FOIA Number: 2018-0758-F

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member: Todd Summers

Subseries:

OA/ID Number: 21080

FolderID:

Folder Title:
Issues - Needle Exchange - Press Articles [1]

Stack:	Row:	Section:	Shelf:	Position:
S	66	6	3	3

beyond the city

Needle-Swap Activists Seize D.C. Office

By KATHY KIELY
Daily News Washington Bureau

WASHINGTON

About a dozen AIDS activists — mostly New Yorkers — took over the White House Office on AIDS Policy yesterday, chaining themselves to furniture to protest President Clinton's refusal to fund needle-exchange programs.

The protesters decked the windows of AIDS czar Sandy Thurman's office — located half a block from the White House — with anti-Clinton banners and posters. Speaking through a megaphone, one of them announced they intended to sit tight until the President reversed his decision.

But within 20 minutes, dozens of uniformed Secret Service agents politely but forcibly removed the protesters, most of whom chanted "Free needles save lives. Lift the ban now!" as they were loaded into a waiting police wagon.

"We wanted to make the point that the Clinton administration's AIDS policy is a total failure," Chris Lanier, a spokesman for a New York City needle-exchange group called National Coalition to Save Lives Now, told the Daily News. Lanier and nine other protesters were booked for disorderly conduct and freed on bail of $50 each.

Seven other New Yorkers, most of them members of the AIDS activist group ACT UP, were among those arrested.

Lanier said Clinton backed down on a 1992 campaign promise when he made a "heinous and immoral" decision in April not to lift a ban on federal funding for needle-exchange programs.

Clinton's decision was privately opposed by most of his top science and medical advisers, who say there is clear evidence that providing hard-core addicts with clean needles is an effective way to

slow the spread of the AIDS virus.

"I've been very clear. I do support needle-exchange programs," Thurman told reporters outside her office, as the Secret Service continued to remove protesters. "This will not go away."

But Clinton administration drug czar Barry McCaffrey and many in Congress oppose needle-exchange programs, arguing they send the wrong signal at a time when the nation is trying to enforce a zero-tolerance policy on drugs.

Back to Beyond the City Index | Back to Top | Next Story

mostNEWYORK
HOME | DISH
NY NOW | NEWS
LIFE | SPORTS
SEARCH | INDEX

NASTAD Issue Brief

a publication of the National Alliance of State and Territorial AIDS Directors
July 1998

An Overview of Recent State Policies, Programs, Data Collection and Evaluation Activities Related to Reducing Perinatal HIV Transmission

1998 Summary Report

The National Alliance of State and Territorial AIDS Directors conducted a brief survey of state health department HIV/AIDS programs in April 1998 to gather recent information on state level activities related to reducing perinatal HIV transmission.[1] The chief goal of the survey was to obtain current trend information on state legislative, policy and regulatory activity, and pinpoint the availability of state specific information on programs, surveillance data and evaluation studies related to perinatal HIV issues.

Many state public health programs are in the process of examining ways to improve efforts to reduce perinatal HIV transmission and demonstrate the effectiveness of HIV prevention interventions. There are also two important benchmarks expected in 1998 related to federal and state policy on perinatal HIV transmission which are requirements of the Ryan White CARE Act Amendments of 1996.

The Institute of Medicine (IOM) of the National Academy of Sciences is undertaking, during 1997-98, an evaluation of the extent to which State efforts have been effective in reducing the perinatal transmission of HIV. Specific issues that the IOM will address include: assessment of factors affecting perinatal HIV transmission (e.g., inadequate provision of prenatal counseling and testing); availability and effectiveness of interventions to prevent the transmission of HIV from mother to newborn; and the extent to which states have implemented existing U.S. Public Health Service guidelines for preventing perinatal transmission of HIV. This report is being carried out by a committee with experts in pediatrics, obstetrics and gynecology, preventive medicine, women's health, social and behavioral sciences, public health practice, epidemiology, program evaluation, health services research, and other fields. The IOM report is expected to be completed by October 1998.

The CARE Act also requires the Secretary of the U.S. Department of Health and Human Services to issue a determination by October, 1998 whether it has become routine practice in the provision of health care in the U.S. to conduct mandatory HIV newborn testing of all infants whose mothers have not undergone prenatal HIV testing. If the Secretary determines that such testing has become routine practice, after an additional 18 months (by April, 2000), a state must demonstrate one

[1] A brief questionnaire was sent to every state health department AIDS program director in March and April 1998. Completed survey responses were received from all states and Puerto Rico with the exception of the District of Columbia, Kansas, Louisiana, Maryland, and New Mexico for a response rate of 90% (47 states out of 52 surveyed).

of the following in order to receive Ryan White Title II funding: a 50 percent reduction in the rate of new perinatally transmitted AIDS cases (or, for states with fewer than 10 cases, a comparable measure) comparing the most recent data to 1993 data; or at least 95 percent of women who received at least two prenatal visits have been tested for HIV; or require HIV testing for all newborns whose mothers have not undergone HIV testing.

Given these important developments, policymakers, researchers and program planners need further information on state efforts to set policies, establish responsive programs, and measure the effectiveness of HIV prevention and care efforts related to perinatal HIV transmission.

Overview of Findings

NASTAD's survey and summary report seek to assist in identifying state activities, describe state progress in implementing the standard of care, and state responses to potential federal legislative requirements. The survey report identifies information sources for further investigation in three main areas:

Policy, legislation and regulations: New, updated information is needed given the rapidly developing nature of both scientific findings and policy change. The report provides an update on developments in several states vis a vis recent state legislation, policies and regulations regarding HIV counseling and testing of pregnant women and newborns, including general trends.

Availability of pediatric HIV/AIDS surveillance information: Information and data is needed to track state pediatric HIV/AIDS cases and perinatal HIV exposure, in order to indicate potential gaps and highlight findings of successful reductions in HIV/AIDS cases. There is significant variability, however, in the scope and types of information collected by state public health programs across the country. The survey seeks to identify and describe the kinds of information that is readily available from states. This information can be used as the basis for further exploring surveillance reports from both the federal Centers for Disease Control and Prevention (CDC) and state public health programs.

Evaluation studies: The survey report identifies research and evaluation studies that have been conducted or are in development which demonstrate progress, successes or problems in implementing the standards of HIV care for women, infants and children.

In addition, the report indicates contact names for further investigation on policy, research and evaluation related to perinatal HIV transmission in most states.

The report is not intended to be the last word on state progress in reducing perinatal HIV transmission, nor be an exhaustive description of state policy, surveillance and evaluation activities. Rather, it is meant as a starter for further investigation, data collection and information dissemination which may be useful for the Institute of Medicine, the U.S. Department of Health and Human Services, states, national organizations and other entities.

Background

In 1994, ACTG 076 Clinical Trial results clearly documented the efficacy of AZT monotherapy in reducing HIV perinatal transmission from HIV-infected mother to infant. Several sets of federal recommendations have been subsequently developed that relate to these findings.

- In 1994, *Recommendations for the Use of Zidovudine [AZT] to Reduce Perinatal Transmission of HIV* were developed outlining use of AZT for pregnant women infected with HIV. These guidelines were revised in 1998 as *Recommendations for Use of Antiretroviral Drugs During Pregnancy for Maternal Health and Reduction of Perinatal Transmission of HIV-1*. They cover use of antiretroviral therapy to reduce perinatal transmission of HIV; special considerations for use of antiretroviral drugs in pregnant women; update clinical trials on use of ZDV chemoprophylaxis to reduce HIV-1 perinatal transmission; and monitoring of pregnant women and infants. Included in these updated guidelines is information about the importance that pregnant women with HIV be treated for their own HIV disease (given data on the efficacy of combination antiretroviral therapies). This is an important consideration given that use of ZDV monotherapy, while demonstrated effective in re-

ducing HIV perinatal transmission, is not a recommended antiretroviral therapy for treatment of HIV disease.

- *Public Health Service Recommendations for HIV Counseling and Voluntary Testing for Pregnant Women* were formulated in 1995, outlining procedures to increase universal counseling and voluntary HIV testing of pregnant women so that they might benefit from these new findings. For women identified as infected with HIV, recommendations were made to provide medical and psychosocial services, offer AZT for reducing perinatal transmission, and provide counseling against breastfeeding.

The Ryan White CARE Act Amendments of 1996 contain multiple provisions related to HIV testing and health and support services for women, infants and children. They include the following:

- Proportionate Spending (Section 2611). Each state must spend a percent of Title II funding for services to women, infants, and children with HIV disease that is not less than their percent of the state's total AIDS cases. For example, in a state where women, infants, and children constitute 30% of the reported AIDS cases, at least 30% of that state's Title II award must be used to support services to women, infants, and children with HIV disease.

- Implementation of PHS Recommendations on HIV Counseling and Testing of Pregnant Women (Section 2625). All states have provided certifications to CDC, by September 1996 as required by this provision, that they have in effect regulations or have adopted measures to implement the *Public Health Service (PHS) Recommendations for HIV Counseling and Voluntary Testing for Pregnant Women*. The PHS recommendations stress that women should be routinely counseled and voluntarily tested for HIV (with informed consent) early during their pregnancy. Those identified as HIV-infected should be counseled and offered antiretroviral therapy to reduce the risk of perinatal HIV transmission, which has been documented as effective in significantly reducing the risk of transmission from mother to fetus. Grants to states are also authorized (although funds have not been appropriated) to conduct counseling on HIV disease for pregnant women; outreach for women at risk of HIV who are not currently receiving prenatal care; making voluntary HIV testing available to such women; and offsetting state costs for implementing CDC's guidelines, surveillance activities for assessing new cases of HIV perinatal transmission, and newborn testing for HIV.

- Perinatal Transmission of HIV Disease (Sections 2626 and 2627). States must annually determine the rate of reported AIDS cases resulting from perinatal transmission; CDC must implement a system for reporting on perinatal transmission AIDS cases; and the Secretary of HHS must determine (by October, 1998) whether it has become routine practice in the provision of health care in the U.S. to conduct mandatory HIV newborn testing of all infants whose mothers have not undergone prenatal HIV testing. If the Secretary determines that such testing has become routine practice, after an additional 18 months (April, 2000), a state must demonstrate one of the following in order to receive Title II funding: a 50 percent reduction in the rate of new perinatal transmission AIDS cases (or, for states with fewer than 10 cases, a comparable measure) comparing the most recent data to 1993 data; or at least 95 percent of women who received at least two prenatal visits have been tested for HIV; or require HIV testing for all newborns whose mothers have not undergone HIV testing. States that implement testing requirements must prohibit health insurance companies from canceling or altering coverage based solely upon the individual's HIV status.

  Based on extensive state and federal surveillance activities, surveys and evaluations, NASTAD does not believe "that it has become routine practice in the provision of health care in the United States to conduct mandatory HIV newborn testing of all infants whose mothers have not undergone prenatal HIV testing." Currently only one state (New York) has policies in place requiring HIV screening of newborns.

- Institute of Medicine Report Evaluating State Efforts to Reduce HIV Perinatal Transmission (Section 2628). The Institute of Medicine shall complete an evaluation of the extent to which state efforts have been effective in reducing HIV

perinatal transmission and analyze barriers to further reductions in such transmission.

These scientific and policy developments represent the backdrop for specific state efforts to reduce perinatal HIV transmission through policymaking, monitoring and evaluating activities.

State Policies/Legislation/Regulations

The survey indicates that there has generally not been a substantial growth in state legislative activity on perinatal HIV issues, with several notable exceptions. Eight out of the 47 states responding (17%) reported some type recent legislative activity in this area. The bulk of state legislative and policy activity in this arena occurred between 1994 and 1996, on the heels of the ACTG-076 findings and implementation of the *PHS Guidelines*. Although there have been fewer laws and regulations enacted since that time in most states, there is a trend in the more recent laws to attempt to *assure* that universal HIV counseling occurs and that testing is offered to pregnant women – generally with the right of refusal. These newer laws and policies may reflect a concern that, although universal counseling and offering of voluntary testing to pregnant woman should be a standard, counseling and testing is not being conducted universally and is being done too selectively in some jurisdictions.

Current or pending activity related to perinatal HIV transmission, whether legislative, policy-related, regulatory in nature or guideline-related was an area of inquiry which NASTAD focused on in the survey. *The following states reported 1998 legislative and policy related activity:*

A new 1998 ***Indiana*** state law authorizes physicians to screen newborns for HIV if the mother was not tested during prenatal care. As originally proposed, the Indiana legislation would have mandated testing of all newborns for HIV, akin to New York State's "Baby AIDS Bill" requirements. The final version of the law authorizes physicians to order the newborn be tested no later than 48 hours after birth if the doctor believes that testing is medically necessary. The physician must notify the mother that the test is being done, and he or she must provide HIV counseling to the mother. The doctor must explain the purpose of the test, outline the risks and benefits of testing, describe how HIV is spread, and discuss how the woman can reduce the chance of transmitting HIV through breast feeding. The woman must be referred to other HIV prevention, health care and psychosocial services. The physician must tell the woman of the result of the newborn's test and the information is to be kept confidential. The only ones exempt from testing are children of parents who voice religious objections.

In April, the Indiana Health Department's executive board approved an emergency rule giving physicians more guidance in following a 1997 state law that requires physicians to counsel all pregnant woman about the risks of HIV and suggest that they be tested, either confidentially or anonymously. A law passed by the 1997 Indiana General Assembly (House Bill 1280) requires obstetricians, family physicians and other providers of prenatal care to conduct HIV counseling, to offer HIV testing to each pregnant woman, and to document this in the patient's chart. But testimony in the 1998 legislative session on newborn screening showed that many providers where not complying with the prenatal counseling and testing statute. According to the state health department, the failure to comply seemed to result mostly from a lack of awareness about the new law and possibly from an incomplete understanding of the importance of counseling and appropriate testing of each pregnant woman regardless of her apparent risk for contracting HIV.

The Indiana State Department of Health will employ two new health educators to work throughout Indiana to educate women and health care providers about the current law and the new rule. In addition, a number of associations and organizations have united with the State Department of Health to provide input into the development and implementation of the new rule. Under the rule, physicians are to fill out a form indicating that they provided counseling and recommended an HIV test. The form reminds physicians that they are to explain why testing is important, but that it is voluntary. It also prompts them to discuss findings of the 076 clinical trial which showed that taking AZT during pregnancy and delivery and after childbirth reduces HIV transmission by two-thirds.

In ***Tennessee***, the "Tennessee HIV Pregnancy Screening Act of 1997" became effective January 1, 1998. This bill requires "...all providers of health care services who assume responsibility for the prenatal care

of pregnant women during gestation to counsel pregnant women regarding HIV infection and, except in cases where women refuse testing, to test these women for HIV and to provide counseling for those women who test positive."

The Tennessee State Department of Health shall make all educational and counseling materials required available to providers responsible for the counseling. After she has received the counseling and information specified, a pregnant woman under the care of a health care provider shall sign a form developed by the Department of Health indicating that she has been informed and indicating her consent or refusal to the HIV testing. A health care provider shall arrange for each pregnant woman under his or her care to be tested for HIV as early as possible in the course of the pregnancy unless the woman has refused testing in writing on the form.

There is a 1998 bill in the ***Delaware*** legislature which would require prenatal HIV antibody testing as part of the routine prenatal STD work-up. The current legislation would rescind the already existing statute which mandates counseling, and requests voluntary testing, if consent is obtained.

The bill "Targeted Outreach for Pregnant Women Act of 1998" passed in the ***Florida*** legislature. The bill is intended to reduce both the number of women who give birth to HIV-infected babies and the number of newborns who have been exposed to illegal drugs. The bill requires the Department of Health to establish a two-year pilot program to provide outreach services to high-risk pregnant women in the five counties (Dade, Broward, Palm Beach, Hillsborough, and Orange) with the highest prevalence rates of HIV in pregnant women and the largest population of substance-exposed newborns.

These services will focus on encouraging high-risk pregnant women to be tested for HIV; educating women not receiving prenatal care on the benefits of such care; providing HIV-infected pregnant women with information so that they can make an informed decision about the use of AZT; linking women with substance abuse treatment when available; and acting as a liaison with Healthy Start, Children's Medical Services, providers funded under the Ryan White CARE Act, and other Department of Health services. The bill takes effect October 1, 1998.

A bill passed the ***South Carolina*** House in March 1998 (HB4387) which mandated counseling of pregnant women, testing with consent/informed refusal, documentation in mothers' record, and testing of newborns whose mother's status is unknown.

Several laws were passed in states in 1997 which relate to counseling and testing of pregnant women; these include the following:

A 1997 ***Arkansas*** law requires that pregnant women, as early as reasonably possible in their pregnancy or, if not attended prenatally, at the time of delivery, must be tested for HIV. If for any reason the pregnant woman is not tested for syphilis, HIV or Hepatitis B, that fact shall be recorded in the patient's records, which, if based upon the refusal of the patient, shall relieve the physician of any responsibility under the law. Every provider shall provide counseling and instruction for HIV in a manner prescribed by the state Department of Health.

A 1997 ***Maryland*** law requires health care providers to counsel pregnant women concerning HIV testing as part of the woman's prenatal care program. The law requires the counseling to include a prescribed set of information. The law also provides: that the pregnant woman is not required to consent to an HIV test; and the pregnant woman will not be denied prenatal care by the health care provider or health care facility because the woman refuses to have a test performed.

In 1997, two pieces of legislation were passed in ***Minnesota*** related to perinatal HIV transmission. All existing statutes were amended concerning medical assistance coverage for diagnostic, screening and preventive services to include "prenatal HIV risk assessment, education, counseling and testing." In addition, funds were appropriated for a 2-year period ($200,000 total) to the Minnesota Department of Health for "activities related to prevention of perinatal transmission of HIV, a statewide education campaign for pregnant women and their health care providers, and demonstration grants to providers to develop procedures for incorporating HIV awareness and education into perinatal care." The state recently released a Request for Proposals for pilot projects for universal counseling and voluntary HIV testing in prenatal clinics. The purpose of the pilot projects is to develop and implement strategies for incorporating counseling and voluntary HIV testing into routine prenatal care. Three projects are being funded in the Minneapolis-St. Paul

metro area and two outside of the metro area for a 12-month period starting July 1, 1998.

Regulation Related Activities (Including Revisions)

Eleven states out of the 47 responding (23%) reported some type of regulation-related activity, including development of guidelines and/or policies, or activities relation to the distribution of information, materials and educational efforts.

The Department of Public Health has a proposed revision of the Notifiable Diseases Act of the ***Alabama*** Code which would authorize the State Board of Health to establish by rule which sexually transmitted diseases and by which procedures pregnant women and newborns will be tested. This revision will permit the State Board of Health to require testing for additional sexually transmitted diseases, notably at this time, HIV infection.

