FOIA Number: 2018-0764-F

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[Issues] - Needles

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Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. table	re: Needle exchange programs (Personal) [partial] (1 page)	00/00/0000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 19400

FOLDER TITLE:
[Issues] - Needles

2018-0764-F
jm2157

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

FACSIMILE

To: Sandy Thurman
Fax #: 632-1096
Re: Conference
Date: October 30, 1997
Pages: 5, including this cover sheet.

Let's discuss!

From the desk of...

Steve Morin, Ph.D.
Associate Staff, Committee on Appropriations
Office of Congresswoman Nancy Pelosi
2457 Rayburn Building
Washington, D.C. 20515

(202) 225-4965
Fax: (202) 225-8259

AIDS Funding

Labor-HHS Appropriations Bill for FY 98

	1997	1998	Change	
Ryan White Program				
Education & Training Centers	16.3	17.3	+1.0	(6%)
AIDS Dental Services	7.5	7.8	+.3	(4%)
Emergency Assistance	450.0	464.8	+14.9	(3%)
Comprehensive Care	250.0	257.5	+7.5	(3%)
AIDS Drug Assistance Program	167.0	285.5	+118.5	(71%)
Early Intervention Programs	69.6	76.3	+6.7	(10%)
Pediatric Demonstrations	36.0	41.0	+5.0	(14%)
Total	996.3	1,150.2	+153.9	(15%)
CDC HIV Prevention	616.8	634.3	+17.5	(3%)
NIH AIDS Research	1,501	1,608	+107	(7%)

Included in the House VA-HUD Appropriations Bill:

Housing Opportunities for Persons with AIDS	171	204	+33	(19%)

PROPOSAL FOR CONFERENCE ON H.R. 2264

(Labor, HHS, Educ, Rel Agencies Appropriations Act, 1998)

OFFERED BY _____

In lieu of the relevant provisions of the House bill and the Senate amendment, insert the following:

SEC. ____. Notwithstanding any other provision of this Act, no funds appropriated under this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

SEC. ____. Section ____ *[the preceding section]* is subject to the condition that a program for exchanging such needles and syringes for used hypodermic needles and syringes (referred to in this section as an "exchange project") may be carried out in a community if—

(1) the Secretary of Health and Human Services determines that exchange projects are effective in preventing the spread of HIV and do not encourage the use of illegal drugs; and

(2) the project is ~~subject to an agreement to carry out the project~~ operated in accordance with criteria established by such Secretary for preventing the

spread of HIV and for ensuring that the project does not encourage the use of illegal drugs.

Statement of Managers

Both the House and Senate bills contained restrictions on the use of federal funds for the distribution of sterile needles for the injection of any illegal drug (Section 505). The Senate bill repeated language from previous appropriations bills allowing the Secretary to waive the prohibition if she determined that such programs are effective in preventing the spread of HIV and do not encourage to use of illegal drugs. The House bill removed the Secretary's authority over this issue.

The conference agreement includes the House bill language prohibiting the use of federal funds for carrying out any program for the distribution of sterile needles or syringes for the injection of any illegal drug. This provision is consistent with the goal of discouraging illegal drug use and not increasing the number of needles and syringes in communities.

The conference agreement also includes bill language limiting the use of federal funds for sterile needle and syringe exchange projects unless 1) the Secretary of Health and Human Services determines that exchange projects are effective in preventing the spread of HIV and do not encourage the use of illegal drugs; and 2) the project is subject to an agreement to carry out the project in accordance with criteria established by the Secretary for preventing the spread of HIV and for ensuring that the project does not encourage the use of illegal drugs. This provision is consistent with the goal of allowing the Secretary maximum authority to protect public health while not increasing the number of needles and syringes in communities.

With respect to the first criteria, the Conferees expect the Secretary to make a determination based on a review of the relevant science. If the Secretary makes the necessary determination, then the Conferees expect the Secretary to require the chief public health officer of the State or political subdivision proposing to use federal funds for exchange projects to notify the Secretary that, at a minimum, all of the following conditions are met: 1) a program for preventing HIV transmission is operating in the community; 2) the State or local health officer has determined that an exchange project is likely to be an effective component of such a prevention program; 3) the exchange project provides referrals for treatment of drug abuse and for other appropriate health and social services; 4) such project provides ~~education~~ information on reducing the risk of transmission of HIV; 5) the project complies with established standards for the disposal of hazardous medical waste; and 6) the State or local health officer agrees that, as needs are identified by the Secretary, the officer will collaborate with federally supported programs of research and evaluation that relate to exchange projects.

MEMORANDUM

To: Bruce Reed

From: Sandy Thurman

Date: October 23, 1996

Re: Needle Exchange

This memorandum is designed to provide background information on the issues surrounding the Secretary of HHS's authority to waive the current restrictions on the use of federal funding for needle exchange programs to reduce the transmission of HIV. A brief overview of the changing epidemic, the public health response, the science, the public opinion, the politics, and other considerations are included.

The Evolving AIDS Epidemic

IV drug use now plays a central role in fueling the spread of HIV, particularly among women, children, and people of color.

HIV/AIDS continues to be considered by some as predominantly a gay white male disease. However, AIDS is increasingly a disease seriously affecting people of color, women, adolescents, and IV drug users. A recent report by CDC estimates that more than 50% of all newly reported cases of AIDS are associated with IV drug use, including drug users, their partners and their children. In fact, IV drug use among parents is now the predominate cause of pediatric AIDS. In the last five years there has been a 32% increase in AIDS cases in people of color (representing 63% of new cases), an increase of 64% in women (representing 20% of new cases), and an increase of 22% among injecting drug users (representing 29% of new cases). The gay community continues to be heavily impacted, but the disease is clearly moving rapidly into poorer and more disenfranchised populations. While death rates and new cases of AIDS have both declined in recent months as a result of better therapies, the rate of new infections has not gone down, and there is great disparity among affected communities. For example: while the death rate from AIDS declined 25% for men, it declined only 10% for women. For white men and women the decline in AIDS deaths was 32%, for Latinos it was 20%, and for Blacks it was only 13%. If we look at primary risk factors for infection, the greatest drop was in gay men, for whom AIDS deaths dropped 30%. For injection drug users the reduction was only 15%, and for heterosexuals (including partners of IV drug users) the decline was only 8%.

It is this burgeoning epidemic among IV drug users, their partners and children that have propelled the issue of needle exchange to the forefront of AIDS policy. As those on the front lines fight to keep these families alive long enough to get them into treatment and off drugs, they seek effective strategies for what often seems an overwhelming task.

Scientific Overview

Credible evidence demonstrates that needle exchange programs reduce the spread of HIV without increasing drug use, thereby saving countless lives.

