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the **Active Voice** +

An educational publication for AIDS activists, advocates and people living with HIV

Summer '97

INSIDE:

**Needle Exchange -
The Facts**

**Feeling Better? -
The Back-to-Work Initiative**

**Capitol Hill Update -
FY98 Appropriations**

**SPECIAL EDITION
THE FACTS ABOUT
NEEDLE EXCHANGE**

the
National
Association
of **People**
with
AIDS

Cindy 2

TALKING POINTS ON NEEDLE EXCHANGE

September 26, 1997

Public health policy should be driven by sound science, not politics.

Injection drug use plays a central role in fueling the AIDS epidemic, particularly among women, children and people of color

- approximately one-third of reported AIDS cases are related to injection drug use
- **66% percent** of all AIDS cases among women--and more than half of AIDS cases among children--are related to injection drug use (either contracted directly through use of contaminated needles, through sexual contact, or mother-to-child transmission)
- intravenous drug use is responsible for the greatest number of new AIDS cases among the heterosexual population

The Secretary of Health and Human Services should retain her authority to gather credible scientific data and, based on that data, to give local communities the flexibility to design HIV prevention programs that meet their needs

- this is the appropriate role of a public health official: assessing the value of various interventions and then allowing local communities the option of using those interventions to address their own unique needs

Americans support needle exchange programs as a tool for preventing the spread of HIV and AIDS

- recent polls conducted by the Tarrance Group (R) and the Kaiser Family Foundation shows that a majority (55%, 66% respectively) of Americans support needle exchange programs

Scientific evidence demonstrates that needle exchange programs reduce the spread of HIV without promoting illegal drug use

- three major reviews (NIH, CDC, National Academy of Science) of over 100 programs have been conducted
- reviews report overwhelming evidence that needle exchange programs can have a positive impact on curbing the spread of HIV among users, their partners, and children
- these reviews found no evidence that needle exchange programs increase drug use by program participants or in communities in which the programs are sited

Removal of the federal restrictions on needle exchange would not create a federal needle exchange program; it would provide local communities with the flexibility to include this strategy as part of a comprehensive HIV prevention program--if they so choose

- it has been the role of the federal government to support the efforts of local health departments without tying their hands--this is surely an extension of that **respectful** policy
- to date, over 100 local communities have pursued needle exchange programs with their own resources

Needle exchange programs provide a critical pathway to drug treatment and health care services

- because IV drug users and their families are often far removed from the help they need, needle exchange programs should be linked to drug treatment, HIV counseling and testing, prevention education, and health care
- the hope offered by the new AIDS treatments can be used as a powerful incentive to program users to get off of and stay off illegal drugs

Needle exchange programs have been endorsed by many prominent national organizations as an important component of comprehensive HIV prevention strategies

- | | |
|---|---|
| • American Medical Association | • National Assoc. of County and City Health Officials |
| • American Bar Association | • National Assoc. of State & Territorial AIDS Directors |
| • American Public Health Association | • National Black Caucus of State Legislators |
| • Association of State & Territorial Health Officials | • U.S. Conference of Mayors |
| • National Academy of Science | |

**FAX TRANSMITTAL****DATE:** 10/24/97**TO:** Sandy**FAX #:****FROM:** Kristin**16 PAGES INCLUDING COVER SHEET**



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

FEB 18 1997

The Honorable Arlen Specter
Chairman
Subcommittee on Labor, Health
and Human Services, and Education
Committee on Appropriations
United States Senate
Washington, D.C.

Dear Senator Specter:

In accordance with the request of the Committee included in Senate Report 104-368, I am transmitting the enclosed report reviewing completed and ongoing research on the efficacy of needle exchange programs in reducing HIV transmission and their impact on illegal drug use.

A number of communities have established outreach programs for out-of-treatment drug users to get them into treatment and to get them to reduce high risk sexual and drug using behaviors. Needle exchange programs have also been developed in many communities to reach injecting drug users who are not in treatment and to reduce the transmission of hepatitis and HIV through the reduction of drug use behaviors and unsafe injection practices.

The intravenous use of illegal drugs is wrong and is clearly a major public health problem as well as a law enforcement concern. Among the many secondary health consequences of injection drug use are the transmission of hepatitis, HIV and other bloodborne diseases. The Department supports a range of activities to cope with these public health issues, from basic research supported by the National Institute on Drug Abuse to substance abuse prevention and treatment programs at the community level.

HIV disease is also an urgent public health problem in our Nation as the leading cause of death among adults age 25-44, and the seventh leading cause of death for all Americans. Injecting drugs with nonsterile equipment is one of three key risk factors for HIV infection, along with unprotected sexual intercourse and untreated sexually transmitted diseases. Unsafe drug injection is the second most frequently reported risk behavior for HIV infection, accounting for a growing proportion of new HIV infections among users, their sexual partners and their children. To realize our goal of effective HIV prevention, it is vital that we identify and evaluate sound public health strategies to address the twin epidemics of HIV and substance abuse.

Page 2 - The Honorable Arlen Specter

The Department has played an important role in supporting evaluations of needle exchange programs as they impact HIV transmission and patterns of drug use. As requested, this report provides the Committee with the findings of published studies conducted in our country, and a description of current research and interim findings where these are available.

Sincerely,

A handwritten signature in cursive script, appearing to read "Donna E. Shalala".

Donna E. Shalala

**REPORT TO THE COMMITTEE ON APPROPRIATIONS
FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES,
EDUCATION AND RELATED AGENCIES**

**NEEDLE EXCHANGE PROGRAMS IN AMERICA:
REVIEW OF PUBLISHED STUDIES AND ONGOING RESEARCH**

**DONNA E. SHALALA
SECRETARY OF HEALTH AND HUMAN SERVICES
FEBRUARY 18, 1997**

REPORT TO THE COMMITTEE ON APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

NEEDLE EXCHANGE PROGRAMS IN AMERICA: REVIEW OF PUBLISHED STUDIES AND ONGOING RESEARCH

Introduction

On September 12, 1996, the Committee on Appropriations for the Departments of Labor, Health and Human Services, Education and Related Agencies made the following request of the Department of Health and Human Services:

"The Committee understands the Department is continuing to support research, reviewing the effect of clean needle exchange programs on reducing HIV transmission, and on whether such programs encourage illegal drug use. The Committee requests that the Secretary provide a report by February 15, 1997 on the status of current research projects, an itemization of previously supported research, and the findings to date regarding the efficacy of needle exchange programs for reducing HIV transmission, and not encouraging illegal drug use." Senate Report 104-368, p.68

In response to the Committee's request, this report provides an overview of the current status of knowledge regarding needle exchange programs (NEPs) with a compilation of relevant reviews and abstracts pertinent to the issues of efficacy of NEPs in reducing HIV transmission and their effect on utilization of illegal drugs. In reviewing the body of literature gathered, it is important to note the wide range of methodologic approaches utilized and the impact of these study design choices on the conclusions drawn. For example, studies varied significantly in terms of study populations, survey instruments, and assumptions made in the design of mathematical models used to predict seroincidence and seroprevalence. Given the significantly different design elements, making comparisons or drawing conclusions across studies requires an understanding of these complexities.

In the Department's assessment, providing the findings and conclusions from specific studies without benefit of the context of their specific methodologies would not facilitate a sound understanding of this issue, as the nature of the findings is not consistent. For these reasons, the original reviews and source documents with their discussions of methodological issues are being provided to the Committee for consideration along with the findings and conclusions. The data presented are limited to published studies conducted in the United States, consistent with the approach taken by the National Academy of Sciences, as the legal and cultural

environments of other countries differ sufficiently enough to raise questions about whether the conclusions are applicable to the United States.

The report is presented in four parts. Part One provides a review of completed studies and published abstracts addressing the efficacy of needle exchange programs for reducing HIV transmission and their effect on illegal drug use. Several major reviews, including a report by the National Research Council/Institute of Medicine (NRC/IOM) analyzes those studies published prior to 1995; subsequent studies are identified individually. Part Two describes the status of federally supported evaluation studies of needle exchange programs, with preliminary findings noted where these are available. Part Three provides the results of a national survey of State and local regulation of syringes and needles. Part Four is a set of Appendices which include the reviews of needle exchange programs described in Part One, two studies published since the NRC/IOM review, and relevant abstracts presented at the XI International AIDS Conference in Vancouver, BC in July, 1996.

I. Review of Published Studies

Three reviews of the literature on needle exchange programs have been commissioned by the federal government: (1) Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy, United States General Accounting Office, March 1993; (2) The Public Health Impact of Needle Exchange Programs in the United States and Abroad, prepared by the faculty and research staffs of the San Francisco and Berkeley campuses of the University of California for the Centers for Disease Control and Prevention, U.S. Public Health Service, in September 1993; and (3) Preventing HIV Transmission: The Role of Sterile Needles and Bleach, National Research Council and Institute of Medicine, September 1995.

Report of the U.S. General Accounting Office

The U.S. General Accounting Office (GAO) was requested by the Chairman of the House Select Committee on Narcotics Abuse and Control to: (1) review the results of studies addressing the effectiveness of needle exchange programs in the United States and abroad, (2) assess 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, and (3) determine whether federal funds can be used in support of studies and demonstrations of needle exchange programs.

The GAO conducted a literature review and site visits to two needle exchange programs. While the GAO noted that there were 32 known needle exchange programs in operation in 27 different U.S. cities or counties, their staff visited only those programs located in Tacoma, Washington and New Haven, Connecticut. Needle exchange programs studied by GAO were located in Australia (1), Canada (1), Netherlands (2), Sweden (1), United Kingdom (3), and the United States (1).

The full report with data from nine needle exchange programs and GAO findings are provided at Appendix A. The Results in Brief are abstracted below:

*Measuring changes in needle sharing behaviors is an indicator often used to assess the impact of needle exchange programs on HIV transmission. We identified nine needle exchange projects that had published results. Only three of these reported findings that were based on strong evidence. Two of these three reported a reduction in needle sharing while a third reported an increase.

One concern surrounding needle exchange programs is whether they lead to increased injection drug use. Seven of the nine projects looked at this issue, and five had strong evidence for us to report on outcomes. All five found that drug use did not increase among users; four reported no increase in frequency of injection and one found no increase in the prevalence of use. None of the studies that addressed the question of whether or not the needle exchange programs contributed to injection drug use by those not previously injecting drugs had findings that met our criteria of strong evidence. Our review of the projects also found that seven reported success in reaching out to injection drug users and referring them to drug treatment and other health services.

We also found the forecasting model developed at Yale University to be credible. This model estimated a 33 percent reduction in new HIV infections among New Haven, Connecticut, needle exchange program participants over 1 year. Based on our expert consultant review, we found the model to be technically sound, its assumptions and data values reasonable and the estimated 33 percent reduction in new HIV infections defensible. This reduction stems from the program's ability to lessen the opportunity for needles to become infected, to be shared, and to infect an uninfected drug user. To gather data in assessing program impact for use in the New Haven model, the researcher developed a new system for tracking and testing for HIV in returned needles.

While these findings suggest that needle exchange programs may hold some promise as an AIDS prevention strategy, HHS is currently restricted from using certain funds to directly support the funding of needle exchange programs. Under the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act of 1992, block grant funds authorized by title XIX of the PHS Act may not be used to carry out any needle exchange program unless the Surgeon General determines that they are effective in reducing the spread of HIV and the use of illegal drugs. However, HHS does have the authority to conduct demonstration and research projects that could involve the provision of needles." Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy, GAO/HRD-93-60, pages 3-4.

Report of the University of California

Under a contract with the Centers for Disease Control and Prevention (CDC), faculty of the University of California, at Berkeley and San Francisco, undertook a review and analysis of the literature on needle exchange programs to answer a set of 14 research questions, including the effect of needle exchange programs on HIV infection rates and prevention of HIV infection and effect on drug using behavior. At the time this study, 37 active needle programs were known to exist in the U.S.; the 33 programs which were up and running for sufficient time to be included in this review operated a total of 102 sites. Over 1900 data sources were analyzed and ranked according to the quality of study design and evidence reported; study results report only on those judged to be of acceptable quality, or better. A complete summary of findings and data sources utilized is provided in the final report at Appendix B.

The Executive Summary of the report is provided below:

"How and Why did Needle Exchange Programs Develop?

Needle exchange programs have continued to increase in number in the US and by September 1, 1993 at least 37 active programs existed. The evolution of needle exchange programs in the US has been characterized by growing efforts to accomodate the concerns of local communities, increasing likelihood of being legal, growing institutionalization, and increasing federal funding of research, although a ban on federal funding for program services remains in effect.

How do Needle Exchange Programs Operate?

About one-half of US needle exchange programs are legal, but funding is often unstable and most programs rely on volunteer services to operate. All but six US needle exchange programs require one-for-one exchanges and rules governing the exchange of syringes are generally well enforced. In addition to having distributed over 5.4 million syringes, US needle exchange programs provide a variety of services ranging from condom and bleach distribution to drug treatment referrals.

Do Needle Exchange Programs Act as Bridges to Public Health Services?

Some needle exchange programs have made significant numbers of referrals to drug abuse treatment and other public health services, but referrals are limited by the paucity of drug treatment slots. Integrating needle exchange programs into the existing public health system is a likely future direction for these programs.

How Much Does it Cost to Operate Needle Exchange Programs?

The median annual budget of US and Canadian needle exchange programs visited is relatively low at \$169,000, with government-run programs tending to be more expensive. Some needle exchange programs are more expensive because they also

provide substantial non-exchange services such as drug treatment referrals. The annual cost of funding an average needle exchange program would support about 60 methadone maintenance slots for one year.

Who Are the IDUs Who Use Needle Exchange Programs?

Although needle exchange program clients vary from location to location, the programs generally reach a group of injecting drug users with long histories of drug injection who remain at significant risk for human immunodeficiency virus (HIV) infection. Needle exchange program clients in the US have had less exposure to drug abuse treatment than IDUs not using the program.

What Proportion of All Injecting Drug Users in a Community Uses the Needle Exchange Program?

Studies of adequately funded needle exchange programs suggest that the programs do have the potential to serve significant proportions of the local injecting drug user population. While some needle exchange programs appear to have reached large proportions of local drug injectors at least once, others are reaching only a small fraction of them. Consequently, other methods of increasing sterile needle availability must be explored.

What Are the Community Responses to Needle Exchange Programs?

Unlike in many foreign countries, including Canada, proposals to establish needle exchange programs in the US have often encountered strong opposition from a variety of different communities. Consultation with affected communities can address many of the concerns raised.

Do Needle Exchange Programs Result in Changes in Community Levels of Drug Use?

Although quantitative data are difficult to obtain, those available provide no evidence that needle exchange programs increase the amount of drug use by needle exchange program clients or change overall community levels of non-injection and injection drug use. This conclusion is supported by interviews with needle exchange program clients and by injecting drug users not using the programs, who did not believe that increased needle availability would increase drug use.

Do Needle Exchange Programs Affect the Number of Discarded Syringes?

Needle exchange programs in the US have not been shown to increase the total number of discarded syringes and can be expected to result in fewer discarded syringes.

Do Needle Exchange Programs Affect Rates of HIV Drug and/or Sex Risk Behaviors?

The majority of studies of needle exchange program clients demonstrate decreased rates of HIV drug risk behavior but not decreased rates of HIV sex risk behavior.

What is the Role of Studies of Syringes in Injection Drug Use Research?

The limitations of using the testing of syringes as a measure of injecting drug users' behavior or behavior change can be minimized by following syringe characteristics over time, or by comparing characteristics of syringes returned by needle exchange program clients with those obtained from non-clients of the program.

Do Needle Exchange Programs Affect Rates of Diseases Related to Injection Drug Use Other than HIV?

Studies of the effect of needle exchange programs on injection-related infectious diseases other than HIV provide limited evidence that needle exchange programs are associated with reductions in subcutaneous abscesses and hepatitis B among injecting drug users.

Do Needle Exchange Programs Affect HIV Infection Rates?

Studies of the effect of needle exchange programs on HIV infection rates do not and, in part due to the need for large sample sizes and the multiple impediments to randomization, probably cannot provide clear evidence that needle exchange programs decrease HIV infection rates. However, needle exchange programs do not appear to be associated with increased rates of HIV infection.

Are Needle Exchange Programs Cost-effective in Preventing HIV Infection?