In ***New York***, regulations became effective February 1, 1998 which add HIV to the list of conditions routinely tested for under the Department's Newborn Screening Program. As a consequence, the result of HIV testing conducted on each newborn is given to his/her mother or, if she is unavailable, to the person legally responsible for consenting to health care for the newborn. Hospitals and birthing centers are required to: (a) inform each new mother in the postpartum setting that her newborn will be tested for HIV and that the result will be returned to her, (b) assess the mother's past HIV-test history, (c) provide the mother with HIV counseling tailored to her past test history and knowledge of HIV status, and (d) assess the mother's needs for special support in the event of a positive test result. Testing is conducted by the State laboratory, and the result is returned to the hospital of birth for transfer to the infant's pediatric provider. Specialized Maternal Pediatric HIV Care Centers are available to provide consultation regarding the post-test counseling and care of HIV-exposed infants and their mothers or to provide these services directly upon referral. It is the responsibility of the birth hospital to ensure that HIV positive newborns and their mothers are linked to care. If the hospital cannot locate the mother or newborn, field follow-up is available from the Department of Health.

Development of Guidelines and/or Policies

Colorado reports multiple types of perinatal HIV related policy as outlined in its Ryan White Title II and HIV prevention appropriations. The HIV prevention community planning comprehensive plan also has a chapter which is devoted to perinatal HIV transmission.

Practice guidelines for providers and insurance companies in the state of ***Maine*** are currently being developed. These guidelines will be for HIV counseling and testing of pregnant women.

In ***Utah,*** the *PHS Guidelines* are part of all counseling and testing local health department contract provisions.

The ***Vermont*** Department of Health, with counsel from an advisory panel, is developing policy that recommends universal HIV counseling and voluntary testing be the "standard of care" for health care providers serving pregnant women and women considering pregnancy. This policy is currently circulating throughout programs within the Health Department, especially within the "Healthy Babies" Program.

Activities related to the Distribution of Information, Materials and Education

There is no formal legislation, but the ***Minnesota*** Department of Health is directing their efforts towards the early diagnosis of HIV during pregnancy. The state has issued an RFP for pilot projects to develop strategies to incorporate universal counseling and voluntary testing into routine prenatal care. The state will also be developing a statewide educational plan directed towards health professionals with a training to reinforce and support the *PHS Guidelines*.

There is no formal legislation in ***Nevada***, but Nevada Medicaid is working with the Health Care Financing Administration (HCFA) to expand outreach efforts to pregnant women in Nevada.

Ohio is in the process of distributing both the *PHS Guidelines* and a brochure summarizing the Department of Health's guidelines on perinatal transmission to practicing physicians. They are doing this in collaboration with American Academy of Pediatrics and Title IV FACES clinics.

A 20 minute pre-test counseling video and a risk behavior/patient consent form has been produced and distributed to all providers of obstetric services in ***West Virginia***. A copy of the risk assessment form is being mailed back to the state AIDS Program in a confidential envelope to monitor that this service is being provided as a standard of care to comply with the *PHS Guidelines* of mandatory counseling and voluntary testing of all pregnant women statewide. Three HIV/AIDS surveillance nurses are following up with providers of obstetric care to encourage compliance and respond to any questions. They are also presenting a segment on HIV/AIDS legal reporting requirements during a one-day provider training course. They have added a new section regarding females' pregnancy status to the HIV history form submitted with blood drawn for HIV antibody testing at public health HIV prevention centers. They have published articles about this perinatal plan in several newsletters/journals. A free, one-day HIV counseling and testing training with continuing education units (CEUs) is being offered at eighteen different locations statewide.

Utah is using additional funds obtained this year to conduct a few additional activities related to perinatal HIV transmission, such as education to providers, consultation to providers, survey of providers and a training workshop.

Previously Enacted Legislation/Regulations/Guidelines/Policies

California Senate Bill 889 became effective January 1996 and required the offering of counseling and testing to all pregnant women in California. The Perinatal Project developed, with the state Office of AIDS, a set of counseling and testing guidelines with supportive material for distribution to all perinatal providers (English and Spanish versions available).

Policy has been communicated to providers around the state of ***Connecticut*** which states that all pregnant women should be offered an HIV test. The state also has legislation on the books that says all obstetricians and gynecologists tell women about the availability of HIV testing.

Statutes in ***Kentucky*** require approximately two hours of HIV/AIDS education for initial and relicensure of 16 different health care professions. In November 1996, the Kentucky HIV/AIDS Program required providers of these courses to include information about perinatal transmission and about ACTG-076 protocols to prevent transmission (this effectively reaches over 65,000 providers each year). The Patient Services Manual issued by the Department of Public Health includes a requirement that all women seen in prenatal clinics be offered HIV counseling/testing as part of the routine diagnostic work-up. These clinics see approximately one-third of the women giving birth in Kentucky each year. This has been in place since October 1995. In addition, HIV Care Coordinators regularly include discussions of perinatal prevention with their female clients.

A law in ***New Jersey*** mandating HIV counseling of pregnant women and offering of voluntary HIV testing went into effect in August 1995. Providers are required to document the counseling and whether the woman chose to be tested.

The ***New York*** State Department of Health has developed two publications which have been disseminated to providers throughout the state: (a) "A Clinician's Guide to HIV Pre-Test and Post-test Counseling;" a tri-fold, pocket-sized card that includes sections on counseling of pregnant women and recommendations on the use of therapy to reduce perinatal transmission, and; (b) "Clinical Guidelines for the Use of ZDV to Reduce Perinatal Transmission of HIV." Regulations which became effective May 1, 1996 require that all facilities regulated by the Department of Health provide HIV counseling with testing recommended to women in prenatal care. State regulated facilities include hospitals, clinics and managed care organizations. The Department of Health does not have the authority to regulate physicians in private practice, but it has worked with the American College of Obstetrics and Gynecology and the American Academy of Pediatrics to ensure that HIV counseling with testing recommended is adopted as a standard of prenatal care in New York State. Educational sessions on the regulation have been held throughout the state. Educational materials about counseling and testing and the reduction of perinatal transmission have been developed for consumers and providers of prenatal care; special educational materials, including an audio tape, have been developed for physicians in private practice.

The ***Massachusetts*** Department of Public Health released a Clinical Advisory in November 1994 that recommended all pregnant women be counseled about HIV and offered testing. The Advisory further out-

lined protocol for administering AZT during the perinatal period. A clinicians guide to HIV pre- and post-test counseling was released by the Department in 1996 which includes a section on perinatal HIV transmission.

A regulation was enacted in ***North Carolina*** in 1995 that required that all pregnant women receive counseling about HIV infection and be offered voluntary HIV testing as part of prenatal care. All providers of prenatal care are required to comply.

During 1992, counseling and testing for HIV among pregnant women was established in ***Puerto Rico*** as an initiative of the Health Department and by 1995 treatment with ZDV for pregnant women with HIV and their newborns (for reduction of perinatal transmission of HIV) was established as public policy. A committee made up of representatives from the State Department Health and outside consultants has established an implementation process and monitoring system throughout the island. Additionally, for the privatized public health system, contract monitoring and implementation are being developed.

It is required in ***Texas*** that all health providers offering prenatal services to pregnant women provide HIV counseling and offer voluntary HIV testing.

The 1995 ***Virginia*** legislature passed a law (Section 54.1-2403.01, Code of Virginia), which became effective in July of 1995 which required that health care providers counsel women seeking prenatal care about HIV and to offer voluntary testing. The law requires physicians to counsel pregnant women about the value of HIV testing as "...a routine component of prenatal care..." and to "...request of each such pregnant woman consent to such testing." If the woman is HIV-infected, the law directs physicians to inform her "...about the dangers to the fetus and the advisability of receiving treatment in accordance with the then current CDC recommendations for HIV-positive pregnant women."

Pediatric HIV/AIDS Surveillance: Tracking the Progress Made

While all fifty states are required to report pediatric AIDS cases, additional surveillance activities related to perinatal HIV transmission varies widely from state to state. Thirty-nine out of the 47 states responding (83%) reported additional types of pediatric or perinatal HIV/AIDS surveillance activities. The following selected examples describe the types of pediatric and perinatal HIV/AIDS surveillance activities reported by states. Additional information may be available on a state-by-state basis by contacting the designated contact person listed at the end of this document.

HIV/AIDS Surveillance Data Related To Perinatal HIV Transmission

HIV infection became reportable with patient and provider name and identifiers in ***Alabama*** in November 1987. The health department works with The Children's Hospital in Birmingham to collect additional surveillance information.

The Office of AIDS in ***California*** contracts with the University of California, San Diego and Stanford University to conduct pediatric AIDS surveillance. A study, began in 1989, covers children under 13 years of age who are HIV infected or have known perinatal exposure to HIV. Both universities conduct active surveillance of records from hospital-based clinics and from HIV-positive pediatric patients cared for through the California Children's Services Program to identify HIV-exposed and HIV-infected children. During 1998 and 1999, the Office of AIDS, in collaboration with Stanford University, will conduct the following activities: 1) identify infants born to HIV-infected women from 1990-1998 at all state surveillance sites; 2) monitor the number of HIV-exposed and HIV-infected infants and children under 13 years of age projected to live in target areas using state maternal HIV seroprevalence rates from 1990 through 1998; and 3) use the Maternal Infant Care Evaluation study to identify all HIV-infected pregnant women delivering between 1990 and 1998 at all statewide surveillance sites.

The state of ***Colorado*** has surveillance information on pediatric AIDS cases and pediatric HIV exposures (whether mother knew HIV status prenatally or whether mother received AZT prenatally or at delivery).

CDC's Surveillance and Evaluation Activities

According to presentations made by CDC to NASTAD and the Institute of Medicine, an effective strategy for preventing perinatal HIV transmission includes a "cascade of steps." This cascade first involves a commitment to preventing HIV infection among men and women, with an emphasis on women of childbearing age. Simultaneously, it involves ensuring access to early prenatal care, universal offering of counseling and testing, acceptance of HIV testing, acceptance and adherence to ZDV and finally, follow-up care for both mother and baby. With this comprehensive strategy and only with this type of strategy will the goal of reducing perinatal HIV transmission be accomplished.

CDC funds a number of current and on-going surveillance and evaluation activities that attempt to address the wide spectrum of surveillance issues related to reducing perinatal HIV transmission. These include:

- *Surveillance to Evaluate Prevention (STEP).* This is an enhanced pediatric surveillance system conducted in four project sites (New Jersey, South Carolina, Michigan, and Louisiana). This system also includes data on HIV-exposed and HIV-infected children.
- *Pregnancy Risk Assessment Monitoring System (PRAMS).* This is a population-based surveillance system based on a sample of women who recently gave birth. The information for this system was gathered through a mailed questionnaire and a telephone follow-up. In 1996, eleven states participated in this study.
- *Prenatal Evaluation Project (P-EVAL).* This project is an in-depth, ongoing four-site project using medical chart reviews and patient interview data.
- *Perinatal Guidelines Evaluation Project (PGEP).* This project includes several discrete studies in four sites (Connecticut, North Carolina, Brooklyn, and Miami) and is based on interviews with pregnant and post-partum women. The prenatal study population is restricted to women whose healthcare providers had discussed HIV with them within the previous two months. The post-partum study population was a cross-section of women delivering at the study's site hospital.
- *Pediatric Spectrum of Disease (PSD).* This study is an 8-site medical record review of HIV-exposed and infected children since 1989.

The *Survey of Childbearing Women (SCBW)* was a population-based survey (discontinued in May 1995) conducted on anonymous newborn heelstick blood samples. It was conducted in 44 states and in the District of Columbia from 1989 through mid-1995. While federal funding for this survey is no longer available, some states have continued to conduct the SCBW with their own state funds.

Trend Data Related to Perinatal HIV Transmission

The following *preliminary* trend information presented to NASTAD and the Institute of Medicine is gathered from CDC's surveillance activities. The information sheds important light on progress made in the U.S. to reduce perinatal HIV transmission.

HIV/AIDS Trends in Women

- It is estimated that between 6,000 and 7,000 HIV-infected women delivered infants each year from 1989-1995. Trend data from the SCBW show a relatively steady national rate of HIV seroprevalence for childbearing women between 1989-1994.
- Significant regional variations do exist. The Northeast (44%) and the South (36%) account for most (80%) of the HIV/AIDS cases in women. The highest rates are found in New York, New Jersey, Florida, Maryland, Connecticut and Puerto Rico. However, while the highest rates were first observed in the Northeast, in the past five years, the greatest increase in rates has occurred in the South.
- African-American and Hispanic women are disproportionately affected by HIV/AIDS.

HIV/AIDS Trends in Infants and Children

- It is estimated that more than 15,000 HIV-infected children have been born to HIV-infected mothers in the U.S.

continued on page 10

since the epidemic began. By the end of 1997, over 7,000 perinatally acquired AIDS cases had been reported to CDC by states with the majority occurring among African-American and Hispanic children.

- Five states and/or territories account for 64% of all perinatally acquired AIDS cases (New York, Florida, New Jersey, California and Puerto Rico).
- From 1984 through 1992, the estimated number of children with perinatally acquired AIDS diagnosed each year increased, then declined 43% from 1992 through 1996. From 1992 to 1996 declines were similar by race/ethnicity, regions of the country and in urban and rural areas.
- Distribution of perinatally-acquired AIDS is highly concentrated, with three-quarters of the cases diagnosed in just eight states/jurisdictions (New York, Florida, New Jersey, California, Puerto Rico, Texas, Maryland and Pennsylvania).
- According to CDC, these trend data point to the conclusion that declines in pediatric AIDS, particularly among infants and particularly since 1994, are principally related to declines in perinatal transmission rates with increasing use of maternal and newborn zidovudine (ZDV).

Prenatal Care

- As compared to the general population, HIV-infected women are much more likely to receive late or no prenatal care.
- Early provisional STEP data indicate that only 63% of HIV-infected women giving birth received prenatal care prior to the third trimester. This compares to 95-97% of women in the general population.
- Additional preliminary STEP data show that the proportion of HIV-infected pregnant women who receive no prenatal care is 35% for illicit drug users but only 6% for non-drug users.

Testing Offered

- Overall, among childbearing women responding to the PRAMS survey, approximately 75% of childbearing women said their health care worker talked to them about HIV testing during pregnancy.
- P-EVAL data indicate that pregnant women were offered counseling and testing at an even higher rate than the PRAMS survey findings.
- Preliminary analysis of STEP data indicates that certain groups are more likely to be offered testing than others. These groups include African-Americans and Hispanics, young women aged 15-19, women with less than a high school education, and women cared for in public care settings and Medicaid-eligible.

Testing Accepted

- Data from the STEP project show that between 60-80% of the study population who were offered HIV testing actually received the test.
- PRAMS data indicate a high test-acceptance rate among childbearing women with 83% of women offered testing actually receiving the test.

Acceptance and Receipt of ZDV by HIV-infected Women

- Pediatric HIV surveillance data from 29 reporting states show that between 1994 and 1996 the proportion of prenatally diagnosed mother-infant pairs receiving some part of the 076 regimen increased from 36% to 80%.
- Preliminary STEP project data based on 1995-1996 chart abstractions for approximately 500 HIV-infected women indicate that only 5% of women offered ZDV refused treatment.

Recommendations

Based on the activities conducted and their findings, CDC's researchers make the following recommendations for achieving greater success in preventing perinatal HIV transmission:

(1) improve prenatal care access and utilization, especially for substance using women;
(2) improve provider knowledge, attitudes, practices especially in private care and managed care settings;
(3) improve client perception of risk and need for testing, and address fears about testing; and
(4) develop interventions to improve adherence to medications.

Surveillance data is available on AIDS trends and on pediatric AIDS cases and on children age 13 and under, reported with HIV infection, in ***Connecticut***.

AIDS surveillance and trend data is available from ***Florida*** for women and children with a confirmed AIDS diagnosis. HIV reporting was implemented in Florida in July 1997. Additional limited HIV surveillance data can be provided on women, pregnant women and HIV-infected children.

Available from ***Hawaii***: pediatric AIDS data, the number of pregnant women tested for HIV, the number of positive pregnant women of those tested, the number of live births and the number and percentage of hospitals with AZT delivery protocol.

Illinois can provide information on pediatric AIDS cases and 1995 seroprevalence data in childbearing women.

Basic information is collected from ***Kentucky***, such as gender, county of residence, etc. (with some potential exceptions due to confidentiality concerns due to a small cell size). The amount of information which is available beyond that would be variable. Since information must be coordinated with obstetricians, gynecologists and pediatricians, they rely on providers to voluntarily supply much of this information.

Pediatric AIDS cases are collected by ***Massachusetts***. In addition, they are involved in the Pediatric Spectrum of Disease Project which evaluates and provides follow-up to children who are identified as being exposed to HIV infection at birth or who are diagnosed with HIV. In Massachusetts, these projects are at all major pediatric programs. Data is also available on women presenting at counseling and testing sites with "prenatal/ ob/gyn" factor as reason for visit, on the number of pregnant women referred to Mass CAP (Massachusetts Women HIV Care and Advocacy Project) and on the use of AZT during pregnancy of women known to be HIV infected (1993-95).

The ***Michigan*** HIV/AIDS Surveillance Section, in conjunction with the CDC, has collected data on the number of children exposed to HIV, the number of children with a confirmed diagnosis of HIV/AIDS, and the number of children that seroreverted (lost maternal antibody) since 1992. In 1995, Michigan received supplemental funding from the CDC to collect more comprehensive data on perinatally exposed children, including information on maternal and neonatal ZDV use.

HIV reporting has been required in ***Minnesota*** since 1985 allowing the state to provide data on HIV/AIDS trends and perinatal transmission.

Data could be provided from ***Nebraska*** on pediatric AIDS (numbers reported by year for the last 10 years), numbers of children reported with HIV infection only, numbers of children reported as perinatally exposed and the number of live births occurring in Nebraska for any specific year

The state of ***New Jersey*** is able to provide information on the changing patterns in ZDV use during pregnancy, delivery and to newborns. In addition, they are part of the STEP projects, which provide for enhanced pediatric surveillance.

Tables are available from ***North Carolina*** listing mode of exposure by year of report for pediatric HIV infections, exposures and AIDS cases.

North Dakota reports that they could provide data concerning HIV in women, whether or not women are childbearing age.

Information from ***Oregon*** from the serosurvey of childbearing women through 1996 and pediatric AIDS cases can be provided.

Pennsylvania can provide information on pediatric AIDS (standard epidemiological data is available i.e., age, sex, race, residents, etc.) in which trends can be demonstrated. In addition, the Survey of Childbearing Women was conducted among childbearing women in Pennsylvania from January 1, 1997 - June 30, 1997 (the 5th year the survey was conducted).

Data on AIDS cases (pediatric and adult) is provided through the surveillance system of the ***Puerto Rico*** Department of Health. A surveillance system for childbearing women identified with HIV infection monitors implementation of the *PHS Guidelines* and access to care for pregnant women and their newborns. An island wide tracking system that captures information in the public health sector has been established to track pregnant women identified as HIV infected. Tracking of implementation of PHS guidelines as well as outcomes for newborn status of infection is monitored

through a centralized level within the Pediatric AIDS program.