In February, the Secretary of HHS reported to Congress on the results of several major studies of needle exchange programs, including those conducted by the National Institutes of Health, the Centers for Disease Control and Prevention, and the National Academy of Sciences. More than 100 programs were reviewed. These studies provided strong and credible evidence that needle exchange programs can have a positive impact on reducing the transmission of HIV among users. This translates into saving the lives of their partners and children. In addition, the studies found no evidence that needle exchange programs increase drug use by program participants or in the communities in which the programs were conducted.

Public Health Overview

The Administration seeks to retain the Secretary's authority to gather and evaluate scientific data not to create a national needle exchange program.

Several years ago, the Congress banned the use of federal funding for needle exchange programs unless the Secretary determines that such programs have been found: (1) to reduce the rate of HIV transmission, and (2) not to encourage the use of illegal drugs. If the Secretary was to make such a determination, based on credible scientific evidence, this would not create a national needle exchange program, as the opposition likes to claim. Such action would simply give state and local public health officials the flexibility to include this strategy as part of a comprehensive HIV prevention program -- if, and only if, they chose to do so.

Although some may frame this debate as solely about federal support for needle exchange programs, it is actually about much more basic public health policy. At the core of this debate are two essential principles of public health: (1) that sound science and not politics should drive policy development, and (2) that state and local public health officials should be given the flexibility to design programs that meet the needs of their citizens. Since the beginning of the AIDS epidemic, these principles have guided the federal role in HIV prevention.

HIV prevention has always been a difficult political challenge -- raising issues that people would rather not talk about. In the early days of AIDS, the controversy was over homosexuality; in 1997, it is over IV drug use. In 1980s, the right wing said that AIDS education targeted at the gay community promoted homosexuality. In 1997, they say that needle exchange programs promote illegal drug use. In each case, public health officials employ these strategies because they have been proven to reduce the transmission of a deadly virus. Consistently throughout the epidemic, HHS has sought to make scientific evidence available, report on the effectiveness of various HIV prevention strategies, and let programmatic decisions be made locally, where the needs can be better assessed and the politics can be better managed. In fighting to retain the Secretary's authority to "let the science drive" and "let local communities decide," the Administration simply seeks to defend longstanding public health principles.

Political Landscape

Although this issue needs to be politically "managed," it is not gays in the military.

Unlike gays in the military, this is not a policy being pushed on those who will be forced to implement it – it is being pushed by them. The current restrictions on federal funding for needle exchange programs tie the hands of city, county, and state health officials who are struggling to save the lives of their citizens. More than 100 needle exchange programs in 27 states have already been developed with state and local funds. Now, the National Association of City and County Health Officials and the Association of State and Territorial Health Officers are seeking the flexibility to use federal HIV prevention funding for this purpose. These officials are joined by a host of mainstream health, public health, and governmental organizations including: the American Medical Association, the Academy of Pediatrics, the American Nurses Association, the American Public Health Association, the National Academy of Sciences, the US Conference of Mayors, the National Black Caucus of State Legislators, and the American Bar Association. Given this line up, it is difficult for the opposition to pass this off as fringe policy put forward by those who do not understand how the system works.

The policy of local control is tremendously popular with the vast majority of Americans. Further, needle exchange programs are supported by a majority of Americans. A 1996 poll done by the Kaiser Family Foundation found that two-thirds of Americans favor providing clean needles to IV drug users. A 1997 poll done by the Republican Tarrance Group found that 55% of voters supported needle exchange programs as a way to curb the spread of AIDS. This poll found 64% of Democrats and 58% of Independents supported needle exchange, with an 11% spread in the South and a 33% spread in the West. In addition, the editorial

boards in all major media markets have solidly supported needle exchange, many challenging the Administration to take a more active leadership role.

Finally, there are bipartisan leaders on Capitol Hill who want to join with the Administration in standing up for sound public health policy. Although the House of Representatives stripped the Secretary of her authority during consideration of the Labor-HHS Appropriations bill, the Democrats supported her by more than a two-to-one margin (141-59). This was true despite the fact that the Democratic Leadership and the Administration devoted little energy to working this vote. In addition, 16 Moderate House Republicans joined with Democrats in the face of serious Leadership pressure to fall in line. On the Senate side, despite right wing efforts to find a champion willing to bring this issue to Senate floor and ensure it was a non-conferencable item, they found no takers. Therefore, the Secretary's authority, originally offered several years ago by Senators Kennedy and Hatch, was affirmed by the Senate as part of the Labor-HHS bill by a vote of 86-14.

In summary, unlike gays in the military, this issue may be sticky, but it is winnable.

Considerations

It is important to consider the potential negative political ramifications of seeking to maintain the Secretary's waiver authority, and at some point, to exercise it. A few such political considerations follow.

The Right Wing: Certainly the Family Research Council will try to use this opportunity to say that the Administration is soft on drugs. However, the Administration's record proves otherwise. On the issue of needle exchange itself, again the Administration is not pushing a national needle exchange program; in fact, the Administration would not support such an effort. We believe that HIV prevention decisions are best made locally. It is the conservatives who often claim that the long arm of federal government has reached too far into state and local decision making. Removing federal restrictions on how local communities spend their HIV prevention dollars is an effort to be less intrusive, not more.

ONDCP: Dialogue with the General has been improving. His willingness to waive comment on the Statement of Administration Policy that went to the Congress supporting the Secretary's authority was a hopeful sign of cooperation. While I certainly understand his concern about sending the wrong message to young people, the vast majority of people who use needle exchange programs are addicts that have been using for more than 10 years. In addition, the research on needle exchange programs demonstrates that such efforts help to bring hard-to-reach users into treatment. If and when the Secretary exercises her authority, conditions should be placed on the use of federal funding to make sure that referrals to drug treatment are an integral part of any program.

The Satcher Nomination: It is true that Dr. Satcher called for the removal of the restrictions on the use of federal funding for needle exchange programs as CDC Director in 1993. This is widely known and could have been used by the right wing to hold up Satcher's confirmation. However, thus far, that has not been the case. No questions on needle exchange were asked at Dr. Satcher's hearing, and although Senator Coats forwarded forty follow-up questions on behalf of the Republicans who did not attend the hearing, again, no needle exchange inquiries. The Labor Committee favorably reported Dr. Satcher's nomination to the full Senate by a vote of 12 to 5. Senator Lott has told Senator Jeffords he believes Satcher will be confirmed. If his confirmation is held up, it is likely to have nothing to do with his views. As Surgeon General, Dr. Satcher can certainly talk about the longstanding public health principles of "let science drive" and "let local public health officials decide".

It is also important to consider the potential negative political ramifications of not maintaining the Secretary's waiver authority, and also at some appropriate time (i.e., after Dr. Satcher is confirmed and the Congress has adjourned), exercising it. A few such political considerations follow.