Multiple mathematical models of needle exchange programs impact support the findings of the New Haven model. These models suggest that needle exchange programs can prevent significant numbers of infections among clients of the programs, their drug and sex partners, and their offspring. In almost all cases, the cost per HIV infection averted is far below the \$119,000 lifetime cost of treating an HIV-infected person." The Public Health Impact of Needle Exchange Programs in the United States and Abroad, Volume 1, pp.iii-v.

Report of the National Academy of Sciences

In 1992, Congress included a provision in the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act directing the Secretary of DHHS to request the National Academy of Sciences (NAS) to conduct a study of the impact of needle exchange and bleach distribution programs on drug use behavior and the spread of infection with the human immunodeficiency virus (HIV). The National Research Council and the Institute of Medicine (NRC/IOM) of the NAS convened an expert panel in 1993, conducted a thorough review of the scientific literature on these issues, and published the report Preventing HIV Transmission: The Role of Sterile Needles and Bleach, in September, 1995.

Approximately 75 needle exchange programs had been initiated in 55 US cities at the time of this report. Data was also newly available assessing the effects of a 1992 Connecticut law decriminalizing the possession of syringes without a prescription.

The scope of the NRC/IOM study extended well beyond the information requested for this report. A review of the scientific data on the effects of needle exchange programs on reduction in HIV transmission rates and impact on drug utilization is presented in Chapter Seven of the report. The text of the full report is provided at Appendix C. The study reviewed and expanded on the previous studies of the GAO and University of California as well as analyzing subsequently published studies through 1994. The NRC/IOM study panel included a discussion of experimental study design and data quality issues in weighing the contribution of published studies. The conclusions and recommendations of the report were based in part on an assessment of the patterns of evidence, and not solely on the quality of evidence in individual studies.

Provided here is a summary of the conclusions of the NRC/IOM panel on the scientific assessment of needle exchange program effectiveness:

Scientific Assessment of Program Effectiveness

- * 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 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." Preventing HIV Transmission: The Role of Sterile Needles and Bleach, Executive Summary, page 4.

Other Recent Studies

Other studies and abstracts published since the NRC/IOM report which address the effects of needle exchange programs on HIV transmission and drug-using behavior are provided at Appendix D. These include: (1) a study published by Des Jarlais et al in Lancet, October 1996 researching the question if NEPs have an individual-level protective effect against HIV transmission, (2) an evaluation commissioned by the Massachusetts Department of Public Health on the effects of a pilot needle exchange program, presenting Year One and Year Two data, and (3) abstracts accepted at the XI International Conference on AIDS held in Vancouver, BC July 1996. Although many abstracts included findings relevant to NEPs, only those designed to specifically study the research questions raised by the Appropriations Committee are included in this report.

- (1) Des Jarlais DC, et al. HIV incidence among injecting drug users in New York City syringe-exchange programmes. Lancet 1996; 348: 987-991.

This study employed meta-analytic techniques to compare HIV incidence among injecting drug users participating in syringe-exchange programs in New York City with that among non-participants. Data from three cohorts (total n=1630) was pooled to assess HIV incidence rates.

- Findings HIV incidence among continuing exchange users in the Syringe Exchange Evaluation was 1.58 per 100 person-years at risk (95% CI 0.54, 4.65) and among continuing exchange users in the Vaccine Preparedness Initiative it was 1.38 per 100 person-years at risk (0.23, 4.57). Incidence among non-users of the exchange in the Vaccine Preparedness Initiative was 5.26 per 100 person-years at risk (2.41, 11.49), and in the National AIDS Demonstration Research cities (non-exchange users) 6.23 per 100 person-years at risk (4.4, 8.6). In a pooled-data multivariate proportional-hazards analysis, not using the exchanges was associated with a hazard ratio of 3.35 (95% CI 1.29, 8.65) for incident HIV infection compared with using the exchanges.

Interpretation We observed an individual-level protective effect against HIV infection associated with participation in a syringe-exchange programme. Sterile injection equipment should be legally provided to reduce the risk of HIV infection in persons who inject drugs." p. 987.

- (2) The Medical Foundation, Final Report: First Year of the Pilot Needle Exchange Program in Massachusetts, October 1995; and Second Year Update: Program Characteristics of Massachusetts Needle Exchange Programs, 1994-95, August 1996.

These two reports were prepared by The Medical Foundation under contract to the Massachusetts Department of Public Health, to evaluate the effects of a pilot needle exchange program (AHOPE) authorized by State law in 1993. Two needle exchange programs served 1,315 and 1,999 unduplicated clients in 1994 and 1995, respectively. The Executive Summary of the 1995 report and the Second Year Update of 1996 summarize study results to the following questions:

- o What were the demographic characteristics of people who enrolled in the program and did the program reach those at risk for HIV infection in Metro Boston and Cambridge
- o What were the reported injection behaviors and risks of program clients
- o How many client-contacts did the program have and what supplies were distributed
- o Did the program act effectively as a "bridge to treatment" for needle exchange clients
- o Did crime increase in areas with needle exchange sites compared to areas without needle exchange sites
- o Did needle stick injuries to public service workers increase as a result of the program

"Conclusion: Upon completion of its first full year of operation, AHOPE has been successful in enrolling 1,315 clients, exchanging 37,575 syringes, and linking 16.6% of the eligible clients to drug treatment. Many of the major concerns regarding the establishment of the program — namely the danger of increased crime, the initiation of young people into drug use and injection, the attraction of addicts from wide geographic areas into Boston, and the possibility of needle stick injuries to public workers — did not come to pass. AHOPE appears to have significantly contributed to the reduction of HIV risk among a diverse population at high risk for HIV infection and transmission with little negative community impact." Final Report: First Year of the Pilot Needle Exchange Program in Massachusetts, October 1995, p.7.

"Conclusion: The program is expanding into areas of the state where there is much need for prevention services while maintaining continuity of care in areas where the program is already established. There is no evidence that the program is attracting young or new injectors, there have been no other negative community impacts. The programs have had significantly positive impacts, both in preventing HIV through the provision of sterile syringes and prevention supplies and education and in the form of enhanced drug treatment linkage for the older, impoverished long-term addicts who utilize the program." Second Year Update: Program Characteristics of Massachusetts Needle Exchange Programs, 1994-1995, August 1996, p.3.

- (3) Abstracts from the XI International Conference on AIDS, Vancouver, BC, July 1996. The following two abstracts reported on US needle exchange programs in Baltimore, MD and New York City.

Vlahov, D et al. Evaluation of the Baltimore Needle Exchange

Program: Preliminary Results. [Abstract Mo.D.361] The following key variables were addressed in the abstract: frequency of drug injection, frequency of needle exchanges, needle sharing patterns, use of shooting galleries, number of injections on the street, and disposal of used needles on the street.

"Conclusion This NEP has recruited a large number of IDUs and preliminary data suggest that the NEP attracts high risk IDUs, and that a reduction in HIV risk drug use is observed."

Schoenbaum, EE et al. Needle Exchange Use Among a Cohort of Drug Users.

[Abstract Tu.C.2523] The abstract reports on a prospective study of injection behaviors among IDUs enrolled in a methadone maintenance program who did and did not utilize a local needle exchange program in the Bronx, New York City between 1985-1993. The following key variables were addressed in the abstract: the percent of clients injecting over time, percent of clients using the needle exchange program, needle sharing behavior, and HIV seropositivity status.

"Conclusion Methadone treated IDUs with access to a needle exchange decreased injection and needle sharing. This pattern of harm reduction, which began years before the needle exchange program opened, occurred in those who did and did not utilize the needle exchange. Needle exchange, as a strategy to decrease injection-related harm, should not be viewed as discordant with methadone treatment."

II. Current Federally Supported Research on Needle Exchange Programs

The Department has taken an active interest in evaluating the public health impact of needle exchange programs since 1992, in light of the opportunity to reduce bloodborne transmissible diseases among IDUs and to serve as a gateway to substance abuse treatment. These research activities have been centered at the National Institute on Drug Abuse (NIDA). A description of NIDA's needle exchange research portfolio which includes 15 funded studies is described in Appendix E. All federally sponsored research is limited by statute to evaluations of existing NEPs and does not support the purchase or distribution of needles.

Of the 15 studies funded by NIDA, only two have been completed. A summary of findings to date follows here. Of 4 studies reporting data on frequency of injection, three report no evidence of increased injection frequency, and one shows a decreased rate of injections. All four of the 15 studies reporting data on multi-person reuse, or sharing, of syringes show a decrease in the reuse of syringes. Data on the prevalence or incidence of hepatitis and HIV is available for 2 of the 15 projects. In one study between 51% - 55% of syringes returned were seropositive; of note, multiple syringes may have been returned by a single

individual affecting interpretation of these results. In the other study, a 33 percent relative reduction in HIV incidence in needle exchange program users was predicted based on a mathematical model. This model was reviewed and assessed to be methodologically sound in the GAO report found at Appendix A.

III. National Survey on the Regulation of Syringes and Needles

A recent national survey of laws and regulations governing the sale and possession of needles and syringes in the United States and its territories is included at Appendix F, to provide the Committee with additional background on the variety of state and local drug paraphernalia laws, syringe prescription statutes, and pharmacy regulations in effect. A number of states and local ordinances have created exceptions to laws and regulations for operators of syringe exchange programs and their participants. An overview of the legislative history and the specifics of exemptions are included along with the results of the national survey.

Summary

This review provides the Committee with an overview of the current status of knowledge regarding the impact needle exchange programs may have on the seroincidence of HIV and their impact on drug use; behavior of needle exchange participants. Overall these studies indicate 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. These studies also indicate 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.

IV. Appendices

- Appendix A. Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy. U.S. General Accounting Office. 1993
- Appendix B. The Public Health Impact of Needle Exchange Programs in the United States and Abroad, Volume 1. San Francisco, CA: University of California. 1993
- Appendix C. Preventing HIV Transmission: The Role of Sterile Needles and Bleach. National Research Council and Institute of Medicine. 1995.
- Appendix D. Des Jarlais DC, Marmor M, Paone D et al. HIV Incidence Among Injecting Drug Users in New York City Syringe-Exchange Programmes. Lancet. 1996;348:987-991.

12

First year report (October 1995) and Second Year Update (August 1996) of the Pilot Needle Exchange Program in Massachusetts. The Medical Foundation, for the Massachusetts Department of Public Health.

Abstracts from the XI International Conference on AIDS, Vancouver, BC July 1996:

- 1) Vlahov D. et al. Evaluation of the Baltimore Needle Exchange Program: Preliminary Results. Abstract Mo.D.361
- 2) Schoenbaum, E. et al. Needle Exchange Use Among a Cohort of Drug Users. Abstract Tu.C.2523

Appendix E. NIDA's Needle Hygiene and Needle Exchange Evaluation Research Program Portfolio, 1992 - Present.

Appendix F. Gostin LO, Lazzarini JD, Jones TS, Flaherty K. Prevention of HIV/AIDS and Other Blood-Borne Diseases Among Injection Drug Users. JAMA. 1997;277:53-62.

PRESIDENTIAL

September 3, 1997

ADVISORY

MEMORANDUM TO ERSKINE BOWLES AND BRUCE REED

COUNCIL ON

FROM:  R. Scott Hitt, Chair, on behalf of the Presidential Advisory Council on HIV and AIDS

HIV/AIDS

The Council understands that an AIDS-related amendment will likely be offered when the House considers the Labor/HHS Appropriations bill this week. This amendment will revoke or effectively revoke the authority of the Secretary of HHS to lift the prohibition on using federal funds for needle exchange programs.

We have vigorously urged the President and Secretary Shalala, most recently in letters sent by the Council in late July and early August, respectively (attached) to exercise this authority. In June in a meeting with community groups, Bruce Reed expressed the President's commitment to ensure at minimum that, if challenged, the Secretary's waiver authority be preserved.

We are extremely concerned by this threatened action and hope that it will not deter Secretary Shalala from acting promptly to lift the ban on federal funding for needle exchange. Achieving the President's stated goal of reducing new HIV infections to zero, thereby saving tens of thousand of lives, creates an urgent need for swift action.

Fairly or unfairly, the community will measure the President's commitment to ending the AIDS epidemic by the vigor of Administration opposition to this Congressional challenge. The White House position must be clear and forcefully put forth.

In light of the overwhelming scientific support for the efficacy of needle exchange programs in preventing new HIV infections, the ban on federal funding of needle exchange should be lifted immediately. According to the Centers for Disease Control and Prevention one-third of all reported AIDS cases are directly or indirectly related to injection drug use. Secretary Shalala's own report to Congress makes clear the scientific support for lifting the ban.

It is paramount that the President provide personal leadership by directing that his Administration implement a viable strategy for lifting the ban, ensure that all relevant Administration personnel are on board and committed to implementing that strategy, and ensure that the full weight of White House support for preserving the Secretary's authority is being exerted.

Memorandum to Erskine Bowles and Bruce Reed

September 3, 1997

Page 2

Many organizations have expressed support for needle exchange programs and their potential for reducing new HIV infections and saving lives. Some of these are the:

American Bar Association;
American Medical Association;
American Public Health Association;
Association of State and Territorial Health Officials;
National Academy of Sciences;
National Black Caucus of State Legislators; and
United States Conference of Mayors.

In addition, major newspapers across the country have expressed their support. Some of these are:

Chicago Tribune
Los Angeles Times
The New York Times
Washington Post
The Plain Dealer (Cleveland)
The Seattle Times

CDCCENTERS FOR DISEASE CONTROL
AND PREVENTION

National Center for HIV, STD, and TB Prevention

Office of the Director
FAX TRANSMITTAL COVER SHEET

From the desk of
Helene D. Gayle, M.D., M.P.H.
Director

Date: 6/25/97**Tel. no.: 404/639-8000****Fax no.: 404/639-8600*****Current Mailing Address Below:******Helene D. Gayle, M.D., M.P.H.******Director, National Center for HIV, STD, and TB Prevention******Centers for Disease Control and Prevention******1600 Clifton Rd., NE******Mailstop E07******Atlanta, Georgia 30333******Pages*** ***(including cover)*******Please address fax confirmations to my assistant, Ruby Booth******Name:*** SANDY THURMAN***Tel. No.:*** 202-632-1090***Fax No.:*** 202-632-1096***Comments:*** AS DISCUSSED

Ruby Booth

BRIEFING MATERIALS

ON

**ACCESS TO STERILE SYRINGES AND SYRINGE
EXCHANGE FOR HIV PREVENTION AMONG
INJECTION DRUG USERS**

FOR

**GENERAL BARRY R. McCaffrey (U.S. - RETIRED),
DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL
POLICY**

**CENTERS FOR DISEASE CONTROL AND
PREVENTION**

ATLANTA, GEORGIA

JUNE 23, 1997

These briefing materials summarize relevant scientific information related to human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) prevention for persons who inject drugs.

Access to sterile syringes is only one component of a comprehensive strategy for HIV prevention among persons who inject drugs and their families. Other key components include: high quality, readily available substance abuse treatment; outreach programs to drug users and their families; HIV prevention programs in jails and prisons; drug courts; HIV counseling and testing programs that reach drug users; and excellent medical treatment programs for drug users who are living with HIV.

1) HIV transmission associated with injection drug use is a key factor in the United States AIDS/HIV epidemic.

More than one third of AIDS cases in the United States are directly or indirectly associated with injection drug use.¹

2) Re-use of blood-contaminated syringes is the mechanism for drug-injection-related HIV transmission.

During the preparation and injection of illicit drugs, the transfer of even minute quantities of blood from one injection drug user (IDU) to another allows the transmission of blood-borne infections. When an IDU draws blood into a syringe to verify that the needle is in a vein, the syringe and needle are contaminated with blood and any blood-borne viruses (e.g., HIV and hepatitis B and C) in that blood. When the blood-contaminated syringe is used by another IDU to inject drugs and/or to prepare drugs for injection, blood-borne infections can be transmitted.

3) Consistent use of sterile syringes by IDUs will substantially reduce HIV transmission and is recommended by scientific and medical authorities.

In May 1997, the United States Public Health Service (PHS)[#] issued an HIV prevention

[#]CDC, Health Resources and Services Administration, National Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration.

bulletin on advice for persons who inject illicit drugs.² Persons who continue to inject drugs should be advised not to reuse syringes and to *use new, sterile syringes to prepare and inject drugs*. These recommendations are supported by earlier recommendations.

The American Medical Association *Physician guide to HIV prevention*³ includes the following advice:

Primary care physicians can help their patients reduce HIV risk from injecting drugs by encouraging their patients to . . .

