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[Questions and Answers on Needle Exchange Study by University of California] [loose]

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Q's and A's on Needle Exchange Study by University of California
September 29, 1993

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What are needle exchange programs?

Needle exchange programs allow persons who inject drugs to exchange used needles and syringes (often made as a single unit) for new, sterile needles and syringes, taking "dirty" or potentially contaminated needles out of circulation among drug injectors. Multiperson use ("sharing") of needles and syringes has been associated with transmission of infection, including HIV, hepatitis B, and an infectious agent causing endocarditis.

Needle exchange programs in the United States vary greatly in size, organizational structure, funding levels, and funding sources. While some programs are small, others have provided needle exchange services to substantial proportions of the local population of injecting drug users (IDUs). Program data indicate that many needle exchange programs do attract substantial numbers of IDUs who regularly exchange needles and syringes and do serve as a bridge to public health services (including treatment of drug dependency).

Why have needle exchange programs been developed?

Limited access to sterile needles and syringes appears to be one of the major factors in the re-use and multiperson use ("sharing") of contaminated needles and syringes. IDUs' access to sterile needles and syringes is limited by state and Federal laws including (1) prescriptions laws that require a physician's prescription for needles/syringes as a condition for their sale by pharmacies (approximately 11 states and the District of Columbia), and (2) drug paraphernalia laws that place criminal penalties on the possession and distribution of needles and syringes (approximately 44 states and the District of Columbia). An additional barrier is the refusal of some pharmacists, in states without prescription laws, to sell needles and syringes to persons who might be IDUs.

Because of the criminal penalties for possession of needles and syringes, many drug injectors do not carry needles and syringes with them, instead borrowing their works from other drug injectors or renting needles and syringes in "shooting galleries." This practice increases the likelihood of using an HIV-contaminated needle/syringe.

Congress has prohibited the use of Federal funds to support needle exchange programs unless the Surgeon General determines that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs.

In July 1991, the National Commission on AIDS recommended: "Remove legal barriers to the purchase and possession of injection equipment. Such legal barriers do not reduce illicit drug injection. They do, however, limit the availability of new/clean injection equipment and therefore encourage the sharing of injection equipment, and the increase in HIV transmission."

Where was the first needle exchange program developed in the United States?

The first comprehensive needle exchange program in the United States opened in 1988 in Tacoma, Washington.

How widespread are needle exchange programs in the United States?

As of September 1993, there were 37 needle exchange programs in 30 U.S. cities. The California legislature recently approved a bill, which is being reviewed by the Governor, to legalize needle exchange. Massachusetts recently passed a law that authorized a pilot needle exchange program, and the State of New York passed specific legislation permitting several needle exchange programs. In addition, Florida, Arkansas, Maryland, and Minnesota are actively considering legislation or administrative changes to allow needle exchange programs.

What are the controversies related to needle exchange?

In the United States, needle exchange has been very controversial, with many offered arguments in support of and in opposition to this type of program.

What is the relationship between injecting drug use and HIV infection?

About one-third of the 315,390 reported AIDS cases in the United States have been directly or indirectly associated with injection drug use. A 1990 study estimated that 250,000 IDUs in the United States were infected with HIV (out of an estimated 1.3 million IDUs, most of whom are not in treatment). HIV is transmitted through injection drug use by the use of contaminated needles and syringes that transfer blood from an HIV-infected IDU to an IDU who is not infected. Transmission of HIV from IDUs to their sex partners has been a major source of HIV infection among heterosexual men and women; more than half of all pediatric AIDS cases (56 percent) occur in infants born to women who are IDUs or who have had sex with an IDU.

How can transmission of HIV among drug injectors be prevented?

To prevent HIV transmission through and related to injection drug use, there is a hierarchy of interventions with generally decreasing effectiveness: first choice--don't start using drugs; second choice--for those who use drugs, stop drug use;

third choice--for those who continue to use drugs, stop (or decrease) injection of drugs; fourth choice--for those who inject drugs, use only sterile needles and syringes; fifth choice--for those who reuse needles and syringes, do not share injection equipment; and sixth choice--for those who share injection equipment, use bleach to disinfect contaminated needles and syringes. A sterile needle and syringe is safer than a needle and syringe that have been disinfected with bleach.