The AIDS Community: This issue has become central to the AIDS community and, rightly or wrongly, it has become symbolic of the Administration's leadership on AIDS. The Administration can and should be proud of the major increases in AIDS funding in the early years. However, with the Balanced Budget Agreement, such major increases in the future are highly unlikely. In addition, each year since the Republicans took the Congress, they have increased AIDS funding above the President's Budget Request. In these times of limited resources, the AIDS community is looking for a new form of leadership, leadership on the difficult policy questions that lie ahead. As pressure on funding intensifies, maximizing the effectiveness of each dollar becomes increasingly important. Generic prevention pamphlets will simply not save the lives of IV drug users and their families.

There is no doubt that the AIDS community would feel abandoned by the Administration if the Secretary's authority is not maintained; a protest might be scheduled for the President's visit to the Human Rights Campaign Dinner, and members of the Presidential Advisory Council have threatened to resign at the December meeting.

The Public Health Community: Many in the public health community have been concerned that the reinventing government reforms at HHS have dismantled the Public Health Service -- traditionally charged with seeing to it that as administrations come and go, politics do not ride rough-shod over public health. Public health officials are concerned that the new HHS structure politicizes public health policy. Walking away from the longstanding public health principles at play in this debate would reinforce this perception. In addition, mayors and their health officials, who have watched significant authority and flexibility turned over to the states, are looking for some help here in dealing with the twin epidemics of AIDS and drugs in our major urban areas.

Communities of Color: Some certainly perceive that the reason that the Administration is not fighting for this important policy is because it does not affect the gay community, known for it's financial support of the campaign. Some have already called it racism, claiming that if the President really wanted to have a national dialogue on race, he would deal with the reality that AIDS is *the* leading cause of death in the African-American community and *a* leading cause in many communities of color. The gay community was able to go out and raise private funding to pay for effective, targeted HIV education programs when the government got squeamish. Unfortunately, disenfranchised communities cannot. While it may be true that the issue of needle exchange is difficult, it is also true that it saves lives. For those who are continuing to watch their friends and families die, the politically sensitive nature of the debate offers little consolation.

Conference Strategies: Since the conference began, the Administration has rightfully supported the Senate position (maintaining the Secretary's authority). At this juncture, some believe that holding the Senate position is unlikely, and that Porter needs to bring back more than a simple "House recedes" to get the bill through. Currently, Senator Specter's office reports that he is holding to the Senate position and hopes the Administration will actively do the same.

Representative Pelosi has drafted a compromise that removes the Secretary's authority and allows state or local public health officials to use HIV prevention funds for needle exchange if a delineated list of criteria have been met. This list of criteria (approval of state or local public health official, referrals to drug treatment, counseling about HIV prevention, safe disposal of needles, and agreement to participate ongoing program effectiveness research) is similar to the criteria HHS has been considering if and when the Secretary exercises her authority. I believe these criteria are responsible and should ultimately be applied to the use of federal funds for needle exchange. However, I have a few concerns about pushing this language now. First, I don't think we should talk compromise until we are down to wire and in a corner. Second, this language strikes the Secretary's authority and the Administration's position is that the Secretary's authority should be maintained. Finally, if the conferees start adding criteria to the list, the language could quickly become a proxy for the House ban.

I believe that, as Senator Specter has requested, we should be active partners in maintaining the Senate language. At the same time, I believe we need to craft an alternative or two -- just in case it becomes necessary. In the end, the Administration will be judged on the role we played in "letting science drive" and "letting state and local public health officials decide". I will bring suggested language to the meeting on Monday.

Role of Public Health Officials: Some have suggested that law enforcement be involved in deciding whether or not needle exchange programs are appropriate. I am very concerned about this for several reasons.

– If it is true that needle exchange programs reduce HIV transmission and do not increase drug use, then this is a public health issue, not a law enforcement issue. Misconstruing the nature of this problem could exacerbate the spread of HIV-- particularly among women and children.

--giving the police the authority to make this important public health decision is a bad precedent that could be inappropriately used by the right wing. For example, gay men with AIDS had to have broken the law in many states to become HIV infected. If the CDC wants all health departments to gather names of HIV(+) individuals, should they be turned over to the police so they can be stopped before they break the law again?

-- Police already have strained relations with communities of color in many urban centers. Putting police in the middle of this issue will only make matters worse.

– Public health officials, working with counselors and outreach workers, are in the best position to reach those addicted to drugs and help them to remain HIV negative and become drug free. The viability of this intervention is seriously compromised by requiring the involvement of law enforcement.

While I believe strongly that state and local communities should be encouraged to work toward a "broad-based buy-in" to all HIV prevention strategies, giving law enforcement veto power over a public health decision is bad policy.

MEMORANDUM

To: Chris Jennings

From: Sandy Thurman

Date: October 7, 1996

Re: Needle Exchange

This memorandum is designed to provide background information on the issues surrounding the Secretary of HHS's authority to waive the current restrictions on the use of federal funding for needle exchange programs to reduce the transmission of HIV. A brief overview of the changing epidemic, the public health response, the science, the public opinion, the politics, and other considerations are included.

I thought that some of this information might be helpful if shared with Bruce or others but I wanted to get your input first. Please let me know what you think.

The Evolving AIDS Epidemic

IV drug use now plays a central role in fueling the spread of HIV, particularly among women, children, and people of color.

HIV/AIDS continues to be considered by some as predominantly a gay white male disease. However, AIDS is increasingly a disease seriously affecting people of color, women, adolescents, and IV drug users. A recent report by CDC estimates that more than 50% of all newly reported cases of AIDS are associated with IV drug use, including drug users, their partners and their children. In fact, IV drug use is now the predominate cause of pediatric AIDS. In the last five years there has been a 32% increase in AIDS cases in people of color (representing 63% of new cases), an increase of 64% in women (representing 20% of new cases), and an increase of 22% among injecting drug users (representing 29% of new cases). The gay community continues to be heavily impacted, but the disease is clearly moving rapidly into poorer and more disenfranchised populations. While death rates and new cases of AIDS have both declined in recent months as a result of better therapies, the rate of new infections has not gone down, and there is great disparity among affected communities. For example: while the death rate from AIDS declined 25% for men, it declined only 10% for women. For white men and women the decline in AIDS deaths was 32%, for Latinos it was 20%, and for Blacks it was only 13%. If we look at primary risk factors for infection, the greatest drop was in gay men, for whom AIDS deaths dropped 30%. For injection drug users the reduction was only 15%, and for heterosexuals (including partners of IV drug users) the decline was only 8%.

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by program participants or in the communities in which the programs were conducted.

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Although some may frame this debate as solely about federal support for needle exchange programs, it is actually about much more basic public health policy. At the core of this debate are two essential principles of public health: (1) that sound science and not politics should drive policy development, and (2) that state and local public health officials should be given the flexibility to design programs that meet the needs of their citizens. Since the beginning of the AIDS epidemic, these principles have guided the federal role in HIV prevention.