- *Use a new needle and syringe each time drugs are injected.*

The 1995 National Academy of Sciences (NAS) report "*Preventing HIV Transmission: the Role of Sterile Needles and Bleach*" included the following conclusion.⁴

For injection drug users who cannot or will not stop injecting drugs, the once-only use of sterile needles and syringes remains the safest, most effective approach for limiting HIV transmission.

4) Laws and regulations restricting the sale and possession of syringes are major factors in limiting access of IDUs to sterile syringes.

The NAS report⁴ includes the following observations:

This sharing [of syringes] behavior is in part a consequence of the restricted availability of sterile needles and syringes.

Laws that make it a criminal offense to possess injection equipment (paraphernalia laws) were designed to decrease the prevalence of injection drug abuse, but they also inhibit users from carrying their own supply of needles and thus unwittingly contribute to the sharing of contaminated ones.

Laws requiring a prescription for the purchase of new needles and syringes (prescription laws) constrain the availability of sterile injection equipment and thus promote the sharing of contaminated equipment.

A survey of "syringe laws" in the United States⁵ found:

Every state and the District of Columbia (DC) have enacted state or local laws or regulations that restrict the sale, distribution, or possession of syringes. Drug paraphernalia laws prohibiting the sale, distribution, and/or possession of syringes known to be used to introduce illicit drugs into the body exist in 47 states and DC. Syringe prescription laws prohibiting the sale, distribution, and possession of syringes without a valid medical prescription exist in 8 states. Pharmacy regulations or practice guidelines restrict access to syringes in 23 states.

5) Changing "syringe laws" in Connecticut in 1992 was associated with HIV prevention gains.

After the 1992 partial repeals of the prescription requirement for syringe purchase and criminal penalties for syringe possession, a joint CDC/Connecticut evaluation found that:^{6 7}

- Sharing of syringes by IDUs decreased by 39%.
- More than 80% of Connecticut pharmacies sold syringes without requiring a prescription.
- The primary source of syringes reported by IDUs shifted from purchases on the street to purchases from pharmacies.

6) Syringe exchange.

a) Syringe exchange programs are increasing in the United States.

A recently published article indicates that 87 syringe exchange programs (SEPs) reported providing services in 71 cities in 29 states and exchanging approximately 14 million syringes for the period January--December 1996.⁸ According to unpublished data from the North American Syringe Exchange Network, as of May 1997, there were more than 110 active SEPs in the United States.

b) The NAS Report endorsed syringe exchange to reduce HIV transmission.

The 1995 NAS report "*Preventing HIV Transmission: the Role of Sterile Needles and Bleach*" offers a comprehensive and extensive review and analysis of the scientific data available on syringe exchange.⁴ The NAS panel included scientists who opposed and who supported syringe exchange. Its report should be considered the best review of this complex issue. Some of its conclusions include:

Needle exchange programs should be regarded as an effective component of a comprehensive strategy to prevent infectious disease.

... well-implemented needle exchange programs can be effective in preventing the spread of HIV and do not increase the use of illegal drugs.

c) Multiple scientific reviews have supported the positions that syringe exchange programs prevent HIV among IDUs and do not increase drug use.

Federal government-sponsored reviews of HIV prevention among IDUs between 1991 and 1995 have supported the conclusions that syringe exchange programs prevent HIV among IDUs and do not increase drug use. Those studies include reports by: the National Commission on AIDS,⁹ the General Accounting Office,¹⁰ the University of California, San Francisco,¹¹ the Centers for Disease Control and Prevention (unpublished), the National Academy of Sciences,⁴ and the Office of Technology Assessment.¹² The recommendations are presented in the attached table.

d) The preponderance of scientific evidence and the urgency of the epidemic of HIV (and other blood-borne infections) among IDUs and their sex partners and children is the basis of public health decisions on syringe exchange.

It is not currently possible to directly measure the extent of illicit drug use or of HIV transmission among drug users, or the effect of programs such as SEPs on these factors. As a consequence, the conclusions of the expert reviews have been based on the preponderance of the evidence in the face of a major public health epidemic, the transmission of HIV and other blood-borne infections through drug injection.

e) High HIV seroconversion among IDUs in Vancouver is not explained.

An HIV seroconversion rate of 18.6 (per 100 person-years) has been reported among IDUs in Vancouver, Canada.¹³ Vancouver has the largest volume SEP in North America (approximately 2.3 million syringes exchanged in 1996) for an estimated population of 6,000-10,000 IDUs who are estimated to make between 5 and 10 million illicit drug injections per year.

HIV seroprevalence among IDUs in Vancouver has increased from approximately 1-2% in 1988-89 to approximately 23% in 1996.

Access to drug and alcohol treatment, methadone maintenance and counseling services remains inadequate in Vancouver. Key factors in this HIV outbreak may include: the recent substantial increase in cocaine injection and that IDUs report high rates of borrowing and lending of used syringes. Other factors associated with HIV seroprevalence include commercial sex work and unstable housing which may relate to use of single-room occupancy hotel rooms in the crowded downtown Vancouver neighborhood where most of the IDUs live.

In Vancouver, there is no epidemiologic evidence that the SEP is causing the HIV transmission among IDUs only that there is an association between SEP use and HIV seroprevalence. This same limitation applies to all studies of SEPs.

The report indicates that health authorities plan to continue the Vancouver SEP and use it as a place to contact high risk IDUs for behavioral interventions.

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Conclusions and Recommendations of U.S. Government-Funded Reports on Syringe Exchange Programs (SEPs) and Syringe Sale and Possession Laws					
Report and Year of Publication	Syringe Exchange Programs Reduce HIV Transmission	Syringe Exchange Programs do not increase drug use	Revoke federal Syringe Exchange Funding Ban?	Recommends Removal of Prescription Requirements for Syringe Purchase	Recommends Removal of Syringes from Drug Paraphernalia Laws
National Commission on AIDS 1991 ^a	Implied ¹	Implied ¹	No position stated	Yes	Yes
General Accounting Office 1993 ^b	Partial yes ²	Partial yes ³	Probable no ⁴	No position stated ⁵	No position stated ⁵
University of California 1993 ^c	Yes	Yes	Yes	Yes	Yes
Centers for Disease Control and Prevention 1993 ^d	Yes	Yes	Yes	Yes	Yes
National Academy of Sciences 1995 ^e	Yes ⁶	Yes ⁶	Yes	Yes	Yes
Office of Technology Assessment 1995 ^f	Implied ⁷	Implied ⁷	No position stated	No position stated ⁷	No position stated ⁷

¹ "Studies of demonstration projects like these have shown that they are an immediate and effective way of addressing the public health threat of HIV and of reducing demand" [page 10]

² "While these findings suggest that needle exchange programs may hold some promise as an AIDS prevention strategy, HHS is currently restricted from using certain funds to directly support the funding of needle exchange programs." [page 4]

³ "Most projects suggest that programs do not increase injection drug use." [page 8]

⁴ Not directly stated but appears to recommend support of needle exchange demonstration programs because conditions for lifting the Federal ban were not met based on the review of data available in 1992. [page 4]

⁵ GAO did not make policy recommendations on prescription requirements or drug paraphernalia laws.

⁶ "well-implemented needle exchange programs can be effective in preventing the spread of HIV and do not increase the use of illegal drugs." [page 253]

⁷ "The availability of sterile needles dose not increase the incidence of illicit drug use and they can play an important role in reducing the transmission of HIV among injection drug users." [page 2] "Taken together, these data and others provide evidence that access to sterile injection needles has a beneficial effect on the drug-related behaviour that puts individuals at risk for contracting HIV." [page 22]



February 1997

The Science of Prevention: CDC's Role in Reducing HIV Infection Among Injection Drug Users

To date, more than a third of all reported AIDS cases in the United States are among injection drug users (IDUs), their heterosexual sex partners, and children whose mothers were IDUs or sex partners of IDUs. This disturbing trend continues: In 1995, 35% of reported AIDS cases were IDU-associated. And as a percentage of cases among heterosexuals, IDU-associated AIDS cuts a wide swath, accounting for 66% of AIDS cases among women and 85% of cases among straight men in 1995. In contrast, only 10% of MSM (men who have sex with men) reported a history of injection drug use.

The Centers for Disease Control and Prevention (CDC) is the lead federal government agency responsible for tracking and preventing HIV/AIDS. In cooperation with other federal agencies and offices responsible for addressing drug use -- for example, the Center for Substance Abuse Prevention (CSAP), the Center for Substance Abuse Treatment (CSAT), the National Institute for Drug Abuse (NIDA), and the White House Office of National Drug Control Policy (ONDCP) -- CDC works to address the HIV/AIDS risks presented by illicit drug use. CDC also works directly with communities to give them the tools they need to address the unique prevention needs of IDUs, their sex partners, and their children.

Translating Science Into Practical Community-Level Prevention

Nationwide, approximately 475,000 drug treatment slots are available at any given time. There is an estimated 1.5 million active drug users. Clearly, Americans' need for drug treatment outstrips capacity to provide it. And, clearly, treating people's addiction reduces and, in many instances, eliminates their risk for HIV infection. What to do, then, to keep people safe from HIV until they can get into treatment?

As communities across America grapple with this question, CDC continues to provide them the science they need to make sound local decisions. Both biomedical and behavioral science information is vital to developing sound prevention programs.

For example, in 1993, CDC, CSAP, CSAT, and NIDA issued a "bleach bulletin" alerting state and community prevention programs to the benefits of IDUs cleaning their syringes with bleach and water. But continuing research into the mechanisms of HIV transmission has shown that syringes are not the sole reservoir for HIV. Water used to rinse syringes, cottons used to filter drugs as they are drawn into needles, and even the shared drug itself -- not the shared syringe -- can harbor human immunodeficiency virus and serve as pools for transmission.

CDC has provided this information to communities, along with behavioral recommendations for users who continue to inject to use a sterile syringe for each injection and not to share water or cottons.

Users in Communities with NEPs Less Likely To Be HIV+

Research presented at the XI International Conference on AIDS in Vancouver shows that IDUs want to use sterile syringes, when they're available.

- A study of 543 active users in Atlanta; Baltimore; Long Beach, California; Miami; Philadelphia; and Connecticut shows that IDUs were more likely to have used a reliable source of virus-free needles in cities with a needle-exchange program (NEP) or without paraphernalia laws that put them at risk of arrest and prosecution if they are carrying a syringe. IDUs reported using needles from reliable sources for fewer injections. The majority reported that it was easy to use a syringe only once, but 39% reported that obtaining sterile syringes was difficult.
- Another study of 3,252 IDUs in seven sites across the country shows that they are more likely to participate in needle exchange if they live within 15 minutes of the NEP. Importantly, NEP users are more likely to be those at highest risk for HIV infection -- that is, to have injected with used needles and to get their syringes from varied and unreliable sources such as friends, drug and needle dealers, sex partners, and family. Even where NEPs exist, however, users reported difficulty obtaining sterile syringes.
- A 1990-94 study of 1,353 IDUs in drug treatment in Los Angeles, New York City, Baltimore, and Seattle shows that 84% reported sharing needles less than half the time. And those who got needles from an NEP were less likely to share. In contrast, obtaining new needles from friends was associated with increased sharing. HIV incidence was estimated at 0% per person-year in LA and 1% per person-year in NYC.

Changing Community Laws Is Another Prevention Avenue

In July 1992, Connecticut changed its state laws to permit purchasing up to 10 syringes without a prescription and possessing up to the same number. CDC worked with the state health department to evaluate the effects of the law changes. Highlights of two studies include:

- 83% of pharmacists in Connecticut sold syringes without prescriptions following the law change.
- IDUs used the pharmacies instead of the street for their syringes. In high drug-use areas, the number of non-prescription syringes sold increased dramatically, with little change in sales of prescription syringes. But in low drug-use areas, there was little change in any syringe sales.
- Users reported a substantial decrease in sharing syringes.
- IDUs age, duration of drug use, and frequency of injection did not change. The number of active IDUs did not change.

Many Tools Are Needed To Combat Two Complex Epidemics

Communities use the biomedical and behavioral science CDC provides to design, develop, deliver, and evaluate HIV prevention programming for IDUs. Research shows there are a variety of prevention tools -- drug prevention and treatment, NEPs, removing legal restrictions to sterile syringes -- that could help prevent HIV transmission. CDC will continue to provide communities with the information they need to tailor local solutions to local problems.

September Journal of AIDS Articles-- Evaluation of Connecticut Repeal of Laws Restricting Access to Sterile Needles and Syringes: available August 25, 1995.

In May 1992, the Connecticut legislature passed new laws designed to increase injecting drug users' (IDUs') access to sterile needles and syringes to reduce the number of HIV infections. The new laws made it legal for pharmacists to sell and for individuals to possess up to 10 syringes without a prescription. To determine if the laws were effective, the Connecticut Department of Public Health worked with the Centers for Disease Control and Prevention to evaluate the impact of the laws on pharmacies' needle and syringe sales and the practices of IDUs. Findings from these studies will be published in 2 articles in the September 1995 issue of the *Journal of AIDS*.

Impact of Increased Legal Access to Needles and Syringes on Community Pharmacies Needle and Syringe Sales--Connecticut, 1992-1993

For the laws to affect HIV prevention, pharmacists had to adopt the new policies and sell non-prescription syringes, and IDUs had to purchase and use nonprescription syringes at pharmacies. This analysis examined sales and policies at selected pharmacies and results from a telephone survey of pharmacy managers (a companion article examines IDUs' practices). The article concludes that the new laws did increase access to sterile syringes based on findings that in November 1993, 83% of all pharmacies sold nonprescription syringes, and sales in five pharmacies in a community with a high prevalence of injecting drug use increased from 460 nonprescription syringes sold per month in June 1992 to 2,482 per month in June 1993, but did not increase in a control community with low injecting drug use prevalence.

Impact of Increased Legal Access to Needles and Syringes on Practices of Injecting-Drug Users and Police Officers--Connecticut, 1992-1993

To determine if the new laws actually influenced the practices of IDUs, researchers surveyed a sample of IDUs (124 in initial and 134 in followup survey). The analysis was based on self-reports by IDUs and concluded that the changes in Connecticut laws were associated with a 39% decrease in reports of syringe sharing and an increase in reports of purchase of syringes from reliable sources. Fewer IDUs reported purchasing syringes on the street after the new laws (74% before versus 28% after), and more IDUs reported buying syringes from a pharmacy after the new laws (19% before versus 78% after). Because of concerns that the laws could result in increased risk of needlestick injuries for police officers, researchers also analyzed injury reports before and after the laws were enacted and found that reported injuries decreased after the new laws were enacted.

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AIDS Associated with Injecting-Drug Use — United States, 1995

Injecting-drug use is the second most frequently reported risk behavior for infection with human immunodeficiency virus (HIV) (1). As of December 31, 1995, of 513,486 cases of acquired immunodeficiency syndrome (AIDS) reported to CDC, 184,359 (36%) were directly or indirectly associated with injecting-drug use. Injecting-drug-user (IDU)-associated AIDS cases include persons who are IDUs* (n=161,891), their heterosexual sex partners (n=18,710), and children (n=3,758) whose mothers were IDUs or sex partners of IDUs (1). This report characterizes persons with and trends in IDU-associated AIDS reported to CDC through 1995 from the 50 states, the District of Columbia, and the U.S. territories.

IDU-associated AIDS cases reported in 1995 were analyzed by sex, race/ethnicity, state, and region[†]. Trends in IDU-associated AIDS among adolescents and adults (aged ≥13 years) were evaluated using the estimated incidence of AIDS-defining opportunistic illness (AIDS-OI), which adjusts for the 1993 expansion of the AIDS surveillance case definition and for reporting delays and anticipated reclassification of cases initially reported with no identified risk (1,2). Trends in estimated AIDS-OI incidence were analyzed by quarter for January 1990–June 1995 (the most recent date for which AIDS-OI incidence can be reliably estimated). For inter-area and intergroup comparisons, estimated IDU-associated AIDS OI incidence rates (per 100,000 population) among adolescents and adults for July 1994–June 1995 were calculated using 1994 Bureau of the Census population estimates by race/ethnicity and region.

IDU-Associated AIDS Cases Reported in 1995

Of 74,180 AIDS cases reported in 1995, a total of 25,860 (35%) were associated with injecting-drug use. Among persons with IDU-associated AIDS, 14,057 (54%) were heterosexual males, 5204 (20%) were female, 3425 (13%) were men who have sex with men (MSM), 2849 (11%) were male and female heterosexual sex partners of IDUs, and 325 (1%) were children whose mothers were either IDUs or sex partners of IDUs. Among persons with IDU-associated AIDS, 50% (12,832) were black, 25% (6509) white, and 24% (6319) Hispanic; Asians/Pacific Islanders (74) and American Indians/Alaskan Natives (88) each accounted for <1% of cases.

