effective training and reliable worker education and discipline. Maintaining sterility of equipment during service delivery in the field is a problem: A WHO study on injection safety revealed that 74% of health workers did not know, or did not answer, if the syringes and needles were sterilized between use¹.

Conventional Disposable Syringes Are Being Reused

Conventional 'throw-away' syringes remain usable after injections because disposal again relies on personal education, will, and discipline. A WHO study on injection safety¹ revealed that for reasons of economy, 88% of health workers reused disposable syringes. A syringe could be reused up to 230 times³.

Y

They all advocate such
a Syringe but won't
Answer Mail

Doctor Hartsock staes prove
it. Put a hundred thousand or more
more into use, show the decline
in Spread of Aids.

Great except I can't produce
the required amount, nor can
afford such a study.

To the Editor: The transmission of blood-borne diseases such as HIV infection and hepatitis B often occurs in a chain from person to person. The accidental or deliberate reuse of unsterilized needles or syringes is a critical link in the chain. The spread of AIDS among intravenous drug users, their sexual partners, and the babies born to them constitutes the fastest-growing portion of the HIV epidemic in the United States. In countries where needle sharing is common among drug abusers, there is a high risk of such accelerated spread of AIDS and hepatitis B.¹ Because of pervasive needle sharing within the intravenous drug culture in the United States, even low-seroprevalence communities are potentially vulnerable to a high level of spread of HIV, such as occurs in New York City.²

Some success has been reported by educational programs seeking to stop needle sharing and from the distribution of bottles of bleach to encourage addicts to clean their syringes between uses.³ Needle-exchange programs, in which addicts are encouraged to trade old syringes and needles for new ones, have been tried in other countries and on a limited basis in the United States. These programs have shown some potential for success, but the results are uncertain at this time.^{4,5}

In developing countries, AIDS and hepatitis B are also spread by the repeated use of inadequately sterilized syringes for legitimate medical purposes. Economic incentives may thwart attempts to dispose of "disposable" syringes, and adequate sterilization between uses may be logistically impossible. A long process of education and of the provision of resources will be necessary to help break this chain of transmission.

Control of HIV infection lends itself to a technological solution. The development and widespread production of a syringe truly designed only for one-shot use could break chains of infection dependent on syringe reuse. Such a form of technology could reduce transmission by curtailing illicit reuse, averting inappropriate reuse in developing countries, and reducing risks of accidental reuse for legitimate medical applications in developed countries. The non-reusable syringe is not a complete answer, but it is critical to reducing the unacceptably high transmission rates for HIV infection and hepatitis B. The development of a non-reusable syringe is now feasible. It is currently estimated that 200 different designs for non-reusable syringes, based on 10 distinctly different concepts, are under development in the United States and abroad.⁶ Some products have been licensed to commercial manufacturers, but no decisions to manufacture have been made. Since 1980 the World Health Organization has been approaching developers and manufacturers to elicit their interest in adapting needle and syringe technology for use in immunization programs in the developing world.⁷

The good news that it is safe and economically advantageous for diabetics to reuse syringes is offset by research in the United Kingdom showing that half the syringes recovered from drug abusers are made to inject insulin.^{8,9} This is probably also true in the United States, where the number of syringes used is staggering. A 1200-bed hospital uses about 4 million syringes and 1.6 million disposable needles per year.¹⁰ The United States uses about 2.5 billion syringes per year. There are various uses for syringes, and no single design yet appears appropriate for all uses. Research and development to create syringes that meet as many needs as possible should be encouraged.

It is time to open debate on a national policy that takes advantage of the development of the single-use nonreusable syringe. Syringes

bought with federal funds could be required to be nonreusable by a given date. Voluntary adoption of the plan by the major manufacturers, with federal subsidies or tax breaks to underwrite retooling and initial production costs, could be considered. Most syringes now manufactured are disposable and meant for one use only. They should be made for use only once. This is not a call for a major change in the philosophy and policy of syringe production, but rather a reinforcement of the intent behind current safe, disposable syringes. It is possible to make disposable syringes truly disposable.

MICHAEL E. SAMUELS, DR.P.H.
University of South Carolina
School of Public Health

Columbia, SC 29208

C. EVERETT KOOP, M.D., Sc.D.
111 Michigan Ave, N.W.

Washington, DC 20010

PETER I. HARTSOCK, DR.P.H.
National Institute on Drug Abuse

Rockville, MD 20857

Laurence Nixon
117 Gamage Ave.
Auburn, ME. 04210
April 18, 1997

Unique Management Enterprises Inc.
Attn. Mr. Anthony Vallelunga
213 Schoolhouse Road
Albany, NY. 12203-1506

Dear Mr. Vallelunga,

I am an RN at a VA Hospital in the North Country and have been there for more years than I care to admit. In this time I have given numerous injections with all sizes and brands of syringes. I recently had the opportunity of examining the new all purpose syringe that your company hopes to put into production. I can, as a long time nurse, feel that this syringe is without a doubt needed. Being able to perform as a syringe and still not being able to be refilled adds a dimension that other syringes lack. Pharmacist fear selling a syringe that can be used multiple times. I would make a great syringe, in most and many immunization programs. Keeping the needle from being reused is a great asset in the needle exchange programs.

Placing this type of syringe in drug stores will allow the addict to buy their own which would take responsibility off the backs of tax payers. I can only wish you all the luck and success in the world in bringing it to market. Without a doubt, the *All Purpose Syringe* will save lives and money.

Sincerely,


Laurence Nixon

THE WHITE HOUSE
WASHINGTON

January 17, 1994

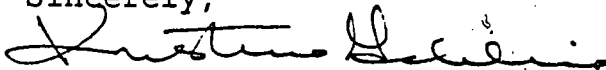
Anthony J. Vallelunga
209 Schoolhouse Road
Albany, New York 12203-5956

Dear Mr. Vallelunga

Thank you for your letter of December 21, 1993, and the attached video providing information about your One Time Use needle and syringe. Should it be able to live up to your expectations and pass the scrutiny of the Food and Drug Administration, it certainly seems to have the potential to reduce HIV exposures.

I am supportive of innovations which are demonstrated to have the potential to reduce the spread of AIDS. I wish you well in your efforts to finance additional development.

Sincerely,



Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

I hope you won't turn out to be a M's Gebbie

**Administration studies
needle exchange plan**

WASHINGTON — The Clinton administration is studying whether to allow federal funding of needle exchange programs to block the spread of AIDS among drug abusers, AIDS policy coordinator Kristine Gebbie said Wednesday.

Gebbie wouldn't speculate when a decision would be made, but told a meeting of the nation's mayors here that they don't have to wait for one.

"What makes a difference is local commitment," Gebbie told the AIDS Task Force of the U.S. Conference of Mayors.

Intravenous drug users are at high risk for catching the HIV virus that causes AIDS. About one-third of U.S. AIDS patients are drug users or sex partners or children of users.

Schen. G02 1/27/94

responded in 1987 to a request by the then Surgeon General C. Everett Koop to expedite the review of patent applications for non-reusable needles and syringes; by March, 1990, approximately 100 patents had been recorded.

29 devices were submitted for discussion at the conference. They included devices with protective features. Such features have been developed to protect health-care workers against needlestick injuries, but were included in the conference agenda because they might be incorporated into SD devices. General concepts for making instruments non-reusable include: (1) the use of a hydrophilic polymer that swells shortly after the injection to block the lumen of the syringe or needle; (2) the insertion of valves into needle hubs and luer tips to allow only one filling and emptying of the barrel; (3) the design of pistons or plungers that break apart or lock after one use; and (4) the incorporation of a mechanism to ensure that a device cannot be reused until it has been heat sterilised.

Peter Evans said that several devices have been successfully field tested for EPI use. Contracts for the first 80 million SD vaccination syringes have been placed by UNICEF, with delivery starting in early 1992. Different safeguards and specification would be needed for SD syringes for use by IDUs or for other medical uses, said Evans. The major requirements are shown in the table.

DESIGN REQUIREMENTS OF SELF-DESTRUCTING SYRINGES FOR DIFFERENT SETTINGS

Design requirement	Setting			
	Immunisation programmes	Medical institutions	Home health care	Injecting drug users
Fixed needle acceptable	Yes	No	Yes	Yes
Choice of needle necessary	No	Yes	No	No
Fill to fixed volume	Yes	No	No	No
Reverse direction of plunger	No	Yes	No	Yes
Remove air	Yes	Yes	Yes	Yes
Aspirate for blood	No	Yes	No	Yes
Anti-needle-stick protection	Yes	Yes	Yes	Yes

Don C. Des Jarlais of Beth Israel Medical Center in New York City warned that, unless adequate supplies of SD syringes are provided, needle-sharing of remaining multiple-use instruments and the use of jury-rigged equipment (such as needles glued to the tips of medicine droppers) might actually increase, thus increasing transmission of HIV and other blood-borne organisms. His colleague Bruce Stepherson, of Narcotics and Drug Research Inc in New York City and a former IDU, also pointed out that syringes that did not enable booting (repeated aspiration and reinjection of blood) are unlikely to be accepted by addicts, so SD instruments should be designed and developed in consultation with IDUs. He disagreed with the view that SD syringes will not have the desired effect because IDUs like to share syringes as a social event. They share out of necessity, he said.

Janine Jagger, of the University of Virginia Medical Center in Charlottesville, stressed that the anti-needlestick feature should be provided not only in SD syringes meant for use in hospitals and clinics but also in those intended for use by IDUs and vaccination programmes. If SD syringes were introduced for IDUs and vaccination programmes, the number of discarded syringes would increase substantially, so protective features would be needed to safeguard the public.

Commissioner of Health for the City of New York and now Dean of the School of Public Health at the University of Minnesota, thought that in resource-poor nations replacement of sterilisation (of syringes designed to be reused) by SD syringes might be "foolish". However, Dr Vadim Pokrovsky of the Soviet Union, who described how reuse of unsterilised needles and syringes in his country had led to the spread of HIV infection, argued that SD syringes might be appropriate for health-care systems in areas where proper sterilisation cannot be assured despite educational efforts.

The meeting ended with agreement that a group be set up to encourage communication between inventors, manufacturers, public health researchers, and administrators, and to encourage WHO or another appropriate agency to oversee the technical development of SD instrumentation to prevent needle-sharing among IDUs. A follow-up conference was proposed and the suggestion was that it be held in conjunction with the 1992 International AIDS Conference.

The Conference was supported in part by the United States National Institute on Drug Abuse, Becton Dickinson, and the Consolidated Edison Company of New York.

New York University School of Medicine,
New York, USA

Michael Marmor

National Institute on Drug Abuse,
Rockville, Maryland

Peter Hartsock

Our syringe meets all the requirements

Health Watch

Men at work

The golf links lie so near the mill
That almost every day,
The children can look out from work
To see the men at play.