South Carolina has continued the childbearing survey ('95 and '96 data). They also have HIV exposure and pediatric AIDS surveillance data. In addition, they are part of the CDC-funded STEP projects, which provide for enhanced pediatric surveillance.

The following data is collected from ***Texas***: 1) Pediatric AIDS since early 80's; 2) Pediatric HIV since 1994; 3) Survey of Childbearing Women: 1988-1995; 1997; 4) Pediatric HIV exposure (1989-1997) from Dallas, San Antonio, Houston, and Baylor; 5) Extended sites added: Lubbock, Ft. Worth, Galveston, Houston (UT), El Paso; 6) SCBW: 1997 Positives sent to CDC for AZT testing (not analyzed yet); and 7) Birth certificate data (Questions asked include the following: Was an HIV test done prenatally? Was HIV test done at delivery? Was AZT given prenatally?)

No HIV surveillance is conducted in ***Vermont*** and they did not participate in the SCBW. Data cells for AIDS case surveillance are small; to date, only 3 AIDS cases have been reported among children.

Surveillance data from ***Virginia*** is available on: 1) pediatric HIV from 1989 to September 1997; 2) SCBW data from 1989-1995; 3) HARS; 4) Mothers who received AZT; 5) HIV test history; 6) Enhanced Pediatric Surveillance (EPS); 7) Medical Record Abstraction.

When an HIV positive woman is reported in ***West Virginia***, obstetric care is indicated on the report form as being received, follow-up with the provider occurs to identify the expected date of delivery, whether AZT is available to the patient or a referral to ADAP is necessary. Finally, the newborn is followed to document seroreversion or HIV infection.

Evaluation Studies

Thirty-six out of the 47 states responding (77%) reported conducting a range of evaluations, activities and surveys related to HIV perinatal transmission. Many of these states have had to use state and local funds to collect this information. The following are some of the activities states have recently conducted or are planning to conduct in the near future.

Pregnant/Post-Partum Women Surveys

From October 1997 to January 1998, the ***California*** Office on AIDS, in collaboration with CDC and four local health departments, conducted a survey among pregnant women seeking prenatal care and women who had delivered within the previous six months. The objectives of this study were to: 1) investigate women's experiences with HIV counseling and testing during prenatal care, and 2) assess knowledge of AZT treatment and related attitudes towards HIV testing. They also surveyed 400 health care providers to determine whether they were complying with state law and Federal recommendations regarding HIV counseling and testing among pregnant women.

A study is currently being completed in ***Connecticut*** focusing on the treatment provided to pregnant women with HIV and their infants. In addition, Connecticut is part of the CDC-funded study in four sites on HIV testing practices of pregnant women, and provider and patient attitudes to HIV testing of pregnant women.

Two surveys in different parts of the state of ***Idaho*** are currently underway, with a third planned for later this year or next. The surveys have been administered to pregnant women admitted to the hospital for delivery. The intent of the survey was to determine the educational needs, who should be targeted (health care providers or the women) and if the needs varied throughout the state.

A post-partum survey of women giving birth in ***Illinois*** (in the city of Chicago) regarding knowledge of HIV status and HIV counseling and testing as part of their prenatal care was conducted.

Data on HIV-test history of each women giving birth in ***New York*** is collected in the postpartum setting. The categories are: (a) tested this pregnancy, (b) tested prior

to this pregnancy, (c) not previously tested, (d) test history unknown. Data analysis involves distribution by HIV-status, region, hospital, race and age. Aggregate data will be distributed annually to county health departments and other entities created by the Department to coordinate local/regional efforts to improve birth outcomes.

The HIV/STD Prevention and Care Section in ***North Carolina*** has conducted a survey of post-partum mothers to determine the proportion of mothers who recently gave birth that recall being counseled for HIV infection during their prenatal visits. That document has been submitted to the office of the State Health Department at this time. Two additional surveys (North Carolina is one of the four CDC study sites where in-depth clinical studies with women and providers is being taking place) have been conducted by researchers at the UNC-Chapel Hill and at Duke University Medical Center.

Focus groups of women in three cities were conducted in ***Pennsylvania*** in 1997 to gauge their experience with physician visits and to gather information about their needs. One of these sessions was videotaped and sent to 500 sites, including obstetrical /gynecological clinics, family planning clinics and drug and alcohol clinics.

A study was conducted in ***Tennessee*** (Evaluation of Implementation of Guidelines to Prevent Perinatal Transmission of HIV Research Study") to learn more about how pregnant women who are infected with HIV use health care and social services.

Prenatal Care Providers

A provider practices survey was done by physicians at the Children's Hospital in ***Colorado***.

There is a Department-wide study in ***Connecticut*** of provider practices concerning testing pregnant women for bloodborne pathogens and other infections.

A statewide provider survey in ***Florida*** is being planned for late 1998, as is a comprehensive study involving two hospitals which will focus on barriers to testing and the use of zidovudine among women in a high and a medium prevalence area. Data to evaluate HIV transmission rates, as well as counseling and testing practices among pregnant women are currently being collected through a network of pediatric AIDS centers throughout the state. Data on prenatal testing for all women who give birth will be available in 1999.

A survey study which will be completed in late spring 1998 will examine the knowledge, attitudes and practices of ***Kentucky*** prenatal care providers with respect to HIV counseling/testing of pregnant women. The final outcome of this study will be the development of recommendations on specific actions that the Kentucky HIV/AIDS Program could take to increase the proportion of prenatal care providers who follow the *PHS Guidelines* on counseling and testing and also increase the proportion of pregnant women who agree to be tested.

Results of a survey conducted in 1995 in ***Massachusetts*** of provider practices concerning counseling and testing are available. Materials from an April 1997 media campaign targeting pregnant women and women of childbearing age encouraging HIV counseling and testing, and materials from New England AIDS Education and Training Center for providers on perinatal HIV transmission (focus is primary care providers) are also available.

A recent study of ***Minnesota*** physicians found that although most support universal counseling and voluntary testing, only 10% are screening patients. Anecdotally, several clinics in the metro area are routinely screening all prenatal patients for HIV. However, the state knows of only one clinic where they have done a chart audit and have confirmed they are testing 95% of prenatal patients. Another OB/GYN clinic at a large hospital had tested 74% of patients who delivered through the third quarter of 1997.

The STD/HIV section in ***Montana*** administered a survey to selected physicians after the *PHS Guidelines* were released. The survey was designed to assess current practices with regards to HIV screening as well as to implement the *PHS Guidelines*. Among other findings, the survey reflected that 90% of the respondents were aware of the PHS guidelines.

New Jersey has conducted a survey of provider practices. In addition, they also have some data from a CDC funded STEP project which evaluated medical records of HIV infected women delivering babies to determine testing and counseling, history, ZDV use, birth outcome, etc.

A survey of all prenatal care providers was conducted June 1997 in ***South Carolina*** to determine the proportion providing routine HIV screening of pregnant women, counseling and documentation. The state also has data from a CDC-funded STEP project which evaluated medical records of HIV-infected women delivering babies to determine testing and counseling, history, ZDV use, birth outcome, etc. They also have data available from patient interviews.

A telephone survey was done in September 1997 of private OB-GYN providers in ***Texas*** which asked about policies and procedures around HIV counseling and testing, and treatment and referral patterns for pregnant women. In addition, a qualitative study was conducted with public providers of obstetrical care to determine provider practices around HIV counseling and testing, treatment and referral of HIV+ pregnant women.

The HIV/AIDS Division in ***Virginia*** surveyed physicians in 1996 about their HIV counseling and testing practices. The survey collected information in several categories, including: 1) physician's response to the July 1995 law on HIV counseling and voluntary testing; 2) HIV counseling and testing practices; 3) acceptance of HIV testing among pregnant women; and 4) AZT treatment of pregnant women.

In ***Washington*** a provider practice survey was done shortly after *PHS Guidelines* were issued. In addition, a telephone survey of the general public seeking information on testing of pregnant women was conducted.

A survey of all providers of obstetric care in late 1995 was conducted and the results were published in ***West Virginia's*** quarterly newsletter, Epi-Log. The state is currently reviewing a form made available for patient self risk assessment and are following up with providers.

Prenatal provider surveys were conducted in ***Wisconsin*** in 1993 and 1996 to determine the level of provider compliance with the PHS guidelines. Reports on these surveys are available.

Medical Record/Chart Review/Monitoring Systems

From August 15, 1997 to December 31, 1997, the ***California*** Office on AIDS, in collaboration with Stanford University, conducted a Linked Maternal-Infant medical record surveillance at two pediatric surveillance sites in the San Francisco Bay Area. This study attempted to define prenatal and delivery history, HIV testing and therapy information, and vital laboratory data. This survey assisted in: 1) identifying maternal risk factors for HIV infection; 2) defining whether recommendations regarding HIV testing and ZDV use during pregnancy and during labor/delivery have been implemented in California communities; 3) determining the rate and timing of prenatal care among HIV-infected pregnant women; 4) identifying risk factors for no or poor prenatal care; and 5) determining the extent of maternal compliance to national recommendations for the medical care of HIV-exposed and HIV-infected infants.

A program in ***Maine***, entitled Pregnancy Risk Assessment Monitoring System (PRAMS), tracks the number of pregnant women who were offered HIV counseling/testing as part of prenatal care. There is also narrative information about provider practices available which was obtained from interviews with providers.

To the extent possible, universal quality of care reviews are conducted on the charts of all HIV-exposed infants and their HIV-infected mothers, including prenatal care charts in ***New York***. Measurement includes: 1) implementation of HIV counseling and testing of pregnant women; 2) quality of care, including the provision of counseling regarding therapy to reduce perinatal transmission and implementation of therapy; 3) identification of demographic and other factors related to access to HIV testing and care, including therapies to reduce perinatal transmission; and 4) identification of demographic and clinical factors related to perinatal HIV transmission.

Newborn Surveys

Special studies are conducted through a Department of Health program which provides PCR testing free of charge for HIV-exposed infants born or residing in ***New York***. These studies focus on clinical factors related to HIV transmission.

Hospital Surveys

In ***Hawaii***, a follow-up survey with hospitals was con-

ducted regarding AZT delivery protocol.

A comprehensive study involving two hospitals in ***Florida*** will focus on barriers to testing and the use of zidovudine among women in a high and a medium prevalence area is planned for late 1998. Data to evaluate HIV transmission rates, as well as counseling and testing practices among pregnant women are currently being collected through a network of pediatric AIDS centers throughout the state. Data on prenatal testing for all women who give birth will be available in 1999.

Need for Further Investigation

It may be fruitful to gather and analyze many of these studies to add to the growing body of literature that is being collected by CDC, HRSA and the IOM as evidence of the way in which progress is being documented and where there may be deficiencies in efforts to implement the PHS guidelines.

This report was produced with the support of a grant from the George Gund Foundation, and with additional support from the AIDS Policy Center for Children, Youth and Families, under a grant from the Ford Foundation

The National Alliance of State and Territorial AIDS Directors
444 North Capitol Street, NW #339
Washington, DC 20001
(202) 434-8090
(202) 434-8092 FAX
Julie M. Scofield, Executive Director
Casey Blass, Chair

This report was prepared by Joseph Kelly and Jennifer Marin.

Contacts For Additional Information

Alabama:
Dr. Marilyn Crain
Director, Family Clinic
phone: (205) 939-6703

Arkansas:
Gary Horton
Director, AIDS/STD Division
phone: (501) 661-2503; fax: (501) 661-2082
email: hort101w@cdc.gov

Alaska:
Noel Rea
Public Health Specialist
phone: (907) 269-8057
email: nrea@epi.hss.state.ak.us

California:
James D. Ruiz, M.D., Dr. P.H.
Epidemiologist
California Department of Health Services
Office of AIDS, 830 S Street, Sacramento, CA 95814
phone: (916) 445-0700; fax: (916) 327-3252
email: Jruiz@hwl.cahwnet.gov

Yvonne Maldonado, M.D.
Assistant Professor
Stanford University School of Medicine, Stanford, CA
phone: (650) 727-6565; fax: (650) 725-8040

James N. Creeger
Chief, AIDS Case Registry Section
830 S Street, Sacramento, CA 95814
phone: (916) 322-1065; fax: (916) 322-0580
email: Jcreeger@hwl.cahwnet.gov

Steve Truax
Acting Chief, HIV Testing—Data Analysis
830 S Street, Sacramento, CA 95814
phone: (916) 323-4317

Mori Taheripour
Innovative Health Solutions
(Technical assistance and educational materials development)
phone: (510) 450-0190
email: mori@innovativehealth.com

Colorado:
Ken Gershman, MD
Manager HIV/STD Surveillance
phone: (303) 692-2657
email: ken.gershman@state.co.us

Mary Kay Myers
Manager HIV/STD Operations
phone: (303) 692-2703
email: mary.myers@state.co.us

Connecticut:
Beth Weinstein
Director, AIDS Program
phone: (860) 509-7832
email: beth.weinstein@po.state.ct.us

Dr. Richard Melchreit
Medical Associate, AIDS Programs
phone: (860)-509-7833
email: melc100w@cdc.gov

Delaware:
James C. Welch, R.N.
HIV/STD/AIDS Director
phone: (302) 739-3032

Florida:
Marlene LaLota, MPH
Program Administrator, Early Intervention Section
Bureau of HIV/AIDS
phone: (850) 921-4446
email: Marlene_LaLota@doh.state.fl.us

Hawaii:
Peter Whiticar
State AIDS Director
phone: (808) 733-9010
email: Whiticar@lava.net

Nancy Partika
Staff AIDS Education Project
phone: (808) 941-6322
email: Partikan@jobsom.biomed.hawaii.edu

Idaho:
Jean Stark
HIV/AIDS Surveillance
phone: (208) 334-6657; fax: (208) 332-7346
email:
starkj{dhwtowers/towers2/starkj}@dhw.state.id.us

Illinois:
Esther Joo
Surveillance Administrator
phone: (312) 814-4846; fax: (312) 814-4844

Indiana:
Laurie Phillips
Indiana Department of Health
phone: (317) 233-7867

Iowa:
John Katz
STD/HIV Program Manager
phone: (515) 281-4936

Kentucky:
Patty Sewell
HIV/AIDS Program Director
phone: (502) 564-2154
email: psewell@mail.state.ky.us

Mollie Adkins
HIV/AIDS Surveillance Coordinator (Pediatric AIDS)
phone: (502) 564-6539; fax: (502) 564-9865
email: madkins@mail.state.ky.us

Sara Dawson
HIV/AIDS Surveillance Coordinator
(HIV/AIDS epidemiology)
phone: (502) 564-6539; fax: (502) 564-9865
email: sdawson@mail.state.ky.us

Jamie Rittenhouse
HIV Services Program Administrator
phone: (502) 564-6539; fax: (502) 564-9865
(Prenatal testing survey project)
email: jritten@mail.state.ky.us

Martha McKinney
Principal Investigator
phone: (606) 625-9614; fax: (606) 625-9001
email: mmckin@iclub.org;

Maine:
Sam Sherman
Program Coordinator, Prenatal HIV Testing Program
phone: (207) 287-3817
email: samantha.sherman@state.me.us

Massachusetts:
Alfred Demaria, M.D.
Director, Bureau of Communicable Diseases
phone: (617) 983-6550
email: alfred.demaria@state.ma.us

Michigan:
Randall S. Pope
Chief, HIV/AIDS Prevention and Intervention Section
phone: (517) 335-8468
email: PopeR@state.mi.us

Minnesota:
Richard Danila
HIV Epidemiologist, Acute Disease Epidemiology,
Minnesota Department of Health
phone: (612) 623-5415

Maria Rubin
Perinatal HIV Prevention Coordinator
AIDS/STD Prevention Services Section
Minnesota Department of Health
phone: (612) 623-5342

Linda Thompson, MD
Hennepin County Medical Center (HCMC)
Department of Pediatrics
MC-867B, 701 Park Avenue South
Minneapolis, MN 55415
phone: (612) 347-2671

Elaine Collison
Assistant Section Manager
AIDS/STD Prevention Services
Division of Disease Prevention and Control
Minnesota Department of Health
phone: (612) 623-5204
email: elaine.collison@health.state.mn.us

Mississippi:
Elisa Houston, RN
Pediatric Surveillance Nurse
phone: (601) 960-7723

Missouri:
Kurt Kleier
Linda Bell
Dr. Robert Hamm
phone: 1(800) 359-6259

Montana:
Jim Murphy
Surveillance Coordinator
phone: (406) 444-0274
email: jmurphy@mt.gov

Nebraska:
Tina Brubaker
HIV/AIDS Surveillance Coordinator
phone: (402) 471-0360; fax: (402) 471-6426
email: tbrubaker@hhs.state.ne.us

Nevada:
Cynthia Huth, MCH
Perinatal Nurse Consultant
phone: (702) 687-4885

Patty Charles
Nevada Area AIDS Education and Training Center
phone: (702) 784-1373

Dale Capurro
Medicaid
phone: (702) 687-4588

Vicki Hamilton
Washoe County District Health Department
phone: (702) 328-3742

Rick Reich
Clark County Health District
phone:(702) 383-1394

New Jersey:
Sindy Paul
Medical Director/Epi. Services Director
phone: (609) 984-6191
email: smp@doh.state.nj.us

New York:
Gloria Maki
Executive Deputy Director
AIDS Institute, New York State Department of Health
phone: (518) 473-7542; fax: (518) 486-1315
email: GJC01@health.state.ny.us

North Carolina:
Delbert E. Williams
Head, Epidemiology/Spec. Studies
phone: (919) 733-9696
email: del_williams@mail.ehm.state.nc.us

North Dakota:
Pam Vukelic
HIV/AIDS Program Manager
phone: (701) 328-3324; fax: (701) 328-1412

Ohio:
Elizabeth Cross
Epi. Supervisor, AIDS Surveillance
35 E. Chestnut, Columbus, OH, 43215
phone: (614) 466-1370
email: ecross@gw.odh.state.oh.us

Oklahoma:
Mark Turner
Director
phone: (405) 271-4636
email: markt@health.state.ok.us

Oregon:
Steve Modesitt
Chief, HIV/STD Surveillance
phone: (503) 731-4029

Puerto Rico:
Rolando Jimenez Mercado
Program Director
phone: (707) 274-5591

Rhode Island:
Lucille Minuto
Assistant Administrator
phone: (401) 222-2320

South Carolina:
Joanne Lafontaine
STD/HIV Surveillance Director
phone: (803) 737-4110

Tennessee:
Herb Stone
HIV/AIDS Surveillance Director
phone: (615) 532-8495
email: HVS2@aol.com

Texas:
Sharon Melville, M.D.
Director, HIV/STD Epidemiology Division
phone: (512) 490-2515
email: sharon.melville@tdh.state.tx.us

Utah:
George Usher
Surveillance Manager
phone: (801) 538-6096
email: gusher@doh.state.ut.us

Vermont:
Paige Lucas
AIDS Surveillance Coordinator
phone: (802) 863-7286; fax: (802) 863-7314
email: @vdhvax.vdh.state.vt.us

Virginia:
Jim Martin
Perinatal HIV Evaluation
phone: (804) 786-6267

Dena McWilliams
HIV/AIDS Surveillance
phone: (804) 786-6267

Washington:
Maria Courogen
Epidemiologist
phone: (360) 236-3458;
email: mtc0303@hub.doh.wa.gov

West Virginia:
Loretta E. Haddy
State Epidemiologist/AIDS Program Director
phone: (304) 558-5358
email: loretta@wvdhhr.org

Wisconsin:
Neil J. Hoxie, MS
Staff Epidemiologist, Wisconsin AIDS/HIV Program
phone: (608) 266-0998
email: hoxienj@dhfs.state.wi.us

Wyoming:
Terrance L. Foley
Program Manager
phone: (307) 777-5800

FAX to BOB HATTOY

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

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

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

On Sunday, after Clinton and McCaffrey's return, word spreads that Shalala's press conference is canceled. At noon on Monday, AIDS Policy Office staffer Daniel Montoya, San Francisco AIDS Foundation's Regina Aragon, Bob Hattoy and others hunker down in AIDS czar Sandra Thurman's office to strategize. They fear that Clinton's AIDS legacy will be defined by his refusal to take this simple, cheap, life-saving step. Thurman gets a call from senior Clinton advisor Rahm Emmanuel. He tells her that the White House has decided to keep the ban in place. Frustrated, Thurman urges more consideration. Former ballet dancer Emmanuel turns a nasty pirouette: "Fuck you!" he yells at Thurman. "I didn't call to argue with you! I called to tell you what to say to the press!"