* Defined as any person who injected drugs at least once after 1977.

[†] Northeast=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; Midwest=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; South=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; West=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming; U.S. territories=Guam, Puerto Rico, U.S. Pacific Islands, and U.S. Virgin Islands.

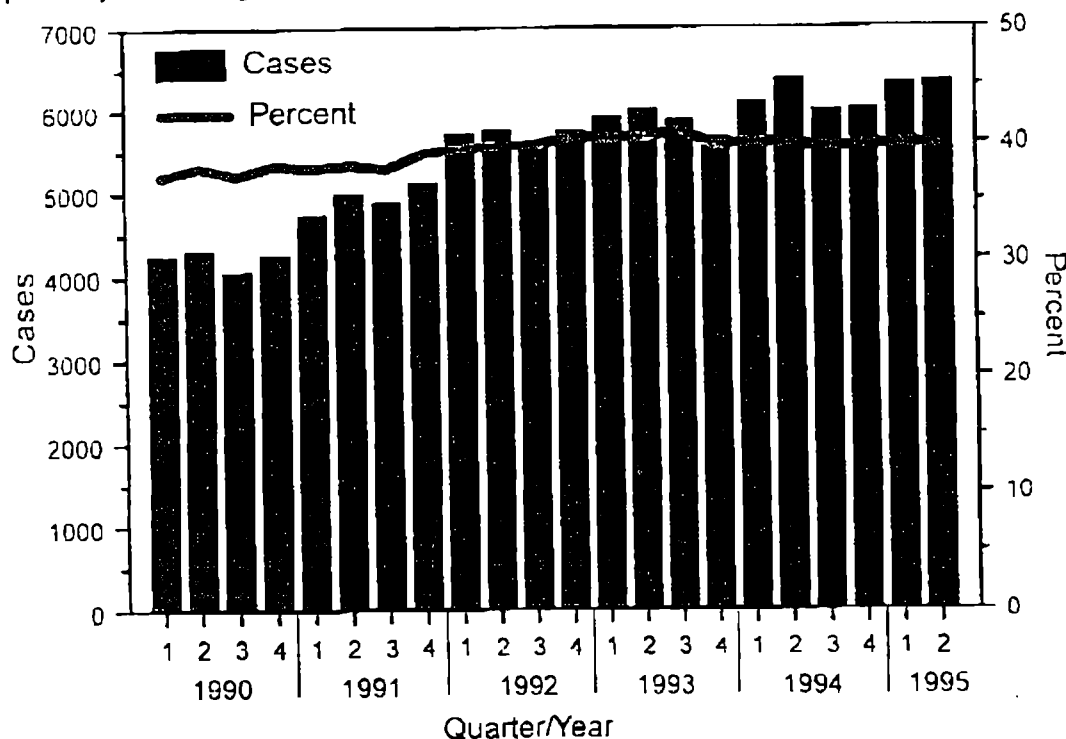
When analyzed by sex and sexual orientation, 66% (7125 of 10,777) of AIDS cases reported among women and 85% (14,985 of 17,686) among heterosexual men with an identified exposure category were IDU-associated. In comparison, 10% (3425 of 34,096) of AIDS cases among MSM had a history of injecting-drug use.

IDU-associated AIDS accounted for >50% of cases reported from Delaware (204 [65%] of 314 cases), Puerto Rico (1647 [63%] of 2604), Connecticut (1018 [61%] of 1676), Maryland (1382 [52%] of 2680), and Rhode Island (121 [52%] of 232) and accounted for 49% from New York (6130 of 12,394) and New Jersey (2155 of 4364). By region, the Northeast accounted for 44% (11,284) of IDU-associated AIDS cases, followed by the South (29%, 7481), West (13%, 3351), Midwest (8%, 2091), and U.S. territories (6%, 1653).

Trends in IDU-Associated AIDS-OI Cases Among Adolescents and Adults, 1990–1995

During January 1990–June 1995, the quarterly number of estimated IDU-associated AIDS-OI cases among adolescents and adults increased 48%, from approximately 4200 cases to approximately 6300 cases (Figure 1). However, most of this increase occurred during the early 1990s (annual increases of 17% during 1990–1991 compared with 4% during 1993–1994). Among female and heterosexual male IDUs, increases in annual AIDS-OI cases were substantial in the early 1990s and smaller in subsequent

FIGURE 1. Estimated number of incident cases* of injecting-drug-user-associated AIDS-defining opportunistic illness (AIDS-OI) and percentage of total AIDS-OI, by quarter year of diagnosis — United States, January 1990–June 1995



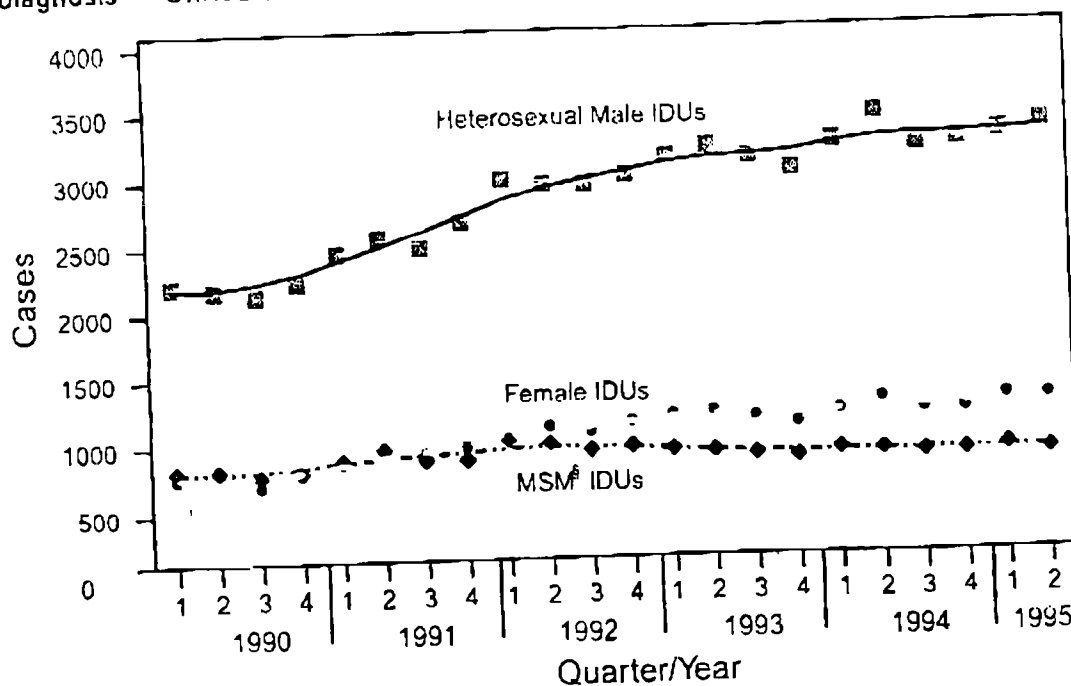
* Estimates are adjusted for delays in reporting and reclassification of cases initially reported without risk (7).

years (Figure 2). In comparison, the number of cases among MSM IDUs peaked in 1992 (approximately 1000 per quarter) and subsequently declined (Figure 2). Among heterosexual sex partners of IDUs, the number of cases increased steadily throughout the 1990s: cases among heterosexual sex partners of IDUs during 1990-1991 increased 23% among women and 19% among men; during January-June 1994 and January-June 1995, increases were 9% among women and 17% among men.

Among non-Hispanic black IDUs, cases increased from January-June 1990 to January-June 1995 by 59% (from approximately 1800 cases to 2800 cases). During January-June 1995, the estimated quarterly number of cases among non-Hispanic blacks (approximately 2800 cases) was more than twice that among non-Hispanic whites (approximately 1300 cases) and Hispanics (approximately 1200 cases) (Figure 3)⁵. From January-June 1990 through January-June 1995, the estimated number of cases in the South increased 62% (from 1000 to 1700 per quarter) and in the West by 56% (from approximately 460 to 700 cases per quarter). In comparison, during 1990-1993, AIDS-OI cases increased approximately 37% (from 1700 to 2400 per quarter) in the Northeast and 68% (from 240 to 400 per quarter) in the Midwest and have remained stable.

⁵Numbers for other racial/ethnic groups were too small for meaningful analysis.

FIGURE 2. Estimated number of incident cases* of AIDS-defining opportunistic illness among injecting-drug users (IDUs), by risk-exposure group and quarter year of diagnosis — United States, January 1990-June 1995[†]

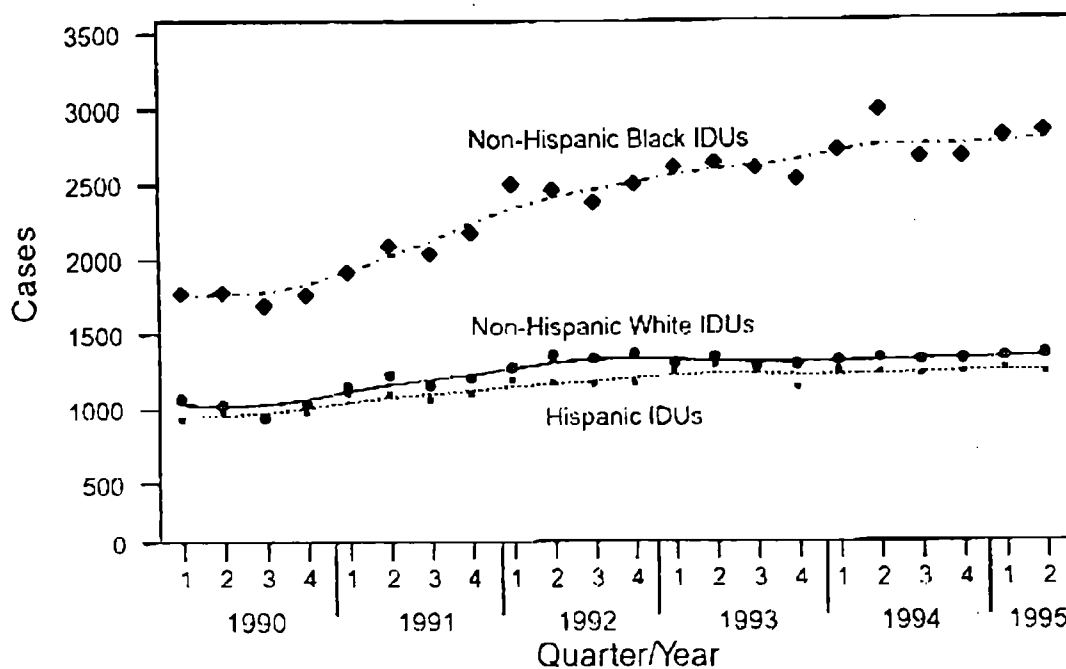


*Estimates are adjusted for delays in reporting and reclassification of cases initially reported without risk (1).

[†]Points represent quarterly incidence; line represents "smoothed" incidence (2).

[‡]Men who have sex with men.

FIGURE 3. Estimated number of incident cases* of AIDS-defining opportunistic illness among injecting-drug users (IDUs), by race/ethnicity† and quarter year of diagnosis — United States, January 1990–June 1995‡



*Estimates are adjusted for delays in reporting and reclassification of cases initially reported without risk (1).

†Numbers for other racial/ethnic groups were too small for meaningful analysis.

‡Points represent quarterly incidence; line represents "smoothed" incidence (2).

Estimated IDU-Associated AIDS-OI Rates Among Adolescents and Adults, July 1994–June 1995

During July 1994–June 1995, the estimated annual incidence rate of IDU-associated AIDS-OI among adolescents and adults was 11.1 cases per 100,000 population. In all regions, estimated IDU-associated AIDS-OI rates were higher for non-Hispanic blacks and Hispanics than non-Hispanic whites (Table 1). Rates were nearly 14-fold higher for non-Hispanic black men (78.7 cases per 100,000 population) and nearly 17-fold higher for non-Hispanic black women (31.8) than for non-Hispanic white men (5.8) and non-Hispanic white women (1.9). Rates for Hispanic men (44.7) and Hispanic women (15.0) were eightfold higher than rates among non-Hispanic whites.

Rates varied substantially by region and were highest in the Northeast (Table 1): of the 13 states with rates ≥ 10 cases per 100,000 population, six were located in the Northeast (New York [39.4 cases per 100,000 population], New Jersey [32.3], Connecticut [24.7], Massachusetts [12.5], Rhode Island [12.4], and Pennsylvania [10.1]), six in the South (Delaware [27.8], Maryland [26.2], Florida [19.3], Georgia [12.2], South Carolina [10.6], and Louisiana [10.5]), and one in the West (Nevada [10.6]). Rates also were high in the District of Columbia (91.9) and Puerto Rico (46.4).

Reported by: Local, state, and territorial health depts. Div of HIV/AIDS Prevention, National Center for STD, HIV, and TB Prevention (proposed), CDC.

TABLE 1. Estimated annual number and rate* of injecting-drug-use-associated AIDS-defining opportunistic illness among persons aged ≥ 13 years, by race/ethnicity[†] and region[‡] — United States, July 1994–June 1995[§]

Race/Ethnicity	Northeast		Midwest		South		West		Total	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
White, non-Hispanic	1,900	(5.8)	550	(1.4)	1,700	(3.2)	1,400	(4.7)	5,600	(3.5)
Black, non-Hispanic	4,900	(117.3)	1,100	(23.4)	5,300	(41.0)	850	(38.7)	12,100	(50.9)
Hispanic	2,800	(87.6)	180	(12.1)	600	(12.0)	550	(6.6)	4,200	(21.9)
Total	10,400	(24.6)	2,000	(4.0)	7,900	(10.7)	3,100	(6.8)	23,300	(11.1)

* Per 100,000 population.

[†] Numbers for other racial/ethnic groups were too small for meaningful analysis.

[‡] Northeast=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; Midwest=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota and Wisconsin; South=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; West=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

[§] Estimates are adjusted for delays in reporting of AIDS cases and anticipated redistribution of cases initially reported with no identified risk.

Editorial Note: The findings in this report underscore three important trends in the AIDS epidemic. First, although annual increases in the number of cases associated with IDUs continue to occur, these increases have been progressively smaller while AIDS incidence among heterosexual partners of IDUs has continued to increase steadily. Second, IDU-associated AIDS has disproportionately increased among heterosexual minorities, particularly among blacks. Finally, although the highest rates of IDU-associated AIDS-OI continued to occur in the Northeast, the numbers of cases in the South and West continued to increase while increases in the Northeast have slowed.

Rates of IDU-associated AIDS in this report were calculated using the total adolescent and adult population. Because the number of IDUs in the United States is unknown, rates of AIDS among IDUs could not be calculated. However, findings of HIV seroprevalence studies among IDUs entering drug treatment centers are consistent with the results of this report: HIV seroprevalence has been consistently highest among IDUs in the Northeast (27%), intermediate in the South (12%), and lowest in the Midwest (7%) and West (3%) (3). In addition, HIV seroprevalence has been consistently higher among non-Hispanic black and Hispanic IDUs than among non-Hispanic white IDUs (3). Racial differences in the number and rate of IDU-associated AIDS cases probably reflect socioeconomic, behavioral, and other risk factors related to injecting-drug use.

Because IDU associated risk for AIDS is probably underreported, the findings in this report represent minimum estimates. Multiple overlapping risk behaviors are associated with HIV/AIDS and account for variations in the epidemiology of this disease. For example, through 1995, 17% of the 128,696 heterosexual men and women IDUs with AIDS also reported having heterosexual contact with an HIV-positive person or a person with other risks for HIV (1,4), emphasizing the strong links between heterosexually acquired AIDS and injecting-drug use. In addition, preliminary findings of a study at six sites to verify exposure risk indicated that 21% (120 of 569) of men and 15% (136 of 877) of women initially reported as having heterosexual contact with an HIV-positive partner or a partner at high risk for HIV infection had an additional risk; of these, most (56% of 120 men and 88% of 136 women) had injected drugs (5).