Sara Cleghorn's bitter quatrain is particularly apt these days as the plight of the children of the world is repeatedly urged upon us in pictures and words, without apparent effect. We see the dreadful portraits of starvation; we read the tales of epidemics of preventable disease, poverty, and homelessness in which the children are centrally featured; and we comfort ourselves that these are the problems of what used to be called the third, or sometimes the fourth, world—of countries that lacked a viable infrastructure, stable government, and the capability for social programming. What then does it mean when we find serious deprivation in the world's most prosperous, technically advanced, economically developed country? In a report from a Senatorial Commission headed by the West Virginia Senator John D. Rockefeller IV, *Beyond Rhetoric*,¹ the United States of America is described as failing in its obligations to children. The report is not subtitled *J'accuse!*, though it might well be. It labels itself A New American Agenda for Children and Families, politely finessing any evidence of neglect, racism, or class bias in the mistreatment of children. The report glosses over the failings with upbeat recommendations, omitting the glaring figures of wretched



R. Scott Hitt, M.D.
Diplomate, American Board of Internal Medicine

Pacific Oaks Medical Group
150 N. Robertson Boulevard, Suite 300
Beverly Hills, CA 90211
Phone: 310.652.2562 Fax: 310.652.2843

August 9, 1995

The Unique Needle
Management Enterprises, Inc.
209 Schoolhouse Road
Albany, NY 12203-5956
Attn: Anthony Vallelunga

Dear Mr. Vallelunga:

Thank you for send the information on this new product. This obviously could be major help in preventing new HIV infections. Please notify me as soon as the FDA approves this product.

Sincerely,

R. Scott Hitt, M.D.

RSH/ne

The F.D.A Approved it, But he then did nothing

06/07/98

11:37

FAX to BOB HATTOY

Shalala, you should resign. You'll do less harm to PWAs.

The first day of April could have been a turning point in ending the AIDS epidemic. That was when Congress's freeze on secretary of health Donna Shalala's power to lift the ban on needle exchange ended. In the week prior to the deadline, it looked like she and President Clinton would finally do what scientists, researchers, public health experts and activists had long pleaded for: Lift the ban. Shalala scheduled a press conference for a big-news Monday, and her office leaked word of the long-overdue announcement. White House staffer Marcia Scott excitedly told F.O.B.-with-AIDS Bob Hattoy, at a chance grocery-store meeting, that "the president's going to do the right thing!"

On the weekend before the planned announcement, General Barry McCaffrey, the U.S. drug czar, sat next to the president on a plane back from Chile, and had his ear for several hours. McCaffrey has had a Swedish-like hold on the president's drug policy for years. He adamantly opposes needle exchange. Sources report that he threatened to resign if the ban was lifted or to denounce Clinton, accusing him of promoting drug use. Unbelievably, McCaffrey, a Clinton appointee, had already alerted anti-Clinton members of Congress to mobilize their forces to maintain the ban.

On Sunday, after Clinton and McCaffrey's return, word spreads that Shalala's press conference is canceled. At noon on Monday, AIDS Policy Office staffer Daniel Montoya, San Francisco AIDS Foundation's Regina

Aragon, Bob Hattoy and others hunker down in AIDS czar Sandra Thurman's office to strategize. They fear that Clinton's AIDS legacy will

S.O.S.

be defined by his refusal to take this simple, cheap, life-saving step. Thurman gets a call from senior Clinton advisor Rahm Emmanuel. He tells her that the White House has decided to keep the ban in place. Frustrated, Thurman urges more consideration. Former ballet dancer Emmanuel turns a nasty pirouette: "Fuck you!" he yells at Thurman. "I didn't call to argue with you! I called to tell you what to say to the press!"

Thurman, refusing to toe the administration line, goes home. Shalala has her press conference, first affirming that needle exchanges save lives while not increasing drug use, and then defending the ban, with NIH head Harold Varmus and new surgeon general David Satcher looking on. *The New York Times* reports that both doctors "shifted uncomfortably in their seats as reporters peppered Dr. Shalala

with questions, although none publicly disagreed about it." But Scott Hitt, Clinton's defender-in-chief as head of his AIDS advisory panel, has had enough. He tells the *Times*: "At best this is hypocrisy. At worst, it's a lie. And no matter what, it's immoral." Thurman declines comment.

I strongly disagree with General McCaffrey's position on needle exchange and, for that matter, the entire failed approach to the so-called war on drugs. But one thing no one can disagree with: McCaffrey knows the power of a high-level appointee's threatened resignation or public denouncement. And he was bold enough to play that card. Sadly, on the issue of needle exchange, the most powerful players on our side never showed that level of courage or effectiveness.

For better or worse, history will likely remember Bill Clinton as good for the gay lobby. Yet in terms of HIV prevention right now there is no issue more urgent than needle exchange. Not gay marriage. Not gays in the military. Not the employment nondiscrimination bill. Decisions made today about whether to lift the ban on needle exchange and to end content restrictions on public AIDS education literally determine if people live or die. Let's hope that Clinton's modestly supportive (albeit failed) initiatives on gay issues are never confused with his record on AIDS, which is one of cowardice, opportunism, callous disregard and cynical dismissal. It is a record of shame, and indefensible.

Everyone in politics with a conscience has a limit beyond which they cannot rationalize actions counter to their own personal morality. For those who care deeply about AIDS, this latest knife in the heart of HIV prevention must surely be the last straw.

In the end Shalala did urge Clinton to lift the ban. Yet her 11th-hour support is too little, too late. Donna, for six years, we've reasoned, begged and screamed for you to exercise leadership on this issue. Instead, most of that time, you took a walk. Now that your boss has barred you from doing what you know is right, you should resign. Go run for governor; go write your book and get rich. You'll do less harm to PWAs or people at risk that way.

A final irony. On the evening of the announcement, Shalala attended a New York City gala for the International Women's Health Coalition, a leading advocate for sexual and reproductive rights in developing countries. Chatting and toasting with the elite of the feminist health movement, Shalala gave no sign that earlier in the day she had selected thousands of women and children for death from dirty needles. Neither did anyone else in the room. ■



Alan D. Strub

PHOTO: WILLIAM HARRIS

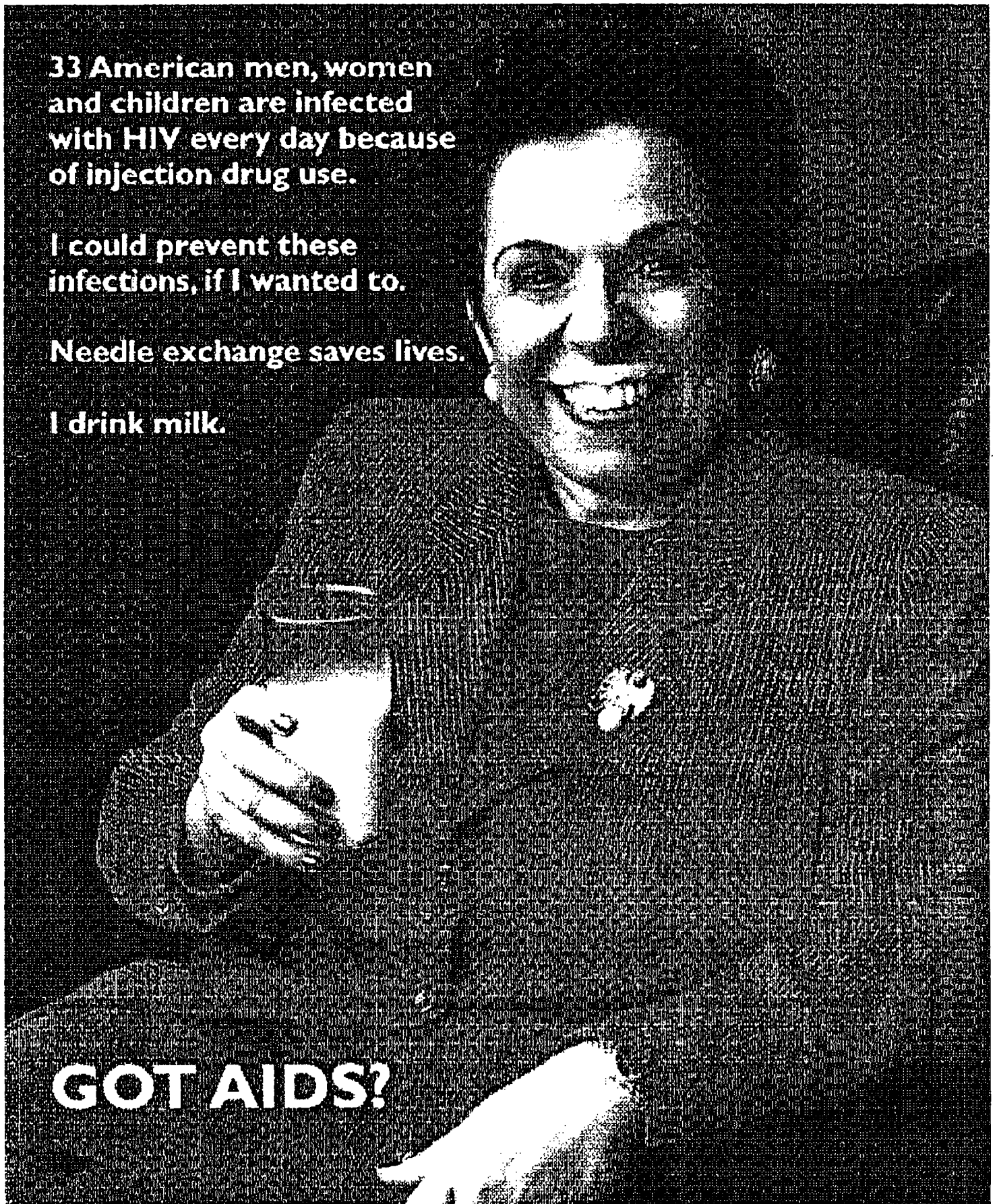
**33 American men, women
and children are infected
with HIV every day because
of injection drug use.**

**I could prevent these
infections, if I wanted to.**

Needle exchange saves lives.

I drink milk.

GOT AIDS?



DRAFT

WHEREAS, on December 6, 1995 at the White House Conference on HIV/AIDS, the President of the United States set the national goal of "(reducing) the number of new (HIV) infections each and every year until there are no new infections," and

WHEREAS, injection drug use annually accounts directly for approximately half of all new HIV infections in this country, and

WHEREAS, injection drug use also plays a major role in sexual partner and perinatal transmission of HIV, and

WHEREAS, numerous scientific studies have concluded that needle exchange programs reduce new HIV infections without encouraging drug use, and

WHEREAS, Secretary of Health and Human Services Donna Shalala has the authority to certify that needle exchange programs meet the obligatory tests prescribed by law and to develop standards for the use of federal funds to support needle exchange programs in cities and states which choose to implement such programs, and

WHEREAS, despite repeated assurances that she was "following the science," the Secretary has ignored the overwhelming scientific evidence presented by government researchers (including the consensus conference of the National Institutes of Health) about the efficacy of these programs, and has refused to make the necessary certification and to lift the federal funding prohibition, and

WHEREAS, failure to act results in needless new infections of HIV, Hepatitis B and Hepatitis C, with the associated increases in human suffering and economic costs, and

WHEREAS, by failing to act the Secretary is seriously impeding the successful implementation of the President's stated goal of reducing the number of new HIV infections until there are none, and

WHEREAS, the pattern of inaction, misrepresentation, disingenuous communication, inconsistent messages, and broken promises on this subject by the Department of Health and Human Services has seriously eroded the Secretary's and the Administration's credibility on all AIDS prevention and related public health matters, and

WHEREAS, by failing to act the Secretary is directly contributing to increased preventable HIV infections, thereby abdicating her responsibility as the nation's chief public health officer,

THEREFORE, BE IT RESOLVED THAT the Presidential Advisory Council on HIV/AIDS urges the President to direct the Secretary of Health and Human Services to immediately certify the efficacy of needle exchange programs in preventing HIV infection while not encouraging drug use; to take such other and further steps as are necessary to accomplish his stated HIV/AIDS prevention goal; and if she fails to expeditiously take such action, to ask for her immediate resignation.