HIV prevention has always been a difficult political challenge -- raising issues that people would rather not talk about. In the early days of AIDS, the controversy was over homosexuality; in 1997, it is over IV drug use. In 1980s, the right wing said that AIDS education targeted at the gay community promoted homosexuality. In 1997, they say that needle exchange programs promote illegal drug use. In each case, public health officials employ these strategies because they have been proven to reduce the transmission of a deadly virus. Consistently throughout the epidemic, HHS has sought to make scientific evidence available, report on the effectiveness of various HIV prevention strategies, and let programmatic decisions be made locally, where the needs can be better assessed and the politics can be better managed. In fighting to retain the Secretary's authority to "let the science drive" and "let local communities decide," the Administration simply seeks to defend longstanding public health principles.

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needle exchange, with an 11% spread in the South and a 33% spread in the West. In addition, the editorial boards in all major media markets have solidly supported needle exchange, many challenging the Administration to take a more active leadership role.

Finally, there are bipartisan leaders on Capitol Hill who want to join with the Administration in standing up for sound public health policy. Although the House of Representatives stripped the Secretary of her authority during consideration of the Labor-HHS Appropriations bill, the Democrats supported her by more than a two-to-one margin (141-59). This was true despite the fact that the Democratic Leadership and the Administration devoted little energy to working this vote. In addition, 16 Moderate House Republicans joined with Democrats in the face of serious Leadership pressure to fall in line. On the Senate side, despite right wing efforts to find a champion willing to bring this issue to Senate floor and ensure it was a non-conferencable item, they found no takers. Therefore, the Secretary's authority, originally offered several years ago by Senators Kennedy and Hatch, was affirmed by the Senate as part of the Labor-HHS bill by a vote of 86-14.

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ONDCP: Dialogue with the General has been improving and the two of us are having breakfast this Friday. His willingness to waive comment on the Statement of Administration Policy that went to the Congress supporting the Secretary's authority was a hopeful sign of cooperation. While I certainly understand his concern about sending the wrong message to young people, the vast majority of people who use needle exchange programs are addicts that have been using for more than 10 years. In addition, the research on needle exchange programs demonstrates that such efforts help to bring hard-to-reach users into treatment. If and when the Secretary exercises her authority, conditions should be placed on the use of federal funding to make sure that referrals to drug treatment are an integral part of any program.

The Satcher Nomination: The Satcher nomination could be used by the right wing as a referendum on needle exchange. However, conversations with those on Capitol Hill makes this seem highly unlikely.There seems to be the feeling that the hearing will proceed without a hitch. However, gun control and the AZT trials for pregnant women in the developing world are still hot topics. It is true that Dr. Satcher called for the removal of the restrictions on the use of federal funding for needle exchange programs as CDC Director in 1993. This is widely known and a reality that will simply need to be managed. He can certainly talk about the longstanding public health principles of "let science drive" and "let local communities decide" as policies he will embrace as Surgeon General. In addition, his views on needle exchange can be wrapped in mainstream public health support by our friends on the Committee. Finally, unlike Dr. Elders, Dr. Satcher would certainly say he opposes legalization of drugs for those who like to claim that needle exchange is a slippery slope to legalization.

It is also important to consider the potential negative political ramifications of not maintaining the Secretary's waiver authority, and at some appropriate time (i.e., after Dr. Satcher is confirmed and the Congress has adjourned), exercising it. A few such political considerations follow.

The AIDS Community: This issue has become central to the AIDS community and, rightly or wrongly, it has become symbolic of the Administration's leadership on AIDS. The Administration can and should be proud of the major increases in AIDS funding in the early years. However, with the Balanced Budget Agreement, such major increases in the future are highly unlikely. In addition, each year since the Republicans took the Congress, they have increased AIDS funding above the President's Budget Request. In these times of limited resources, the AIDS community is looking for a new form of leadership, leadership on the difficult policy questions that lie ahead. As pressure on funding intensifies, maximizing the effectiveness of each dollar becomes increasingly important. Generic prevention pamphlets will simply not save the lives of IV drug users and their families.

There is no doubt that the AIDS community would feel abandoned by the Administration if the Secretary's authority is not maintained; I have heard a protest would be scheduled for the President's visit to the Human Rights Campaign Dinner, and several members of the Presidential Advisory Council would resign at the December meeting.

The Public Health Community: Many in the public health community have been concerned that the reinventing government reforms at HHS have dismantled the Public Health Service -- traditionally charged with seeing to it that as administrations come and go, politics do not ride rough-shod over public health. Public health officials are concerned that the new HHS structure politicizes public health policy. Walking away from the longstanding public health principles at play in this debate would reinforce this perception. In addition, mayors and their health officials, who have watched significant authority and flexibility turned over to the states, are looking for some help here in dealing with the twin epidemics of AIDS and drugs in our major urban areas.

Communities of Color: Some certainly perceive that the reason that the Administration is not fighting for this important policy is because it does not affect the gay community, known for it's financial support of the campaign. Some have already called it racism, claiming that if the President really wanted to have a national dialogue on race, he would deal with the reality that AIDS is *the* leading cause of death in the African-American community and *a* leading cause in many communities of color. The gay community was able to go out and raise private funding to pay for effective, targeted HIV education programs when the government got squeamish. Unfortunately, disenfranchised communities cannot. While it may be true that the issue of needle exchange is difficult, it is also true that it saves lives. For those who are continuing to watch their friends and families die, the politically sensitive nature of the debate offers little consolation.

Recommendations: Let us discuss.

MEMORANDUM

To: Chris Jennings

From: Sandy Thurman

Date: October 7, 1996

Re: Needle Exchange

This memorandum is designed to provide background information on the issues surrounding the Secretary of HHS's authority to waive the current restrictions on the use of federal funding for needle exchange programs to reduce the transmission of HIV. A brief overview of the changing epidemic, the public health response, the science, the public opinion, the politics, and other considerations are included.

I thought that some of this information might be helpful if shared with Bruce or others but I wanted to get your input first. Please let me know what you think.

The Evolving AIDS Epidemic

IV drug use now plays a central role in fueling the spread of HIV, particularly among women, children, and people of color.

HIV/AIDS continues to be considered by some as predominantly a gay white male disease. However, AIDS is increasingly a disease seriously affecting people of color, women, adolescents, and IV drug users. A recent report by CDC estimates that more than 50% of all newly reported cases of AIDS are associated with IV drug use, including drug users, their partners and their children. In fact, IV drug use is now the predominate cause of pediatric AIDS. In the last five years there has been a 32% increase in AIDS cases in people of color (representing 63% of new cases), an increase of 64% in women (representing 20% of new cases), and an increase of 22% among injecting drug users (representing 29% of new cases). The gay community continues to be heavily impacted, but the disease is clearly moving rapidly into poorer and more disenfranchised populations. While death rates and new cases of AIDS have both declined in recent months as a result of better therapies, the rate of new infections has not gone down, and there is great disparity among affected communities. For example: while the death rate from AIDS declined 25% for men, it declined only 10% for women. For white men and women the decline in AIDS deaths was 32%, for Latinos it was 20%, and for Blacks it was only 13%. If we look at primary risk factors for infection, the greatest drop was in gay men, for whom AIDS deaths dropped 30%. For injection drug users the reduction was only 15%, and for heterosexuals (including partners of IV drug users) the decline was only 8%.