Measures for reducing the occurrence of IDU-associated AIDS include preventing the initiation of injecting-drug use, increasing the number of IDUs in drug treatment, encouraging safer injecting practices among IDUs, and promoting safer sexual behaviors among IDUs and their sex partners (6,7). For example, in Connecticut, partial repeal of needle prescription and drug paraphernalia laws in 1992 allowing purchase of needles and syringes by IDUs without a prescription and possession of this equipment without medical need decreased the sharing of syringes by IDUs (8). In addition, some jurisdictions have implemented needle and syringe exchange programs to provide IDUs with sterile injection equipment and access to drug-abuse treatment and some services (9). Persons who continue to inject drugs should be screened periodically for HIV infection and advised of measures that may reduce risks for infection (10).

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- f. Office of Technology Assessment. The effectiveness of AIDS prevention efforts. Washington, D.C., 1995

AMERICAN FOUNDATION FOR
AmFAR
AIDS RESEARCH

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FACSIMILE COVER SHEET

DATE:

8/14

TO:

Todd

FROM:

X

Jane Silver

 Scott Sanders Jim OlesonTOTAL # OF PAGES:
(INCLUDES COVER)

MESSAGE:

Here is ABA Resolution
and 1996 Kaiser Poll (see page 11 of
Questionnaire. I'll get you Switzerland info
as soon as I get it.

**AMERICAN BAR ASSOCIATION
SECTION OF INDIVIDUAL RIGHTS AND RESPONSIBILITIES
CRIMINAL JUSTICE SECTION
STANDING COMMITTEE ON SUBSTANCE ABUSE
COMMISSION ON HOMELESSNESS AND POVERTY
COMMISSION ON MENTAL AND PHYSICAL DISABILITY LAW
NATIONAL LESBIAN AND GAY LAW ASSOCIATION**

RECOMMENDATION

RESOLVED, That in order to further scientifically based public health objectives to reduce HIV infection and other blood-borne diseases, and in support of our long-standing opposition to substance abuse, the American Bar Association supports the removal of legal barriers to the establishment and operation of approved needle exchange programs that include a component of drug counseling and drug treatment referrals.

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News Release



EMBARGOED UNTIL:

9:00 a.m. E.T.

Tuesday, March 26, 1996

2400 SAND HILL ROAD

MENLO PARK

CALIFORNIA 94025

For further information contact:

Matt James or

Tina Hoff

TEL 415 854-9400

FAX 415 854-4800

AMERICANS SUPPORT STRONG MEASURES TO PREVENT SPREAD OF AIDS: INCLUDING SEX EDUCATION, CONDOMS IN THE SCHOOLS, CLEAN NEEDLES, AND MORE CONDOM ADS ON TV

Parents Most Worried About Spread of AIDS Among Youth; The Number One Thing Parents Say They Need Help With Is Talking With Children About AIDS Prevention

Washington, D.C. -- To help fight the spread of AIDS, Americans today support a range of sometimes controversial efforts -- more condom ads on television, depictions of safe sex in the entertainment media, providing condoms and AIDS education in the schools, distributing clean needles to IV drug users, among others -- according to the latest public knowledge and attitude survey by the Kaiser Family Foundation. Americans are also grappling with AIDS at home. The number one thing parents say they need is help talking with their children about AIDS prevention.

Virtually all Americans (95%) think AIDS information should be provided in the schools, including 69% who think children should start receiving AIDS education at the latest by age 12; seven out of ten Americans (72%) think the major television networks should accept condom advertisements; two-thirds (66%) favor providing clean needles to IV drug users; and 63% say there should be more references to condom use in movies and television. However, when asked whether they thought high schools should provide condoms or just information about AIDS to teens, Americans were almost evenly divided: 49% say just AIDS/HIV information and 46% say making condoms available should be the priority. Support for AIDS prevention measures persists across demographic groups.

Eight out of ten (77%) parents with children under 21 years of age say they are concerned about their child getting AIDS, including 53% who say they are very concerned. When asked about the information they want most about AIDS, five out of ten parents (49%) say they need more information about "what to discuss with children about prevention." Getting information about where to go for help if exposed to the AIDS virus was the number two information need, picked by 12% of parents.

As part of the Kaiser Family Foundation's AIDS Public Information Project, announced at a press conference today in Washington, D.C., the Kaiser Family Foundation has produced a guide for parents on how to talk with their children about AIDS/HIV. *Talking With Your Kids About AIDS* is available free-of-charge to parents and others through the Kaiser Family Foundation's publication request line at 1 (800) 656-4KFF. Ask for the AIDS Public Information Kit.

-- more --

"As a nation, we should be proud of the job we've done to educate ourselves about AIDS. But, clearly, many Americans still want and need more information about this deadly disease, particularly when it comes to protecting our children," said Mark D. Smith, Executive Vice President, Kaiser Family Foundation. "Without a cure or vaccine, an informed public is still the best way to prevent the spread of AIDS."

Americans Concerned About AIDS Both Personally and for the Nation

Strong public support for specific actions may be driven by the fact that many Americans continue to report they are personally concerned about the spread of AIDS:

- Four out of ten say they are concerned about getting AIDS themselves, including 22% who are "very concerned" and 18% who are "somewhat concerned." (In a 1991 survey conducted by the Roper Organization, 27% of Americans said they were "very concerned" and 18% said they were "somewhat concerned about getting AIDS);
- 43% say AIDS is a "very serious" problem for people they know;
- 39% say they personally know or have known someone with AIDS or the HIV virus;
- Three quarters (74%) agree that "people who get AIDS are no different from people like me in their values and goals."

Minorities and those with low incomes and less education are most likely to be personally concerned about AIDS. A majority (55%) of African Americans and 38% of Hispanics say they are personally "very concerned" about getting AIDS, as compared to 16% of whites. More than a third (35%) of people with annual incomes under \$10,000 say they are "very concerned," as compared with only 14% of those with incomes over \$50,000 per year. Similarly, while 34% of those without a high school degree say they are "very concerned" about getting AIDS, only 14% of college graduates say they are.

Four out of ten (44%) of Americans name AIDS as the "most urgent health problem facing this nation" -- more than any other health issue, including cancer (27%) or rising health care costs and lack of health care coverage (27%). (Multiple responses accepted.) These ratings are generally consistent with earlier survey findings from six years ago, when 49% of Americans named AIDS as "the most urgent health problem" over other health concerns (*Los Angeles Times* poll, 1/90). Moreover, many Americans (48%) fear that the country is "losing ground" in the fight against the disease. Perhaps as a result, half of the population thinks federal spending to fight AIDS is "too low" as compared with spending on other health and medical problems.

AIDS in America. Last year the number of reported AIDS cases in the United States passed the half million mark. More than 300,000 people in the U.S. have died from AIDS. Recent trends in the epidemic include an increase in the proportion of cases occurring among women (now 18% of all AIDS cases) and a growing impact on minorities. The prevalence of AIDS is six times higher among African Americans and three times higher among Hispanics than among whites.

Americans Perceive Some Progress in Fight Against AIDS

While many Americans don't seem to see larger gains in the fight against AIDS, they appear to be encouraged by the progress that has been made to date in some aspects of AIDS prevention and treatment. Significant percentages of Americans think at least "some" progress has been made in:

- protecting people who get blood transfusions from AIDS-tainted blood, 87%;
- keeping people who have AIDS alive longer, 70%;
- reducing the spread of AIDS among gay men, 65%;
- reducing the spread of AIDS to sexually active heterosexuals, 64%;
- reducing the spread of AIDS from pregnant women to their children, 62%;
- reducing the spread of AIDS among teenagers, 59%;
- reducing the spread of AIDS among IV drug users, 48%; and
- finding a cure, 47%.

Furthermore, eight out of ten Americans (81%) say a greater investment in AIDS research would be effective in fighting the spread of AIDS and most (58%) say federal spending on AIDS research and treatment of people with AIDS has been worth the cost.

Americans Generally Informed about AIDS/HIV, Although Some Gaps in Knowledge Persist

Surveys generally find that Americans are ill informed about most national issues, but not when it comes to AIDS/HIV. Most Americans are fairly well-informed about the disease itself -- the transmission, prevention, and treatment of AIDS/HIV. They know that:

- AIDS can be transmitted during sexual intercourse, 97%;
- a pregnant woman with AIDS can pass the virus to her baby, 94%;
- no vaccine is currently available to protect a person from getting AIDS, 88%; and
- drugs are available that can "lengthen the life of a person infected with AIDS," 75%.

Most people (54%), however, think 100,000 or fewer Americans have died from AIDS, when in fact it's more than three times that number. While underestimating the number of lives lost to AIDS, many Americans (51%) overstate the impact here relative to the rest of the world, believing that half or more of all AIDS cases occur in this country. In reality, 38% do.

Some important gaps in knowledge about the prevention and treatment of AIDS persist:

- Seven out of ten Americans do not believe (or are unsure whether) a pregnant woman with AIDS can "reduce the risk of her baby being born infected by taking certain drugs." (In February 1994, the National Institutes of Health released the findings from clinical trials indicating that zidovudine (AZT) therapy reduced by as much as two-thirds the risk of perinatal HIV transmission from infected pregnant women to their infants);
- A majority (52%) think "on average" AIDS symptoms develop within 5 years of HIV infection, including 12% who think symptoms usually appear much sooner, within 6

months or less. (On average, AIDS symptoms develop between 5-10 years after infection); and

- Half of the population (51%) incorrectly thinks a person can get AIDS while "giving or donating blood for use by others." (There are no known cases of HIV transmission as a result of donating blood. Some of the confusion may be related to perceived risk of receiving blood transfusions. Even so, according to a recent study in the *Journal of the American Medical Association*, the actual risk of HIV transmission in a Red Cross center is one for every 450,000-660,000 donations of screened blood.)

"As the findings about Americans' awareness about preventing the spread of AIDS from mother to child indicate, being 'aware' of a problem -- or, in this case, even that progress is being made -- does not necessarily translate into knowledge about what options exist," said Dr. Smith.

Significant Percentages of Americans Distrustful of Information About AIDS/HIV

Although most Americans believe they are receiving accurate information about the AIDS epidemic, significant percentages are dubious about what the government and media are telling:

- More than a third (34%) do not believe the government is telling the whole truth about AIDS; and
- A quarter do not believe the media is telling the whole truth about AIDS.

In addition, fewer but still some Americans question the origins of the epidemic:

- Eighteen percent believe there is some truth to reports that the AIDS virus was produced in a germ-warfare laboratory; and
- Twelve percent believe that AIDS came from God to punish homosexual behavior.

Methodology

The Kaiser Survey on Americans and AIDS/HIV was a national random-sample telephone survey of 1,511 adults, 18 years and older, including over samples of 250 African Americans and 250 Hispanics. The survey was designed by the Kaiser Family Foundation and conducted by the Foundation and Princeton Survey Research Associates (PSRA) between November 27-December 17, 1995, prior to Magic Johnson's announcement that he would resume playing professional basketball. The margin of sampling error for the national sample is plus or minus 3 percent. The margin of sampling error may be higher for some of the sub-sets looked at in this analysis, which have smaller populations.

* * *

The Kaiser Family Foundation, based in Menlo Park, California, is a non-profit, independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. The Foundation's work is focused on four main areas: health policy, reproductive health, HIV, and health and development in South Africa.

Copies of the actual questionnaire and top line data for the findings reported in this release are available by calling the Kaiser Family Foundation's publication request line at 1 (800) 656-4KFF and asking for the AIDS Public Information Kit. Included in this kit are: the *Talking With Your Kids About AIDS* guide and fact sheets on the HIV epidemic and specific topics related to AIDS prevention and treatment. Currently the fact sheets are available online at www.kff.org.



The Kaiser Survey on Americans and AIDS/HIV

March 1996

Questionnaire and National Toplines

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1. What do you think is the MOST urgent health problem facing this nation TODAY? Is there another health problem you think is almost as urgent? (Multiple answers accepted)

Total %	
44	AIDS
27	Cancer
27	Health care costs & health insurance - access
11	Heart
4	Drugs
4	Elderly
15	Other
8	Don't know/Refused

2. Now, I'd like to ask you about the way the problem of AIDS affects THIS COUNTRY today. Do you think the problem is ABOUT THE SAME as it has been, that the country is MAKING PROGRESS in this area, or that the country is LOSING GROUND?

Total %	
15	About the same
32	Country making progress
48	Country loosing ground
<u>5</u>	Don't know/Refused
100	

3. How serious a problem do you think AIDS is for people you know? For people you know, do you think AIDS is...(READ)

Total %	
43	A very serious problem
17	A somewhat serious problem
15	Not too serious a problem, OR
22	Not a serious problem at all
<u>3</u>	Don't know/Refused
100	

4. Bearing in mind the different ways people can get AIDS, how concerned are you, personally, about getting AIDS? Are you... (READ)

Total %		African Americans %	Hispanics %	Income less than 10,000 %	Income more than 50,000 %	No high school degree %	College graduate %
22	Very concerned	55	38	35	14	34	14
18	Somewhat concerned	16	13	12	20	14	19
22	Not too concerned, OR	15	22	17	29	21	24
38	Not at all concerned	14	27	36	37	31	43
*1	Don't know/Refused	*	0	*	*	*	*
100		100	100	100	100	100	100

BASED ON PARENTS OF CHILDREN AGED 21 YEARS OR YOUNGER - 666 RESPONDENTS

5. How concerned are you about a son or daughter getting AIDS? Are you ... (READ)

Total %	
53	Very concerned
24	Somewhat concerned
10	Not too concerned, OR
11	Not at all concerned
0	Don't know/Refused
100	

* An asterisk indicates a value of less than one percent.

6. Please tell me whether you think each of the following statements about AIDS is true or false — OR if you don't know whether it is true or false. The first one is...(READ AND ROTATE)

	True %	False %	DK %	
Any person with the AIDS virus can pass it along to someone else during sexual intercourse	97	2	1	=100
A pregnant woman who has the AIDS virus can give it to her baby	94	3	3	=100
A pregnant woman who has the AIDS virus can reduce the risk of her baby being born infected by taking certain drugs	30	36	34	=100
There are drugs available to treat AIDS or the AIDS virus which can lengthen the life of a person infected with AIDS	75	14	11	=100
There is a vaccine available to the public that protects a person from getting AIDS	5	88	7	=100
A person can get AIDS or the AIDS virus infection while giving or donating blood for use by other	51	46	3	=100

7. After someone is infected with the HIV virus that causes AIDS, about how long on average does it take before AIDS symptoms develop ... (READ)

Total %	
12	Six months or less
16	One to two years
24	Three to five years
29	Five to 10 years
5	More than 10 years?
<u>14</u>	Don't know/Refused
100	

8. Now I'd like you to think about ALL the people around the world who have ever been infected with the AIDS virus, including those who have died. Of every 100 AIDS cases worldwide, about how many do you think have been in the United States? Just give me your best guess by naming any number between one and 100.

Total %	
22	Under 25%
6	25%
16	26-49%
15	50%
10	51%-74%
6	75%
9	76%-99%
11	100%
4	Don't know/Refused
100	
50%	MEAN

9. Now I'd like your impressions about the number of people in this country who have died from AIDS. We don't expect you to know the actual number, but would like you to make your best guess. Do you think the number of people who have died is less than 10,000, up to 100,000, up to 500,000, up to one million, or more than a million?

Total %	
14	Less than 10,000
40	Up to 100,000
24	Up to 500,000
12	Up to 1,000,000
7	More than one million
4	Don't know/Refused
100	

10. Now I'd like you to think about federal spending to fight AIDS. Compared with the money the federal government spends on research and treatment to combat other health and medical problems such as heart disease and cancer, do you think federal spending on AIDS research and treatment is too high, too low or about right?

Total %	
12	Too high
50	Too low
31	About right
<u>7</u>	Don't know
100	

11. Up to this point, do you think federal government spending on AIDS research has generally been worth the cost, or hasn't it produced enough results to be worth the cost?

Total %	
58	Worth the cost
35	Results not worth the cost
<u>7</u>	Don't know/Refused
100	

12. What about federal spending on treatment for people with AIDS? Do you think federal government spending to help pay for AIDS treatment has generally been worth the cost, or hasn't it produced enough results to be worth the cost?

Total %	
58	Worth the cost
36	Results not worth the cost
<u>6</u>	Don't know/Refused
100	

13. Now I'd like your impression of how much progress there has been in AIDS TREATMENT in this country since the disease was first identified. (First,) how much progress do you think has been made in....: a lot, some, only a little, or no progress?