S.O.S.

Thurman, refusing to toe the administration line, goes home. Shalala has her press conference, first affirming that needle exchanges save lives while not increasing drug use, and then defending the ban, with NIH head Harold Varmus and new surgeon general David Satcher looking on. *The New York Times* reports that both doctors "shifted uncomfortably in their seats as reporters peppered Dr. Shalala with questions, although none publicly disagreed about it." But Scott Hitt, Clinton's defender-in-chief as head of his AIDS advisory panel, has had enough. He tells the *Times*: "At best this is hypocrisy. At worst, it's a lie. And no matter what, it's immoral." Thurman declines comment.

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

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

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

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

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

Sean D. Strub

PHOTO: WILLIAM HARRIS

What's the Point?

Puncture pundits square off on devilish data

Edited by RonniLyn Pustil
Reported by Scott Hess

Call it a syringe-swap-supporter's nightmare and a "Just Say No"-er's dream come true. The riddling results of a Montreal needle-exchange study, published in December's *American Journal of Epidemiology*, stoked major flames in both camps. What's the dope? Researchers led by Julie Bruneau of the University of Montreal found that intravenous-drug users (IDUs) who got their works at city needle-exchange programs got HIV more often than people who copped their needles elsewhere, including over the counter in pharmacies -- that's legal in Montreal. Nearly 1,600 IDUs were eyeballed for 21 months, and 89 got HIV; the probability for a needle-exchanger was more than double that of a non-NEPer -- 33 percent to 13 percent. Despite the data, Montreal health authorities have upped the number of syringe services. Bruneau is quick to caution against conclusions from this specific study that NEPs in general cause seroconversion. "We are beyond the question of whether needle exchange works," she told *POZ*. "It is part of a puzzle in a prevention strategy."

David Vlahov, PhD
Professor of Epidemiology, Johns Hopkins School of Public Health
"The data reflect a unique set of circumstances in that the exchange was open for restricted hours late at night in Montreal's red-light district. The comparison group had access to sterile needles through pharmacies -- not available in most places in the United States. So the higher rates of HIV among NEP users reflects a subgroup at much higher risk who were less likely to use other sources for sterile needles. The study is instructive in recognizing that NEPs are aimed at the highest-risk individuals -- so it is better at showing who NEPs attract rather than how well they work."

Peter Lurie, MD
Assistant Research Scientist, University of Michigan
"Those opposed to NEPs have been exploiting the results of this study for years, even as it remained unpublished. My

concern is that the Family Research Council and members of Congress will distort the findings in an attempt to permanently cut off federal funding for NEPs. The research is subject to misinterpretation by less than scrupulous, politically driven people. The public policy conclusions I draw from the study: NEPs should not have caps, there should be more of them, and they are ideal places to offer risk-reduction efforts. While it was important that the study be published, whether that info outweighs the political costs is another matter."

Vince Marrone
Director of Public Policy, The Lindesmith Center, New York City
"Two things to keep in mind about the Montreal study: Program attendees were much more likely to engage in high-risk activities, including sharing syringes and having unprotected sex. And the study wasn't designed to evaluate the efficacy of NEPs, but rather to 'observe' differences between IDUs who did and did not frequent them. As a result, the only fair conclusion is that individuals who share syringes and engage in unsafe sex are at high risk for HIV infection."

Dr. Bart Majoor
Clinical Psychologist, St. Ann's Corner of Harm Reduction, New York City
"This particular Montreal NEP was small and open odd hours -- from 9 pm to 4 am. What that tells me is, it's reaching the highest-risk IDUs -- like street prostitutes -- who don't have time to go to a pharmacy. The life they live is very hasty. They go to NEPs for more than needles, like a cup of coffee or relaxation. This study doesn't show that NEPs don't work, but that we have to look at harm reduction and how it works. The lesson learned: More needles and no limits on distribution. The one-to-one rule in needle exchange isn't at all connected to the reality."

Alan Clear
Executive Director, Harm Reduction Coalition, New York City
"We need to look at how this data can inform the program design and how they can improve the work they do with IDUs. Whether it's increase syringes or HIV education, there needs to be a self-awareness of what an NEP supplies -- a meeting place for IDUs where networks can form. Unless the program is able to get sound prevention messages into those networks, there will be problems."

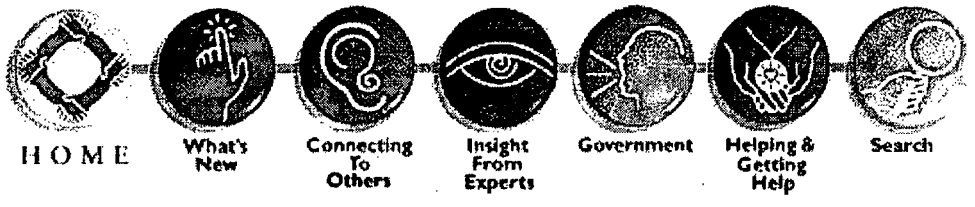
Steffanie Strathdee, PhD
Director of Epidemiology, British Columbia Center for Excellence for HIV/AIDS
"First, the findings do not suggest NEPs are harmful -- far from it. But the results are not surprising. In cities like Montreal, Vancouver, San Francisco and Baltimore, IDUs who attend NEPs are precisely those who practice the

riskiest behaviors. If these behaviors are not taken into account, one could draw the erroneous conclusion that NEPs don't work. And they do work. One only has to look at the mounting evidence supporting NEPs, including six U.S. government-commissioned reports."

Shepherd Smith
Founder, Americans For a Sound AIDS/HIV Policy, Virginia
"The results should surprise no one. It seems logical that if individuals have access to free needles, that doesn't then make them more responsible in respect to those needles. Too much hope was put into NEPs being successful, and certainly this study calls for a more objective look at their benefits."

Victor Zonana
Spokesperson, U.S. Department of Health and Human Services
"No comment."

Previous article | Next article | Back to *POZ* May 1998 contents page



AIDS ACTION COMMITTEE

FAX COVER SHEET
PUBLIC POLICY AND LEGAL AFFAIRS

Please deliver to: Todd Summers	
Of:	
FAX Number: 202.456.2438	Phone Number:
Date: 6.4.98	No. Of Pages (including cover): 11
From: Amy Rosenberg	

AIDS Action Committee
131 Clarendon St.
Boston, MA 02116
FAX: (617) 262-6135
Phone: (617) 450- 1434

Comments: Here's the coverage from the Globe, Bay Windows, & IN Newsweekly. Also an editorial from the NY Times (which you probably have). Let me know if you need anything else.

ELLEN GOODMAN

I was wrong! Needle-exchange programs work

Sooner or later, anyone who makes a living offering up opinions gets asked the same question: "Have you ever changed your mind?" After the ink is dry, after the column is sent into the electronic ozone, have you ever disagreed with you?

There must be some primal anxiety behind this frequent inquiry. I suppose people all share a high school nightmare of being exposed, seen mentally unzipped, caught changing our minds in public.

But since the only way to avoid changing a mind is by closing that mind, it happens.

Today I disagree with me, or rather with the me that once opposed needle-exchange programs. When AIDS activists first proposed that we pass out clean needles to drug addicts as a way of slowing the spread of HIV, I thought it was a bad idea.

In the moral struggle between principle and pragmatism, I went for this principle: The government shouldn't oppose drugs with the one hand and provide paraphernalia with the other. Too much ambiguity would be passed out with the needles.

Back then in 1988, the evidence, mostly from Europe, was scant. No one knew whether a needle-exchange program truly slowed the rate of HIV infection. No one knew whether it encouraged more drug users. In that atmosphere, there was a strong argument to be made against allowing the same government to arrest a drug user and to supply him with a syringe.

Now I know better. Now we all should know better. Now the moral equation has shifted. The pragmatic view is the more principled.

On Monday, we got another one of those split-the-difference decisions for which the Clinton administration is infamous. A reluctant Donna Shalala, secretary of health and human services, delivered the real mixed message on AIDS and needles:

Yes, for the first time, government officials acknowledged scientific evidence proving that needle-exchange programs reduce HIV and save lives *without* increasing drug use. No, the ban against allowing communities to use federal AIDS prevention money for such programs will not be lifted.

They said: We know it works, but we won't do it. They encouraged local communities to support such programs, but refused them federal money.

The much-heralded dispute inside the government over this policy could be read in the body language of squirming public health officials. Some 33 people a day are infected with HIV as a result of intravenous drug use. Forty percent of the new cases – addicts, their partners, their children – come directly or indirectly from contaminated needles.

By one estimate as many as 17,000 lives could have been saved since 1993 when Clinton came into office. At a cost of 10 cents a syringe.

But at the same time, the drug czar, former General Barry McCaffrey was more intent on saving kids from mixed messages than saving civilians from HIV. And the president, who is far better at reading the public than leading it, sided with those political honchos who fear being vulnerable to one virus above all others: political attacks.

It was widely assumed that if the White House lifted the ban, the Congress would have clamped it back down with new legislation. But even in this split-the-difference format, Gingrich & Company made a predictable hit. On Tuesday, at a press conference about smoking, Republicans accused the president of throwing "in the towel when it comes to the war on drugs."

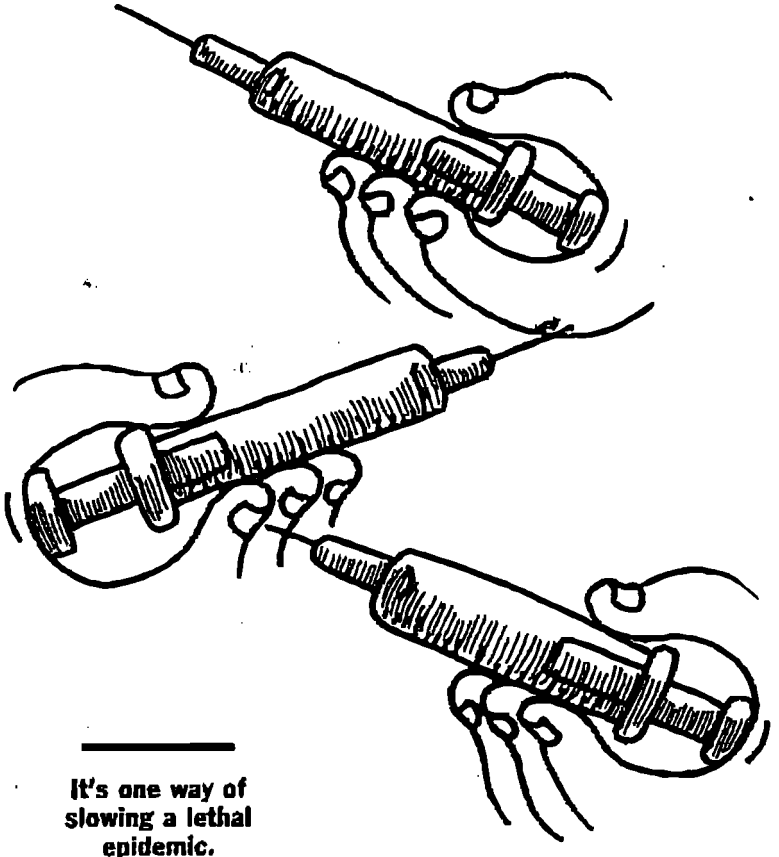
Indeed, in one of the rare moments when I ring with Gingrichian agreement, the speaker said sarcastically, "Now the president should be clear. If he thinks that needle exchanges are good, why is he not paying for them?" May I add seriously: Why not let local communities decide how to use federal money for AIDS prevention?

This is a president who picks his fights carefully. So carefully that he rarely loses. And rarely wins.

Needle-sharing drug addicts at risk for HIV are nobody's favorite underdog. As a new convert, I am still uneasy about providing addicts with clean needles when we want them to "get clean."

But since everybody seems to be worrying about mixed messages, try the far bleaker ones in today's air: We know how to slow a lethal epidemic. We know one way to help prevent the spread of HIV from drug addict to partner to child. We just aren't going to do it.

Go ahead, explain that to the kids.



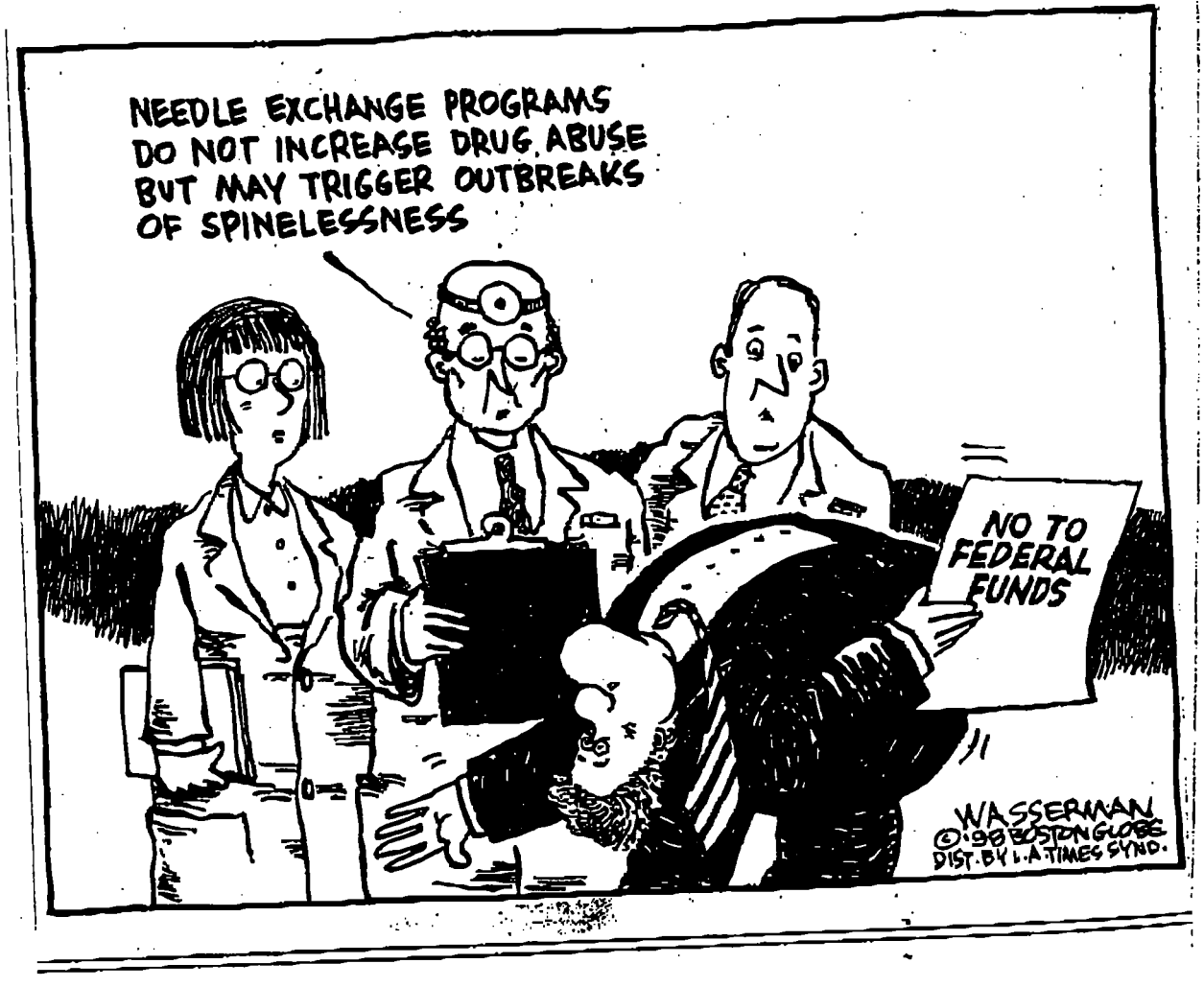
It's one way of slowing a lethal epidemic.

MARGARET SCOTT ILLUSTRATION

Ellen Goodman is a Globe columnist.

THE BOSTON GLOBE • THURSDAY, APRIL 23, 1998

Wasserman's view



THE BOSTON GLOBE • TUESDAY, APRIL 21, 1998

'Exchange programs do not encourage the use of illegal drugs.'
DR. HAROLD VARMUS

Supplying needles to addicts 'sends entirely the wrong message.'
REP. GERALD SOLOMON

Needle exchanges endorsed but won't get federal funds

By Richard A. Knox
GLOBE STAFF

Scientific evidence "clearly shows" that providing free sterile syringes to illicit drug users prevents the spread of AIDS while not promoting drug use, the Clinton administration said yesterday. But it balked at allowing federal funds to pay for controversial needle-exchange programs.

The long-awaited decision surprised and angered AIDS activists and public health authorities, who had hoped the administration would bow to data rather than to politics.

"This is like refusing to throw a life raft to a drowning person," said David Harvey of the AIDS Policy Center.

Dr. Mathilde Krim, chairman of the American Foundation for AIDS Research, called the decision "immoral" and "totally contrary to the practice of public health."

Critics of needle exchanges claimed victory. "Supplying drug addicts with needles is counterproductive and sends entirely the wrong message," said Representative Ger-

NEEDLES, Page A14

White House resists funding needle exchanges

■ NEEDLES
Continued from Page A1

ald Solomon, a New York Republican who proposes to take away presidential discretion about funding such programs.

The split decision reflected a battle within the administration between health officials and General Barry McCaffrey, director of the White House Office on Drug Policy, who opposes needle exchange programs. McCaffrey reportedly was instrumental in killing a proposal to use federal money for pilot programs in 10 cities.