It is this burgeoning epidemic among IV drug users, their partners and children that have propelled the issue of needle exchange to the forefront of AIDS policy. As those on the front lines fight to keep these families alive long enough to get them into treatment and off drugs, they seek effective strategies for what often seems an overwhelming task.

Scientific Overview

Credible evidence demonstrates that needle exchange programs reduce the spread of HIV without increasing drug use, thereby saving countless lives.

In February, the Secretary of HHS reported to Congress on the results of several major studies of needle exchange programs, including those conducted by the National Institutes of Health, the Centers for Disease Control and Prevention, and the National Academy of Sciences. More than 100 programs were reviewed. These studies provided strong and credible evidence that needle exchange programs can have a positive impact on reducing the transmission of HIV among users. This translates into saving the lives of their partners and children. In addition, the studies found no evidence that needle exchange programs increase drug use

by program participants or in the communities in which the programs were conducted.

Public Health Overview

The Administration seeks to retain the Secretary's authority to gather scientific data not to create a national needle exchange program.

Several years ago, the Congress banned the use of federal funding for needle exchange programs unless the Secretary determines that such programs have been found: (1) to reduce the rate of HIV transmission, and (2) not to increase the use of illegal drugs. If the Secretary was to make such a determination, based on credible scientific evidence, this would not create a national needle exchange program, as the opposition likes to claim. Such action would simply give state and local public health officials the flexibility to include this strategy as part of a comprehensive HIV prevention program -- if, and only if, they chose to do so.

Although some may frame this debate as solely about federal support for needle exchange programs, it is actually about much more basic public health policy. At the core of this debate are two essential principles of public health: (1) that sound science and not politics should drive policy development, and (2) that state and local public health officials should be given the flexibility to design programs that meet the needs of their citizens. Since the beginning of the AIDS epidemic, these principles have guided the federal role in HIV prevention.

HIV prevention has always been a difficult political challenge -- raising issues that people would rather not talk about. In the early days of AIDS, the controversy was over homosexuality; in 1997, it is over IV drug use. In 1980s, the right wing said that AIDS education targeted at the gay community promoted homosexuality. In 1997, they say that needle exchange programs promote illegal drug use. In each case, public health officials employ these strategies because they have been proven to reduce the transmission of a deadly virus. Consistently throughout the epidemic, HHS has sought to make scientific evidence available, report on the effectiveness of various HIV prevention strategies, and let programmatic decisions be made locally, where the needs can be better assessed and the politics can be better managed. In fighting to retain the Secretary's authority to "let the science drive" and "let local communities decide," the Administration simply seeks to defend longstanding public health principles.

Political Landscape

Although this issue needs to be politically "managed," it is not gays in the military.

Unlike gays in the military, this is not a policy being pushed on those who will be forced to implement it -- it is being pushed by them. The current restrictions on federal funding for needle exchange programs tie the hands of city, county, and state health officials who are struggling to save the lives of their citizens. More than 100 needle exchange programs in 27 states have already been developed with state and local funds. Now, the National Association of City and County Health Officials and the Association of State and Territorial Health Officers are seeking the flexibility to use federal HIV prevention funding for this purpose. These officials are joined by a host of mainstream health, public health, and governmental organizations including: the American Medical Association, the Academy of Pediatrics, the American Nurses Association, the American Public Health Association, the National Academy of Sciences, the US Conference of Mayors, the National Black Caucus of State Legislators, and the American Bar Association. Given this line up, it is difficult for the opposition to pass this off as fringe policy put forward by those who do not understand how the system works.

The policy of local control is tremendously popular with the vast majority of Americans. Further, needle exchange programs are supported by a majority of Americans. A 1996 poll done by the Kaiser Family Foundation found that two-thirds of Americans favor providing clean needles to IV drug users. A 1997 poll done by the Republican Tarrance Group found that 55% of voters supported needle exchange programs as a way to curb the spread of AIDS. This poll found 64% of Democrats and 58% of Independents supported

needle exchange, with an 11% spread in the South and a 33% spread in the West. In addition, the editorial boards in all major media markets have solidly supported needle exchange, many challenging the Administration to take a more active leadership role.

Finally, there are bipartisan leaders on Capitol Hill who want to join with the Administration in standing up for sound public health policy. Although the House of Representatives stripped the Secretary of her authority during consideration of the Labor-HHS Appropriations bill, the Democrats supported her by more than a two-to-one margin (141-59). This was true despite the fact that the Democratic Leadership and the Administration devoted little energy to working this vote. In addition, 16 Moderate House Republicans joined with Democrats in the face of serious Leadership pressure to fall in line. On the Senate side, despite right wing efforts to find a champion willing to bring this issue to Senate floor and ensure it was a non-conferencable item, they found no takers. Therefore, the Secretary's authority, originally offered several years ago by Senators Kennedy and Hatch, was affirmed by the Senate as part of the Labor-HHS bill by a vote of 86-14.

In summary, unlike gays in the military, this issue may be sticky, but it is winnable.

Considerations

It is important to consider the potential negative political ramifications of seeking to maintain the Secretary's waiver authority, and at some point, to exercise it. A few such political considerations follow.

The Right Wing: Certainly the Family Research Council will try to use this opportunity to say that the Administration is soft on drugs. However, the Administration's record proves otherwise. On the issue of needle exchange itself, again the Administration is not pushing a national needle exchange program; in fact, the Administration would not support such an effort. We believe that HIV prevention decisions are best made locally. It is the conservatives who often claim that the long arm of federal government has reached too far into state and local decision making. Removing federal restrictions on how local communities spend their HIV prevention dollars is an effort to be less intrusive, not more.

ONDCP: Dialogue with the General has been improving and the two of us are having breakfast this Friday. His willingness to waive comment on the Statement of Administration Policy that went to the Congress supporting the Secretary's authority was a hopeful sign of cooperation. While I certainly understand his concern about sending the wrong message to young people, the vast majority of people who use needle exchange programs are addicts that have been using for more than 10 years. In addition, the research on needle exchange programs demonstrates that such efforts help to bring hard-to-reach users into treatment. If and when the Secretary exercises her authority, conditions should be placed on the use of federal funding to make sure that referrals to drug treatment are an integral part of any program.