	<u>A lot</u> %	<u>Some</u> %	<u>Only a little</u> %	<u>No progress</u> %	<u>DK</u> %	
Keeping people who have AIDS alive longer	24	46	24	4	2	=100
Finding a cure for AIDS	11	36	37	15	1	=100

14. Now I'd like to ask how much progress you think there has been in AIDS PREVENTION in this country since the disease was first identified. (First,) how much progress do you think has been made in....: a lot, some, only a little, or no progress?

	<u>A lot</u> %	<u>Some</u> %	<u>Only a little</u> %	<u>No progress</u> %	<u>DK</u> %	
Reducing the spread of AIDS generally	29	43	22	6	*	=100
Reducing the spread of AIDS among gay men	26	39	20	11	4	=100
Reducing the spread of AIDS to sexually active heterosexuals	21	43	24	8	4	=100
Reducing the spread of AIDS among teenagers	21	38	30	9	2	=100
Reducing the spread of AIDS among IV drug users	15	33	33	16	3	=100
Protecting people who get blood transfusions from AIDS-tainted blood	66	21	9	2	2	=100
Reducing the spread of AIDS from pregnant women to their children	22	40	25	10	3	=100

15. What about...? If this happened, would it be very effective, somewhat effective, not too effective, or not at all effective in fighting the spread of AIDS?

	<u>Very effective</u> %	<u>Somewhat effective</u> %	<u>Not too effective</u> %	<u>Not at all effective</u> %	<u>DK</u> %	
The government putting more money into AIDS research	39	42	11	6	2	=100

16. We're interested in what information people like you need about AIDS prevention. Please tell me which, if any, of the following you need more information about. (First,) do you need more information about...? (Multiple answers accepted.)

Total % (answering yes)	
18	Proper way to use condoms
29	What to discuss with partners about sex
54	What to discuss with children about AIDS prevention
47	The blood test for the virus which causes AIDS
48	Where to go for help if exposed to the AIDS virus

17. ASKED IF MENTIONED MORE THAN ONE ITEM IN Q16: In which ONE of these areas is it most important for you to get more information?

Total %	% for Parents of children under 21	
1	1	Proper ways to use condoms
6	4	What to discuss with partners about sex
36	49	What to discuss with children about AIDS prevention
10	7	The blood test for the virus which causes AIDS
15	12	Where to go for help if exposed to the AIDS virus
31	26	None of these
<u>1</u>	<u>1</u>	Don't know/Refused
100	100	

18. In general, at what age — if at all — do you think it is appropriate for children to start receiving information about AIDS in school?

Total %	
7	6 or younger
13	7-9 years old
49	10-12 years old
25	13-15 years old
3	16-17 years old
1	No age appropriate/Don't give out information
<u>2</u>	Don't know/Refused
100	

19. Do you think high schools should just provide teenagers with information about AIDS and how it is spread, OR do you think high schools should go further and make condoms available to those teenagers who want them?

Total %	
49	Just provide information about AIDS
46	Make condoms available
1	Don't want AIDS education in schools
<u>4</u>	Don't know/Refused
100	

20. Do you think the major television networks should or should not accept advertising from condom manufacturers for broadcast?

Total %	
72	Should
25	Should not
<u>3</u>	Don't know/Refused
100	

21. When story-lines in movies and television deal with sexual relationships, do you think there ought to be more references to condom use as a way to prevent AIDS, or are there enough references already included?

Total %	
63	Ought to be more references to condoms
29	Enough references to condoms now
4	Shouldn't have sex on TV movies (volunteered)
<u>4</u>	Don't know/Refused
100	

22. Do you favor or oppose having clinics make clean needles available to IV drug users to help stop the spread of AIDS?

Total %	
66	Favor
30	Oppose
4	Don't know/Refused
100	

23. Please tell me how much you agree or disagree with each of the following statements about AIDS. First, do you completely agree, mostly agree, mostly disagree, or completely disagree that...

	Completely <u>agree</u> %	Mostly <u>agree</u> %	Mostly <u>disagree</u> %	Completely <u>disagree</u> %	DK %	
a. The government is telling the truth about AIDS	14	48	23	11	4	=100
b. The media is telling the truth about AIDS	14	58	20	5	3	=100
c. People who get AIDS are no different from people like me in their values and goals	43	31	13	11	2	=100
d. There is some truth in the reports that the AIDS virus was produced in a germ-warfare laboratory	4	14	27	44	11	=100
e. AIDS came from God to punish homosexual behavior	6	6	16	69	3	=100

24. Do you personally know anyone who now has AIDS, has died from AIDS, or has tested positive for the HIV virus?

Total %	
39	Yes
61	No
*	Don't know/Refused
100	

As part of the Kaiser Family Foundation's AIDS Public Information Project, announced at a press conference March 26, 1996 in Washington, D.C., the Kaiser Family Foundation has produced a guide for parents on how to talk with their children about AIDS/HIV. *Talking With Your Kids About AIDS* is available free-of-charge to parents and others through the Kaiser Family Foundation's publication request line at 1 (800) 656-4KFF by asking for the AIDS Public Information Kit. Also included in this kit are fact sheets on the HIV epidemic and specific topics related to AIDS prevention and treatment. Currently the fact sheets are available online at www.kff.org.

MEMORANDUM TO BRUCE REED

FROM: Sandy Thurman, Office of National AIDS Policy

SUBJECT: Needle Exchange Programs

This memorandum is to give you an update on the Hill and community politics around the needle exchange, as this issue is going to heat up in the next two weeks.

House L/HHS Appropriations The House L/HHS Subcommittee is likely to mark up the FY 1998 appropriations bill the week of July 15. At Subcommittee, there's every reason to believe Chairman Porter (R-IL) has included identical language to last year giving the Secretary of HHS authority to waive the ban on federal funding of needle exchange programs. We've been told 6 Republicans sent a letter to Porter indicating they intend to submit an amendment to strip the Secretary of this authority. Mr. Porter probably has the votes to win this at Subcommittee, but at full committee it is much dicier, much less a full House vote. It's unclear if Rep. Livingston will stick by his standard of keeping riders off Approps. bills when it comes to conservative social agenda issues.

Dept. of Health and Human Services It's my understanding that a fair level of consensus has been reached at staff level around a limited lifting of the needle exchange ban -- with a clear set of conditions to be met before funds are used. A final discussion with the Secretary is still pending.

Public Health/Community Politics As you know, the U.S. Conference of Mayors passed a resolution favoring local flexibility and opposing a federal ban on needle funding. The American Medical Association passed a resolution calling for the lifting of the ban last week. The issue is getting more mainstream political cover with AMA, and the public health arguments have been put out front.

The AIDS community is nearly united in believing that the House action will come out unfavorably, with a loss of the Secretary's authority. They are pushing for early action, lifting the ban before the House Appropriations process begins. Rep. Stokes (D- OH) who sits on Approps and is a leader in the Congressional Black Caucus has been sending signals that he is willing to be vocal in support of lifting the ban -- and the CBC will likely follow his lead when the time comes. They are waiting for the Administration.

Timing Issues There are pros and cons to moving ahead to lift the ban on needle exchange. Briefly -

Page 2 - Needle Exchange

Pros

- o There is some clear momentum to ride on after USCM and the AMA.
- o If the Secretary lifts the ban before House action, respected public health/scientific voices like Harold Varmus are freed up to meet with Reps. Porter, Obey and a few key members to walk through the scientific data underlying the decision. Porter may need the scientific credibility and public health arguments at Subcommittee to help hold Members and stem the slide to a partisan vote.
- o By acting early, the Administration could get credit for having taken the right public health stance on needle exchange as a component of HIV prevention with the public health community and the advocacy groups. The onus for keeping the ban would shift to the Congress -- where the accusations of playing politics with public health can be roundly debated.
- o If the House acts before the Administration to strip the Secretary of her authority to waive the ban, the Administration is subject to criticism that it never intended to act and seeks only to blame Congress -- as it did nothing between February and July on the issue.

Cons

- o There will clearly be media critical of any federal funding of needle exchange
- o There will be action to strip the Secretary's authority -- with or without the Administration's action on lifting the ban. Action to lift the ban is unlikely to provoke conservative amendments alone -- these already appear to be in the works.
- o *Undermines Admin's no tolerance stance on drugs*
Some anti-drug groups will try to portray the Administration as starting down the slippery slope of drug legalization by lifting the ban. This will call for vigorous public health arguments and raising the banner of NGA, USCM, ASTHO, AMA, and other state/local public health groups.

Next Steps

I think our best course is to go ahead and get this issue off our plate and onto the lap of Congress by lifting the ban. This is where the groups are at. We continue to take a battering from all sides by sitting on it much longer. I think HHS needs to hear White House support for moving ahead expeditiously. I have had several meetings with General McCaffrey's staff, and am setting up a briefing for him with Dr. Varmus of NIH at the General's request. Your support with ONDCP to keep a simple and consistent message from the Administration remains important.



HRC

If syringe exchange is finally recognized by the federal government as a legitimate HIV intervention measure, it's reasonable to believe that the U.S. government will attempt to develop standards for regulatory oversight. After years of apathy and neglect on this aspect of the AIDS epidemic, there is no evidence that federal agencies have the knowledge or expertise to competently develop such standards. The following are minimum standards for effective syringe exchange provision developed by the Harm Reduction Coalition's Public Policy Committee and the National Coalition to Save Lives Now!

Syringe exchange participants must have access to anonymous services;

Syringe exchange must be available in and accessible to communities in which drug users live and/or frequent;

Any and all organizations capable of providing syringe exchange services should be allowed to do so;

Over-the-counter sale of syringes and syringe exchange programs are both important aspects of HIV prevention and complement each other. The existence of one approach should not preclude the implementation of the other;

No limits should be placed on the number of syringes a participant may exchange at a given visit;

No limits should be placed on the frequency of visits an individual may make to an exchange site;

Access to services must be low-threshold, i.e. non-intrusive registration, walk-in hours or reasonable waiting time, etc;

Protocols and policies must be developed with input from needle and syringe exchange participants and providers;

Drug injectors must be recognized as essential partners in the development of program services and policies;

Syringe exchange programs can be used to facilitate access to drug treatment and other services, but should not be used to coerce participants into those services; and

Syringe exchange must be recognized as a valid stand-alone HIV prevention measure. Continued access to syringe exchange services must not rest on fulfilling other conditions.

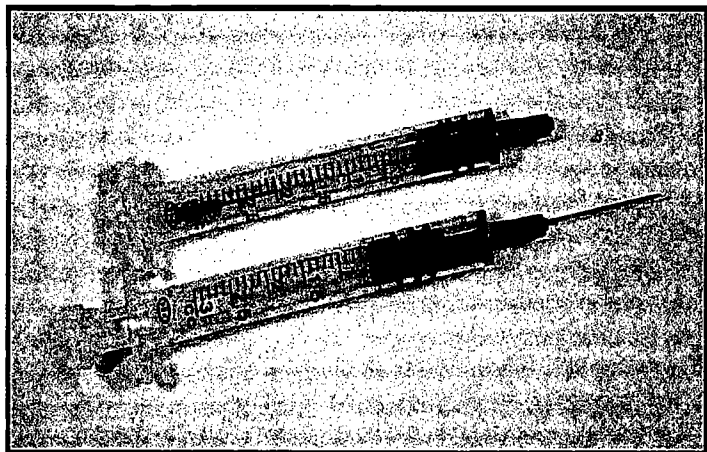
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website: <http://www.harmreduction.org>



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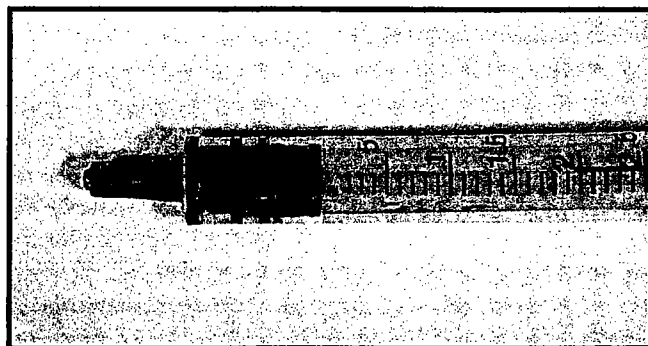
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John Mitnick, President
MedSafe Technologies LLC
1100 Peachtree Street, Suite 2800
Atlanta, Georgia 30309-4530
Phone: 404.685.6700; Fax: 404.815.6555
E-mail: medsafetec@aol.com

Congress of the United States

House of Representatives

Washington, DC 20515

April 27, 1998

Federal Funds for Drug Needles?

Dear Colleague:

As you know, the Clinton Administration recently endorsed needle exchange programs for drug addicts. This is an outrage and that is why we have just introduced legislation, H.R. 3717, to permanently ban the use of federal funds for needle distribution.

Numerous studies - including those done by General McCaffrey's Office of National Drug Control Policy - have concluded that needle exchange programs increase illegal drug use. In addition, they do not reduce the spread of HIV. A recent study published in the prestigious *American Journal of Epidemiology* confirmed this: drug addicts who participate in needle exchange programs are 2.2 times more likely to contract HIV than addicts who do not participate.

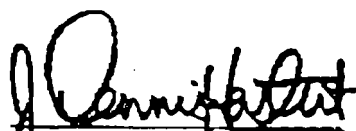
We have led the fight against illegal drug use and we are not going to allow the pro-drug contingent in this Administration to reverse the progress we have made.

Please support our legislation when it comes to the floor this week.

Sincerely,


GERALD B. H. SOLOMON
Member of Congress


TOM DELAY
Member of Congress


DENNIS HASTERT
Member of Congress


BOB BARR
Member of Congress


ROGER WICKER
Member of Congress

Jane Silver

From: Carschmid@aol.com
Sent: Friday, March 05, 1999 8:09 AM
To: Jane.Silver@amfar.org
Subject: another needle bill-introduced 3/4/99

By Mr. GOODLATTE (for himself, Mr. Goode, Mr. Armey, Mr. Cox, Mr. Blunt, Mr. Tiahrt, Mr. Barr of Georgia, Mr. Coburn, Mr. Barton of Texas, Mr. Pickering, Mr. Whitfield, Mr. Bryant, Mr. Shadegg, Mr. Mica, Mr. Goss, Mr. Istook, Mr. Calvert, Mr. Bachus, Mr. Fossella, Mr. Largent, Mr. English, Mr. Latham, Mr. Hostettler, Mr. Paul, Mr. Ballenger, Mr. Sessions, Mr. Doolittle, Mr. Peterson of Pennsylvania, Mr. Packard, Mr. Schaffer, Mr. Herger, Mr. Hayworth, Mr. Cunningham, Mr. Franks of New Jersey, Mr. Jenkins, Mr. Knollenberg, Mr. Dickey, Mr. Weldon of Florida, Mr. Green of Wisconsin, Mr. LoBiondo, Mr. DeMint, Mrs. Myrick, Mr. Hilleary, Mr. Fletcher, Mr. Everett, Mr. Tancredo, Mr. Salmon, Mr. Forbes, and Mr. McCollum):

H.R. 982. A bill to prohibit the expenditure of Federal funds for the distribution of needles or syringes for the hypodermic injection of illegal drugs; to the Committee on Commerce.

Jane Silver

From: Carschmid@aol.com
Sent: Friday, March 05, 1999 8:18 AM
To: Jane.Silver@amfar.org
Subject: goodlatte statement

INTRODUCTION OF LEGISLATION TO PROHIBIT FEDERAL FUNDS FROM BEING USED TO
DEVELOP NEEDLE EXCHANGE PROGRAMS -- HON. BOB GOODLATTE (Extension of
Remarks - March 04, 1999)

[Page: E356]

HON. BOB GOODLATTE

in the House of Representatives

THURSDAY, MARCH 4, 1999

•Mr. GOODLATTE. Mr. Speaker, I rise today to introduce bipartisan legislation that will continue the war on drugs by prohibiting federal funds from being used to develop needle exchange programs. These programs are harmful to communities and undermine our nation's drug control efforts. Similar legislation overwhelmingly passed the House last year with broad bipartisan support.

•Drug abuse continues to ravage our communities, our schools and our children. Heroin use is again on the rise. Unfortunately, thousands of children will inject hard core drugs like heroin and cocaine for the first time this year, and many of them will not make it to adulthood. To deal with this problem, we must have a firm commitment by the federal government to end the cycle of addiction and abuse that destroys so many lives.

•Not only are needle exchange programs in conflict with federal law, but the results of community-based needle exchange programs have been disastrous. Needle exchange programs result in towns with higher crime, schools that are littered with used drug paraphernalia, and neighborhoods that are magnets for drug addicts and the high-risk behavior that accompany them.