8TH STORY of Level 1 printed in FULL format.

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Chicago Tribune

March 26, 1998 Thursday, NORTH SPORTS FINAL EDITION

SECTION: COMMENTARY; Pg. 21; ZONE: N

LENGTH: 821 words

HEADLINE: THE CHILDREN CLINTON NEGLECTS

BYLINE: Steve Chapman.

BODY:

We know Bill Clinton cares deeply about children because he tells us so. Hardly a day goes by that he doesn't unveil some new program to improve the lot of the little ones. Just this week, he's been in Africa proclaiming his determination to help even kids living half a world away "because we want to see the light that is in these children's eyes forever, and in the eyes of all other children."

Well, maybe not all other children. Back here in America, hundreds of kids are born every year infected with the virus that causes AIDS. The president has the power to take action that would prevent many of these infections and save the lives of a lot of children who have not yet been born. But year after year, he has refused to lift a finger on their behalf.

Once known as a gay men's disease, AIDS is increasingly an affliction of drug users. Every day, 33 Americans are infected with the virus because they use a contaminated syringe to inject themselves with illicit drugs--or because they are the sexual partners or the offspring of someone who did. The most tragic cases are the infants. Between July 1996 and June 1997, 552 babies emerged from the womb already infected by their mothers. Most of the mothers either used drugs intravenously or had sex with a user.

Hard-hearted types can say that gay men are to blame when they contract AIDS through unsafe sex or that heroin addicts are to blame when they use dirty needles to do something that is against the law. But they can't very well blame newborns for getting the disease. Infants are in no position to take preventive measures. If they're to be spared the virus, someone else has to take preventive measures for them.

The simplest one is a blindingly obvious idea known as needle exchange. AIDS activists have found that if you give drug users access to sterile syringes, lo and behold, many decide they would really prefer not to risk their lives just to get high. Needle-exchange programs let them trade their old, dirty needles for new, sterile ones, thus preventing the virus from making the jump from one addict to another.

These programs have been around for more than a decade, and a wealth of experience has proven their value. In 1995, a panel of experts commissioned by the National Academy of Sciences concluded that "well-implemented needle-exchange programs can be effective in preventing the spread of HIV and do not increase the use of illegal drugs." Last year, a report issued by the National Institutes of Health said, "There is no longer any doubt that these

Chicago Tribune, March 26, 1998

programs work."

A 1997 study in Montreal is cited by critics because it found that one needle-exchange program appeared to raise the HIV transmission rate. But the scientists who conducted the study said it should not be interpreted as evidence that needle exchange doesn't help. And the American Journal of Epidemiology, which published their report, accompanied it with an editorial saying that what drug users in Montreal need "is not less needle exchange, but more."

The issue has been settled beyond serious doubt. Yet this is how much the federal government spends on AIDS prevention every year: \$634 million. And this is how much of the money goes to finance needle exchange: zero.

The law says federal funds cannot be used in these programs--unless the president wants them to. As of April 1, all he has to do is direct his Health and Human Services secretary, Donna Shalala, to certify that needle exchanges slow HIV transmission and do not encourage drug use--to certify, in short, what everybody knows. The president's own advisory council on AIDS recently urged him to lift the ban. White House AIDS adviser Sandra Thurman agrees.

But with each new call for him to show some courage, the president has remained in hiding. An HHS spokesman says Shalala is still reviewing the scientific evidence. That makes about as much sense as reviewing who won the 1998 Super Bowl: You can rerun the videotape as many times as you want, but the score always comes out the same. Apparently her review won't be done until Jan. 20, 2001, at which point it will become someone else's headache.

Why is the administration stalling? Partly because the president doesn't want to give Republicans a chance to portray him as soft on drugs. And partly because he doesn't want to have to overrule White House drug czar Barry McCaffrey. Gen. McCaffrey thinks funding needle exchange would give kids the idea that we don't really object to drug use--which is like saying that allowing alcoholics to get treated for liver ailments under Medicaid amounts to an endorsement of drunkenness.

Clinton clearly would like to be remembered as the president who did more than any other to help children. But when it comes to the kids whose lives could have been saved by needle-exchange programs, he will be remembered for doing nothing.

LANGUAGE: ENGLISH

LOAD-DATE: March 26, 1998

Boston Globe 4/1/98

Squeamish on needle exchanges

Boston and Cambridge have had a needle exchange program for four years now, and despite opponents' warnings, intravenous drug use has not increased as a result. What has happened is that drug addicts have reduced their chances of getting and spreading AIDS while increasing their chances of getting into treatment. According to the Massachusetts Department of Public Health, about 600 addicts enroll in the program each year, receiving not just sterile needles but drug education, HIV prevention materials, and referrals to detox centers or other treatment options. Many addicts simply drop in for the needles and skip the counseling, but the program is a crucial bridge to treatment when they are ready for it.

At the federal level, a 1992 congressional ban on funding needle exchange programs expired yesterday. Unfortunately, the Clinton administration has not taken the lead in restoring funds for this life-saving plan. The administration is split, with drug czar Barry McCaffrey opposed, Clinton's AIDS adviser, Sandra Thurman, in favor, and Secretary of Health and Human Services Donna Sha-

lala - who is charged with deciding the question - determinedly straddling the fence.

McCaffrey argues that the government should be sending an unambiguous "no use" message and that the money is better spent on treatment. Certainly needle exchange programs cannot be a substitute for drug treatment or prevention. But they are a proven means of AIDS prevention. Sources as reliable as the Centers for Disease Control, the National Institutes of Health, and the General Accounting Office have concluded that needle exchange efforts reduce HIV transmission without increasing drug use. Still the administration calls for more study.

In the meantime, needles are speeding AIDS infections. Intravenous drug users, their sexual partners, and their children represent the largest segment of people with AIDS in Massachusetts: 46 percent. Fortunately, needle programs are cheap, and local funds and private donations can fill in. But the real message the Clinton administration is sending is that clean-needle programs are somehow tainted. That is not just wrong; it is deadly.

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Northampton
Provincetown*yes***MICHIGAN**Detroit
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Ferndale
Kalamazoo*no***MINNESOTA**

Minneapolis (3)

*yes***MISSOURI**

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OHIO *no*
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OREGON *maybe*
Portland

PENNSYLVANIA *direct*
Philadelphia

RHODE ISLAND *maybe*
Providence

TEXAS *no (direct (Houston))*
Austin
Dallas

WASHINGTON *yes*
Everett
Mt. Vernon
Olympia (2)
Seattle (3)
Tacoma (2)
Vancouver
Yakima

WISCONSIN *yes*
Clinton
Madison
Milwaukee

WASHINGTON, DC *yes (direct)*
Washington, DC

PUERTO RICO *no (direct)*
Bayamon
Hato Rey
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TOTAL: 27 states; Washington, DC; Puerto Rico

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DEBRA J. SAUNDERS -- Needles, Pinheads And Politicians

DEBRA J. SAUNDERS

Tuesday, April 28, 1998

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URL: <http://www.sfgate.com/cgi-bin/article.cgi?file=/chronicle/archive:1998/04/28/ED32729.DTL>

SAN FRANCISCO'S needle exchange program has been an unqualified success: The city has not reported a single case of pediatric AIDS in three years. And there's not exactly a shortage of junkie moms in San Francisco either.

HIV infection among women is low. Nationally, 14.9 percent of adults with HIV are women. In San Francisco the figure is about 3.2 percent. "One of the reasons is that we've had needle exchange from early on in San Francisco," Derek Gordon of the San Francisco AIDS Foundation opined. The needle initiative prevented HIV from spreading through the needle community. For the bargain price of about \$500,000 annually, the program has spared the lives of children born to drug shooters.

Last year I spent an evening at a local exchange for women. A stream of women -- some down and out, a few remarkably smart looking -- turned in 1,615 used needles. Workers and volunteers in turn provided the women with 1,615 clean needles, drug treatment referrals for the rare user who asked, juice, food, vitamins, medical checks and a play area so that children wouldn't have to watch their moms clutching needles.

A lesson learned: Even self-destructive drug addicts can care enough about their health to save their needles up for Thursday nights, gather those of their friends and schlep to Valencia Street to trade them in for clean paraphernalia.

Amazing grace, after I wrote a column about the needle exchange, I didn't receive a single complaint from a neighbor. That's how well it was run. (As an aside, there is another exchange a block from The Chronicle. I'm a quiet needle exchange neighbor myself.) Having written the above, this is where I am supposed to trash President Clinton for not keeping his campaign pledge to earmark federal funds for needle exchanges. This is where I'm supposed to excoriate Health and Human Services Secretary Donna Shalala as well, because Clintonia didn't change its policy despite hints that a shift was coming. I can't. I see the success of San Francisco's needle exchange -- and I cringe when I think of what would happen to it if federal funds entered the picture. Federal funds inevitably come with strings attached. I shudder at how Uncle Sam could botch a good program: paperwork, reporting requirements, a phone book-size code on which disability-friendly and transit-accessible buildings could be used, staffing regulations, motor voter, formulas for gender, age and ethnic representation. Ugh.

You know that if this Congress would approve funding only for an exchange program if members could add something truly counterproductive or stupid -- like, require clean-needle recipients to watch a DARE film.

(And it's not just because Congress is craven. It's also because members understand the need to take their constituents' legitimate concerns to the table when they fund any program.)

Which presents a point that needle-exchange supporters generally seem to have forgotten: Not every good deed gets federal money. Some things are better handled by private charities and local institutions. Needle exchange doubtless is one of them. What's more, with zillionaire George Soros' second annual donation of \$1 million to needle programs, there is reason to believe that private largesse can continue to carry the load.

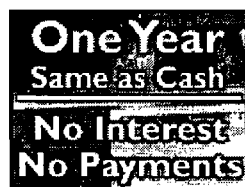
Clinton critics have faulted the president for putting politics ahead of lives. But if they

really want to save lives, they might lay off Clinton and instead fight for funding of smart local programs.

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Playing Politics With the Public's Health

By Judy Mann

Wednesday, April 29, 1998; Page D15

President Clinton has decided against using federal funds to support needle exchange programs that have been shown to slow the spread of AIDS without encouraging the use of intravenous drugs.

Hello, politics; goodbye, public health.

Clinton was leaning heavily toward some kind of federal support for needle exchange programs after studies found that free, clean needles could save 33 people a day from getting HIV by sharing dirty needles. The plan had the backing of Health and Human Services Secretary Donna E. Shalala, and she reportedly had the support of Vice President Gore, along with most of the administration's senior health officials.

Clinton's mind, according to news reports, began to change when his political advisers warned that the political costs of backing such a controversial program were too high. They argued that it would only invite another showdown with Republicans who control the Hill, and who could overturn the decision.

Conservatives argue that giving free needles to addicts sends the wrong message of condoning illegal drug use. Barry R. McCaffrey, the retired general who heads the Office of National Drug Control Policy, also warned that needle exchanges would undermine the administration's commitment to fighting illegal drugs.

The upshot of all this was a last-minute change of heart by Clinton and a sort of loony mixed-bag announcement that although science has demonstrated that the programs work and don't increase drug use, buying needles for addicts sends the wrong message. Might save lives, but sends the wrong message.