The Satcher Nomination: The Satcher nomination could be used by the right wing as a referendum on needle exchange. However, conversations with those on Capitol Hill makes this seem highly unlikely.There seems to be the feeling that the hearing will proceed without a hitch. However, gun control and the AZT trials for pregnant women in the developing world are still hot topics. It is true that Dr. Satcher called for the removal of the restrictions on the use of federal funding for needle exchange programs as CDC Director in 1993. This is widely known and a reality that will simply need to be managed. He can certainly talk about the longstanding public health principles of "let science drive" and "let local communities decide" as policies he will embrace as Surgeon General. In addition, his views on needle exchange can be wrapped in mainstream public health support by our friends on the Committee. Finally, unlike Dr. Elders, Dr. Satcher would certainly say he opposes legalization of drugs for those who like to claim that needle exchange is a slippery slope to legalization.

It is also important to consider the potential negative political ramifications of not maintaining the Secretary's waiver authority, and at some appropriate time (i.e., after Dr. Satcher is confirmed and the Congress has adjourned), exercising it. A few such political considerations follow.

The AIDS Community: This issue has become central to the AIDS community and, rightly or wrongly, it has become symbolic of the Administration's leadership on AIDS. The Administration can and should be proud of the major increases in AIDS funding in the early years. However, with the Balanced Budget Agreement, such major increases in the future are highly unlikely. In addition, each year since the Republicans took the Congress, they have increased AIDS funding above the President's Budget Request. In these times of limited resources, the AIDS community is looking for a new form of leadership, leadership on the difficult policy questions that lie ahead. As pressure on funding intensifies, maximizing the effectiveness of each dollar becomes increasingly important. Generic prevention pamphlets will simply not save the lives of IV drug users and their families.

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Recommendations: Let us discuss.

DISTRIBUTION OF STERILE NEEDLES

Both the House and Senate bills contained restrictions on the use of federal funds for the distribution of sterile needles for the injection of any illegal drug (section 505). The Senate bill repeated language from previous appropriations bills allowing the Secretary to waive the prohibition if she determined that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs. The House bill removed the Secretary's authority over this issue.

The conference agreement includes the House language prohibiting the use of federal funds for carrying out any program for the distribution of sterile needles or syringes for the injection of any illegal drug. This provision is consistent with the goal of discouraging illegal drug use and not increasing the number of needles and syringes in communities.

The conference agreement also includes bill language limiting the use of federal funds for sterile needle and syringe exchange projects until March 31, 1998. After that date such projects may proceed if (1) the Secretary of Health and Human Services determines that exchange projects are effective in preventing the spread of HIV and do not encourage the use of illegal drugs; and (2) the project is operated in accordance with criteria established by the Secretary for preventing the spread of HIV and for ensuring that the project does not encourage the use of illegal drugs. This provision is consistent with the goal of allowing the Secretary maximum authority to protect public health while not increasing the overall number of needles and syringes in communities.

With respect to the first criteria, the conferees expect the Secretary to make a determination based on a review of the relevant science. If the Secretary makes the necessary determination, then the conferees expect the Secretary to require the chief public health officer of the State or political subdivision proposing to use federal funds for exchange projects to notify the Secretary that, at a minimum, all of the following conditions are met: (1) a program for preventing HIV transmission is operating in the community; (2) the State or local health officer has determined that an exchange project is likely to be an effective component of such a prevention program; (3) the exchange project provides referrals for treatment of drug abuse and for other appropriate health and social services; (4) such project provides information on reducing the risk of transmission of HIV; (5) the project complies with established standards for the disposal of hazardous medical waste; and (6) the State or local health officer agrees that, as needs are identified by the Secretary, the officer will collaborate with federally supported programs of research and evaluation that relate to

exchange projects.

It is hoped that the delay in implementation of the provision with regard to exchange projects will allow the authorizing committees sufficient time to conduct a complete review and evaluation of the scientific evidence, as well as any conditions proposed by the Secretary, and consider the need for legislation with regard to these programs. It is the intent of the conferees that the Appropriations Committees refrain from further restrictions on the Secretary's authority over exchange after March 31, 1998.

THE ROLE OF NEEDLE EXCHANGE PROGRAMS IN HIV PREVENTION

David Vlahov, Ph.D. and Benjamin Junge, M.H.Sc.
Department of Epidemiology
The Johns Hopkins University
School of Hygiene & Public Health

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Injection drug users are at risk for HIV and other blood-borne infections. The principle mode of transmission is parenteral through multiperson use of needles and syringes. The mechanism of contamination is through a behavior called "registering," whereby drug users draw back on the plunger of a syringe after venous insertion to ensure venous placement before injecting drug solutions. Strategies to prevent or reduce parenteral transmission of HIV infection need to focus on reducing, if not eliminating all together, the multiperson use of syringes that have been contaminated. The principle underlying these strategies has been stated clearly in the recommendations of the 1995 National Academy of Sciences Report on preventing HIV infection as follows: "For injection drugs the once only use of sterile needles and syringes remains the safest, most effective approach for limiting HIV transmission."[1] This principle was echoed in the 1996 American Medical Association's booklet, A Physician's Guide to HIV Prevention,[2] and in 1995 in the booklet of the U.S. Preventive Services Task Force, The Guide to Clinical Prevention Services.[3] More recently, this principle has been codified in a multiagency HIV Prevention Bulletin.[4]

The first line of prevention is to encourage injection drug users to stop using drugs all together. However, for drug users who cannot or will not stop drug use, owing to their addiction, other strategies are needed two major strategies have been developed to provide sufficient sterile needles and syringes to drug users to be able to reduce transmission of HIV and other blood-borne infections. The first is needle exchange programs, and the second is modification of syringe prescription and paraphernalia possession laws or ordinances. Hereafter, we will refer to the latter as deregulation of prescription and paraphernalia laws.

Needle Exchange Programs. There are now over 110 needle exchange programs in the

United States.[5] By comparison there are 2,000 or more outlets in Australia, and hundreds in Great Britain. The exchange programs, are varied in terms of organizational characteristics.[1,6] Some operate out of fixed sites, others are mobile. Some are legally authorized, others are not. Funding, staffing patterns, policies, and hours of operation vary considerably among the different programs.

Despite different organizational characteristics, the basic description and goals of needle exchange programs are the same. Namely, first, they provide sterile needles in exchange for contaminated or used needles in order to increase access to sterile needles and to remove contaminated syringes from circulation in the community. Second, and equally important, needle exchanges are there to establish contact with otherwise hard-to-reach populations in order to deliver health services, such as HIV testing and counseling, as well as referrals to treatment for drug abuse.

Over time, numerous questions have arisen about Needle Exchange Programs, such as whether these programs encourage drug use and whether they result in lower HIV incidence. These questions have been summarized and examined in a series of published reviews and government-sponsored reports. The government-sponsored reports include those from the National Commission on AIDS in 1991;[7] the U.S. Government Accounting Office in 1993;[8] the University of California and Centers for Disease Control Report in 1993;[6] and the report from the National Academy of Sciences in 1995.[1]

As to whether needle exchange programs increase drug use among participants, the 1993 California report examined published reports that involved comparison groups (Table 1). Because the sampling and data collection methods varied considerably between studies, the

summary has been reduced here to show whether needle exchange was associated with a beneficial, neutral, or adverse effect. Of the eight reports which examined the issue of injection frequency, we find that three showed a reduction in injection frequency, four showed a mixed or neutral effect, (i.e., no change), and one initially recorded an increase in injection frequency.