•Providing free hypodermic needles to addicts so they can continue to inject illegal drugs sends a terrible message to our children--that Congress has given up on the fight to stop illegal drug use and that the federal government implicitly condones this illegal activity. As lawmakers, we have a responsibility to rise up and fight against the use and spread of drugs everywhere we can. We should start by making it harder, not easier to practice this deadly habit. This bipartisan, common sense legislation will reaffirm the federal government's commitment to the war on drugs.

•While supporters of these dangerous programs can overlook the damage they do to our communities and our children simply because they believe

they serve a public health interest, the medical evidence is simply not there. Studies have shown that addicts who use needle exchange programs are more likely to contract HIV or other blood-borne viruses. A recent study published in the American Journal of Epidemiology concluded that there was no indication that needle exchanges protected against blood-borne infections. In fact, the study concluded, 'there was no indication of a protective effect of syringe exchange against HBV or HCV infection. Indeed, highest incidence of infection occurred among current users of the exchange, even after adjusting for confounding variables.'

•Mr. Speaker, when the President unveiled his anti-drug strategy, Vice-President Gore stated, 'We must mount an all-out effort to banish crime, drugs and disorder and hopelessness from our streets once and for all.' Yet, in the words of the President's own National Drug Czar, General Barry McCaffrey, 'these programs are magnets for all social ills--pulling in crime, violence, addicts, prostitution, dealers and gangs and driving out hope and opportunity.' Mr. Speaker, we will never banish crime, drugs, disorder and hopelessness by providing those responsible for it with the tools of their trade.

•The United States government must never give up on the war against the deadly drugs that continue to destroy our neighborhoods, our schools and so many of our families. We should not tell our children 'Don't do drugs,' on the one hand, while giving them free needles to shoot up with the other. We need a national drug control policy which emphasizes education, interdiction, prevention and treatment--NOT subsidies for addicts.

•I urge my colleagues to heed the advice of General McCaffrey and ensure that the federal government is not in the business of subsidizing irresponsible, reckless and illegal behavior. The federal government should provide leadership, NOT needles.

Statements/Resolutions/Policies on Increased Access to Clean Needles and Syringes

American Medical Association

H95.958 Syringe and Needle Exchange Programs
The AMA encourages needle exchange programs

American Medical Association A Physician Guide to HIV Prevention

Primary care physicians can help their patients reduce HIV risk from injecting drugs by encouraging their patients to...

- Abstain from using drugs and to seek treatment.
- Use a new needle and syringe each time drugs are injected.
- Have their own personal injection equipment that is never shared.
- Share only needles and syringes that have been correctly cleaned.
- Use condoms with sex partners who share injection equipment.

Resolution 435 - Needle and Syringe Exchange Programs

...That the AMA encourage the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection.

That the AMA initiate and support legislation revoking the 1988 federal ban on funding for needle exchange programs for injecting drug users.

That the AMA strongly encourage state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription.

American Academy of Pediatrics

Reducing the Risk of Human Immunodeficiency Virus Infection Associated With Illicit Drug Use, Pediatrics, December 1994, Provisional Committee on Pediatric AIDS

Conclusions and Recommendations:

The adverse consequences of illicit drug use are multiple and are a major factor in the spread of HIV infection to infants, children, and adolescents. The American Academy of Pediatrics believes that initiatives to address these consequences should include:

1) preventing illicit drug use, the ready availability of treatment to individuals who are drug users, and reducing the risk associated with continued drug use.

2) programs that improve knowledge about decontamination of injection equipment and provide access to sterile injection equipment thereby can reduce the spread of HIV and prevent new cases of AIDS. These programs should be encouraged and expanded; linked to drug treatment; and conducted within the context of continuing research to document effectiveness and clarify those factors that contribute to desired outcomes.

3) a reassessment of laws regarding the possession of needles, syringes, and bleach from a public health perspective with attention to both the desire to minimize the potential that such statutes might discourage individuals from engaging in risk-reducing behavior, and the continuing goal of discouraging illicit drug use.

American Foundation for AIDS Research

February 1997 Letter to President Clinton

The ethical imperative to provide sterile injection equipment to intravenous drug users is strongly supported by the nation's foremost bioethicists : Consensus Statement "On the Ethics of Denying Injection Drug Users Access to Sterile Injection Equipment"

...These principles inform our conclusion that the failure to fund needle exchange efforts, with the predictable loss of life that can be traced to HIV infections that might have been averted, is ethically unacceptable.

...We believe that a failure to lift the federal ban on funding of needle exchange programs represents a policy that will consign thousands of men, women and children to early deaths. By every principle of medical ethics this situation calls out for a change.

American Public Health Association

9515: Syringe and Needle Exchange and HIV Disease
therefore

1. Urges both Congress and the executive branch take positive steps to support syringe and needle exchange programs;
2. Urges state and local governments to take steps to improve drug users' access to clean injection equipment (e.g. through decriminalizing possession of injection equipment and institution of needle and syringe exchange programs) and to ensure that such programs complement the drug abuse treatment system; and
3. Urges further evaluation of programs to provide sterile injection equipment.

Association of State and Territorial Health Officials

Policy Statement: Needle Exchange

ASTHO promotes the following policy:

- ... Therefore ASTHO recommends that drug users who continue to inject should be advised of the following guidelines for reducing their risk of infection with injection-related blood-borne infections: Use a new sterile syringe to prepare drugs for injection; Only use clean or never-before-used "cookers and "cotton" in preparing drugs; Use clean water from a reliable source (tap water) and, if possible, sterile water for preparing drugs; Clean the injection site prior to injection with a new alcohol swab; Use a new sterile syringe to inject drugs; Use only syringes obtained from a safe, reliable source (e.g., pharmacy or syringe exchange); Never re-use or share syringes or drug preparation equipment; Safely dispose of syringes after one use.)

- As this nation's lead public health authority, the U.S. Public Health Service should provide in writing clear policy statements regarding the importance of sterile needles and syringes for injection drug users who continue to inject and clear advice to interested states on 1) how to increase access to sterile needles and syringes and 2) to deregulate possession of needles and syringes.

- The federal government should not restrict the use of federal funds for needle exchange services to also interested states and localities the financial flexibility to support successful prevention and treatment initiatives within their jurisdiction.

- As a possible public health strategy to reduce the transmission of injection-related blood-borne infections, states should explore the removal of legal barriers such as drug paraphernalia and prescription laws, which criminalize the distribution and/or possession of needles and syringes.

- States with needle exchange programs should continue development of state and local syringe exchange programs incorporating a strong evaluation component and disseminating the results of the evaluation research to the public health community. Interested states should develop and implement procedures to identify process, outcome and cost-effectiveness evaluation measures to assess the effectiveness of increased needle access.

- State health departments should explore conducting educational programs with pharmacists, police and members of the legal system about the public health importance of sterile syringes for drug users who continue to inject.

- States should provide leadership strategies to increase access to sterile needles and syringes in communities where such strategies are deemed an important component of the public health approach to reducing injection related blood borne infections. Such leadership could include community/provider education and outreach, as well as financial support for successful community based programs.

- Any strategy, whether developed at the federal, state, or local level, should make a good faith effort to include in the planning and implementation processes members of those communities affected/infected by injection related blood borne infections.

National Alliance of State and Territorial AIDS Directors

NASTAD Resolution

Action to Reduce the Transmission of HIV and Other Diseases Through Increased Access to clean Needles and Syringes

Therefore, be it resolved that:

NASTAD calls upon legislative bodies in the US to increase access to sterile needles and syringes and deregulate possession of needles and syringes and other drug paraphernalia as well as increase access to drug treatment for those individuals ready for such treatment.

NASTAD calls upon federal, state and local agencies carrying out HIV prevention programs to encourage injection drug users who continue to inject: to always use sterile needles and syringes obtained from a reliable source (i.e. pharmacy or syringe exchange program) to prepare and inject drugs; to use new cookers, cotton and water each time; and to safely dispose of injection equipment and other materials after one use.

NASTAD encourages each state health department to work with pharmacy boards and police organizations to convince them of the public health importance of sterile injection equipment for injection drug users who continue to inject, and to work together to increase access to sterile injection equipment and for deregulation of possession of needles and syringes.

NASTAD calls on the Department of Health and Human Services to provide in writing clear policy statements regarding the importance of sterile needles and syringes for injection drug users who continue to inject, and clear advice to states to change laws to increase access to sterile needles and syringes and to deregulate possession of needles and syringes. The Department is encouraged to expand resources for drug treatment and to facilitate linkages between syringe exchanges and treatment, health, and social service agencies.

National Black Caucus of State Legislators

Resolution 97-09 Support for Needle Exchange Programs to Limit the Rate of HIV Infection

Be it Further Resolved, that in the face of mounting positive evidence NBCSL calls on Congress to lift the ban on the use of federal funds for needle exchange programs; and

Be it Finally Resolved, that NBCSL calls upon legislative bodies throughout the country to amend drug paraphernalia and prescription requirements in consultation with their state public health authorities to allow greater access to sterile needle and syringes for those addicted to injection drugs.

New York Academy of Medicine

Report of the Academy Committee on Medicine in Society

Legal barriers to obtaining sterile needles and syringes should be removed. We support the enactment of the New York State legislative proposal to permit the sale by pharmacies of hypodermic needles and syringes without a prescription, and to deregulate the distribution and possession of sterile needles and syringes as a cost-effective approach to preventing HIV transmission.

We support increasing the availability of needle exchange programs to all those who seek such services; these programs should incorporate into their outreach services education on the proper disposal of needles. The State Legislature should substantially increase appropriations for state-sponsored needle exchange programs to \$7 million in order to expand capacity at the state's eleven existing programs, develop new programs, and increase the availability of supplies necessary to implement needle exchange. In addition, we advocate rescinding the present ban on utilizing federal funds for needle exchange programs and research.

U.S. Conference of Mayors

Resolution No.26: Rationale for Needle Exchange Programs
65th Annual Conference of Mayors Meeting June, 1997

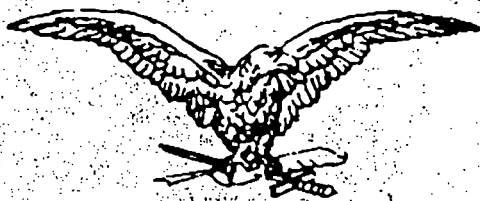
Now, Therefore, Be It Resolved, that the Secretary of the Department of Health and Human Services, in recognition of the overwhelming scientific evidence that needle exchange is effective in preventing the spread of HIV and does not increase the use of illegal drugs, exercise the waiver authority provided under the FY1997 Labor, Health and Human Services, Education and Related Agencies appropriations legislation; and

Be It Further Resolved, that needle exchange is only one, vital component of a comprehensive HIV prevention program, including information, medical treatment, substance abuse treatment and a broad range of complementary social services necessary to prevent the spread of HIV: and

Be It Further Resolved, that state and local public health officials, consistent with the scientific and public health evidence supporting needle exchange as an effective HIV prevention tool, may utilize appropriate Federal resources for needle exchange programs, as a part of a community's comprehensive HIV prevention plan.

July 1997

LOS ANGELES TIMES EDITORIALS



Needle Programs Are Needed

Evidence is in: They can reduce AIDS without fostering drug use

Understandably uneasy with government agencies giving drug addicts needles and other paraphernalia, Congress prohibited federally funded needle exchange programs in 1988. The ban could be lifted, Congress said, when there was proof that such programs reduced transmission of the AIDS virus without increasing illegal drug use. Now, that time has come.

Since 1993, several major studies have shown that the programs that give addicts clean needles in exchange for used ones decrease HIV infection in injected-drug users by 30%, increase the likelihood that addicts will enter drug treatment programs and do nothing to lead nonusers into drug habits. But, unlike in most developed nations, many U.S. state laws and federal law prohibit government from supplying clean needles. (California does not prohibit private programs, but Gov. Pete Wilson has thrice vetoed bills that would have explicitly legalized such programs.)

Prohibitions cost lives and money. According to the federal Centers for Disease Control, most of the 41,000 new HIV infections each year occur among injected-drug users and their sexual partners and children. The average cost of lifetime care for those infected with HIV or

suffering from AIDS runs about \$120,000, while each sterile needle costs 10 cents.

Citing "an urgent public health need," the American Medical Assn. and the U.S. Conference of Mayors have called for revocation of the 1988 law and of similar state laws prohibiting needle exchange programs. In a resolution sponsored by Los Angeles Mayor Richard Riordan and San Francisco Mayor Willie Brown, the Conference of Mayors went a step further, urging Health and Human Services Secretary Donna Shalala to use her authority to permit federal funding.

Reflecting the conventional wisdom in Washington, conservative public policy analyst Gary L. Bauer says the idea of lifting the ban on needle exchange is unthinkable because it "strikes the average voter in the gut as being against common sense." But recent polls suggest otherwise: A Kaiser Family Foundation survey last year found that 66% of Americans support needle exchange programs.

Washington should listen to the civic leaders and public health experts who have seen close up how the programs can be an effective and inexpensive way of curbing the spread of a deadly disease.

The New York Times

Founded in 1851

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Federal Funds for Clean Needles

Health and Human Services Secretary Donna Shalala says in a new report to the Senate that needle-exchange programs are an effective way to combat the spread of H.I.V., the virus that causes AIDS. But the Secretary does not go far enough. It is time the Clinton Administration lifted the ban on Federal funding for needle-exchange programs.

Such programs now exist in more than 50 American cities, including New York. They provide intravenous-drug users with sterile needles, thus reducing the likelihood that addicts will share needles contaminated with H.I.V. The programs typically have very small budgets, often are run by volunteers and are plagued with unstable funding from year to year. Yet even these modest programs have been effective.

Secretary Shalala's report reviews the research on the issue. Earlier studies done by the National Academy of Sciences, the General Accounting Office, the Centers for Disease Control and the University of California at Berkeley found that providing addicts with sterile needles could help slow the spread of the virus. Equally important, those studies found no evidence that needle-exchange programs increased the amount of drug use by addicts or attracted new users.

More recent studies done for the Massachusetts Department of Public Health and in Baltimore by the Johns Hopkins School of Public Health con-

firmed those observations. Federally funded studies conducted by the National Institute on Drug Abuse also report no increase in the frequency of drug injection associated with needle-exchange programs. A conference of scientists convened by the National Institutes of Health on AIDS prevention stated unequivocally last week that there is no doubt that needle-exchange programs work.

The consistency of these findings justifies Federal support to help pay for needle-exchange programs in communities that need and want them. Unfortunately, the debate continues to focus on politics and morality rather than public health needs. Opponents argue that providing addicts with needles implies approval of drug abuse. They forget that addicts can infect their spouses and offspring who do not abuse drugs and yet must live with the consequences of dirty needles.

Congress imposed the ban on Federal funding for needle exchanges in 1992. But the Administration can lift the ban if the Surgeon General declares that the programs can reduce H.I.V. spread and do not increase drug use. Secretary Shalala's report offers ample evidence that both requirements have been met. The Administration no doubt wants to avoid giving its opponents any reason to bash President Clinton for being soft on drugs. But lives can be saved with needle-exchange programs. The President should show some courage on this issue.

THURSDAY, APRIL 3, 1997

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Point taken

Studies of needle-exchange programs show a practicality that must be recognized

The use of illegal drugs is wrong and physically devastating both to individuals and communities. The consumption of cocaine, heroin and widely available barbiturates not only plays havoc in society, but contributes directly to predatory crime, human misery, loss of life and enormous public expense.

Just over two years ago, however, this newspaper took a position related to illegal drugs that we have now reconsidered. That opinion, born out of a sense of moral outrage and frustration in the failing effort on the war on drugs, declared that an experimental needle-exchange program the city of Cleveland had sanctioned amounted to morally untenable surrender.

Given the dearth of hard data on the effectiveness of needle exchanges and our conclusion that any effort that provided syringes to addicts would only encourage consumption, we judged the needle-exchange program misguided. Although we agreed that better efforts were needed to slow the spread of HIV among intravenous drug users, we could not quite conceive of how providing needles to addicts could retard the spread of AIDS.

The facts have overtaken our prior conclusion. Those facts demonstrate that needle exchanges do reduce the incidence of HIV transmission among addicts who inject drugs. Just as important, such programs have not increased drug use.