Are we truly expected to think that in this era of mass communications, in which billions of dollars are spent each year on refining advertising messages so that we pick a particular brand of toothpaste over another, we can't develop a message about needle exchange programs? That we can't make it very clear to users that the purpose of the program is to stem the spread of HIV, not to make it easier for them to get stoned? Surely counselors involved in needle exchange programs could make that clear to addicts, even if no one can make it clear to conservatives.

Within days of the administration's fold on needles, there came a report from the Centers for Disease Control and Prevention that the

HIV epidemic has continued to spread throughout the population, with women and minorities increasingly at risk, as are young men and women ages 13 to 24.

And guess where else there continue to be high rates of new infections? That's right: among intravenous drug users. Male homosexual sex caused 32 percent of the cases diagnosed from 1994 to 1997, while injecting drugs and heterosexual sex each accounted for 18 percent. Most of the heterosexual transmissions involved women having sex with infected male drug users. Drugs and homosexual sex accounted for an additional 4 percent of cases. All told, drugs may be in play in nearly as many cases of HIV transmission as male homosexual sex.

According to the studies cited by the administration, free clean needles save 33 people a day from getting HIV, which means the program could save 12,045 people a year from HIV infection, which ultimately results in AIDS. That is a significant number of people whose lives could be saved.

AIDS and breast cancer advocates often are compared for their lobbying skills and political clout. But there is one huge difference between the two diseases: We don't know what causes breast cancer, and we do know what causes AIDS. To me, this makes it all the more unconscionable not to take whatever measures are available to protect people from the disease.

But people whose business is public health aren't running the show. Drugs are considered a criminal problem, and addicts and dealers are bread and butter for the country's enormous law enforcement lobby. Drug addiction is still not widely viewed as an illness that needs to be treated, but as behavior that needs to be punished.

Our prisons are bulging with drug offenders: More than a million people a year are busted for drug crimes, more than 60 percent of federal prisoners are drug offenders, and almost 25 percent of state prisoners are. We have 1 million people in state and federal prisons, and an additional half-million in local jails. We've gone from spending \$1 billion a year on the "war on drugs" that President Ronald Reagan launched more than 15 years ago to a \$16 billion-a-year war chest, of which two-thirds is spent on law enforcement and ineffectual efforts to eliminate foreign drugs and only one-third is spent on treatment and prevention. Budgets for agencies involved in drug efforts have soared, and the agencies have acquired all sorts of razzle-dazzle technology. They've busted some big overseas networks, shut down money laundering operations and nabbed some big operators. What they haven't done is reduce the flow of drugs into the United States or the production of them here.

So when administration officials, and conservatives, talk about sending the wrong message in the war on drugs by offering clean needles to addicts, one can reasonably ask, "What war on drugs?" We have spent about \$290 billion on a war that hasn't worked. Cocaine and heroin are cheaper than ever before. Teenage use of marijuana has doubled since 1990.

The military model has failed to stop the supply. We ought to be shifting our resources over to public health officials who can treat

addictions and reduce the demand. We ought to stop talking war and start talking treatment.

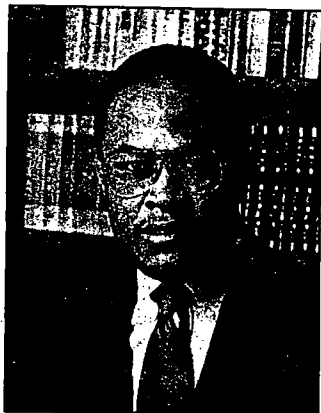
Meanwhile, it is just plain cruel to sacrifice a needle exchange program that can save thousands of lives a year to a politically powerful drug war lobby that has failed repeatedly to deliver.

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Best Practices

Needle Exchange Programs Benefit Everyone



Baltimore Mayor Kurt L. Schmoke

Drug abuse is at the root of a host of problems that threaten the well being of our city, including crime, child neglect, and neighborhood blight. Because 80 percent of new AIDS cases in Baltimore are linked to injection drug use, drug abuse is also the City's biggest public health threat.

Health Department officials estimate that there are approximately 43,000 heroin and cocaine addicts in Baltimore. Despite this staggering problem, Baltimore City currently has only 5,700 drug treatment slots. This means that we are only able to help about 16,000 addicts a year. What's more, there is up to a four-month wait for drug treat-

ment. And drug addicts are not patient people. When they finally take the step to get help, they need that help now. Clearly, we must do more to meet this pressing need.

The case for drug treatment is strong. Respected research studies have found that treatment is cost-effective and that those who are in treatment or who complete treatment are much less likely to commit crimes or engage in high-risk behavior. Such individuals also are much more likely to become productive members of society than their drug using counterparts.

In addition, we know that it is impractical to jail every person who has a drug habit. Maryland's prisons are already overcrowded with people charged with various drug offenses, and we know that young black men are disproportionately represented in this population. After serving their sentences, these young men not only must forever bear the label "ex-con," they also are likely to leave prison with the yearning for drugs still intact, and the downward spiral of addiction and addiction-related crime begins anew.

Given these harsh realities, Baltimore has been seeking additional drug treatment funds from the federal government for the last three years — to no avail. The problem is too grave for us to wait any longer for outside funding. That's why I recently moved to create a \$5 million pool of funds, drawn from existing City resources, to enable us to expand drug treatment programs.

These reallocated funds will allow us to provide treatment slots for an additional 5,000 addicts. Most importantly, we plan to use these funds to leverage additional money from local and national foundations, as well as through federal grants, to enable us to treat thousands more. I'm pleased that the Greater Baltimore Committee already has expressed an interest in lending its support to this initiative, and I hope we will be successful in receiving support from other sources as well.

Alongside moving to expand drug treatment, Health Commissioner Dr. Peter Beilenson and I have been working vigorously to win approval from the Maryland General Assembly to extend the City's Needle Exchange Program. The program has been a key weapon in the City's battle against AIDS, the number one killer of Baltimoreans between the ages of 25 and 44. Drug users who share needles account for the vast majority of these

cases.

We launched needle exchange as a demonstration project in 1994, after three years of lobbying the state legislature. The program's authorization runs out this summer, and we are now asking the legislature to make the program permanent. There is no mystery behind this request: needle exchange has been a success.

In launching the program, we wanted to see if giving addicts the opportunity to exchange used needles for clean ones would reduce the transmission of HIV among injection drug users, their sexual partners, and their children. Our experience is showing that it is. Johns Hopkins researchers who recently evaluated the program found that enrolled addicts lower the risk of contracting AIDS by almost 40 percent.

The Needle Exchange Program has also been valuable from a drug treatment standpoint. It provides addicts with counseling and information on drug treatment options and, upon request, places them in drug treatment programs. Some participants who were drawn to the program initially because of the promise of free needles, later used the program as a stepping stone to drug treatment. This is particularly significant because many in the program are what the Health Department calls "harder core addicts," those with long-term addictions and less likelihood of having previously been in drug treatment.

Even those in the program who continue to use drugs have benefited through their participation. Studies show there is a 20 percent reduction in needle sharing and other drug behaviors that put addicts at high risk for AIDS as well. In many ways, then, the program is helping to save lives.

Our most earnest hope is that ultimately all the participants in the program — and every drug addict in Baltimore — will seek treatment. They won't be able to do that if the treatment slots aren't there. My recent plan to almost double the number of drug treatment slots in Baltimore will certainly help. But the City can't meet this pressing need on its own. That is why we are intensifying our efforts to seek more outside support for drug treatment. In seeking that support, our basic message is simple: Drug treatment doesn't just benefit addicts. Helping people break the bondage of drug addiction and become productive, law abiding citizens benefits everyone.

In November of 1993, our task force, known as the Mayors Working Group on Drug Policy Reform, came up with several recommendations:

- Support a needle exchange program
- Support pilot programs in your communities
- Support State legislation exempting needles from paraphernalia laws
- Recommend to the Surgeon General that the federal ban on use of federal funds for needle exchange can be overturned

Expand treatment and linkage of drug treatment to primary care/training requirements

- Seek additional funding for expansion of treatment slots
- seek funds for health clinics to provide methadone maintenance and withdrawal services to those who are opioid dependent
- enable primary care providers to give substance abuse treatment in their own health care settings
- Support the training of primary health care personnel in the diagnosis and treatment of substance abuse problems

Expand Drug Maintenance Options

- Seek a broader distribution of Oral Methadone
- Seek changes in state regulation to raise the upper limit on the magnitude of oral methadone doses
- Seek changes in federal law, allowing for "low threshold" programs of oral maintenance

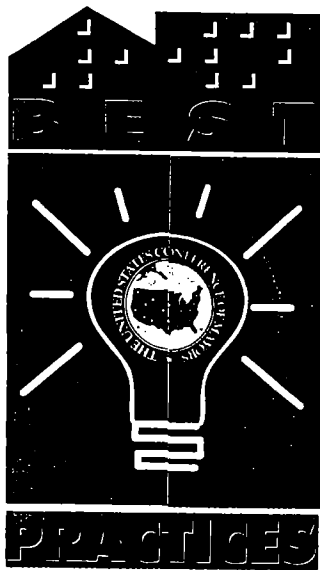
Review Police, Prosecutorial and Judicial Practices

- Review police practices and arrest policies
- Support the creation of a drug court as a mechanism for promoting prosecutorial discretion and court diversion which is consistent with a public health approach to handling drug offenders

Establish a Public Information Campaign

- Conduct a public education campaign designed to inform the public about the failures of current drug control policies

For more information contact Dr. Peter Beilenson, Baltimore Health Commissioner at (410) 396-4387.



Mayors are invited to submit the "Best Practices" of their cities to U.S. MAYOR. Contact Public Affairs at (202) 293-7330 or fax to (202) 293-2352.

FOLLOW-UP TO NEEDLE EXCHANGE DECISION

This provides a list of options to address concerns raised as a result of the needle exchange decision.

Reinforce the Administration's Commitment to Prevention

- Increase funding for HIV prevention at CDC, which received no increase in the FY99 budget (except for a \$5 million earmark from the \$30 race and health line at CDC) - amended budget request? supplemental?
- Increase funding for drug treatment - amended budget request? supplemental?
- Publish scientific report provided to Secretary
- ONAP creates public-private partnership to help support local NEPs

Tell AIDS advocates that HHS scientists will be able to support needle exchange

- NIH and CDC scientists can provide technical support as local communities make decisions about needle exchange
- HHS can prepare technical assistance capacity, materials, and peer support for needle exchange programs (particularly to help them integrate with drug treatment and other health care service providers)

Move the focus of attention to more productive areas

- Radio address or event to coincide with the anniversary of the President's HIV vaccine announcement (May 18)
- Find events related to other issues

Support retention of Secretary's authority to lift ban

VIEWPOINTS

Needle Exchanges Can Save Lives

By Robert Dawidoff

IMAGINE IF YOU were the nation's top public health official and you could save thousands of lives and curb the spread of AIDS with your signature. That is the opportunity facing Secretary of Health and Human Services Donna Shalala. On April 1, she can authorize federal support for needle exchange programs for intravenous drug users and thereby significantly reduce the transmission of HIV.

Intravenous drug users habitually share their hypodermic needles, exposing each other as well as their sexual partners and their offspring to the deadly disease. In an exchange program, addicts turn in their used dirty needles for clean ones.