In terms of attracting youth or new persons into needle exchange programs in the United States, programs that have no minimum age restriction have reported that recruitment of participants who are under 18-years-old was consistently less than one percent; this low rate of use was noted in studies that were done in San Francisco,[9] and New Haven [10] as well as our recent studies in Baltimore.[11] However, recent studies have also shown that new injectors, who are adolescent or young adults are also at extremely high risk for HIV infection.[12] In response to this problem, Los Angeles has recently developed a needle exchange program specifically directed at new initiates into injection drug use (P. Kerndt, personal communication).

Another question is whether the presence of needle exchange programs in a community conveys a message to youth that condones and encourages drug use. This issue is particularly difficult to study. In 1993, the University of California CDC report authors examined longitudinal national drug use indicator data, e.g., data from the DAWN Project, which monitors emergency room mentions of drug abuse related admissions.[6] Comparisons of data before and after opening of needle exchanges and between cities with and without needle exchange programs showed no significant trends.

The only systematic study to date of trends in drug use within a community following the opening of a needle exchange comes from Amsterdam.[13] Using data on admissions to treatment for drug abuse, Buning and colleagues noted that the proportion of drug users under the age of

22-years declined from 14% in 1981 to 5% in 1986; the needle exchange program, opened in 1984. The opening of the needle exchange did not increase the proportion of drug users overall, or those under 22-years. Thus, the currently available data argue against needle exchange as encouraging drug use.

Another issue is whether needle exchanges will result in more contaminated syringes found on the street. If a needle exchange is designed as a one-for-one exchange, the answer is no. In Baltimore, a carefully designed systematic street survey was performed which showed no increase in discarded needles following the opening of a needle exchange program.[14] An update following two years of surveys has shown a similar trend, that there has been no increase.[15]

Findings of behavioral change associated with needle exchange are varied. A number of published studies have compared levels of risky behavior among injection drug users participating and those not participating in needle exchange. As the University of California/CDC report noted earlier, methods varied considerably between these published reports, so that the summary here (**Table 1**) sorts the studies into whether and how the needle exchange has shown an effect (i.e., risk-reduction, no effect, or an adverse effect).

In terms of drug risks, Table 1 shows there were 14 studies that looked at the frequency of needle sharing. Remember this is the most dangerous behavior in terms of drug related risk of HIV transmission. In those studies, ten showed a reduction in needle sharing frequency, four had no effect, and none showed any increase in needle sharing.

Similar trends were noted for the practice of giving away syringes; three showed a reduction in this practice; one no effect; and one an increase. Three out of four studies reporting on this behavior showed a positive effect. Finally, in terms of sexual risk behavior, few studies

overall have examined the impact on needle exchange on sexual risks. This area merits further investigation because sexual transmission among injection drug users is an important area.

The next question about needle exchange programs is whether such programs actually reduce the incidence of HIV infection in injection drug users. While the idea of using only sterile needles makes the question of efficacy seem obvious, the real question centers on how effective the programs are in practice, and how subject such programs are to the ubiquitous "Law of Unintended Consequences."

The studies of the impact on needle exchange on the incidence of HIV infection in the United States are few, primarily because funding for such evaluation is relatively recent and sample size requirements are large. The first study shown in Table 2 was conducted by Holly Hagan and colleagues in Tacoma, Washington.[16] In that city, the prevalence, and, therefore, the incidence of HIV was extremely low. A needle exchange was initiated with the goal of maintaining it at a low level. Two case control analyses were done using hepatitis B and hepatitis C virus infection as outcome variables, because the epidemiology of these two viruses are similar to HIV, although transmission of hepatitis is more efficient that HIV. In these studies, needle exchange participation was associated with over an 80% reduction in the incidence of hepatitis infection. Over time there has been stable, that is, not rising HIV prevalence.

In terms of HIV studies, Kaplan and Heimer at Yale utilized information about HIV test results of washes from syringes returned to the New Haven Needle Exchange Program and constructed, an elegant statistical model to estimate that needle exchange reduced HIV incidence by 33%.[17] This model has been reviewed by three independent statistical reviewers who have

judged the model sound in estimates as reasonable or even conservative.[1,6,8]

More recently, Des Jarlais and colleagues from New York City[16] published a prospective study of seroconversion between attendees and non-attendees of needle exchange. In this study, he estimated a 70% reduction in HIV incidence. Several other studies are ongoing in San Francisco, Chicago, and Baltimore, but their findings are too preliminary to present at this time.

In terms of HIV seroconversion studies from needle exchanges with comparison groups from outside of the United States, data are available from Amsterdam and Montreal.[19,20] In Amsterdam, data from a case control study nested within an ongoing cohort study identified a slightly increased risk of HIV seroconversion with needle exchange use; however, when the analyses were examined by calendar time, the needle exchange was initially protective but the association reversed over time.[19] The authors attributed their results to the needle exchange losing lower risk users to pharmacy access over time, leaving a core of highest risk users within the exchange.

More recently a study was published using a case-control analysis nested within a cohort study in Montreal.[20] Of 974 HIV seronegative subjects followed an average 12 months, there were 89 subjects who seroconverted; consistent use of needle exchange compared to non-use was associated with an odds ratio for HIV seroconversion of 10.5 which remained elevated even during multivariate adjustment. The authors concluded that needle exchange programs was associated with higher HIV rates and speculated that the exchange may have facilitated formation of new social networks that might have permitted broader HIV transmission. In an accompanying commentary,[22] Lurie criticized the Montreal Study saying that the more likely explanation for the findings was that powerful selection forces attracted the most risky injection

drug users as evidenced by substantial differences in the baseline data the exchangers versus non-exchangers (exchangers had higher injection frequencies, lower proportion with a history of drug abuse treatment, more likely to share needles and use shooting galleries, high HIV prevalence). Lurie attributed the differences to the hours and locations of the exchange (late night in the red light district), therefore attracting only a select subset of users.

In Vancouver, Strathdee reported on HIV incidence in a cohort of injection drug users of whom 92% were enrolled in needle exchange.[22] The incidence 18.6 (100 person years) was associated with low education, unstable housing, commercial sex, borrowing needles, injecting with others, and frequent use of needle exchange. The related study by Archibald and colleagues demonstrates a selection of higher risk persons into needle exchange in Vancouver.

The point to consider is what accounts for the discrepancy between the U.S. and non-U.S. studies. From a methodological perspective, there are selection factors that could be operating. For example, in Vancouver, a study was done to compare characteristics of exchangers versus non-exchangers, or high frequency versus low frequency exchangers; this study showed that the high frequency exchangers were more likely to engage in high risk activities.[20] While the Vancouver study showed that self-selection into needle exchange results in leaving a comparison group that is not similar in other respects, the data do suggest that needle exchange has been successful in recruiting high risk users.