Health and Human Services Secretary Donna Shalala recently briefed a Senate committee evaluating the effectiveness of needle exchanges. Her conclusion: "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."

No less authorities than the National Academy of Sciences, the General Accounting Office and the Centers for Disease Control have concluded that such programs work. These research-based organizations say programs they monitor have radically reduced the numbers of HIV-tainted needles in circu-

lation and have slowed the rate of infection. That means such endeavors have prevented the infection of some babies who might otherwise have been born HIV-positive and spared others who would have been at risk from a drug-addicted spouse.

Indeed, the GAO, after evaluating a forecast model developed at Yale University, estimated that an exchange program operating in New Haven, Conn., had reduced the rate of new HIV infections by 33 percent. That much-criticized program also has proved an effective route into drug treatment for users. Furthermore, the National Academy of Sciences concluded that 75 needle-exchange programs it examined offered no credible evidence that such efforts encourage drug use.

Needle exchange is not a panacea. Heroin addicts, by their nature, are destructive to themselves and those around them. But AIDS is now the leading cause of death for Americans between the ages of 25 and 44. Although the number of deaths experienced in some high-risk groups has declined recently, the rate of new infection among IV drug users has skyrocketed. This group, fueling an epidemic that is decimating some urban neighborhoods, desperately needs to be reached.

Finally, it costs nearly \$120,000 for the care of someone stricken with AIDS. A clean needle costs 6 cents. When we wrote our original needle-exchange editorial in February 1995, Cleveland had not joined the ranks of cities with more than 2,000 documented cases of HIV infection. Today, that has changed. Cleveland now ranks among the top 15 cities in documented cases.

Heroin users now compose the fastest-growing group of people with AIDS. They pass this illness off to unborn children, lovers and, ultimately, to wider society. Making clean needles accessible to them has been shown not only to save some of their lives, but to save our money.

That in itself makes needle exchange a worthy endeavor.

LETTERS

Drug addiction is health problem, not moral issue

Anti-drug czar Barry McCaffrey says providing syringe exchanges to intravenous drug users sends "the wrong message" ("Needle exchanges still stir debate," News, Thursday).

Drug use is a public health problem, not a moral issue. Those who treat it as a question of morality are making a big mistake. Using his philosophy, the message becomes, "You use drugs, therefore you are a bad person and deserve the diseases you contract from your drug use." However, sooner or later, people who don't use intravenous drugs will also be infected with these diseases. Then what's the message?

Here's my message: Grab a clue and blow this "drug war" to smithereens.

Linda S. Collins
Merriam, Kan.

Syringe exchange is effective

"We're all concerned about the AIDS epidemic," said Family Research Council's Robert Maginnis. He's obviously not sufficiently concerned to advocate for the one program known throughout the world to prevent the spread of AIDS among and from drug injectors: syringe exchange.

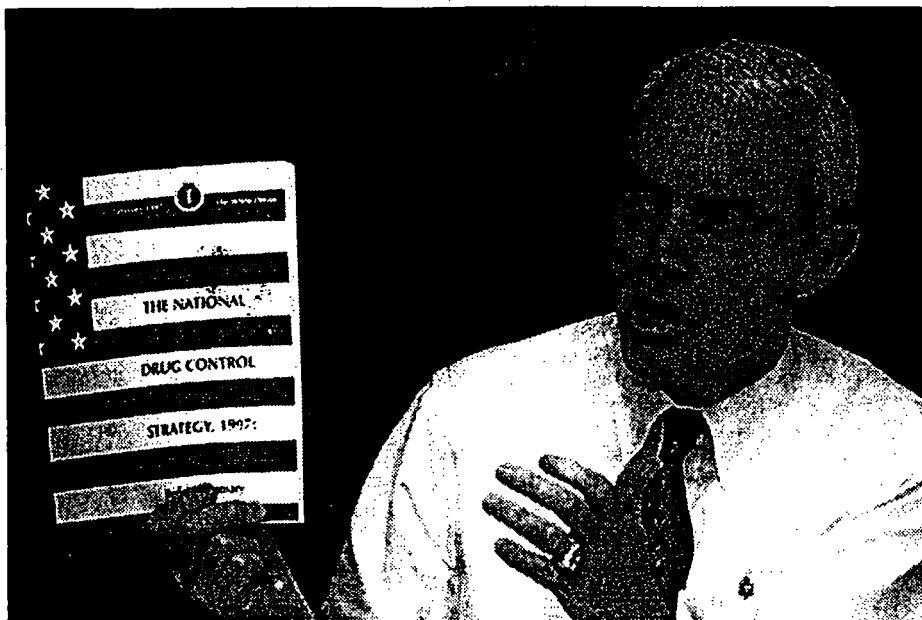
Undersized and underfunded syringe-exchange programs continue to save lives across America while this rump group of irrational fanatics continues to attempt to mislead Americans with ineptly constructed disinformation.

Syringe exchange is supported by more than a dozen highly respected organizations. In opposition to those groups we have tobacco supporter Sen. Jesse Helms, R-N.C., plus Gary Bauer and his Family Research Council. I leave it to the wisdom of your readers to decide in which hands the American people should place the future of our nation's health.

Joey Tranchina, executive director
AIDS Prevention ACTION Network Inc.
Redwood City, Calif.

Exchange first step to cure

Barry McCaffrey speaks of a wrong message to kids. Give me a break. A far worse message is sent when we allow addicts to contract and spread the AIDS virus



By Paul T. Whyte, USA TODAY

McCaffrey: Letter writers take issue with his opposition to needle exchange programs.

through unclean needles. More than 190,000 Americans have been infected with HIV from infected needles. All of the government's own studies show that needle exchanges dramatically reduce the transmission of the AIDS virus without encouraging drug abuse. In fact, needle exchanges often refer addicts to drug-treatment programs.

Let's be clear: People don't experiment with drugs, or stay on them, because somebody gave them a clean needle.

Michael Shellenberger, co-director
Communication Works
San Francisco, Calif.

Better message for kids

As a mother, I strongly disagree with Barry McCaffrey's statement that needle-exchange programs send "the wrong message" to people who are addicted and trying to avoid HIV infection. These programs send the *right* message, which is that we encourage you to protect yourself and your loved ones from HIV so you can

live, avoid HIV and get off drugs.

McCaffrey's stance also ignores the fact that seven federally funded scientific studies have concluded that needle-exchange programs work in preventing HIV without increasing drug use.

American needle exchanges are structured to be operated as public health programs so that used needles are actually traded in for clean syringes.

Needle-exchange programs that have been instituted in the United States bear no resemblance to those cited by the Family Research Council. Many U.S. programs offer vouchers for quick access to drug-treatment programs. As such, they provide a cost-effective way to deliver critically needed health care and education to a hard-to-reach population.

We must provide these health messages to all of our children, including those who are addicted.

Ann Kurth, executive director
Mothers' Voices
New York, N.Y.

REPORT TO THE COMMITTEE ON APPROPRIATIONS
FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES,
EDUCATION AND RELATED AGENCIES

NEEDLE EXCHANGE PROGRAMS IN AMERICA:
REVIEW OF PUBLISHED STUDIES AND ONGOING RESEARCH

DONNA E. SHALALA
SECRETARY OF HEALTH AND HUMAN SERVICES
FEBRUARY 18, 1997

REPORT TO THE COMMITTEE ON APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

NEEDLE EXCHANGE PROGRAMS IN AMERICA: REVIEW OF PUBLISHED STUDIES AND ONGOING RESEARCH

Introduction

On September 12, 1996, the Committee on Appropriations for the Departments of Labor, Health and Human Services, Education and Related Agencies made the following request of the Department of Health and Human Services:

"The Committee understands the Department is continuing to support research, reviewing the effect of clean needle exchange programs on reducing HIV transmission, and on whether such programs encourage illegal drug use. The Committee requests that the Secretary provide a report by February 15, 1997 on the status of current research projects, an itemization of previously supported research, and the findings to date regarding the efficacy of needle exchange programs for reducing HIV transmission, and not encouraging illegal drug use." Senate Report 104-368, p.68

In response to the Committee's request, this report provides an overview of the current status of knowledge regarding needle exchange programs (NEPs) with a compilation of relevant reviews and abstracts pertinent to the issues of efficacy of NEPs in reducing HIV transmission and their effect on utilization of illegal drugs. In reviewing the body of literature gathered, it is important to note the wide range of methodologic approaches utilized and the impact of these study design choices on the conclusions drawn. For example, studies varied significantly in terms of study populations, survey instruments, and assumptions made in the design of mathematical models used to predict seroincidence and seroprevalence. Given the significantly different design elements, making comparisons or drawing conclusions across studies requires an understanding of these complexities.

In the Department's assessment, providing the findings and conclusions from specific studies without benefit of the context of their specific methodologies would not facilitate a sound understanding of this issue, as the nature of the findings is not consistent. For these reasons, the original reviews and source documents with their discussions of methodological issues are being provided to the Committee for consideration along with the findings and conclusions. The data presented are limited to published studies conducted in the United States, consistent with the approach taken by the National Academy of Sciences, as the legal and cultural

environments of other countries differ sufficiently enough to raise questions about whether the conclusions are applicable to the United States.

The report is presented in four parts. Part One provides a review of completed studies and published abstracts addressing the efficacy of needle exchange programs for reducing HIV transmission and their effect on illegal drug use. Several major reviews, including a report by the National Research Council/Institute of Medicine (NRC/IOM) analyzes those studies published prior to 1995; subsequent studies are identified individually. Part Two describes the status of federally supported evaluation studies of needle exchange programs, with preliminary findings noted where these are available. Part Three provides the results of a national survey of State and local regulation of syringes and needles. Part Four is a set of Appendices which include the reviews of needle exchange programs described in Part One, two studies published since the NRC/IOM review, and relevant abstracts presented at the XI International AIDS Conference in Vancouver, BC in July, 1996.

I. Review of Published Studies

Three reviews of the literature on needle exchange programs have been commissioned by the federal government: (1) Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy, United States General Accounting Office, March 1993; (2) The Public Health Impact of Needle Exchange Programs in the United States and Abroad, prepared by the faculty and research staffs of the San Francisco and Berkeley campuses of the University of California for the Centers for Disease Control and Prevention, U.S. Public Health Service, in September 1993; and (3) Preventing HIV Transmission: The Role of Sterile Needles and Bleach, National Research Council and Institute of Medicine, September 1995.

Report of the U.S. General Accounting Office

The U.S. General Accounting Office (GAO) was requested by the Chairman of the House Select Committee on Narcotics Abuse and Control to: (1) review the results of studies addressing the effectiveness of needle exchange programs in the United States and abroad, (2) assess 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, and (3) determine whether federal funds can be used in support of studies and demonstrations of needle exchange programs.

The GAO conducted a literature review and site visits to two needle exchange programs. While the GAO noted that there were 32 known needle exchange programs in operation in 27 different U.S. cities or counties, their staff visited only those programs located in Tacoma, Washington and New Haven, Connecticut. Needle exchange programs studied by GAO were located in Australia (1), Canada (1), Netherlands (2), Sweden (1), United Kingdom (3), and the United States (1).

The full report with data from nine needle exchange programs and GAO findings are provided at Appendix A. The Results in Brief are abstracted below:

"Measuring changes in needle sharing behaviors is an indicator often used to assess the impact of needle exchange programs on HIV transmission. We identified nine needle exchange projects that had published results. Only three of these reported findings that were based on strong evidence. Two of these three reported a reduction in needle sharing while a third reported an increase.

One concern surrounding needle exchange programs is whether they lead to increased injection drug use. Seven of the nine projects looked at this issue, and five had strong evidence for us to report on outcomes. All five found that drug use did not increase among users; four reported no increase in frequency of injection and one found no increase in the prevalence of use. None of the studies that addressed the question of whether or not the needle exchange programs contributed to injection drug use by those not previously injecting drugs had findings that met our criteria of strong evidence. Our review of the projects also found that seven reported success in reaching out to injection drug users and referring them to drug treatment and other health services.

We also found the forecasting model developed at Yale University to be credible. This model estimated a 33 percent reduction in new HIV infections among New Haven, Connecticut, needle exchange program participants over 1 year. Based on our expert consultant review, we found the model to be technically sound, its assumptions and data values reasonable and the estimated 33 percent reduction in new HIV infections defensible. This reduction stems from the program's ability to lessen the opportunity for needles to become infected, to be shared, and to infect an uninfected drug user. To gather data in assessing program impact for use in the New Haven model, the researcher developed a new system for tracking and testing for HIV in returned needles.

While these findings suggest that needle exchange programs may hold some promise as an AIDS prevention strategy, HHS is currently restricted from using certain funds to directly support the funding of needle exchange programs. Under the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act of 1992, block grant funds authorized by title XIX of the PHS Act may not be used to carry out any needle exchange program unless the Surgeon General determines that they are effective in reducing the spread of HIV and the use of illegal drugs. However, HHS does have the authority to conduct demonstration and research projects that could involve the provision of needles." Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy, GAO/HRD-93-60, pages 3-4.

Current issue
Contents
Subscribers
Back issues
Circulation
Editorial
Free releases
Links
Search
Home
Conferences
Subscription

Editorial

Needle-exchange programmes in the USA: time to act now

One in three of the more than 570 000 AIDS cases reported in the USA since the beginning of the epidemic has been caused, directly or indirectly, by injection drug misuse. Although HIV-infection rates among homosexual men have fallen, rates due to intravenous drug misuse have soared and about half of new HIV infections now can be traced to that source. Those affected are not only the drug misusers infected by contaminated needles but their sexual partners (most of whom have been poor, black, and Hispanic women) and the children of women infected by drug misuse or sexual contact with infected drug misusers. Injection drug misuse is now the leading primary cause of paediatric AIDS.

Yet, despite this epidemic, the USA remains one of the few industrialised countries that refuses to provide easy access to sterile syringes. Of the 100 or so US needle-exchange programmes most are small and underfunded, and some are illegal. Most US states still have laws on drug paraphernalia or syringe prescription that make it a crime to give a drug misuser a clean needle.

The Clinton Administration now has an opportunity to address this problem. In 1997 the US Congress banned the use of Federal funds for needle-exchange programmes until March 31, 1998, but after that date the legislation allows funding if the Secretary of Health and Human Services determines that exchange programmes are effective in preventing the spread of HIV and do not encourage the use of illegal drugs. But with the deadline fast approaching, the Secretary of Health and Human Services, Donna Shalala, has yet to make an official determination, causing AIDS activists to wonder whether the Administration will refuse to endorse needle-exchange programmes out of fear that the step will open the President to the charge that he is "soft on drugs".

If this is true, it would be a remarkably callous decision for the Administration to make. Yet, given the weight of the scientific evidence supporting the efficacy of needle-exchange schemes, it is hard to attribute the reluctance to back such programmes to anything other than political considerations. Study after study has found that needle-exchange programmes reduce the risk of HIV infection. In 1993, a study on needle-exchange programmes by the Centers for Disease Control and Prevention and the University of California, San Francisco, concluded that "the time has arrived for federal, state, and local governments to remove the legal

and administrative barriers to increased needle availability and to facilitate the expansion of needle exchange programmes in the US". In 1995, the National Academy of Science's Institute of Medicine, an independent organisation set up by Congress for advice on scientific and technical matters, concluded that needle-exchange programmes were effective and did not encourage illegal drug use. In 1997 an independent consensus panel convened by the National Institutes of Health found that "an impressive body of evidence suggests powerful effects from needle-exchange programmes . . . there is no longer doubt that these programs work".

Just last month, the President's Advisory Council on HIV/AIDS issued a report urging the Administration to move immediately to end the ban on Federal funding for needle exchanges. "The debate at this time should no longer be if, but how, needle exchange programs should be established", wrote the council's chairman, R Scott Hitt. And the debate is not academic. A study published in *The Lancet* last year by Peter Lurie and Ernest Drucker, who used conservative estimates of interventions that give injection drug misusers access to sterile injection equipment, concluded that if the USA had adopted such programmes in 1987, it could have prevented between 4394 and 9666 HIV infections. Moreover, they found that if current policies are not changed, an additional 5150-11 329 preventable HIV infections could occur by the year 2000 in the USA. Who will stop these preventable infections? The Clinton Administration should act now. Delay is costing lives.

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Top

Current issue	Feedback	Subscriptions	Back issues	Classifieds
For authors	Press releases	Links	Search	Home
Contact us	Site map			

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CONFERENCE REPORT ON H.R. 2264, DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 1998 (House of Representatives - November 07, 1997)

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.