April 1 date is significant because federal legislation prohibiting federal support of needle exchange expires on March 31. If these programs can be shown to reduce the spread of AIDS without encouraging drug use, then HHS may proceed with the exchange. Needle exchange has been shown to meet these conditions. So what are public health officials waiting for? They must seize this chance to save American lives.

Needle exchange is nobody's ideal solution to the problems of AIDS transmission or intravenous drug use. But there is no doubt that it works. According to studies of five New York City needle exchange programs, the HIV-infection rate was cut by two-thirds. The urgency and effectiveness of needle exchange have been endorsed by the president's own advisory council on AIDS, the American Medical Association, the National Academy of Sciences, the American Public Health Association, the National Commission on AIDS, the U.S. Conference of Mayors and the American Bar Association, to name a few.



Robert Dawidoff is a professor of American history at Claremont Graduate University.

Between 650,000 and 900,000 people in the United States are infected with HIV, and more than a million Americans inject illegal drugs. New medical therapies have reduced AIDS deaths significantly but have no impact on the rate of infection. There is a scientific consensus that clean needles and safer sex significantly reduce the rates. But the focus of public response has been on treatment, not prevention, as if these were competitive goals.

The habitual sharing of needles spreads AIDS among users, their sexual partners and their babies. A large proportion of the estimated 6,000 cases of pediatric AIDS can be traced to shared needles. One third of all AIDS cases and more than half of those involving women result from injections of drugs or having sex with people who do. Fighting drug use is hard enough. When you add AIDS and its transmission, however, the public health system is overwhelmed.

Needle exchange programs safely dispose of used needles. Most programs refer clients to HIV testing and counseling and drug treatment programs. A 1997 study, published in *The Lancet* (a British medical journal), estimated that needle exchange programs might have prevented between 4,400 and 9,700 HIV infections, which would have saved as much as half a billion dollars in health care expenditures. The same study estimated that needle exchange might prevent 11,300 more cases among drug injectors, their sexual partners and their children.

It isn't hard to figure out why the government is not preparing the



Needles: Gary Vukobrat

Newsday 3/24/98

Clean Needles

— Continued from Page A37

public to support needle exchange. Officials seem to have confused saving American lives with saving their own skins.

It may well be that the political consequences of instituting needle exchange will be as contentious as the administration apparently fears. But politics as usual will not stop the AIDS plague. Courageous, professional and mature decisions about public health will. Surely we have learned something from the deadly results of government inaction during the first decade of the AIDS epidemic.

An informed public must make it politically dangerous for the administration not to act on April 1 to save lives. Otherwise a missed opportunity will become a fatal April Fool's joke.

Newsday
3/24/98

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New York City Graphic

Newsday 3/24/98

6:15 A.M.
Dunne

Newsday
3/24/98

Clean Needles

— Continued from Page A37

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NEEDLE EXCHANGE

Ds who voted for Hastert but may be willing to change their vote	Ds who voted against Hastert who may wish to change their vote	Rs who voted against Hastert
Costello (IL) - *	Allen (ME) - ?	Campbell (CA)
Gordon (TN) - C, ?	Boucher (VA) - C	Cooksey (LA)
Green (TX) - C	Brown (CA) - ?, *	Foley (FL)
Hamilton (IN) - *, R	DeGette (CO) - C, *	Frelinghuysen (NJ)
Johnson (WI) - *, ?	Deutsch (FL) - C, *	Ganske (IA)
Klink (PA) - C, *	Eschoo (CA) - C, *	Greenwood (PA)
LaFalce (NY) - *	Evans (IL) - ?, *	Horn (CA)
Lipinski (IL) - *	Furse (OR) - C, R, *	Houghton (NY)
Luther (MN) - *, ?	Gejdenson (CT) - ?, *	Johnson (CT)
10. Karen McCarthy (MO) - *, C	Hinchey (NY) - ?, *	Kolbe (AZ)
McNulty (NY) - *	Hooley (OR) - ?, *	Leach (IA)
Minge (MN) - *	Kind (WI) - ?, *	McCrery (LA)
Oberstar (MN) - *	Kucinich (OH) - ?*	Morella (MD)
Pascrell (NJ) - *, ?	Lampson (TX) - ?	Shays (CT)
Peterson (MN) - *,	Maloney (CT) - ?, *	Thomas (Ca)
Poshard (IL) - HO, *	Manton (NY) - C, *	Young (FL)
Roemer (IN) - *	McGovern (MA) - ?, *	
Strickland (OH) - *, C, ?	Olver (MA) - ?, *	
Stupak (MN) - *, C	Pallone (NJ) - C, *	
Visclosky (IN) - *	Pomery (ND) - ?	

	Price (NC) - ?, *	
	Sawyer (OH)- C, ?	
	Sherman (CA) - ?, *	
	Smith, Adam (WA) - ?, *	
	Snyder (Ark)- ?	
	Stabenow (MI) - , ?, *	
	Tierney (MA)- ?, *	

C- Commerce Committee member

* State has needle exchange program

? - Difficult Race

R- retiring

HO- seeking higher office

House Vote Detail

CONGRESS: 105 **SESSION:** 1**ROLL CALL NUMBER:** 391**RESULT:** Passed**VOTE DATE:** 09-11-97**CONGRESSIONAL RECORD PAGE:** 7233**BILL-AMEND NUMBER:** H.R. 2264 - A028**SPONSOR:** Hastert**VOTE TYPE:** Recorded Vote**QUESTION:** On agreeing to the Hastert amendment (A028)**TITLE:** An amendment to delete the provisions of the bill to allow implementation of hypodermic needle exchange programs, if the Secretary of Health and Human Services determines such programs to be effective in preventing the spread of HIV and do not encourage the use of illegal drugs.

Vote Matrix: H.R. 2264 - A028				
	Y	N	PRESENT	NOT VOTING
Democratic	59	141	0	6
Republican	207	16	0	3
Other	0	1	0	0
Total	266	158	0	9

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House Information Resources

House Votes

Member Response List**Bill Number: H.R. 2264****Congress: 105-1****Roll Call: 391****View: Democrats voting AYE**

Member	ST	CD	Party	Response
Baessler	KY	06	D	AYE
Barcia	MI	05	D	AYE
Bentsen	TX	25	D	AYE
Boswell	IA	03	D	AYE
Boyd	FL	02	D	AYE
Clement	TN	05	D	AYE
Condit	CA	18	D	AYE
Costello	IL	12	D	AYE
Cramer	AL	05	D	AYE
Danner	MO	06	D	AYE
Davis (FL)	FL	11	D	AYE
Doyle	PA	18	D	AYE
Edwards	TX	11	D	AYE
Etheridge	NC	02	D	AYE
Goode	VA	05	D	AYE
Gordon	TN	06	D	AYE
Green	TX	29	D	AYE
Hall (OH)	OH	03	D	AYE
Hall (TX)	TX	04	D	AYE
Hamilton	IN	09	D	AYE
Hefner	NC	08	D	AYE
Hinojosa	TX	15	D	AYE
Holden	PA	06	D	AYE
John	LA	07	D	AYE
Johnson (WI)	WI	08	D	AYE
Kildee	MI	09	D	AYE
Kleczka	WI	04	D	AYE
Klink	PA	04	D	AYE
LaFalce	NY	29	D	AYE
Lipinski	IL	03	D	AYE
Luther	MN	06	D	AYE
Mascara	PA	20	D	AYE
McCarthy (MO)	MO	05	D	AYE
McIntyre	NC	07	D	AYE
McNulty	NY	21	D	AYE
Minge	MN	02	D	AYE

Mollohan	WV	01	D	AYE
Murtha	PA	12	D	AYE
Oberstar	MN	08	D	AYE
Ortiz	TX	27	D	AYE
Pascarell	NJ	08	D	AYE
Peterson (MN)	MN	07	D	AYE
Poshard	IL	19	D	AYE
Reyes	TX	16	D	AYE
Rodriguez	TX	28	D	AYE
Roemer	IN	03	D	AYE
Sandlin	TX	01	D	AYE
Sisisky	VA	04	D	AYE
Skelton	MO	04	D	AYE
Spratt	SC	05	D	AYE
Stenholm	TX	17	D	AYE
Strickland	OH	06	D	AYE
Stupak	MI	01	D	AYE
Tanner	TN	08	D	AYE
Taylor (MS)	MS	05	D	AYE
Traficant	OH	17	D	AYE
Turner	TX	02	D	AYE
Visclosky	IN	01	D	AYE
Wise	WV	02	D	AYE

Information Services	Votes Search
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House Information Resources

House Votes

Member Response List**Bill Number: H.R. 2264****Congress: 105-1****Roll Call: 391****View: Republicans voting NO**

Member	ST	CD	Party	Response
Campbell	CA	15	R	NO
Cooksey	LA	05	R	NO
Foley	FL	16	R	NO
Frelinghuysen	NJ	11	R	NO
Ganske	IA	04	R	NO
Greenwood	PA	08	R	NO
Horn	CA	38	R	NO
Houghton	NY	31	R	NO
Johnson (CT)	CT	06	R	NO
Kolbe	AZ	05	R	NO
Leach	IA	01	R	NO
McCrery	LA	04	R	NO
Morella	MD	08	R	NO
Shays	CT	04	R	NO
Thomas	CA	21	R	NO
Young (FL)	FL	10	R	NO

[Information Services](#)
[Votes Search](#)
House Information Resources

--- NOES 158 ---

<i>Abercrombie</i>	<i>Furse</i>	<i>Morella</i>
<i>Ackerman</i>	<i>Ganske</i>	<i>Nadler</i>
<i>Allen</i>	<i>Gejdenson</i>	<i>Neal</i>
<i>Andrews</i>	<i>Gephardt</i>	<i>Obey</i>
<i>Baldacci</i>	<i>Greenwood</i>	<i>Olver</i>
<i>Barrett (WI)</i>	<i>Gutierrez</i>	<i>Owens</i>