US Surgeon General David Satcher, former chief of the Centers for Disease Control and Prevention, favors more needle exchange programs. "If we had more prime quality needle exchange programs, we would save more lives," Satcher said.

In certifying the effectiveness of needle-exchange programs, the administration noted that more than 60 percent of new AIDS cases in many regions result fromdrug users sharing needles. Needle-sharing also transmits hepatitis B and other blood-borne diseases.

Nine years ago, Congress passed a law that bars federal funding of needle exchange programs unless the secretary of health and human services certifies, on the basis of scientific evidence, that they curtail transmission of the human immunodeficiency virus (HIV) and do not increase illicit drug use.

'The governor, the public health commissioner, and the Department of Public Health support needle exchange programs, with the stipulation that municipalities ... decide.'

MARK LECCESE, *Mass. public health spokesman*

Secretary Donna E. Shalala, the nation's top health official, declared that a "meticulous scientific review has now proven that needle exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs."

Dr. Harold Varmus, director of the National Institutes of Health, backed her up. "Recent findings have strengthened the scientific evidence that needle exchange programs do not encourage the use of illegal drugs," Varmus said.

But Shalala said the Clinton administration has decided that "the best course at this time" is to let local communities "use their own dollars" for needle exchange programs.

Nationwide there are currently about 110 needle exchange programs, about half of which are sanctioned. The rest are tolerated by law enforcement authorities or operate underground. But all are relatively small-scale, advocates said.

Needle exchange programs have been endorsed by an array of medical and public health organizations, including the American Medical Association and the American Public Health Association.

Some observers of the long-running debate say the administration's decision represents a victory of election-year politics over public health.

"It's probably very smart politics to continue the restrictions on federal funds," said Donald DesJarlais, director of chemical dependency research at Beth Israel Medical Center in New York City.

"If Shalala had permitted the use of federal funds, there's a 99 percent chance Congress would have overridden it anyway," DesJarlais said. "Now the secretary of health and human services has made a scientific finding, but no one can get up and say Clinton tried to give needles to drug addicts."

While he was disappointed about the administration's withholding of federal funds, DesJarlais said its unequivocal statement about needle-exchange studies "will be very helpful for local decision makers who want to make their prevention planning on scientific evidence."

He was also relieved that the administration did not release federal funds with restrictions that were widely rumored to be under consideration, such as an absolute time limit on a drug user's participation in a needle exchange program.

Krim, a longtime veteran of emotional battles over AIDS funding, predicted "an uproar in the AIDS community," but said that was a calculated strategy on the administration's part.

"I think Mr. Clinton decided to let the Congress handle it," Krim said in interview. "He will let the activists go after Congress."

State health officials said the administration's stance will not affect needle exchange programs already in operation, and may make it somewhat easier to expand them because of the explicit federal endorsement.

In Massachusetts, "the governor, the public health commissioner, and the Department of Public Health support needle exchange programs, with the stipulation that municipalities be allowed to decide for themselves," said Mark Leccese, a department spokesman.

"We've believed for a couple of years that needle exchange does decrease the spread of HIV and does not lead to increased drug use," Leccese added.

Massachusetts currently has state-funded needle exchange programs in Boston, Cambridge, Provincetown, and Northampton. State officials have been stymied in their attempts to expand to other communities, such as New Bedford, in part because opponents claimed that the benefits were not supported by sound data.

In the current fiscal year, the state Legislature funded needle exchange programs for 10 communities, even though only four programs are under way.

Beth Weinstein, director of AIDS programs in the Connecticut Department of Public Health, said Shalala's Solomonlike decision "split the baby and gave some to each side."

"There will be a lot of concern in the AIDS community that this is a hollow action, because it's not accompanied by funding to carry out the programs," said Weinstein, who oversees $400,000 in Connecticut funding for five needle exchange programs.

Weinstein echoed other advocates of needle exchange in saying that such programs are "an effective way not only of stemming HIV infection but of getting people into treatment."

Varmus, the NIH director, said this is now backed up by evidence. A Baltimore study last October showed that drug-treatment programs linked to needle exchange programs have high levels of retention.

An NIH report last year concluded that needle exchange programs reduced risky needle-sharing behavior by as much as 80 percent, with a resulting 30 percent or greater reduction in HIV transmission.

May 3, 1998 ISSUE 7.36 the NEWS WEEKLY

news

Shalala fudges on needle exchange

by Bob Roehr

WASHINGTON — With one hand the Clinton administration officially lifted the ban on federal funding of needle exchange, to help reduce the spread of HIV. And with the other hand it declared that it was not going to fund such lifesaving programs.

Secretary of Health and Human Services Donna Shalala surrounded herself with the Directors of the NIH and CDC, and the Surgeon General at an April 20 Washington news conference as she announced: "This is another life-saving intervention, which requires a careful local design."

She hoped that the pronouncement would galvanize syringe programs at the state and local levels by sending a signal that the federal government endorses the efforts. But she was equally adamant in announcing that "we will not release federal funds at this point." This lack of money to back up her words was a policy of "Do as I say, not as I do."

Shalala did not explain how federal funding and local design were incompatible. In fact she could not, for that combination is the essence of how both CDC prevention activities and Ryan White services for AIDS are carried out.

In formally acknowledging the science of needle exchange programs she finally succumbed to the accumulated years of

NEEDLES continues page 12

research and pressure from scientists and AIDS advocates. Literally dozens of studies have demonstrated that fact. In February of last year a NIH Consensus Conference on HIV Prevention went so far as to call politics the greatest threat to public health. That continues to be the case today.

Reaction from the AIDS community was swift and uniformly negative. "It is unconscionable that the administration acknowledges that needle exchange programs work and save lives, then turn their backs on people who are in need," said Daniel Zingale, executive director of the AIDS Action Council.

"At best this is hypocrisy, at worst, it's a lie," charged R. Scott Hitt MD, chairman of the Presidential Advisory Council on HIV/AIDS (PACHA). "And no matter what, it's immoral."

The Council issued a statement redoubling their call for federal funding of needle exchange programs as part of a comprehensive program of reducing new HIV infections. It said that Shalala's action was "akin to refusing to throw a life preserver to a drowning person, the American public should be outraged" at her doublespeak. It urged the President to "check his moral compass and then take bold action."

This is "totally perverse," added Alexander Robinson, a Washington AIDS lobbyist and chair of the PACHA committee on prevention. "Once again this administration has managed to do something that satisfies no one." The manner in which Shalala delivered her message "undermined the belief that this is a viable intervention" to reduce the spread of HIV.

He faulted the administration's entire orientation toward substance abuse. The White House talks of treatment but gives only "lip service and billboards," Robinson said. "What we have not seen is money for treatment." However, the President's budget does call for significantly more money for policing functions in the "war on drugs."

"Shalala abdicated her responsibility to protect the health of United States citizens today," charged James Loyce, Jr., executive director of AIDS Project Los Angeles. "This egregious disregard for science and public health may sacrifice the lives of 33 Americans who will be infected by dirty needles each day on the altar of political expediency."

"The fact is, virtually every infant born with HIV and most of the women who have acquired HIV in recent years can credit Bill Clinton and Donna Shalala with their illnesses," said Sean Strub, publisher of *Poz* magazine. "This was a litmus test issue. If she truly recognized the science and the efficacy of these programs, she should have been willing to resign over it or go public in favor of federal funding."

CORNELIUS BAKER OF THE NATIONAL ASSOCIATION OF PEOPLE WITH AIDS, RIGHT, IS JOINED BY OTHER AIDS ACTIVISTS DURING A WASHINGTON NEWS CONFERENCE MONDAY, APRIL 20, 1998, TO DISCUSS A CLINTON ADMINISTRATION DECISION TO NOT ALLOW FEDERAL TAX DOLLARS TO FUND NEEDLE EXCHANGE PROGRAMS. FROM LEFT ARE, PAUL KAWATA OF THE NATIONAL MINORITY AIDS COUNCIL; WINNIE STACHELBERG OF THE HUMAN RIGHTS CAMPAIGN; DANIEL ZINGALE OF AIDS ACTION; AND BAKER. (AP PHOTO/RUTH FREMSON)

"This administration has shown a callous disregard for the disproportionate impact this decision will have on communities of color and women," said Pat Christian, executive director of the San Francisco AIDS Foundation.

Cornelius Baker, executive director of the National Association of People With AIDS (NAPWA), all but called the decision racist. Earlier this year the Clinton administration announced an initiative to eliminate racial disparities in health, including HIV. That goal will be impossible to achieve without needle exchange.

"There can be only one reason why the Clinton Administration is refusing to display leadership on the issue of needle exchange," lamented Baker, "This is a community they do not care about."

"It defies logic to determine a program's efficacy and then not fund the program, especially in the middle of an epidemic," marveled Congresswoman Nancy Pelosi (D-California). "The Administration's decision shows a lack of political will in the midst of a public health emergency."

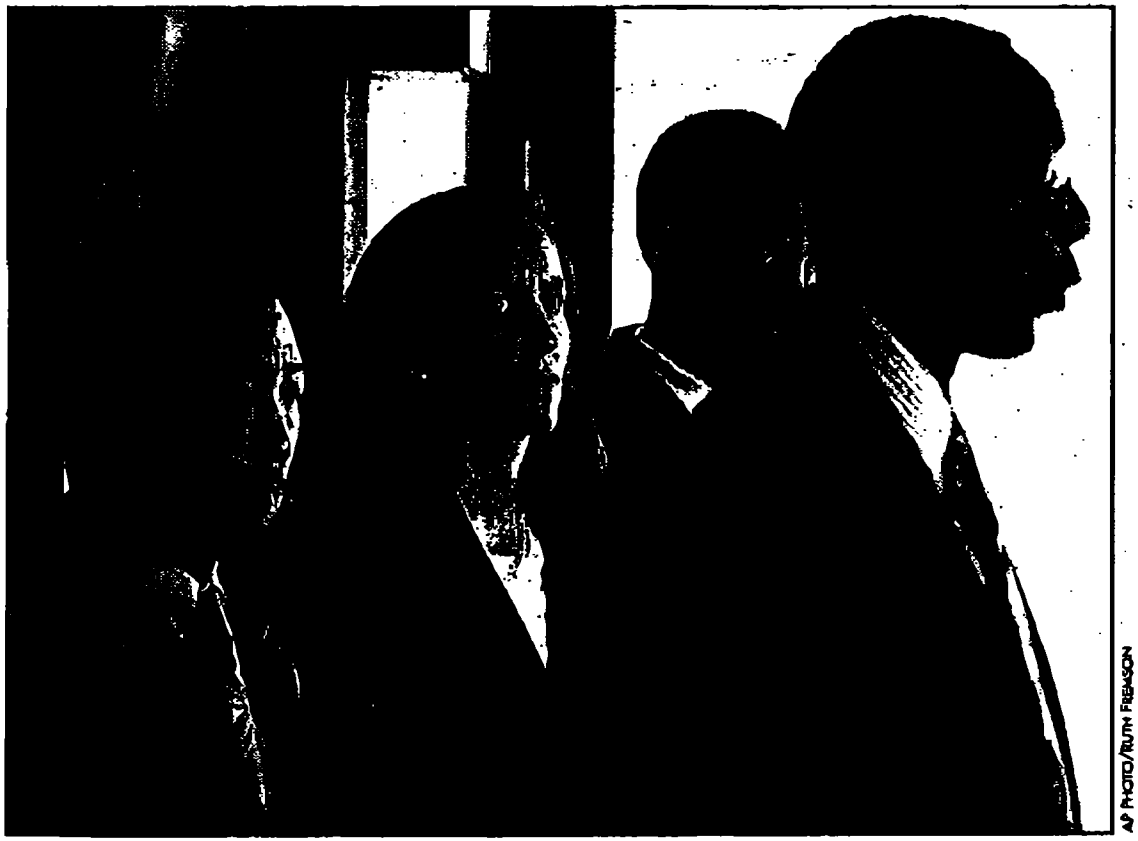
"It is clear that politics triumphed over public health in the end," said Winnie Stachelberg, political director of the Human Rights Campaign (HRC). "The administration today validated the politics of the Family Research Council, which wishes to play politics with peoples lives. We find this position to be indefensible."

The right was justifiably jubilant but loath to admit it In a statement released this past weekend, Senator Chuck Grassley (R-Iowa) said that federal funding of needle exchange "would in reality use tax dollars and the authority of the federal government to push drug paraphernalia into already drug-ravaged inner cities. This is reckless and irresponsible." The Senator obviously based this upon experience living in the mean "inner cities" of Iowa.

Even Shalala's half-measure was "an intolerable message that it's time to accept drug use as a way of life," to Senator John D. Ashcroft (R-Missouri). He is running for the Republican nomination for President and is thought by many to be the favorite of the Christian right.

And in response, Senator Paul Coverdell (R-Georgia) introduced a bill that would prevent the HHS secretary from ever lifting the ban. That effort has the full backing of the far right Family Research Council.

LOCAL • NEWS • NATIONAL



AP PHOTO/RUTH FREMSON

Cornelius Baker of the National Association of People with AIDS, right, is joined by other AIDS activists during a Washington news conference April 20 to discuss a Clinton administration decision to not allow federal tax dollars to fund needle exchange programs. From left are, Paul Kawata of the National Minority AIDS Council; Winnie Stachelberg of the Human Rights Campaign; Daniel Zingale of AIDS Action and Baker.

Despite evidence of success, Clinton fails to support needle exchanges

Decision draw ire of AIDS groups, Elizabeth Taylor

by Lauran Neergard
AP Medical Writer

In a decision that is being described as "disgraceful" and "empty" by everyone from gay and AIDS groups to actress Elizabeth Taylor, the Clinton administration refused on April 20 to use federal tax dollars to buy clean needles for drug addicts, even though it said needle exchanges fight AIDS without encouraging illegal drug use.

Health and Human Services Secretary Donna Shalala said her scientific endorsement should encourage more communities to start their own needle exchanges. But Shalala, under orders from the White House, sidestepped a political fight with conservatives and stopped short of providing communities with federal money to let addicts swap dirty needles for clean ones.

The decision angered Taylor. "It is with great disappointment that I see that, once again, our colleagues in Washington have chosen to play politics with human lives," said Taylor in an April 21 statement

Continued on page 17

Despite evidence, no support for needle exchanges

Continued from page 3

issued through the American Foundation for AIDS Research (AmFAR), which she co-founded.

"It is somewhat gratifying that, after many months of study, the Secretary of Health and Human Services, Donna Shalala, has made a positive determination and has validated the science which demonstrated, many years ago, that needle exchange programs reduce HIV infections and do not increase drug use," Taylor continued.

"A scientific determination is an empty gesture, however, that can be made meaningful only when this administration puts its money where its mouth is and allows the federal funding of needle exchange programs at the community level," concluded the world's most famous AIDS activist.

"They've now said we know how to save lives and we don't want to do what's necessary to save the lives," said an angry Dr. Scott Hitt, chairman of President Clinton's AIDS advisory council. "This administration is now publicly stating how to slow it [the AIDS epidemic] down and is saying they lack the courage to do it."

"It's like saying the world is not flat but not funding Columbus' voyage," added Daniel Zingale of AIDS Action.

Republicans continued to argue that needle exchanges were bad policy, and Rep. Gerald Solomon, R-N.Y., said he would push for Congress to ban federal funding altogether in case Shalala changed her mind.

"Why not simply provide heroin itself, free of charge, courtesy of the American taxpayer?" asked Sen. John Ashcroft, R-Mo.

President Clinton's own drug policy chief, Barry McCaffrey, spent the weekend arguing that needle exchanges jeopardize the administration's war on drugs and send the wrong message to children. Officials familiar with the heated debate said McCaffrey's objections were central to killing a proposed compromise, a pilot project paying for needle exchanges in 10 cities.

Asked about the criticisms, National Institutes of Health Director Harold Varmus said that they were being made only by politicians, not scientists. Every major public health organization has supported needle exchanges, including the American Medical Association, the American Public Health Association, the American Academy of Science, the American Bay Association and the National Lesbian and Gay Health Association (NLGHA).

"The President promised that science would drive his decision," observed NLGHA Executive Director Beverly Saunders Biddle. "Yet the science has been ignored and the Presdident missed the opportunity to help stop the spread of HIV."

Those who operate needle exchange programs are also outraged, saying that such programs have important goals beyond successfully slowing the spread of the epidemic.

"Our program uses scarce city resources to reach extremly high risk populations," noted Jim Graham, executive director of Washington's Whitman-Walker Clinic, and NLGHA board member. "It is more than just a program to exchange dirty needles for clean needles — it is a gateway for people into drug treatment and counseling programs."

"The President's lack of leadership is disgraceful, especially considering he knows these funds are hard to come by at the state and local level," said Kerry Lobel, executive director of the National Gay and Lesbian Task Force.

Half of all people who catch HIV are infected by needles or by sex with injecting drug users, or are children of infected addicts.

The decision bitterly disappointed AIDS activists, who said they couldn't recall another medical program the government had declared lifesaving but refused to try to pay for.

The Clinton administration is counting on Shalala's endorsement to persuade communities to expand the 110 needle exchanges now operating in 22 states. And Surgeon General David Satcher suggested communities could avoid the political impasse: Seek federal dollars for all other HIV prevention activities, from youth education to drug treatment, so that local money could be directed to buy needles.

When asked if more funding would help, Satcher responded: "Yes, we think we would save more lives."

The nation's top science organizations have long said needle exchanges would cut the AIDS toll. Activists say federal funding is key to expanding the programs.

But Congress banned federally funded needle exchanges unless Shalala certified that such programs fight the spread of HIV without encouraging drug use.

On April 20, Shalala did that, saying a review of studies concluded that programs that provide drug counseling and push addicts into treatment work best. Among the evidence:

- A Baltimore study of almost 3,000 addicts found a needle-exchange program cut the number of shared needles and the times tainted needles were discarded in the streets. It also got a significant number of addicts into treatment: Just 6 percent were getting treatment when they first arrived at the needle exchange, but 16 percent were after using the program for six months.
- A study in The Lancet found 29 cities worldwide that opened needle exchanges experienced a 5.8 percent decline in HIV spread, while 52 cities that didn't offer clean needles experienced a 5.9 percent increase in the virus.

(Jeff Epperly contributed to this report.)▼

THE BOSTON GLOBE • SATURDAY, MAY 9, 1998

Needle plan is backed in Springfield

ASSOCIATED PRESS

SPRINGFIELD – The city health council has declared a public health emergency, and ordered the city to start a needle exchange program for drug addicts.

City Council President William Boyle immediately challenged the legality of the health council's move Thursday. City councilors voted down a needle exchange program in 1996, and let it die in committee last year.

The city health council declared a public health emergency.

"It was a bold step and I'm sure controversial," said Helen Caulton, the city's health director. "But the Public Health Council believed it was necessary at this point in the epidemic."

Health board members said the state-funded program that allows drug addicts to exchange used hypodermic needles for new needles is needed to halt the spread of AIDS and hepatitis through addicts sharing needles.

Mayor Michael Albano, who supports the needle exchange program, said legal questions exist and will have to be reviewed.