At another level the U.S. studies involve evaluation of a needle exchange in comparison to people that do not have access to a needle exchange program or access to sterile needles through other sources. In contrast, the Canadian and Dutch studies have involved comparisons that do have an alternative source to sterile needles, principally access through pharmacies; their

studies may have selected into the needle exchange the people who cannot get needles from pharmacy. Thus, the effectiveness of needle exchange programs depends upon understanding who constitutes the comparison group.

More recently, an ecological analysis was published with serial HIV seroprevalence data for 29 cities with NEPs and 52 cities without such programs.[25] The results, although subject to a possible ecological fallacy, indicated a 5.8% decline in HIV prevalence per year in cities with NEPs and a 5.9% increase in cities without exchange.

Deregulating syringe prescription and paraphernalia laws: In 1992, Connecticut changed their State laws to permit sale and possession of up to ten syringes at a time. The CDC, in conjunction with the state of Connecticut, conducted studies which examined whether IDUs utilized pharmacies; the answer is, they did.[24] The second area they examined is how that pharmacy utilization affected needle sharing behaviors in the two samples of IDUs that were interviewed, 52% reported sharing needles before the law changed, and 31% did so after the law changed.[25] While these data are encouraging, data on needle disposal and the HIV incidence are not yet available.

Summary: Access to sterile needles and syringes is an important, even vital component of a comprehensive HIV prevention program for injection drug users. The data on needle exchange in the United States are consistent with the conclusion that these programs do not encourage drug use and that needle exchanges can be effective in reducing HIV incidence. Other data show that needle exchange programs help people to stop drug use through referral to drug treatment programs.[6] The studies outside of the United States are important for reminding us that unintended consequences can occur. While changes in needle prescription and possession laws

and regulations have shown promise, the identification of organizational components that improve or hinder effectiveness of needle exchange and pharmacy-based access are needed.

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NOTE: Dave which one do you want to use the one above or this one---23. Hurley SF, Jolley DJ, Jaldoo J. Effectiveness of needle exchange programs for prevention of HIV infection. Lancet 310:1797-1800,1997.

Table 1. Summary of Studies of Behavioral Change Within NEPs

Outcome Measures	Beneficial NEP Effect	Mixed or Neutral NEP Effect	Adverse NEP Effect
Drug Risk:			
Sharing frequency	10	4	
Give away syringes	3	1	1
Needle cleaning	3	1	
Injection frequency	3	4	1
Sex Risk:			
Number of partners	2	1	
Partner choice	1	1	
Condom Use	1	1	1

Source: UCSF/CDC, 1993.

Table 2. Impact of Needle Exchange Programs (NEPs) on Incidence of Blood-borne Infections in the United States

Author	City	Design	Outcome	% Reduction
Hagan	Tacoma	Case-control	HBV HCV	83% 86%
Kaplan	New Haven	Mathematical modeling based on testing of syringes returned to NEP	HIV	33%
Des Jarlais	New York	Prospective study of seroconversion; NEP is external cohort and IDUs in neighboring regions	HIV	70%

WHAT NEEDLE EXCHANGE PROGRAMS ARE	Needle exchange programs are about - public health workers getting dirty needle off the street and away from kids - **exchanging** those contaminated needles for clean ones - reducing the spread of HIV and helping get drug users into treatment
AIDS STILL A PRIORITY	The President continues to make the fight against HIV/AIDS a top priority. Since he took office: • **funding for care and treatment** for people living with HIV/AIDS has more than **tripled** and funding for **research** has increased by **50%** • **drug assistance programs** that provide promising new therapies to people with HIV/AIDS have increased by more than **450%** • **a new vaccine research center** is being built at the National Institutes of Health to focus on the President's goal of finding an AIDS vaccine within 10 years • **drug approval** at the Food and Drug Administration has been accelerated to record times
GOAL OF NEPs	Goal of needle exchange programs is to stop HIV and to provide a bridge to drug treatment. Needle exchange is the **beginning of the process** to stop the dual epidemics of HIV and drug abuse - it is not the end, it's a means to an end.
HOW DO YOU FEEL?	I am disappointed, not defeated. - long history - had our share of disappointments - the Administration took a big step forward in certifying the scientific merit of NEPs
SCIENCE LEADS POLITICS	Particularly in the context of AIDS the politics have always lagged behind sound science - examples: - prevention messages promoting homosexuality - condom availability promoting sexual activity - needle exchange promoting drug use This has also been true for other public health issues: - this was just another example - like tobacco, the fight can be long and emotionally charged - politics have often lagged behind science - in the end, once the dialogue begins science always wins

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McCAFFREY	General McCaffrey has his opinion, but - **Dr.** Shalala, **Dr.** Varmus, **Dr.** Satcher, and **Dr.** Fauci are all of one mind on the science - so did the American Medical Association, American Public Health Association, American Academy of Pediatrics
RACE	I am very encouraged that the President has begun the conversation on race relations in this country - recent civil rights meeting at the White House - needle exchange was on the agenda because AIDS is raging in communities of color - 65% of new infections are people of color
RACE LEADERS WANT DRUG TREATMENT AND NEPs	Leaders from communities of color have been telling us for years that the solution to drug abuse was more aggressive drug treatment - only one treatment slot for every 10 drug users in need of treatment - these same leaders have told us that until we get there, needle exchange programs save lives
NO MIXED MESSAGE TO KIDS	Needle exchange programs don't send a mixed message to kids - doesn't encourage drug use any more than giving out matches encourages smoking (b)(6) [001] - drug prevention among youth is important - treatment for those who are addicted is important - needle exchange programs are important
WHAT WE'VE LEARNED FROM DEBATE	What we've learned from the debate: - people don't understand addiction - therefore don't understand why needle exchange programs help stop drug use, not encourage it - need to continue our outreach on drug use and AIDS - need to help America understand more about addiction - need to explain how NEPs are a bridge to treatment (Baltimore study)
CHILDREN	IV drug use causes over **75% of pediatric AIDS cases** in this country - if we want to stop pediatric AIDS in this country, we need needle exchange programs and treatment

VANCOUVER	The study has been misinterpreted and misused - the scientists that did the Vancouver study argued (in a New York Times op-ed) that their science was being misused - there was a higher rate of HIV among NEP participants because the programs were effectively targeting hard-core drug users who were already at risk - the public health experts in Vancouver credit their NEP for keeping the high HIV rate from going even higher - they also argued that there biggest problem was the lack of drug treatment
LEGACY	14 years ago when I started this work on AIDS, the debate was about condoms - similar debate about public health versus politics and moralizing - We won that debate and today we can all celebrate the fact that the rate of new HIV infections are declining the the gay community. - we proved our point then and I'pm confident we will prove the point again when politics catches up with science