While it is clear that effectiveness of HIV prevention varies at different levels of this hierarchy of choices, it is also clear that many persons will continue to use and inject drugs. HIV prevention efforts for IDUs should incorporate multiple components that address the risks at each level of drug use. Preventing the initiation of drug use is important. Treatment of drug abuse is crucial in helping IDUs stop or decrease drug use and injection. Outreach and education services are essential for the majority of drug users who are not in drug treatment. The availability of sterile needles and syringes is important for IDUs who cannot stop injecting drugs.

What are CDC's current prevention efforts for IDUs?

Current CDC prevention efforts for IDUs include support and evaluation of street outreach programs in a variety of settings that help encourage drug users to discontinue drug use and seek treatment. These programs further emphasize the importance of never sharing injection equipment, using a sterile needle and syringe, or, as a minimum, using bleach to help disinfect "works" that will be reused, when no safer option is available. However, **disinfecting previously used needles and syringes is not as safe as always using a sterile needle and syringe.** For persons who cannot stop injecting drugs and do not have access to sterile needles, needle exchange programs have been cited by some as helpful in preventing transmission of HIV since it provides IDUs access to new, sterile needles.

Why did CDC fund this study?

In May 1991, senior CDC officials met with top officials in the Office of National Drug Control Policy to discuss the role of injection drug use in HIV transmission, and endorsed the idea that a compilation and analysis of research on this issue would be valuable in evaluating the public health impact of needle exchange programs. Since this issue was very controversial, it was believed that the project would be most objective and effective if undertaken by a university. In addition, it was recognized that it would be a large project, requiring extensive resources.

In April 1992, CDC funded the University of California, Berkeley, School of Public Health, to conduct a project to describe and evaluate the public health impact of needle exchange programs in the United States and Canada. The project's goal was to address 14 broad research questions which include the major policy issues

related to needle exchange programs (e.g., the effects on community drug use, discarded needles/syringes in the community, community reactions to needle exchange, HIV incidence, and impact on other bloodborne infections such as hepatitis B).

How much did CDC pay for this study?

CDC provided \$179,550 in fiscal year (FY) 1992 and \$165,331 in FY 1993 (for a total of \$344,881) to the University of California to conduct this study.

How and where was the study conducted?

The goal of the project was to "assess the public health impact of needle exchange programs." The project had four components: formal review of existing research, site visits to needle exchange programs, mail surveys of other needle exchange programs, and cost-effectiveness modeling.

The University of California team consisted of 12 researchers from multiple disciplines, with none of the investigators specifically in favor of or opposed to needle exchange programs. In addition, the team convened a 13-member advisory committee to provide community and expert input to the project.

The University of California project reviewed a total of 1,972 sources during the study, which included 475 journal articles, 381 conference abstracts, 236 reports, 499 newspaper articles, and 159 unpublished documents.

In addition, the project staff has made site visits to selected needle exchange programs. The site visits were done between May and September 1992 and typically involved a 3-day visit by a three-person team. The site visit included interviews of program staff, police, HIV epidemiologists, public health officials, and opponents and supporters of needle exchange programs; structured observations of the operations of the needle exchange programs; and focus groups of IDUs who use the program(s) and those who do not.

Site visits were completed in 9 U.S. cities with 12 needle exchange programs:

Berkeley, CA	San Francisco, CA
Boston, MA	Santa Cruz, CA
New Haven, CT	Seattle, WA
New York City, NY	Tacoma, WA
Portland, OR	

Site visits were also completed in 3 Canadian cities with 5 needle exchange programs:

Montreal, PQ	Vancouver, BC
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Toronto, ON

In addition, less extensive site visits were carried out in Boulder, Colorado; London, England; and Amsterdam, The Netherlands. The project team also surveyed 20 U.S. needle exchange programs using a mail questionnaire (no site visits were made to these programs).

The 13 exchange programs assessed by the University of California study have been categorized as follows: four of the programs are run by local or State governments, one by a community-based organization (CBO) with a government contract, three by CBOs without government support, and five by "activist" organizations. Of the 13 programs, 8 were operated legally, while 5 were classified as "illegal" (3 had understandings with local/State authorities who do not enforce the laws violated, and 2 were "underground").

The University of California project team also gathered extensive data on the costs of operating needle exchange programs. The cost data were used in mathematical models of the cost-effectiveness of needle exchange programs.