THE NEW YORK TIMES **EDITORIALS/LETTERS** WEDNESDAY, APRIL 22, 1998

Topics of The Times

Cowardice on Clean Needles

In a calculated duck, the Clinton Administration has refused to lift a nine-year-old ban on using Federal money to finance needle exchange programs. Officials readily admit that repeated studies have shown needle exchange programs can help prevent the spread of AIDS without encouraging illegal drug use. But Barry McCaffrey, the Administration's drug czar, continues to insist that needle exchange programs send a message to children that drugs are acceptable.

His preoccupation with symbolism flies in the face of brutal facts. The Surgeon General, Dr. David Satcher, says that 40 percent of all new H.I.V. infections are directly or indirectly caused by contaminated needles, including cases in infants born to infected drug abusers or their infected spouses.

The Administration hoped that by keeping the current ban, liftable at White House discretion, it could fend off more repressive legislation. But conservatives in Congress are poised to offer anti-needle-exchange bills anyway. Instead of making a principled decision, President Clinton is fecklessly trying to appease conservatives with a policy that will cost thousands of lives.

White House Drug and AIDS Advisers Differ on Needle Exchange

By CHRISTOPHER S. WREN

The debate over the propriety of anding out sterile syringes to people ho inject illegal drugs, to reduce ie spread of AIDS, has reached the /hite House, where President Clin- on's two main policy advisers on the ssue have staked out opposing posi- ions.

Their disagreement makes pros- ects for Government financing of ieedle-exchange programs more un- ikely when a ban on such spending, mposed by Congress in 1992, expires it the end of March.

One adviser, Sandra L. Thurman, he White House director of national AIDS policy, advocates spending on he programs as a way of saving lives by reducing the incidence of AIDS contracted from shared nee- dles.

But at a spirited meeting on Tues- day, the other adviser, Barry R. McCaffrey, the retired Army general who is the Administration's director of national drug policy, firmly op- posed any Government subsidy. In a subsequent letter to Ms. Thurman, he reiterated his belief that buying clean needles for drug users would send the wrong message to young Americans who are being told that illegal drug use is wrong. The money, he said, would be better used expand- ing drug treatment programs.

"As public servants, citizens and parents we owe our children an un- ambiguous 'no use' message," Gen- eral McCaffrey wrote. "And if they should become ensnared by drugs, we must offer them a way out, not a means to continue addictive behav- ior."

His letter was leaked to some members of Congress. A copy was provided to The New York Times by someone opposed to needle ex- changes.

General McCaffrey's fervent oppo- sition to paying for needle ex- changes, and the esteem with which he is regarded on Capitol Hill, will probably undercut whatever support exists for exchange programs. Many members of Congress already op- pose the concept or do not want to look as if they are soft on drug use in a Congressional election year.

In a joint statement released on Saturday, Ms. Thurman and General McCaffrey sought to play down their increasingly public differences over needle exchange. They said they agreed on other issues, like the need to make drug treatment programs more widely available.

They said they would leave it to Donna E. Shalala, Secretary of Health and Human Services, to settle the needle exchange issue. Ms. Sha- lala, who has sided with General McCaffrey on other drug policy ques- tions, has yet to decide whether the needle exchange programs deserve Government money.

Congress asked her to determine whether the programs prevent the spread of H.I.V., the virus that causes AIDS, without encouraging the use of illegal drugs. In February 1997, a report released by the Nation- al Institutes of Health said "there is no longer any doubt that these pro- grams work" to prevent the spread of H.I.V. and said that "needle ex- change programs should be imple- mented at once." Ms. Shalala said that she wanted to study the matter.

Dwindling hope for Federal money for syringes.

In his letter to Ms. Thurman, Gen- eral McCaffrey pointed out that the Government does not ban needle ex- changes, and that approximately 100 communities have set up programs.

The public health consequences of sharing dirty needles is not insignifi- cant. Approximately 280,000 to 300,000 Americans suffer from AIDS and as many as 600,000 others are infected with H.I.V., according to Ms. Thurman's office. The Centers for Disease Control and Prevention esti- mate that one-third to one-half of new H.I.V. cases involve people who injected drugs or had sex with people who did. The cost of caring for an adult with AIDS can exceed $100,000.

"You have to understand that ev- ery day, 33 Americans become in- fected as a result of drugs," Ms. Thurman said on Saturday in a tele- phone interview. While not all cases of H.I.V. can be prevented, she said, "I think we have a moral obligation to stop as many as we can."

Public tolerance for needle pro- grams has increased. A Harris poll reported in October that 71 percent of the Americans surveyed support- ed needle exchanges. The poll was commissioned by the Lindesmith Center, a group that advocates nee- dle exchange programs.

Other groups that have endorsed the programs, in principle, include the American Bar Association, the American Medical Association, the American Public Health Association and the United States Conference of Mayors. In August, George Soros, the international financier and philan- thropist, donated $1 million to fi- nance needle-exchange programs in the San Francisco area.

Both supporters and critics of the programs have cited studies to sup- port their arguments. Dr. Peter Bei- lenson, the City Health Commission- er in Baltimore, reported to a House subcommittee in September that his city's needle-exchange program had reduced significantly the sharing of used needles and provided a point of access to medical treatment for hard-core addicts.

Ms. Thurman agreed that needle- exchange programs have become conduits to health care. "This is an opportunity often for people to pull their lives together," she said. "If using a needle exchange program fa- cilitates it in some way, we need to look at it very seriously."

But critics have cited another study, which reports that intra- venous drug users who joined Mon- real's needle-exchange program be- came infected with H.I.V. at a higher rate than nonparticipants. The study was published last year in the Amer- can Journal of Epidemiology.

If the ban on Government money is lifted, General McCaffrey wrote, "There is the troubling question of how such a message would be re- ceived by our young people."

Ms. Thurman replied: "I know he has concerns about that and I do too, but the overwhelming evidence is that people coming into needle-ex- change programs are older.

"Nobody's going to stick a needle in their arm because someone hands them a needle."

The New York Times

Founded in 1851

ADOLPH S. OCHS, *Publisher 1896-1935*
ARTHUR HAYS SULZBERGER, *Publisher 1935-1961*
ORVIL E. DRYFOOS, *Publisher 1961-1963*
ARTHUR OCHS SULZBERGER, *Publisher 1963-1992*

ARTHUR OCHS SULZBERGER JR., *Publisher*

JOSEPH LELYVELD, *Executive Editor*
BILL KELLER, *Managing Editor*
GERALD M. BOYD, *Deputy Managing Editor*
JOHN M. GEDDES, *Deputy Managing Editor*

Assistant Managing Editors
SOMA GOLDEN BEHR, JACK ROSENTHAL
CAROLYN LEE, ALLAN M. SIEGAL

HOWELL RAINES, *Editorial Page Editor*
PHILIP M. BOFFEY, *Deputy Editorial Page Editor*

JANET L. ROBINSON, *President, General Manager*
DANIEL H. COHEN, *Senior V.P., Advertising*
RICHARD H. OILMAN, *Senior V.P., Operations*
SCOTT H. HEEKIN-CANEDY, *V.P., Planning*
DENNIS L. STERN, *V.P., Human Resources*
DAVID A. THURM, *V.P., Production*

PENELOPE MUSE ABERNATHY, *President, News Services*
MARTIN A. NISENHOLTZ, *President, Electronic Media*

The Politics of Needles and AIDS

By Julie Bruneau and Martin T. Schechter

Debate has started up again in Washington about whether the Government should renew its ban on subsidies for needle-exchange programs, which advocates say can help stop the spread of AIDS. In a letter to Congress, Barry McCaffrey, who is in charge of national drug policy, cited two Canadian studies to show that needle-exchange plans have failed to reduce the spread of H.I.V., the virus that causes AIDS, and may even have worsened the problem. Congressional leaders have cited these studies to make the same argument.

As the authors of the Canadian studies, we must point out that these officials have misinterpreted our research. True, we found that addicts who took part in needle exchange programs in Vancouver and Montreal had higher H.I.V. infection rates than addicts who did not. That's not surprising. Because these programs are in inner-city neighborhoods, they serve users who are at greatest risk of infection. Those who didn't accept free needles often didn't need them since they could afford to buy syringes in drugstores. They also were less likely to engage in the riskiest activities.

Canadian findings are distorted.

Also, needle-exchange programs must be tailored to local conditions. For example, in Montreal and Vancouver, cocaine injection is a major source of H.I.V. transmission. Some users inject the drug up to 40 times a day. At that rate, we have calculated that the two cities we studied would each need 10 million clean needles a year to prevent the re-use of syringes. Currently, the Vancouver program exchanges two million syringes annually, and Montreal, half a million.

A study conducted last year and published in The Lancet, the British medical journal, found that in 29 cities worldwide where programs are in place, H.I.V. infection dropped by an average of 5.8 percent a year among drug users. In 51 cities that had no needle-exchange plans, drug-related infection rose by 5.9 percent a year. Clearly these efforts can work.

But clean needles are only part of the solution. A comprehensive approach that includes needle exchange, health care, treatment, social support and counseling is also needed. In Canada, local governments acted on our research by expanding needle exchanges and adding related services. We hope the Clinton Administration and Congress will provide the same kind of leadership in the United States. □

Julie Bruneau is an assistant professor of psychiatry at the University of Montreal. Martin T. Schechter is a professor of epidemiology at the University of British Columbia.

Mike Causey

Health Plans Aren't Permitted to Just Say No

The Office of Personnel Management has told federal health plans that they cannot substitute their own judgment and withhold payment for medically necessary drugs, treatments or procedures cleared by the Food and Drug Administration.

Experts say the directive won't have a major impact on most plans or the people they cover. But it could be critical in cases in which plans balk at paying for drugs or treatments they consider "investigational" or "experimental."

The FDA's new "fast track" program is intended to speed up approval of many drugs and other medical products, and OPM makes clear that the health plans are to cover products approved through that process.

OPM runs the federal health program. The program covers nearly 10 million people worldwide, including hundreds of thousands of current and retired federal workers and family members in the Washington area.

The April 2 notice—sent to health plans but not individual policyholders—says in part:

"When the FDA has approved a drug, device or biological product, all [federal health plans] must provide coverage when the product is used for its intended purposes and labeled indications, as approved by FDA, if those purposes and indications would otherwise be eligible for benefits under the plan's benefit structure. This includes coverage for related injection, infusion, surgery, or other services necessary for administration or utilization of the drug, device or biological product in the manner for which it was approved. However, as with all other covered benefits, the services must be medically necessary and appropriate for the patient's condition."

The OPM letter also says that all plans "must cover drugs, devices, and biological products which are intended for the treatment of serious or life-threatening conditions, that have received FDA approval through FDA's Accelerated Approval or 'Fast Track' process. Such approvals are based on FDA's determination that, based on an assessment of preliminary studies, the product provides meaningful therapeutic benefits to patients over existing treatments. FDA may approve such products subject to post-approval to validate or confirm the effect on clinical outcomes. The existence of such postmarketing approval trials may not be used as justification for denying benefits on the basis that the services are experimental or investigational."

However, OPM goes on to say: "We are not requiring plans whose benefit structure does not currently include coverage for medical devices, equipment, and products as described above to add such coverage in order to comply with the requirements of this letter. Rather, our intent is to assure consistency of application of existing coverage by requiring that services as described above that would otherwise be eligible for coverage not be denied on the basis that the plan considers them experimental or investigational. Plans should not substitute their judgment for that of FDA concerning the appropriateness of use of FDA-approved products when they are used for FDA-approved intended purposes."

Maryland Legislative Briefing

A panel of legislators will report on the actions of the Maryland General Assembly at the April 28 luncheon of the Gaithersburg chapter of the National Association of Retired Federal Employees. The meeting will be held at Asbury Methodist Village. For information, call **Roma Diehl** at 301-869-7348.

Bilingual Jobs

The Social Security Administration has openings for bilingual (Spanish-, Chinese-, Korean-, Vietnamese-speaking) service representatives. The Grade 5 through 8 jobs ($21,421 to $38,199 a year) are in the Washington area and Winchester, Va. Call **Mary Pastorius**, at Social Security's Philadelphia office, at 215-597-2485.

Personnel Jobs

The Immigration and Naturalization Service is looking for a personnel staffing specialist and a staffing and classification specialist, both Grade 12 ($47,066 to $61,190 a year). Applicants must have civil service status. Send résumés to the INS, 425 I St. NW, Room 2038 (Attention: **Phyllis Moulder**), Washington, D.C. 20536.

Settle Settles

John Settle is the new director of program development for the Alexandria-based Public Administration Forum. He's an expert in alternate dispute resolution techniques and former chairman of the appeals board at the Department of Health and Human Services.

WA Sit Post Pg D2 4/9/98

The New York Times

Founded in 1851

ADOLPH S. OCHS, Publisher 1896-1935
ARTHUR HAYS SULZBERGER, Publisher 1935-1961
ORVIL E. DRYFOOS, Publisher 1961-1963
ARTHUR OCHS SULZBERGER, Publisher 1963-1992

ARTHUR OCHS SULZBERGER JR., Publisher

JOSEPH LELYVELD, Executive Editor
BILL KELLER, Managing Editor
GERALD M. BOYD, Deputy Managing Editor
JOHN M. GEDDES, Deputy Managing Editor

Assistant Managing Editors
SOMA GOLDEN BEHR
CAROLYN LEE
JACK ROSENTHAL
ALLAN M. SIEGAL

HOWELL RAINES, Editorial Page Editor
PHILIP M. BOFFEY, Deputy Editorial Page Editor

JANET L. ROBINSON, President, General Manager
DANIEL H. COHEN, Senior V.P., Advertising
RICHARD H. OILMAN, Senior V.P., Operations
SCOTT H. HEEKIN-CANEDY, V.P., Planning
DENNIS L. STERN, V.P., Human Resources
DAVID A. THURM, V.P., Production

PENELOPE MUSE ABERNATHY, President, News Services
MARTIN A. NISENHOLTZ, President, Electronic Media

The Politics of Needles and AIDS

By Julie Bruneau and Martin T. Schechter

Debate has started up again in Washington about whether the Government should renew its ban on subsidies for needle-exchange programs, which advocates say can help stop the spread of AIDS. In a letter to Congress, Barry McCaffrey, who is in charge of national drug policy, cited two Canadian studies to show that needle-exchange plans have failed to reduce the spread of H.I.V., the virus that causes AIDS, and may even have worsened the problem. Congressional leaders have cited these studies to make the same argument.

As the authors of the Canadian studies, we must point out that these officials have misinterpreted our research. True, we found that addicts who took part in needle exchange programs in Vancouver and Montreal had higher H.I.V. infection rates than addicts who did not. That's not surprising. Because these programs are in inner-city neighborhoods, they

Canadian findings are distorted.

serve users who are at greatest risk of infection. Those who didn't accept free needles often didn't need them since they could afford to buy syringes in drugstores. They also were less likely to engage in the riskiest activities.

Also, needle-exchange programs must be tailored to local conditions. For example, in Montreal and Vancouver, cocaine injection is a major source of H.I.V. transmission. Some users inject the drug up to 40 times a day. At that rate, we have calculated that the two cities we studied would each need 10 million clean needles a year to prevent the re-use of syringes. Currently, the Vancouver program exchanges two million syringes annually, and Montreal, half a million.

A study conducted last year and published in The Lancet, the British medical journal, found that in 29 cities worldwide where programs are in place, H.I.V. infection dropped by an average of 5.8 percent a year among drug users. In 51 cities that had no needle-exchange plans, drug-related infection rose by 5.9 percent a year. Clearly these efforts can work.

But clean needles are only part of the solution. A comprehensive approach that includes needle exchange, health care, treatment, social support and counseling is also needed. In Canada, local governments acted on our research by expanding needle exchanges and adding related services. We hope the Clinton Administration and Congress will provide the same kind of leadership in the United States. □

Julie Bruneau is an assistant professor of psychiatry at the University of Montreal. Martin T. Schechter is a professor of epidemiology at the University of British Columbia

lines and traffic points, perhaps secretary of the Fairfax County be and should be immediately im-

Needle exchange programs save valuable lives and money

In my opinion

Matthew Murguia

There are two key questions surrounding the debate on needle exchange programs (news story, April 29; editorial, April 30): Do they decrease HIV infection? Do they increase drug use?

The Institute of Medicine, the U.S. General Accounting Office, the Secretary of Health and Human Services, and President Clinton have provided clear answers. Each has said that scientific research clearly shows needle exchange programs reduce HIV infection and do not increase drug use.

Opponents of needle exchange programs where a clean, non-HIV-infected needle is traded, one-for-one, for a used, possibly HIV-infected needle) like to cite two studies conducted in Canada as "evidence" that they do not work. According to the authors of those studies, critics of needle exchange programs "misinterpreted our research."

The Canadian researchers stated in a column in the April 9 New York Times that, based on their research, needle exchange programs reduce the spread of HIV and do not increase drug use.

In fact, they also point out that Canadian "local government acted on our research by expanding needle exchanges and adding related [treatment] services." They went on to call upon the Clinton administration and Congress to "provide the same kind of leadership in the United States."

Many studies, conducted in the United States and internationally, have found no evidence that needle exchange programs encourage drug use. Clear findings from this extensive research are what led the president to state recently that "the weight of the medical research" shows that needle exchange programs reduce HIV infection and do not increase drug use.

The president's statement follows earlier endorsement of needle exchange programs by such national organizations as the American Public Health Association, the American Bar Association, the National Medical Association, the National Alliance of State and Territorial AIDS Directors, the National Association of County and City Health Officers, the U.S. Conference of Mayors, and the Congressional Black and Hispanic caucuses.

Each of these organizations believes that needle exchange programs are a useful tool, along with treatment, in fighting the spread of HIV.

More than 100 needle exchange programs operate in the U.S., including programs in Washington, D.C., Baltimore and soon in Prince George's County, Md. These programs are saving lives, not to mention the $140,000 in lifetime health care costs for a person with HIV disease.

The Alexandria Task Force on HIV has responded to this compelling information by calling for a dialogue on needle exchange programs. In Alexandria, 192 individuals had contracted HIV directly through injection drug use (as of last December).

The state of Virginia reported 3,908 individuals with HIV or AIDS, of which 31 percent of the HIV cases and 28.5 percent of the AIDS cases were directly connected to injection drug use. The need for such programs is clear.

The first public health priority in combating HIV and drug abuse should be to get abusers into treatment so they can get the help they need to stop using illegal drugs and avoid HIV infection. However, substance abuse treatment slots are in short supply, and there are scant signs of increased government funding for these services.

Needle exchange programs, while not a perfect substitute for drug abuse treatment, nonetheless have been proven effective in reducing HIV infection among injection drug users. The decision to support or oppose such programs therefore becomes deeply moral and ethical.

Exchanging dirty needles for clean ones no more sends a message of condoning drug use than providing health care coverage for people who smoke endorses smoking. Yes, illicit drug use is a crime and smoking is not, but both can have devastating consequences on individuals and society.