<i>Becerra</i>	<i>Harman</i>	<i>Pallone</i>
<i>Berman</i>	<i>Hilliard</i>	<i>Pastor</i>
<i>Berry</i>	<i>Hinchey</i>	<i>Pelosi</i>
<i>Bishop</i>	<i>Hooley</i>	<i>Pickett</i>
<i>Blagojevich</i>	<i>Horn</i>	<i>Pomeroy</i>
<i>Blumenauer</i>	<i>Houghton</i>	<i>Price (NC)</i>
<i>Bonior</i>	<i>Hoyer</i>	<i>Rahall</i>
<i>Boucher</i>	<i>Jackson (IL)</i>	<i>Rangel</i>
<i>Brown (CA)</i>	<i>Jackson-Lee (TX)</i>	<i>Rivers</i>
<i>Brown (FL)</i>	<i>Jefferson</i>	<i>Rothman</i>
<i>Brown (OH)</i>	<i>Johnson (CT)</i>	<i>Roybal-Allard</i>
<i>Campbell</i>	<i>Johnson, E. B.</i>	<i>Rush</i>
<i>Capps</i>	<i>Kanjorski</i>	<i>Sabo</i>
<i>Cardin</i>	<i>Kaptur</i>	<i>Sanchez</i>
<i>Carson</i>	<i>Kennedy (MA)</i>	<i>Sanders</i>
<i>Clay</i>	<i>Kennedy (RI)</i>	<i>Sawyer</i>
<i>Clayton</i>	<i>Kennelly</i>	<i>Schumer</i>
<i>Clyburn</i>	<i>Kilpatrick</i>	<i>Scott</i>
<i>Conyers</i>	<i>Kind (WI)</i>	<i>Serrano</i>
<i>Cooksey</i>	<i>Kolbe</i>	<i>Shays</i>
<i>Coyne</i>	<i>Kucinich</i>	<i>Sherman</i>
<i>Cummings</i>	<i>Lampson</i>	<i>Skaggs</i>
<i>Davis (IL)</i>	<i>Lantos</i>	<i>Slaughter</i>
<i>DeFazio</i>	<i>Leach</i>	<i>Smith, Adam</i>
<i>DeGette</i>	<i>Levin</i>	<i>Snyder</i>
<i>Delahunt</i>	<i>Lewis (GA)</i>	<i>Stabenow</i>
<i>DeLauro</i>	<i>Lofgren</i>	<i>Stark</i>
<i>Deutsch</i>	<i>Lowey</i>	<i>Stokes</i>
<i>Dicks</i>	<i>Maloney (CT)</i>	<i>Tauscher</i>
<i>Dingell</i>	<i>Maloney (NY)</i>	<i>Thomas</i>
<i>Dixon</i>	<i>Manton</i>	<i>Thompson</i>
<i>Doggett</i>	<i>Markey</i>	<i>Thurman</i>
<i>Dooley</i>	<i>Martinez</i>	<i>Tierney</i>
<i>Engel</i>	<i>Matsui</i>	<i>Torres</i>
<i>Eshoo</i>	<i>McCarthy (NY)</i>	<i>Towns</i>
<i>Evans</i>	<i>McCrery</i>	<i>Velazquez</i>
<i>Farr</i>	<i>McDermott</i>	<i>Vento</i>

<i>Fattah</i>	<i>McGovern</i>	<i>Waters</i>
<i>Fazio</i>	<i>McHale</i>	<i>Watt (NC)</i>
<i>Filner</i>	<i>McKinney</i>	<i>Waxman</i>
<i>Flake</i>	<i>Meehan</i>	<i>Wexler</i>
<i>Foglietta</i>	<i>Menendez</i>	<i>Weygand</i>
<i>Foley</i>	<i>Millender-McDonald</i>	<i>Woolsey</i>
<i>Ford</i>	<i>Miller (CA)</i>	<i>Wynn</i>
<i>Frank (MA)</i>	<i>Mink</i>	<i>Yates</i>
<i>Frelinghuysen</i>	<i>Moakley</i>	<i>Young (FL)</i>
<i>Frost</i>	<i>Moran (VA)</i>	

--- NOT VOTING 9 ---

<i>Bonilla</i>	<i>Gonzalez</i>	<i>Payne</i>
<i>Borski</i>	<i>Hastings (FL)</i>	<i>Schiff</i>
<i>Delhums</i>	<i>Meek</i>	<i>Taylor (NC)</i>

HR 3717 IH

105th CONGRESS

2d Session

H. R. 3717

To prohibit the expenditure of Federal funds for the distribution of needles or syringes for the hypodermic injection of illegal drugs.

IN THE HOUSE OF REPRESENTATIVES

April 23, 1998

Mr. SOLOMON (for himself, Mr. WICKER, Mr. HASTERT, Mr. BARR of Georgia, and Mr. DELAY) introduced the following bill; which was referred to the Committee on Commerce

A BILL

To prohibit the expenditure of Federal funds for the distribution of needles or syringes for the hypodermic injection of illegal drugs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PROHIBITION REGARDING ILLEGAL DRUGS AND DISTRIBUTION OF HYPODERMIC NEEDLES.

Part B of title II of the Public Health Service Act (42 U.S.C. 238 et seq.) is amended by adding at the end the following section:

'PROHIBITION REGARDING ILLEGAL DRUGS AND DISTRIBUTION OF HYPODERMIC NEEDLES

'SEC. 247. Notwithstanding any other provision of law, none of the amounts made available under any Federal law for any fiscal year may be expended, directly or indirectly, to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.'

SEC. 2. CONFORMING AMENDMENT.

Section 506 of Public Law 105-78 is repealed.

END

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
April 20, 1998

Contact: HHS Press Office
(202) 690-6343

RESEARCH SHOWS NEEDLE EXCHANGE PROGRAMS REDUCE HIV INFECTIONS WITHOUT INCREASING DRUG USE

Health and Human Services Secretary Donna E. Shalala announced today that based on the findings of extensive scientific research, she has determined that needle exchange programs can be an effective part of a comprehensive strategy to reduce the incidence of HIV transmission and do not encourage the use of illegal drugs.

Under the terms of Public Law 105-78, the Secretary of HHS is authorized to determine that such programs reduce the transmission of the human immunodeficiency virus (HIV) and do not encourage the use of illegal drugs. The act's restriction on federal funding, however, has not been lifted.

"This nation is fighting two deadly epidemics -- AIDS and drug abuse. They are robbing us of far too many of our citizens and weakening our future," said Secretary Shalala. "A meticulous scientific review has now proven that needle exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs. It offers communities that decide to pursue needle exchange programs yet another weapon in their fight against AIDS."

While the use of federal funds continues to be restricted, and criteria for their use have not been established, Secretary Shalala emphasized that needle exchange programs that have been successful have had the strong support of their communities, including appropriate State and local public health officials. The science reveals that successful needle exchange programs refer participants to drug counseling and treatment as well as necessary medical services, and make needles available on a replacement basis only.

The Administration has decided that the best course at this time is to have local communities which choose to implement their own programs use their own dollars to fund needle exchange programs, and to communicate what has been learned from the science so that communities can construct the most successful programs possible to reduce the transmission of HIV, while not encouraging illegal drug use.

Since the AIDS epidemic began in 1981, injection drug use has played an increasing role in the spread of HIV and AIDS, accounting for more than 60% of AIDS cases in certain areas in 1995. To date, nearly 40% of the 652,000 cases of AIDS reported in the U.S. have been linked to injection drug use. More than 70% of HIV infections among women of childbearing age are related either directly or indirectly to injection drug use. And more than 75% of babies diagnosed with HIV/AIDS were infected as a direct or indirect result of injection drug use by a parent.

Communities' use of needle exchange programs has increased throughout the epidemic. According to data reported to the Centers for Disease Control and Prevention, communities in 28 states and one U.S. territory currently operate needle exchange programs, supported by State, local, or private funds. Many of these programs provide a direct linkage to drug treatment and counseling as well as needed medical services.

Since 1989, the use of federal funds for needle exchange programs has been restricted by the Congress. Funding has, however, been authorized by the Congress to conduct research into the efficacy of such programs as a public health intervention to reduce transmission of HIV and to examine the impact of such programs on drug use. The federal government has supported numerous studies of the effectiveness of needle exchange programs in reducing the transmission of HIV among injection drug users, their spouses or sexual partners, and their children. Many of these studies also examined whether or not needle exchange programs encourage the use of illegal drugs.

In February 1997, Secretary Shalala reported to Congress that a review of scientific studies indicated that needle exchange programs "can be an effective component of a comprehensive strategy to prevent HIV and other blood borne infectious diseases in communities that choose to include them." She also directed the Department's scientific agencies to continue to review research findings regarding the effect of needle exchange programs on illegal drug use. The scientific evidence indicates that needle exchange programs do not encourage illegal drug use and can, in fact, be part of a comprehensive public health strategy to reduce drug use through effective referrals to drug treatment and counseling.

"An exhaustive review of the science in this area indicates that needle exchange programs can be an effective component of the global effort to end the epidemic of HIV disease," said Harold Varmus, MD, Director of the National Institutes of Health. NIH has funded much of the research into the effectiveness of needle exchange programs and their impact on drug use. "Recent findings have strengthened the scientific evidence that needle exchange programs do not encourage the use of illegal drugs," Dr. Varmus said. Specifically, he cited:

- In March 1997, the National Institutes of Health published the Consensus Development Statement on Interventions to Prevent HIV Risk Behaviors. That report concluded that needle exchange programs "show a reduction in risk behaviors as high as 80% in injecting drug users, with estimates of a 30% or greater reduction of HIV." The panel also concluded that the preponderance of evidence shows either a decrease in injection drug use among participants or no changes in their current levels of drug use.
- An October 1997, study of needle exchange programs in Baltimore, Maryland, indicated that needle exchange programs that are closely linked to or integrated with drug treatment programs have high levels of retention in drug treatment. A 1998 NIH Consensus Conference report on the effectiveness of treatment for heroin addiction found that drug treatment programs can assist heroin users in halting their drug use.

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

April 20, 1998

Contact: HHS Press Office
(202) 690-6343

NEEDLE EXCHANGE PROGRAMS: PART OF A COMPREHENSIVE HIV PREVENTION STRATEGY

Overview: Since 1981, injection drug use has played an increasing role in the spread of HIV and AIDS, accounting for more than 60% of AIDS cases in certain areas in 1995. To date, nearly 40% of the 652,000 cases of AIDS reported in the U.S. have been linked to injection drug use. More than 70% of HIV infections among women of childbearing age are related either directly or indirectly to injection drug use. And more than 75 percent of babies diagnosed with HIV/AIDS were infected as a direct or indirect result of injection drug use by a parent.

To protect individuals from infection with HIV and other blood-borne infections, several communities have established needle or syringe exchange programs. In communities that choose to use them, needle exchange programs are a form of public health intervention to reduce the transmission of the human immunodeficiency virus (HIV) among drug users, their sex partners, and their children. They provide new, sterile syringes in exchange for used, contaminated syringes. Many needle exchange programs also provide drug users with a referral to drug counseling and treatment, medical services, and provide risk reduction information.

Under the terms of Public Law 105-78, federal funds to support needle exchange programs were conditioned on a determination by the Secretary of Health and Human Services that such programs reduce the transmission of the human immunodeficiency virus (HIV) and do not encourage the use of illegal drugs. The Secretary has made that determination. The Act's restriction on federal funding, however, has not been lifted.

The Administration has decided that the best course at this time is to have local communities which choose to implement their own programs use their own dollars to fund needle exchange programs, and to communicate what has been learned from the science so that communities can construct the most successful programs possible to reduce the transmission of HIV, while not encouraging illegal drug use.

In a February 1997 report to Congress, Health and Human Services Secretary Donna E. Shalala reported that a review of the findings of scientific research indicated that needle exchange programs "can be an effective component of a comprehensive strategy to prevent HIV and other blood borne infectious diseases in communities that choose to include them."

On April 20, 1998, Secretary Shalala announced that a review of research findings indicated that needle exchange programs also "do not encourage the use of illegal drugs."

FEDERAL RESEARCH ON NEEDLE EXCHANGE

While Congress has restricted the use of federal funds for needle exchange programs since 1989, lawmakers have authorized funding for research into the efficacy of needle exchange programs as a public health intervention to reduce the transmission of HIV and to examine the impact of such programs on drug use. The federal government has supported and will continue to support research into the effectiveness of needle exchange programs.