What do the results of the study mean? Is CDC advocating that the federal government should provide clean needles and syringes to drug users?

CDC is in the process of carefully reviewing this 500-page report. It is clear this report represents a tremendous effort to examine an important health option for preventing transmission of HIV infection. We plan a detailed review of the report and its findings and will be in a position to comment after that is done.

How can CDC support the use of taxpayer money to give out needles or syringes and promote drug use? I thought CDC supported healthy behaviors.

CDC has not taken a position on whether needle exchange is an appropriate strategy for preventing transmission of HIV infection. However, the agency recognizes that sterile needles and syringes are important in HIV prevention for individuals who cannot or will not stop injecting drugs.

What was the relationship between CDC and the University of California in producing the study?

The final report was independently produced by the University of California project team, and the findings, conclusions, and recommendations are solely theirs.

Why has it taken so long for CDC to address this issue?

Since needle exchange programs are relatively recent occurrences in the United

States (the first comprehensive needle exchange program was begun in 1988), and data have not been available to examine the public health value of such programs, we believe CDC has moved expeditiously in studying this issue. CDC contracted with the University of California through the Association of Schools of Public Health in early 1992 to perform this study.

When will CDC comment on the report?

CDC will comment on the report when agency officials and staff have had the opportunity to carefully review the final report and its findings.

Why was this report delayed so long in its release?

The report represents a tremendous amount of carefully done work. The data collected and analyzed by the University of California project team were voluminous, and it has simply taken this amount of time to complete the study and prepare the final report.

Has the U.S. government done other studies of needle exchange programs?

On March 23, 1993, in response to a 1991 request from Representative Charles Rangel, the Government Accounting Office (GAO) issued a report entitled "Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy."

In addition to the GAO study, the National Institute on Drug Abuse (NIDA) is funding three projects related to needle exchange:

- In March 1992, NIDA awarded a 3-year grant to Yale University, entitled "A Syringe Tracking and Testing Program for IVU Epidemics." The grant does not fund needle exchange but supports analysis of needle exchange programs and collection of other data from an existing, independently funded needle exchange. This project uses a syringe marking and tracking system; sensitive tests to detect blood, HIV, and hepatitis B virus in syringes; and a mathematical model to determine the effects of the needle exchange on the circulation of viruses in syringes. The project data base includes more than 60,000 needles and syringes distributed and more than 60,000 needles and syringes turned in to the exchange. According to preliminary findings:
 - The time that a needle/syringe is "in circulation" has decreased and needle/syringe return rates have increased.
 - Mathematical modeling estimates at least a one-third decrease in HIV transmission.

- Methods of estimating needle sharing are being explored, since client responses to baseline surveys suggest that 11 percent of injections involve sharing, while tracking of needles returned to the program suggests a much higher prevalence of sharing.
- In April 1993, NIDA funded a longitudinal cohort study of the impact of the Seattle-King County Needle Exchange, which has been in operation since April 1989 and has exchanged more than 600,000 needles and syringes.
- Also in April 1993, NIDA awarded a grant for an evaluation of Prevention Point, a needle exchange program in San Francisco.

Congress has mandated that NIDA fund a contract with the National Academy of Sciences to study five questions for "programs that distribute both clean needles and bleach."

What is the Canadian government's policy on needle exchange?

The Canadian Government played a key role in the start-up of needle exchange programs through a special federal initiative for IDU HIV prevention that emphasized needle exchange programs. A 1989 initiative provided Canadian federal matching funds for provincial programs for HIV prevention for IDUs; these programs include needle exchange. In Canada, needle exchange programs have broad public support and little public or professional opposition. All of the needle exchange programs in Canada are legal.

There are 28 needle exchange programs in 7 of the 10 Canadian provinces. Through March 1992, more than 1.5 million needles and syringes were distributed by four of the five Canadian needle exchange programs visited during the University of California study. In 1989, the Canadian government also funded nine projects to evaluate the needle exchange programs funded through the IDU/needle exchange initiative. The consolidated results of those evaluation projects should be available in the next several months.

What is the next step for CDC and for PHS?

CDC staff are in the process of carefully reviewing the study and its findings. We are making a copy of the report available to senior PHS officials for their review.