Needle exchange programs send a message to drug abusers that their lives are valued and that society wants to prevent further HIV infection so that, hopefully, drug users can obtain treatment and eventually get off of drugs.

Drug abuse is a crime, and it should stay that way. But it is also a moral crime not to help prevent individuals from getting a deadly disease when we know how.

Matthew Murguia of Alexandria serves as a citizen-at-large member of the Alexandria Task Force on AIDS. The views expressed here are his own.

THE ALEXANDRIA JOURNAL

Publisher & C.E.O.: **Ryan Phillips**
President & C.O.O.: **Karl Spain**
Circulation Director: **E.C.Hoover**
National Advertising Director: **Toby Hall**

Senior Editor: **Jane Touzalin**
Metro Editor: **William Hollyer**
Tempo Editor: **Linda Schubert**
Sports Editor: **Paul Bergeron**
Opinion Page Editor: **Alan Fogg**
Sunday Editor: **Barbara Kreisler**

To call The Journal:
News (703) 846-8340
News fax (703) 846-8366
Sports (703) 846-8332
Soundoff (800) 445-NEWS
Tempo (703) 846-8328
Classified (703)846-8400

Display Ads (703) 846-8370
Circulation (703) 846-8500
Business Office (703) 846-8304
Send e-mail to: vaedit@jrnl.com or JournalExp@aol.com
On the World Wide Web: http://www.jrnl.com

Subscription rates:	**In town**	**Out of town**
One year	$78	$97
Six months	$42	$55

or call for **subscription information:** 1-800-531-1223

NNA NATIONAL NEWSPAPER ASSOCIATION — The Audit Bureau

THE ALEXANDRIA JOURNAL (ISSN 0273-639X) is published daily except Saturdays and postal holidays by Ryan Phillips at 6408. Edsall Rd. Alexandria, VA 22312-6475. Periodicals Postage paid at Alexandria, VA and at additional mailing offices. POSTMASTER: Send changes to THE ALEXANDRIA JOURNAL, 6408 Edsall Rd., Alexandria, Va. 22312-6475.

Cummings could have been sentenced to as much as 10 years in prison for voluntary manslaughter. Prosecutors said Cummings plot-

droxide concentration, he said. Cleanup of the spill began Sunday night and ran until Wednesday afternoon, Holcomb said.

"It's very disconcerting to have two incidents one right after the other," said Manassas City Councilman J. Steven Randolph. "We're watching it very closely. It's a big operation and

by afternoon, she said.

Prince William Hospital spokeswoman Cynda Tipple said the rapid arrival of patients from Dominion prompted the facility to invoke its disaster plan for the first time since 1996 when a group of schoolchildren fell ill at the Manassas Regional Airport.

The plan, intended to handle situations in which an unusually

5/14/98 Editorial Page

JAMA®
The Journal of the American Medical Association

Editor-In Chief
George D. Lundberg, MD

Abstracts - March 18, 1998

JAMA

The Public and the War on Illicit Drugs

Robert J. Blendon, ScD; John T. Young, MPhil

This article presents what Americans think about the policies subsumed under the label of the "War on Drugs." It is based on an analysis of 47 national surveys conducted between 1978 and 1997. The major results are that most Americans rely on the mass media for information about the scope of the drug abuse problem; Americans do not think that the Wars on Drugs have succeeded, but they do not want to quit on these efforts; weak support exists for increasing funding for drug treatment; support for preventive education has increased during the 1990s; criminal justice responses remain very popular; for many, illicit drug use is a moral rather than a public health issue; the public supports allowing physicians to prescribe marijuana for severe illness, but opposes the general legalization of marijuana and other illicit drugs; and needle exchange programs are supported by a bare majority, but only when they are told that the American Medical Association supports these programs.

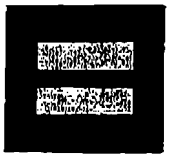
JAMA. 1998;279:827-832

Read the Science News Update for this article
Table of Contents

Journals • JAMA • AMNews • JAMA Condition-Specific Sites
Archives of: Internal Medicine • Dermatology • Family Medicine • Ophthalmology
Neurology • General Psychiatry • Otolaryngology • Surgery • Pediatrics

Site Update Search Questions Reader Services Classified Ads
Advertising Information Post Office

"American Journal of Epidemiology"
Vol. 146, No. 12, 1997



HUMAN
RIGHTS
CAMPAIGN

1101 14th Street NW
Washington, DC 20005
website http://www.hrc.org
phone 202 628 4160
fax 202 347 5323

News Release

FOR IMMEDIATE RELEASE
Wednesday, March 18, 1998

Contact: David M. Smith
Phone: (202) 216-1547
Pager: (800) 386-5996

HRC CALLS FOR BOLDER LEADERSHIP FROM CLINTON ADMINISTRATION ON HIV/AIDS PREVENTION

Cites No Confidence Vote by President's HIV/AIDS Panel, Alarming Trends in African-American Community

WASHINGTON -- The Human Rights Campaign called on the Clinton administration Wednesday to radically step up HIV prevention efforts in light of the recent vote of no confidence from the President's Advisory Council on HIV/AIDS and a new report showing alarming attitudes in the African American community.

"It is time for Health and Human Services Secretary Donna Shalala to publicly state that needle exchange programs work, and that they do not encourage drug abuse," said Winnie Stachelberg, HRC's political director.

On Tuesday, the President's Advisory Council on HIV/AIDS unanimously passed a resolution expressing no confidence in the administration's commitment and willingness to achieve the President Clinton's stated goal of "reducing the number of new infections annually until there are no new infections." They called on Shalala to issue an immediate determination on needle exchange programs.

Also Tuesday, the Henry J. Kaiser Family Foundation released a survey about African Americans and HIV/AIDS at a conference at Harvard University entitled "The Untold Story: AIDS and Black Americans." The survey found that a majority of African Americans -- 52 percent -- feel that the AIDS crisis is the leading health problem facing the nation today. It also found that only 22 percent of respondents felt the federal government "cares a lot" about AIDS, while a mere 18 percent felt the government "does a lot" in the fight against the disease.

"While the Clinton administration has done more that any other administration in the fight to end this epidemic, it must redouble its efforts as the epidemic expands and so gravely impacts communities of color, women and children," Stachelberg said. "More than 35 percent of all reported AIDS cases and 43 percent of new AIDS cases are among African Americans, according to the Centers for Disease Control and Prevention. African-American women make up 60 percent of all new AIDS cases reported among women. These trends must be reversed."

Significantly, while the overall rate of AIDS deaths have declined 32 percent among whites, the decline has been only 13 percent for African Americans. African Americans comprise 12 percent of the U.S. population.

"While the president's HIV prevention budget includes a modest amount to address these disparities, the administration's $2 million decrease in HIV prevention funding at the CDC is unacceptable," Stachelberg added. "The budget numbers and lack of action on needle exchange do not reflect the president's goal of reducing new HIV infections to zero. They also do little to alleviate the concerns revealed in the Kaiser survey."

Polls indicate that the American public supports needle exchange programs. The Kaiser survey found 59 percent of African Americans favor them, and an HRC-commissioned poll in April 1997 found 55 percent of all Americans also favor such programs.

There is support in Congress as well. Last month, California Democratic Reps. Maxine Waters, chair of the Congressional Black Caucus and Xavier Becerra, chair of the Congressional Hispanic Caucus, wrote to Shalala urging her to act on needle exchange. "Minority populations are disproportionately affected by HIV/AIDS and this scientifically proven intervention is one way to stop this trend," they said.

The Human Rights Campaign, the largest national lesbian and gay political organization, with members throughout the country, effectively lobbies Congress, provides campaign support, and educates the public to ensure that lesbian and gay Americans can be open, honest, and safe at home, at work, and in the community.

- 30 -

Wash. Times 12.15.97

Crack pipe dreams

By Rachel Ehrenfeld

President Clinton should be hailed by his AIDS advisers for his refusal to fund "needle-exchange" programs. Instead, they allege, he lacks "courage and political will." Providing drug addicts with clean syringes in exchange for dirty ones will reduce the risky behavior associated with injecting dangerous drugs, they argue, and thus reduce HIV infections. This "feel-good" solution makes sense to sober people, but drug addicts are a unique population to which logic does not apply.

This is why the president should continue to resist the AIDS lobby: Recent results of epidemiological studies in Baltimore, Montreal and Vancouver, British Columbia, show a tremendous increase in new HIV and AIDS cases among participants in needle-exchange programs. "Injecting Drug Use Associated With More AIDS Cases in Maryland Than Nationally" is the title of the report published in October by the Center for Substance Abuse Research at the University of Maryland. Its findings are alarming: While injecting drugs accounts for 26 percent of AIDS cases nationally, in Maryland it accounts for 42 percent, of which the majority (52 percent) are in Baltimore.

Baltimore's long-standing needle-exchange program was established under the auspices of Mayor Kurt Schmoke. The mayor's "enlightened attitude towards the drug problem," said billionaire financier-philanthropist George Soros, was the reason he awarded Baltimore $25 million to expand the city's progressive social projects. But if the recent results of Maryland's AIDS study are any indication, we can expect that Mr. Soros' money, coupled with Mr. Schmoke's "enlightened attitude," will cause a rapid growth of new HIV and AIDS cases in Baltimore and Maryland.

Evidently, these disturbing results do not alarm the Washington-based Drug Policy Foundation (DPF) and San Francisco's Tides Foundation. Both organizations are supporting alternative drug policies, especially "harm-reduction" and needle-exchange programs. Both are funded by Mr. Soros. DPF has received several million dollars from Mr. Soros in the past four years, and the Tides Foundation was in August the recipient of a $1 million gift from Mr. Soros for needle exchanges.

Both organizations have now gone one incredible step further, to fund the distribution of safe-crack-user kits: the Piper (Crack) Smokers user kit, which includes paraphernalia and instruction for "Safer Using" and "Things Not To Do," and the "Shoot Smart, Shoot Safe" pamphlet, which has "tips for safer crack injection." This brochure seems to make a new development in the campaign to legalize or medicalize illegal drugs.

In addition to instructions on "how to," the brochure contains pictures demonstrating proper injection. A person who had never used crack before will find the instruction quite helpful. The kits and free needles are distributed through needle-exchange programs of the health departments of Philadelphia and Bridgeport, Conn.

These "harm productionists" are people and organizations that take their lead and most of their funding from Mr. Soros. In 1996, it was largely Mr. Soros' funding that led to the successful campaign to amend local laws to permit the use of "medical" marijuana in California and all other illegal drugs in Arizona. (The initiative has since been reversed in Arizona by the legislature, but the Clinton administration has failed to pursue a reversal in California.)

In his book "Soros on Soros," he says, "If it were up to me, I would establish a strictly controlled distribution network through which I would make most drugs, excluding the most dangerous ones like crack, legally available." But now the foundations that he sponsors are funding the distribution of safe-crack-user kits for smokers and injectors.

"The people who distribute these are harm-productionists and not harm-reductionists," said Dr. Robert DuPont, the first director of the National Institute on Drug Abuse (NIDA), "because they promote drug use." Mr. Soros, who claims to be the champion of "open societies" and individual freedom, now seems to promote the worst king of slavery: crack addiction. Doesn't he see the inconsistency?

Mr. Soros' vision of an "open society" does not allow for prohibitionist drug policies and the implementation of the criminal justice code in drug abuse cases. He claimed in a Sept. 1 Time magazine cover story that he has already given $90 million and is soon planning to add $15 million more to advance alternative drug policies.

With the advantage of Mr. Soros' checkbook advocacy and advanced marketing techniques heavy on "compassion," pro-legalization initiatives to "medicalize" or "decriminalize" drugs in other states in the United States by the end of 1998 are in full gear. And Mr. Soros does not limit his efforts to push forward his agenda. Last week, he endorsed the campaign for "medical" marijuana launched by the Independent newspaper in England. If successful, Britain had better brace itself for the safe-crack-user kits that are bound to follow.

Mr. Soros' relentless efforts and many millions of dollars have made a noticeable difference: Endorsing drug "medicalization," "decriminalization" or "legalization" has become the politically correct thing to do. Even U.S. drug policy is now focused more on "treatment" than "war."

Mr. Soros now says he does not support drug legalization. What he does, he says, is help "to fight the evils of the drug laws." And since drug prohibition does not work, it will be more realistic, Mr. Soros claims, to provide drugs to those who need them. Mr. Soros and his pro-drug activists' message is that drug use is here to stay, constituting a civil right.

Marc Galanter, director of the Division of Alcoholism and Drug Abuse at the New York University Medical Center, disagrees. "Cocaine presents a dangerous health risk at any level (especially crack) and the demonstration of its supposed safe use can only support its abuse."

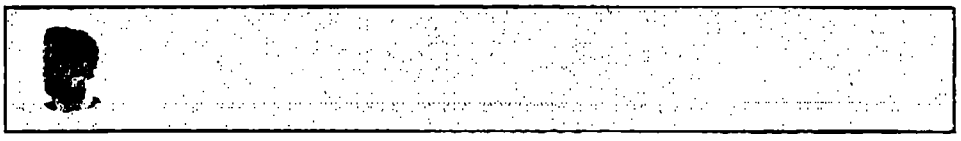
As for needle exchange as a prevention for AIDS, Dr. Curtis observed that "the fact is that sexual promiscuity associated with crack is the lead cause for new cases of HIV and AIDS."

Perhaps this information will give the president the courage he needs to resist his AIDS advisers.

Rachel Ehrenfeld is the author of "Narco-Terrorism" and "Evil Money: Encounters Along the Money Trail."

Wash Times (cont'd) 12-16-97

The Sacramento Bee



CAPITOL/POLITICS

■VOICES
Bee columnists share their latest and personal favorites.

■COLUMNISTS
The latest views from George Will, Dave Barry and more.

■POLITICS
News from the U.S. Capitol, beltway and beyond.

■CAPITOL ALERT
Breaking news from the state capital.

■ALMANAC
Area politics, city and county profiles, history and more.

■SEARCH FOR:
GO

AIDS czar breaks ranks, endorses needle programs

By Dorsey Griffith
Bee Staff Writer
(Published March 26, 1998)

■SAN FRANCISCO -- The White House's AIDS czar publicly contradicted the Clinton administration Wednesday and endorsed needle exchange programs as an effective way to combat the spread of the AIDS virus.

Sandra Thurman, appointed by the president last year as director of the Office of National AIDS Policy, predicted that scientific evidence showing that needle exchange programs work without promoting illegal drug use will prevail in setting the administration's AIDS policy.

"Public health should be driven by science, not politics," she said, addressing the National AIDS Update Conference in San Francisco.

Also Wednesday, renowned AIDS researcher Dr. Jay Levy told attendees of the weeklong conference that a protein found in certain cells of long-term HIV survivors could lead to the development of an AIDS vaccine. And he suggested that the triple-drug therapies now prescribed to anyone newly infected with HIV, the virus that causes AIDS, may actually harm the body's own ability to fight the disease.

Thurman, whose remarks were interrupted by a heckler demanding federal action on needle exchange programs, said that every day 33 Americans become infected with HIV as a result of drug injections. "I am haunted by the responsibility to use my position to do everything I can to stop this carnage," she said in advancing needle exchange programs.

She said scientific studies have validated the view of public health and medical organizations -- that handing out sterile syringes to people who inject illegal drugs reduces the spread of AIDS without leading to more illegal drug use.

Last year, the National Institutes of Health reported that "there is no

longer any doubt that these programs work" and urged immediate action on them.

About 100 cities and counties throughout the country have needle exchange programs, including San Francisco. In Sacramento County, supervisors have opposed a needle exchange program.

The federal government prohibits the use of federal money to pay for the programs and Clinton's drug czar, Barry R. McCaffrey, wants it to stay that way.

Both McCaffrey and Thurman have said they would leave it to Donna E. Shalala, secretary of health and human services, to make the decision about funding.

"Hopefully, as our nation's top public health official, Secretary Shalala would consider science first and foremost in determining any public health policy," said Derek Gordon, communications director of the San Francisco AIDS Foundation. "Sadly, up until now it would appear that politics and not science has been leading the decision-making in the president's administration."

On the medical front, Levy, a University of California, San Francisco, virologist who was one of the first scientists to isolate the organism that causes AIDS, said the discovery of a special class of cells that appears to protect some people from active infection by the AIDS virus could be the key to developing an effective vaccine.

In some people infected with the virus, CD8 cells appear to block the virus from reproducing and protect other cells already infected. While everyone has these cells, the immune system is only capable of recognizing them in some individuals. Levy's studies have linked the role of CD8 cells in long-term survivors of HIV infection and in adults and children at high risk of the disease.

These cells produce a protein that Levy and his colleagues still do not understand but, once identified, could be manufactured and used in a vaccine, he said.

"We know there are people who have a natural immune response controlled by CD8 cells," he said.

In the meantime, physicians should be cautious about prescribing the triple-drug cocktails that have been shown to prolong and enhance the lives of people infected with the AIDS virus, he said.

The triple-drug therapies -- two older AIDS drugs plus one of the newer class of medicines called protease inhibitors -- have revolutionized AIDS care. Typically people start on them as soon as they learn they are infected, even before they get sick.

But Levy contends the therapies could compromise the body's natural immune system, which in some people appears to block infection of HIV. Levy recommends that doctors wait to use the drugs until a person's T-cell count is below 350, a measure of the body's infection-fighting cells, and have viral loads of more than 30,000, a measure of the amount of HIV in the blood. Levy said the numbers are based on an estimate of when the immune system can no longer handle the virus.

Levy noted that the antiviral drugs do many good things: They block new viruses, cause an increase in T-cells, and they help the immune system fight some disease-causing agents.

But these drugs do not directly attack cells infected with HIV, he said. They are toxic, and they can lead to resistant strains of the virus. They can also suppress the natural anti-HIV immune response.

"Let's wait until we really need those drugs," he said. "By waiting you are holding onto your options. But if you jump onto the drugs right away, the immune system doesn't have any chance to respond."

BACK TO TODAY'S BEE | BACK TO CAPITOL/POLITICS | SACBEE HOME


Women and
Children First
US AIDS EPIDEMIC

Every day, men, women and children are needlessly infected with HIV because of tainted needles.

The American Medical Association, the National Institutes of Health, the President's own AIDS Advisory Council and 71 percent of the American people agree: Needle exchange programs reduce HIV infection and don't increase drug use. President Clinton, Vice President Gore and Secretary Shalala should act now to allow federal funds to be used by local communities to remove HIV-tainted needles from our streets.

Needle exchange saves lives.

For more information call 202-986-1300 or go to www.aidsaction.org

until it's over™
AIDS ACTION

41181

GOP assails needle funding

Shalala undecided on lifting of ban

By Joyce Howard Price
THE WASHINGTON TIMES

House and Senate Republicans yesterday assailed President Clinton's reported plan to lift a decade-old ban on federal funding for needle-exchange programs and pledged legislation to block or undo such a move.

"Just when you thought that the Clinton drug policy couldn't get any worse, people in his administration are talking about subsidizing the habits of drug addicts," said House Rules Committee Chairman Gerald B.H. Solomon of New York.