Effect of Needle Exchange Programs on HIV Transmission

Three major expert reviews of the scientific literature on needle exchange programs conclude that such programs can be an effective component of a comprehensive community-based HIV prevention effort. Additionally, needle exchange programs can provide a pathway for linking injection drug users to other important services such as risk reduction counseling, drug treatment, and support services. The reviews include:

- *Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy*, United States General Accounting Office, March 1993, is an extensive review of U.S. and international data looking at the effects of needle exchange programs. It estimated that a needle exchange program in New Haven, Connecticut, had led to a 33% reduction in HIV infection rates among drug users in that city.
- *The Public-Health Impact of Needle Exchange Programs in the United States and Abroad*, prepared by the University of California, San Francisco, September 1993, reported that needle exchange programs served as an important bridge to other health services, particularly drug counseling and treatment. It also found that needle exchange programs reached a group of injecting drug users with long histories of drug use and limited exposure to drug treatment.
- *Preventing HIV Transmission: The Role of Sterile Needles and Bleach*, National Research Council and Institute of Medicine, September 1995, concluded that needle exchange programs have beneficial effects on reducing behaviors such as multi-person reuse of syringes. It estimated a reduction in risk behaviors of 80% and reductions in HIV transmission of 30% or greater.

Based on that scientific evidence, in February 1997, Secretary Shalala reported to Congress that a review of scientific findings indicated that needle exchange programs "can be an effective component of a comprehensive strategy to prevent HIV and other blood borne infectious diseases in communities that choose to include them." She also directed the Department's scientific agencies to continue to review research findings regarding the effect of needle exchange programs on illegal drug use.

Impact of Needle Exchange Programs on Drug Use

Extensive research indicates that needle exchange programs do not encourage illegal drug use and can, in fact, reduce drug use through effective referrals to drug treatment and counseling. Several recent studies strengthen the conclusion that needle exchange programs do not encourage the use of illegal drugs. They include:

- In March, 1997, the National Institutes of Health published the Consensus Development Statement on Interventions to Prevent HIV Risk Behaviors. That report concluded that needle exchange programs "show a reduction in risk behaviors as high as 80% in injecting drug users, with estimates of a 30% or greater reduction of HIV." The panel also concluded that the preponderance of evidence shows either a decrease in injection drug use among participants or no changes in their current levels of drug use.
- An October 1997, study of needle exchange programs in Baltimore, Maryland, (Brooner et al., Abstract presented to the American Public Health Association, October 1997) reported that needle exchange programs that are closely linked to or integrated with drug treatment programs actually reduce the incidence of drug use with high levels of retention in drug treatment. A 1998 NIH Consensus Conference report on the effectiveness of treatment for heroin addiction found that drug treatment programs can assist heroin users in halting their drug use.

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American Medical Association

Physicians dedicated to the health of America



Statement

Statement attributable to: Nancy W. Dickey, MD
President-Elect
American Medical Association

"The American Medical Association recognized one year ago, in a policy statement adopted by our House of Delegates, that important advances to arrest the AIDS epidemic could be made through responsible needle exchange and drug treatment programs. Traditionally, AMA policy follows science, and as Secretary Shalala notes scientific evidence clearly shows that needle exchange is effective in curtailing HIV transmission and that the availability of clean needles does not increase drug abuse.

"We hope that drug treatment programs review the growing body of evidence concerning these serious public health issues, and take appropriate actions to intervene effectively."

-4-20-98-

For further information, contact: James Stacey 202 789-7419



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

**Assistant Secretary for Health
Office of Public Health and Science
Washington D.C. 20201**

APR 20 1998

MEMORANDUM TO THE SECRETARY

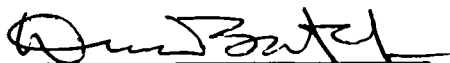
SUBJECT: Review of Scientific Data on Needle Exchange Programs

At your request, we have reviewed the scientific studies on the effectiveness of syringe and needle exchange programs. Attached is our review. It includes:

- o Appendix A: The Department's February 1997 Report to Congress
- o Appendix B: Recent data analysis completed since February 1997
- o Appendix C: Summary document reviewing the scientific literature by outcome measures of interest
- o Appendix D: Data summary specifically addressing the criteria established by Congress as conditions for federal funding for needle exchange programs

After reviewing all of the research, we have unanimously agreed that there is conclusive scientific evidence that needle exchange programs, as part of a comprehensive HIV prevention strategy, are an effective public health intervention that reduces the transmission of HIV and does not encourage the use of illegal drugs. In addition, when properly structured, needle exchange programs can provide a unique opportunity for communities to reach out to the active drug injecting population and provide for the referral and retention of individuals in local drug treatment and counseling programs and other important health services.

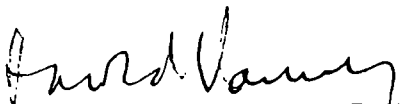
Therefore, based on the scientific data, we strongly recommend that you certify that needle exchange programs are effective in reducing the transmission of HIV and do not encourage the use of illegal drugs.



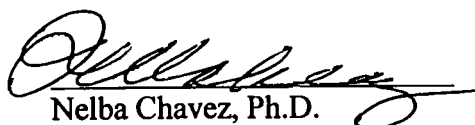
David Satcher, M.D., Ph.D.
Assistant Secretary for Health
Surgeon General



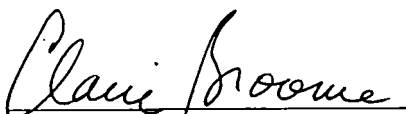
Margaret Hamburg, M.D.
Assistant Secretary for
Planning and Evaluation



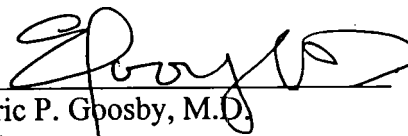
Harold Varmus, M.D.
Director
National Institutes of Health



Nelba Chavez, Ph.D.
Administrator
Substance Abuse and Mental Health
Services Administration



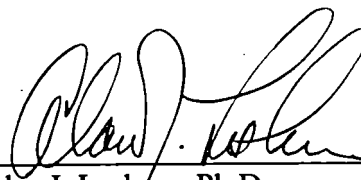
Claire Broome, M.D.
Acting Director
Centers for Disease Control and Prevention



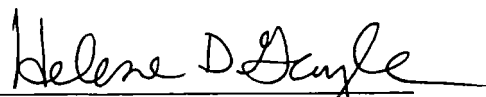
Eric P. Goosby, M.D.
Director
Office of HIV/AIDS Policy



Anthony Fauci, M.D.
Director
National Institute of Allergy and
Infectious Diseases



Alan I. Leshner, Ph.D.
Director
National Institute on Drug Abuse



Helene Gayle, M.D., M.P.H.
Director
National Center for HIV, STD and
TB Prevention, CDC

NEEDLE EXCHANGE PROGRAMS IN AMERICA: REVIEW AND EVALUATION OF SCIENTIFIC RESEARCH

Introduction

In September 1996, the Committee on Appropriations for the Departments of Labor, Health and Human Services, Education and Related Agencies requested the Secretary of the Department of Health and Human Services to provide a review of the scientific research on needle exchange programs. In response to that request, the Department provided a report to Congress in February 1997 with an overview of the status of scientific research on needle exchange programs, including a compilation of relevant studies and abstracts pertinent to the efficacy of needle exchange programs in reducing HIV transmission and their effect on utilization of injection drugs.

The February 1997 report included two extensive summaries (National Academy of Science/Institute of Medicine 1995, and University of California at Berkeley/San Francisco 1993) evaluating the research literature on the effectiveness of needle exchange programs for the prevention of HIV transmission among injection drug users and their effect on utilization of illegal drugs. An earlier report by the General Accounting Office (1993) reviewed the results of studies addressing the effectiveness of needle exchange programs in the United States and abroad, with an assessment of the credibility of a forecasting model developed at Yale University that estimates the impact of a needle exchange program on the rate of new HIV infections. The conclusion provided in the February 1997 report stated that needle exchange programs can be an effective component of a comprehensive strategy to prevent HIV and other blood borne infectious diseases in communities that choose to include them, and that needle exchange programs can have an impact on bringing difficult to reach populations into systems of care that offer drug dependency services, mental health, medical and support services.

Since the completion of the February 1997 report to Congress, a number of researchers have published data in peer-reviewed journals or presented research findings at national conferences. The National Institutes of Health also published an NIH Consensus Development Statement, Interventions to Prevent HIV Risk Behaviors, in March 1997. That document summarized the proceedings of an NIH Consensus Development Conference, which evaluated the available scientific information regarding the effectiveness of interventions designed to prevent HIV transmission, including needle exchange programs.

Consistent with the February 1997 report to the Congress, this report is limited to those studies conducted in the United States, with the exception of the inclusion of Canadian research data from Vancouver and Montreal. The National Academy of Sciences/Institute of Medicine previously reviewed the unpublished data from Montreal, now published in final form. Other international studies are not reviewed here, as drug use patterns are highly context sensitive in terms of both social, cultural and economic factors and findings could not be generalized to the U.S. population.

This report builds upon the February 1997 report to Congress, expanding on that summary to include newly available data and the implications for policy.

HIV Transmission Through Injection Drug Use

The consequences of injection drug use have become the driving force in the HIV epidemic in the United States. Half of all new infections are caused by the sharing of injection equipment contaminated with HIV, either due to injection drug use or through unprotected sex with an injection drug user or birth to a mother who herself, or whose partner, was infected with HIV through drug use. The proportion of AIDS cases and new HIV infections attributable to injection drug use has been rising steadily. Over 75% of new HIV infections in children result from injection drug use by a parent. The impact has been most devastating in communities of color, which accounted for 65% of newly reported AIDS cases between July 1996 - June 1997.

The primary goal of needle exchange programs is to reduce the transmission of HIV and other blood borne infections, such as hepatitis B (HBV) and hepatitis C (HCV), associated with drug injection by providing sterile needles in exchange for potentially contaminated ones. Researchers from Yale University empirically demonstrated that provision of sterile syringes results in removing from circulation contaminated syringes that could potentially be re-used, thereby decreasing the transmission risk associated with sharing contaminated equipment. In addition to exchanging syringes, needle exchange programs are effective access points for populations with multiple high risk behaviors for HIV infection to receive other services. Many needle exchange programs provide an array of other services including referrals to drug treatment and counseling, HIV testing and counseling, and screening for sexually transmitted diseases and tuberculosis. There are more than 100 needle exchange programs now operating in 71 cities and 28 states and one territory in the United States.

Summary of Research Findings on Needle Exchange Programs

This section summarizes in brief the primary research findings regarding needle exchange programs. A more extensive review of the studies included in the February 1997 DHHS Report to the Appropriations Committee can be found at Appendix A; an analysis of those studies completed since February 1997 is provided at Appendix B. A summary table of needle exchange research studies examining specific outcomes of interest is provided at Appendix C. A subset of this table identifying those studies reporting on the two criteria established in the Public Law 105-78 Appropriations legislation is provided at Appendix D.

Empirical Studies in the United States Needle exchange programs have been implemented in low, moderate and high HIV prevalence sites in an attempt to reduce the spread of HIV and other blood borne infectious diseases among injection drug users. A discussion of some of the methodological issues pertinent to studies on needle exchange is provided later in this document.

In brief, findings from a comprehensive review of the literature indicate that needle exchange programs: increase the availability of sterile injection equipment and reduce the proportion of contaminated needles in circulation (Kaplan and Heimer 1992, Kaplan 1994, and Heimer et al. 1993); reduce drug-related risk behaviors such as multi-person re-use of syringes (Hagan et al. 1991 and 1993, Guydish et al. 1993, Oliver et al. 1994, Paone et al. 1994, DesJarlais et al. 1994, Watters et al. 1994, Singer et al. 1997, and Vlahov et al. 1997); increase drug treatment referrals (Heimer 1994) and entry into drug treatment (Hagan et al. 1993, Singer et al. 1997, and Vlahov et al. 1997); have successfully referred participants to drug treatment with resulting high drug treatment retention rates and reduced HIV risks (Brooner and Vlahov 1997); have shown small improvements in reducing sexual risk behaviors among needle exchange participants (Watters et al. 1994, DesJarlais et al. 1994, and Paone et al. 1994); have maintained low prevalence of blood borne HBV and HCV infections (Heimer et al. 1993, DesJarlais et al. 1995, Hagan et al. 1994, and Paone et al. 1994); have reduced HIV seroprevalence rates in certain cities (Hurley, Jolley and Kaldor 1997); and have reduced the rate of new blood borne infections like HIV and HBV among program participants (Hagan et al. 1991 and 1995, and DesJarlais et al. 1996). Additional information on the study design and findings of the studies listed above can be found in the summary documents at Appendices C and D.

Empirical Studies in Canada Two recent observational studies from Vancouver (Strathdee et al. 1997) and Montreal (Bruneau et al. 1997) reported a higher incidence of HIV among injection drug users participating in needle exchange than non-exchange participants. In Vancouver, HIV seroprevalence was estimated to be stable at 1%-2% among the injection drug using population from 1988, when the needle exchange program was established, through 1993. In 1994, a rapid expansion of the HIV epidemic took place, with a baseline seroprevalence of 23.2% observed in a prospective cohort study of injection drug users. Preliminary analysis from this cohort study found an HIV incidence rate of 18.6 per 100 person years. This study reported on a number of behavioral and social risk factors associated with HIV seropositive status, including a high level of injectable cocaine use, prostitution and longer histories of injection drug use. The presence of multiple behavioral risk factors confounded the ability to isolate participation in needle exchange as a predominant or predictive factor for HIV infection. Subsequent 1997 data from this cohort have showed a decline in HIV incidence to 4.4 per 100 person years.

An observational cohort study of injection drug users was conducted in Montreal. In a baseline assessment of HIV seroprevalence, individuals who attended a needle exchange program reported higher frequencies of risk behaviors associated with drug injection and more frequent involvement in prostitution activities. In a prospective HIV seroincidence analysis, HIV incidence among persons attending the needle exchange program was 7.9 per 100 person years, compared to 3.1 per 100 person years among non-attenders. As in the Vancouver study, demographic, behavioral and social factors were identified that in aggregate defined the high risk profile of those persons also attending needle exchange programs. A more complete review and analysis of these two studies is provided at Appendix B.

Synthesis Reports

Institute of Medicine

In 1995, the National Academy of Sciences/Institute of Medicine published a report, Preventing HIV Transmission: The Role of Sterile Needles and Bleach, reviewing the cumulative body of scientific literature available at that time. A summary of the conclusions of the NAS/IOM panel on the scientific assessment of needle exchange program effectiveness is provided as follows:

“On the basis of its review of the scientific evidence, the panel concludes:

- o needle exchange programs increase the availability of sterile injection equipment. For the participants in a needle exchange program, the fraction of needles in circulation that are contaminated is lowered by this increased availability. This amounts to a reduction in an important risk factor for HIV transmission.
- o The lower the fraction of needles in circulation that are contaminated, the lower the risk of new HIV infections.
- o There is no credible evidence to date that drug use is increased among participants as a result of programs that provide legal access to sterile equipment.
- o The available scientific literature provides evidence based on self-reports that needle exchange programs do not increase the frequency of injection among program participants and do not increase the number of new initiates to injection drug use.
- o The available scientific literature provides evidence that needle exchange programs have public support, depending on locality, and that public support tends to increase over time.” p.4

The IOM concluded that “needle exchange programs should be regarded as an effective component of a comprehensive strategy to prevent infectious disease.” (p.4)

NIH Consensus Development Statement

In March 1997, the National Institutes of Health published the Consensus Development Statement on Interventions to Prevent HIV Risk Behaviors, summarizing the proceedings of a Consensus Development Conference. A panel of non-Federal experts evaluated the available scientific information regarding behavioral interventions to reduce risk for HIV/AIDS. Presentations of scientific data were made to the panel by distinguished researchers, including ongoing evaluation studies of needle exchange programs. Specific behaviors and community contexts that produce elevated risks for HIV infection were reviewed, as well as the spectrum of available interventions to reduce behavioral risks. After reviewing the data on needle exchange programs, the panel concluded that these programs have beneficial effects on reducing behaviors

such as multi-person re-use of syringes. They reported that "studies show a reduction in risk behaviors as high as 80% in injecting drug users, with estimates of a 30% or greater reduction of HIV." (p.11) The panel also concluded that the preponderance of evidence shows either a decrease in injection drug use among participants or no changes in their current levels of use.

University of California at Berkeley and San Francisco Study for the CDC

In 1993 the University of California published a review and analysis of the literature on needle exchange programs to answer a number of research questions, including the effect of needle exchange programs on HIV infection rates and HIV risk behaviors. Study findings reported included the following: needle exchange programs served as a bridge to other health services, particularly drug abuse treatment; needle exchange programs generally reached a group of injecting drug users with long histories of drug injection and limited exposure to drug abuse treatment; there was no evidence that needle exchange programs increased the amount of drug use in participants or changes in overall community levels of drug use; needle exchange programs did not result in an increase in the number of discarded syringes in public places; the rates of HIV drug risk behaviors were reduced in needle exchange participants; needle exchange programs were associated with reductions in hepatitis B among injection drug users; and, the data were too limited at that time to draw conclusions about needle exchange programs and reductions in HIV infection rates.

Summary of New Research Findings

Since completion of the Department of Health and Human Services' February 1997 report to the Congress on needle exchange programs, several scientific studies have added new data on the effects of needle exchange programs, corroborating and expanding knowledge about the role needle exchange programs play in reducing HIV transmission. In addition, these new data continue to demonstrate that needle exchange programs do not encourage drug use, and in fact will increase referrals into drug treatment for hard-to-reach populations. A more complete description of these studies is provided at Appendix B.

In a study by Vlahov et al. (1997), reductions in high risk drug use behaviors and an increase in enrollment in drug treatment were observed in a cohort participating in the needle exchange program. In a study by Brooner et al (in press), a high rate of acceptance of substance abuse treatment and retention in treatment was demonstrated among injection drug users referred from needle exchange programs, despite greater severity of drug use and high risk behaviors for HIV and psychosocial problems in this group. Hurley et al (1997) identified decreased HIV seroprevalence among 29 cities with needle exchange programs compared to 52 cities without these programs, with cities selected according to the availability of HIV prevalence data for their injection drug using population for 2 or more years. Two studies from Canada reported increased HIV incidence among injection drug users also using needle programs, but the design of these studies and the behavioral characteristics of the study populations limit the

generalizability of the findings to the United States populations. Subsequent data from one Canadian study (Vancouver) has shown a significant decrease in HIV incidence since publication of the first study.

Methodological Considerations

In reviewing the scientific data on needle exchange, it is relevant to note the wide range of methodologic approaches utilized and the impact of these study design choices on the conclusions drawn. As was noted in the 1995 report by the National Academy of Sciences/Institute of Medicine, some of the studies that examine needle exchange and bleach distribution programs have various limitations including inadequate sample size, improper controls and problematic measures including self-reporting instruments. In behavioral research, these study designs and instruments are the best available tools to describe complex behaviors. In addition, multiple behavioral risk factors, including drug choices such as cocaine, confound the ability to isolate cause and effect relationships for HIV transmission among injection drug users. This whole body of research is burdened by these constraints.

Nevertheless, as the NAS/IOM report states "... the limitations of individual studies do not necessarily preclude us from being able to reach scientifically valid conclusions based on the entire body of literature available. The situation resembles the exploration of the relationship between cigarette smoking and lung cancer; virtually every individual study was vulnerable to some particular objection, yet collectively those studies justified a compelling conclusion. It was essential for the panel first to distinguish between studies of high quality and those of lesser quality, and then to weigh the credibility of the findings, according to their completeness and soundness. Using this approach, the panel based its conclusions on the pattern of evidence provided by a set of high-quality studies, rather than relying on the preponderance of evidence across less scientifically sound studies." p. 3-4

Maximizing the Public Health Benefits of Needle Exchange Programs

In assessing the public health benefits gained from needle exchange programs, certain characteristics have consistently emerged from the research data that confirms the unique role that needle exchange programs can play as part of the public health response to an epidemic driven by injection drug use. To ensure that federal dollars are maximized in this effort, a careful consideration of those factors most predictive of public health benefit must be heeded. To this end, it is critical that no reduction in drug treatment capability occur, as substance abuse treatment remains the long term strategy for reducing injection drug use and the associated risk of HIV transmission. Needle exchange programs are appropriately supported as an HIV prevention activity in those communities that choose to develop them. Other important factors include local support of health department leaders and affected communities for needle exchange as a necessary component of a broader, comprehensive HIV prevention plan. Those programs which consistently provide referral to medical and drug treatment afford the greatest opportunity

to reduce HIV infection and decrease injection drug use. Concerns among communities have highlighted the need for appropriate disposal of hazardous wastes. Where collection and disposal of used syringes has been implemented, and syringes are provided on a replacement basis only, community support has been achieved. Those programs that operate in accordance with state and local laws, or which are granted waivers from applicable laws, have shown the greatest success in linking together the range of medical and drug treatment services needed by their clients. Finally, there is an important role for ongoing evaluation of needle exchange programs to maximize their effectiveness in reaching high risk populations and providing the means for injection drug users to eliminate or reduce both their risks for HIV and injection drug use.

Public Health Implications

The scientific data now available have established the utility of needle exchange programs in reducing new HIV infections with no evidence of increasing injection drug use. The data supports the unique role needle exchange programs can play in creating an access point into social services, drug treatment and medical care for the population most responsible for new HIV seroconversions. This role as a conduit into care is amplified in that needle exchange programs offer, at multiple points in time, repeated opportunities for prevention intervention as well as an ongoing opportunity to develop trusting relationships between professional staff and the injection drug-using population. This is often the most significant social connection in an active drug user's life and creates a foundation with which future interventions may depend. In addition to the immediate replacement of a contaminated needle with a clean one, we see the efficacy of a needle exchange program as dependent on its relationship to a constellation of services that are directed at identifying high risk populations and creating formal conduits into care.

The public health need to target high risk populations most responsible for driving HIV seroconversion rates is evident. Our understanding of how HIV moves through communities must be structured into responses to epidemiologic surveillance data that describe modes of transmission. This includes allowing States and localities to coordinate their resources and target them to those population groups that cannot stop participating in high risk behaviors. However, federal funding is only appropriate for those programs that provide the critical linkages with drug treatment and health care services and incorporate the spectrum of prevention services that have proven effective HIV prevention tools.

We remain committed to exploring through research those factors that affect the demonstrated utility of needle exchange programs in curtailing transmission of HIV in communities and the relative effects on drug use and entry into drug treatment.

Attachments

- Appendix A: 1997 Report to Congress
- Appendix B: Analysis of Recent Data
- Appendix C: Summary Tables of Research Studies
- Appendix D: Summary of Data by Statutory Criterion