"Addiction and rehabilitation need to be addressed, but this approach is entirely backwards. You wouldn't take a knife out of the hand of someone who is suicidal and give them a handgun in return," he said.

Congress imposed a six-month moratorium on the use of federal funds for needle programs that ended March 31. Mr. Solomon said he will introduce a bill for a permanent funding ban and will also attach an amendment to a spending measure to ensure that no AIDS dollars are used for needle-exchange programs.

Sen. Paul Coverdell, Georgia Republican, sent a letter to Mr. Clinton saying he was "disturbed" by the administration's abrupt change of policy, which "directly contradicts Clinton drug czar Barry McCaffrey's opposition to

see **NEEDLES**, *page A4*

NEEDLES

From page A1

such programs."

If the funding ban is lifted, Mr. Coverdell said, he'll immediately introduce a bill to reinstate it.

The Washington Times reported yesterday that a decision to lift the ban could come as early as Monday. Administration officials told the newspaper that the decision would result from a report by Health and Human Services Secretary Donna E. Shalala to Mr. Clinton that purportedly concluded giving clean needles to drug users blunts the spread of AIDS and curbs drug use.

But late yesterday Melissa Skolfield, a spokeswoman for HHS, said, "While HHS continues to look at research [on needle-exchange programs], Secretary Shalala has not yet certified that needle-exchange programs do not encourage drug use."

And because of that, Mrs. Skolfield said, "she has not made a decision" on whether the funding ban should be lifted.

Asked when Miss Shalala might decide the issue, the HHS spokeswoman said, "She'll be making an announcement when she feels the science is there. We have no timetable."

James R. McDonough, director of strategy for the Office of National Drug Control Policy — which considers needle exchanges a failure — said the "gist of [the story in The Washington Times] is correct."

By lifting the 1988 ban on using federal dollars for such programs, Mr. Clinton would allow existing AIDS funds to be used to pay for local programs to give clean needles to drug addicts. Intravenous drug users are a major risk group for infection with HIV, and for years public health officials have urged them not to share needles, which increases their risk.

Mr. Clinton's AIDS office, headed by Sandra L. Thurman, has made lifting the needle-exchange funding ban its top goal. And reports Thursday that the White House intended to do so indicated she apparently had won the battle with Mr. McCaffrey.

The Office of National Drug Control Policy was concerned, given that a member of its staff recently traveled to Vancouver, British Columbia, to examine its 10-year-old program, which is the largest in the world.

The president's drug office found that HIV infections were higher among users of free needles than those without access to them and the death rate from drugs soared after the program was instituted, from 18 a year in 1988 to 150 in 1992.

Mrs. Skolfield of HHS acknowledged the department told Congress a year ago that "a review of scientific studies show that needle-exchange programs can be an effective strategy in preventing HIV in communities that choose to include them."

But when Congress imposed the ban on using federal funds for the programs, it said it could be lifted only when HHS certified that it would both reduce the spread of HIV and not encourage drug use. The latter remains an open question, Mrs. Skolfield said.

Congressional fax machines were busy yesterday as members sent out statements, condemning any plans the White House might have to lift the ban.

"Against the strong advice of his own drug-policy czar, President Clinton appears set to remind Americans again just why our society is losing a war it was once winning — the war for a drug-free America," said House GOP Conference Chairman John A. Boehner, Ohio Republican.

"With drug use among our nation's teen-agers on the rise, and drug-related violence and crime destroying our nation, the president's position is morally irresponsible and amounts to giving 'aid and comfort' to our nation's enemies in the American war on drugs."

Rep. Linda Smith, Washington Republican, released a statement saying it "will truly be a sad day in America . . . if the Clinton administration goes forward with lifting the 10-year-old-ban."

Meanwhile, the mayors of San Francisco, Detroit, Seattle, Baltimore and New Haven, Conn., yesterday urged the administration to allow federal funds to be used for needle-exchange programs.

March 23, 1998

White House Drug and AIDS Advisers Differ on Needle Exchange

By CHRISTOPHER S. WREN

The debate over the propriety of handing out sterile syringes to people who inject illegal drugs, to reduce the spread of AIDS, has reached the White House, where President Clinton's two main policy advisers on the issue have staked out opposing positions.

Their disagreement makes prospects for government financing of needle-exchange programs more unlikely when a ban on such spending, imposed by Congress in 1992, expires at the end of March.

One adviser, Sandra Thurman, the White House director of national AIDS policy, advocates spending on the programs as a way of saving lives by reducing the incidence of AIDS contracted from shared needles. But at a spirited meeting on Tuesday, the other adviser, Barry McCaffrey, the retired Army general who is the administration's director of national drug policy, ferociously opposed any government subsidy.

In a subsequent letter to Ms. Thurman, he reiterated his belief that buying clean needles for drug users would send the wrong message to young Americans who are being told that illegal drug use is wrong. The money, he said, would be better used expanding drug treatment programs.

"As public servants, citizens and parents we owe our children an unambiguous 'no use' message," McCaffrey wrote. "And if they should become ensnared by drugs, we must offer them a way out, not a means to continue addictive behavior."

His letter was leaked to some members of Congress. A copy was provided to The New York Times by someone opposed to needle exchanges.

McCaffrey's fervent opposition to paying for needle exchanges, and the esteem with which he is regarded on Capitol Hill, will probably undercut whatever support exists for exchange programs. Many members of Congress already oppose the concept or do not want to look as if they are soft on drug use in a congressional election year.

In a joint statement released on Saturday, Ms. Thurman and McCaffrey sought to

play down their increasingly public differences over needle exchange. They said they agreed on other issues, like the need to make drug treatment programs more widely available.

They said they would leave it to Donna Shalala, the secretary of health and human services, to settle the needle exchange issue. Ms. Shalala, who has sided with McCaffrey on other drug policy questions, has yet to decide whether the needle exchange programs deserve government money.

Congress asked her to determine whether the programs prevent the spread of HIV, the virus that causes AIDS, and do not encourage the use of illegal drugs. In February 1997, a report released by the National Institutes of Health said "there is no longer any doubt that these programs work" to prevent the spread of HIV and said that "needle exchange programs should be implemented at once." Ms. Shalala said that she wanted to study the matter.

In his letter to Ms. Thurman, McCaffrey pointed out that the government does not ban needle exchanges, and that approximately 100 communities have set up programs.

The public health consequences of sharing dirty needles is not insignificant. Approximately 280,000 to 300,000 Americans suffer from AIDS and as many as 600,000 others are infected with HIV, according to Ms. Thurman's office. The Centers for Disease Control and Prevention estimate that one-third to one-half of new HIV cases involve people who injected drugs or had sex with people who did. The cost of caring for an adult with AIDS can exceed $100,000.

"You have to understand that every day, 33 Americans become infected as a result of drugs," Ms. Thurman said on Saturday in a telephone interview. While not all cases of HIV transmission can be prevented, she said, "I think we have a moral obligation to stop as many as we can."

Public tolerance for needle programs has increased. A Harris poll reported in October that 71 percent of the Americans surveyed supported needle exchanges. The poll was commissioned by the Lindesmith Center, a group that advocates needle exchange programs.

Other groups that have endorsed the programs, in principle, include the American Bar Association, the American Medical Association, the American Public Health Association and the U.S. Conference of Mayors. In August, George Soros, the international financier and philanthropist, donated $1 million to finance needle-exchange programs in the San Francisco area.

Both supporters and critics of the programs have cited studies to support their arguments. Dr. Peter Beilenson, the city health commissioner in Baltimore, reported to a House subcommittee in September that his city's needle-exchange program had reduced significantly the sharing of used needles and provided a point of access to medical treatment for hard-core addicts.

Ms. Thurman agreed that needle-exchange programs have become conduits to health care. "This is an opportunity often for people to pull their lives together," she said.

"If using a needle-exchange program facilitates it in some way, we need to look at it very seriously."

But critics have cited another study, which reports that intravenous drug users who joined Montreal's needle-exchange program became infected with HIV at a higher rate than nonparticipants. The study was published last year in the American Journal of Epidemiology.

If the ban on government money is lifted, McCaffrey wrote, "There is the troubling question of how such a message would be received by our young people."

Ms. Thurman replied. "I know he has concerns about that and I do too, but the overwhelming evidence is that people coming into needle-exchange programs are older."

"Nobody's going to stick a needle in their arm because someone hands them a needle," she said.

The New York Times

Founded in 1851

ADOLPH S. OCHS, *Publisher 1896-1935*
ARTHUR HAYS SULZBERGER, *Publisher 1935-1961*
ORVIL E. DRYFOOS, *Publisher 1961-1963*
ARTHUR OCHS SULZBERGER, *Publisher 1963-1992*

ARTHUR OCHS SULZBERGER JR., *Publisher*

JOSEPH LELYVELD, *Executive Editor*
BILL KELLER, *Managing Editor*
GERALD M. BOYD, *Deputy Managing Editor*
JOHN M. GEDDES, *Deputy Managing Editor*

Assistant Managing Editors
SOMA GOLDEN BEHR
CAROLYN LEE
JACK ROSENTHAL
ALLAN M. SIEGAL

HOWELL RAINES, *Editorial Page Editor*
PHILIP M. BOFFEY, *Deputy Editorial Page Editor*

JANET L. ROBINSON, *President, General Manager*
DANIEL H. COHEN, *Senior V.P., Advertising*
RICHARD H. OILMAN, *Senior V.P., Operations*
SCOTT H. HEEKIN-CANEDY, *V.P., Planning*
DENNIS L. STERN, *V.P., Human Resources*
DAVID A. THURM, *V.P., Production*

PENELOPE MUSE ABERNATHY, *President, News Services*
MARTIN A. NISENHOLTZ, *President, Electronic Media*

The Politics of Needles and AIDS

By Julie Bruneau and Martin T. Schechter

Debate has started up again in Washington about whether the Government should renew its ban on subsidies for needle-exchange programs, which advocates say can help stop the spread of AIDS. In a letter to Congress, Barry McCaffrey, who is in charge of national drug policy, cited two Canadian studies to show that needle-exchange plans have failed to reduce the spread of H.I.V., the virus that causes AIDS, and may even have worsened the problem. Congressional leaders have cited these studies to make the same argument.

As the authors of the Canadian studies, we must point out that these officials have misinterpreted our research. True, we found that addicts who took part in needle exchange programs in Vancouver and Montreal had higher H.I.V. infection rates than addicts who did not. That's not surprising. Because these programs are in inner-city neighborhoods, they serve users who are at greatest risk of infection. Those who didn't accept free needles often didn't need them since they could afford to buy syringes in drugstores. They also were less likely to engage in the riskiest activities.

Canadian findings are distorted.

Also, needle-exchange programs must be tailored to local conditions. For example, in Montreal and Vancouver, cocaine injection is a major source of H.I.V. transmission. Some users inject the drug up to 40 times a day. At that rate, we have calculated that the two cities we studied would each need 10 million clean needles a year to prevent the re-use of syringes. Currently, the Vancouver program exchanges two million syringes annually, and Montreal, half a million.

A study conducted last year and published in The Lancet, the British medical journal, found that in 29 cities worldwide where programs are in place, H.I.V. infection dropped by an average of 5.8 percent a year among drug users. In 51 cities that had no needle-exchange plans, drug-related infection rose by 5.9 percent a year. Clearly these efforts can work.

But clean needles are only part of the solution. A comprehensive approach that includes needle exchange, health care, treatment, social support and counseling is also needed. In Canada, local governments acted on our research by expanding needle exchanges and adding related services. We hope the Clinton Administration and Congress will provide the same kind of leadership in the United States. □

Julie Bruneau is an assistant professor of psychiatry at the University of Montreal. Martin T. Schechter is a professor of epidemiology at the University of British Columbia.

THE TENNESSEAN
PERSPECTIVE
D
Local 2D
World, nation 3D
Editorials 4D
SUNDAY, APRIL 26, 1998

EARL OF SPENCER
Diana's brother is losing his luster
Page 3D

Perspective Forum

Clean needle program: a good idea?

The idea is this: Allow IV drug users to turn in used, dirty needles for clean ones, and the rate of HIV infection will drop. How valuable are such programs?

Debbie Runions, Nashville, a member of President Clinton's Advisory Council on HIV/AIDS:

The President admitted that needle-exchange programs save lives and do not increase drug use, but he refused to lift the ban on federal monies for that purpose. He said he didn't want to send a mixed message about illegal drug use.


RUNIONS

Well, Mr. President, let me tell you the clear message you send to Americans addicted to drugs, their partners and their children: "We don't care if you live or die. You are expendable in our society."

African-Americans and Latinos are most severely impacted by HIV infection related to drug use. As of June 1997, the Centers for Disease Control reported that people of color account for 72% of the male and 78% of the female cumulative AIDS cases directly and indirectly related to injection drug use.

President Clinton's decision sends the unspoken, but real, message that America would be better off without people of color.

Lt. Jess Andrews, Vice Division of the Metro Police Department:

I'm not sure needle-exchange programs will work.

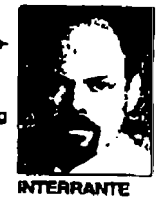
If addicts have clean needles and use them, then there would be less disease. But the fact is that an addict, in the heat of the moment when he wants a fix, will use a dirty needle. If there are two people together, ready to shoot up drugs, and they have only one needle between them, then they're going to share that one needle.

This is like real life: There's always somebody late, somebody who doesn't have his stuff together. So, the addict might prefer a clean needle, but if it's not there, he'll use the dirty needle instead.

These programs might help in a few cases, but my experience is that addicts will take the risk of getting disease, no matter what.

Joe Interrante, executive director of Nashville CARES:

These programs are needed and have proven to be effective in reducing the transmission of HIV without increasing drug use.


INTERRANTE

Obviously, these programs are most effective when they are part of a larger strategy that includes access to treatment for drug abuse. Ultimately, we want to get addicts into treatment, but there are fewer such programs today than there used to be in this country.

Needle exchange has a broad level of support from health groups. Since a large body of research has answered crucial questions, many groups have endorsed needle-exchange as an effective HIV-prevention strategy.

Dr. Stephanie Bailey, director, Metro Health Department:

The biggest risk factor today is among IV drug users. If I'm exchanging a needle with residual blood in it for a clean needle, I remove the risk of transmitting HIV.

Through most of the needle exchange programs, you get drug users into treatment programs.

Even our own experience in Davidson County with needle exchange programs showed decreased risk in transmitting the virus and increased admission to treatment programs.

The Perspective Forum is a weekly feature in which *Tennessean* editors choose a timely topic and solicit views on it from members of the Middle Tennessee community.

Post-it® Fax Note 7671	Date 4/27	# of pages ▶ 1
To Daniel	From Deb	
Co./Dept.	Co.	
Phone #	Phone # 615 226-3533	
Fax # 202 456-2938	Fax #	

3RD STORY of Level 1 printed in FULL format.

April 4, 1998, Saturday, City Edition

SECTION: METRO/REGION; Pg. B1

LENGTH: 674 words

HEADLINE: Local activists tout needle exchange;
Success in fighting AIDS is noted as some urge US to finance effort

BYLINE: By Zachary R. Dowdy, Globe Staff

BODY:

Four years after the state began its first needle exchange program, local public health officials say their success at checking the spread of AIDS - without encouraging drug use - makes a strong case for lifting a ban on federal funding of such programs nationally.

The heavy lobbying in favor of clean needle programs comes just as a congressional moratorium on federal funding has expired. The lobbying is directed at US Health and Human Services Secretary Donna Shalala, who must decide whether to align the federal government with program advocates.

"This is definitely an opportunity for people to express their views and do some organizing now," said John Auerbach, executive director of the Boston Public Health Commission.

Activists and health care providers in favor of the programs say they have stacks of studies refuting fears of increased drug use when addicts are allowed to swap dirty needles for clean ones. HIV, the virus that causes AIDS, can be passed via contaminated needles.

In the past three years, in fact, one out of every five people who received clean needles in Boston or Cambridge was referred to drug treatment, said Auerbach.

A stream of studies - some federally funded - conducted during the funding ban suggest that needle exchange programs curb HIV transmission and steer addicts away from back alleys and into treatment without increasing drug use.

"We definitely have demonstrated that, far from being a deterrent for people to seek treatment, needle exchange can actually be a vehicle for people to seek treatment," Auerbach said.

AIDS activists will demonstrate in support of needle exchange programs on Tuesday morning, when US Surgeon General David Satcher, who supports needle exchange, will speak at the USS Constitution in Charlestown Navy Yard.

Alan I. Leshner, director of the National Institute for Drug Abuse, told the Globe on Thursday that Shalala would likely make a decision on the lifting of the ban in the next few months.

Critics of the programs, such as Robert Maginnis of the Washington, D.C.-based Family Research Council, say the government should pressure addicts "into safe lifestyles" instead of financing needle exchanges.

Maginnis, senior policy adviser at the council, said anything other than abstinence sends the wrong message to young people, who might interpret federal support for the programs as support for drug use.

Backers of the state programs in Boston and Cambridge, Northampton, and Provincetown scoff at that view and say that 10 years of study have proven the programs worthy of federal support.

"The science is overwhelmingly clear that needle exchange programs save lives," said Robert Greenwald, director of public policy and legal affairs for the AIDS Action Committee in Boston.

He cited a 1993 study by the General Accounting Office, a 1993 study by the University of California, and a study by the National Research Council, among others.

Yesterday, state public health commissioner Howard Koh toured the needle exchange program at the Northampton-based Family Planning Council of Western Massachusetts to mark the release of a report detailing the program's success since its opening in December 1995.

The program in its first year served 195 people, and 88 people were successfully referred to drug treatment programs.

The Boston and Cambridge sites, dubbed Addict's Health Opportunity Program and Exchange, see between 3,500 and 6,000 clients each year, with about 600 new enrollees each year.

Approximately 600 of the people who came to the program seeking needles were referred to treatment programs, DPH figures show.

Federal support could buttress efforts in New Bedford to start a needle exchange program, said Jennifer DeBarros of Treatment on Demand. That organization lost a fight for such a program when New Bedford voters defeated the measure in a referendum.

"People are in data denial," she said. "People don't really want to look at the facts. They want to think that it's not good to give addicts needles."

LANGUAGE: ENGLISH

LOAD-DATE: April 7, 1998

4TH STORY of Level 1 printed in FULL format.

April 2, 1998, Thursday, City Edition

SECTION: METRO/REGION; Pg. B2

LENGTH: 703 words

HEADLINE: Report shows heroin a larger part of drug picture

BYLINE: By Dolores Kong, Globe Staff

BODY:
The crack and cocaine epidemic in the Boston area has leveled off over the last five years but heroin appears to be taking its place, while marijuana use among Massachusetts adolescents has risen dramatically, new statistics show.

The latest data on the shifting patterns of substance abuse also show that people getting state-funded treatment in Greater Boston are older and more likely to be homeless than five years ago, and that intravenous drug use now accounts for about half of the state's newly diagnosed AIDS cases, the highest percentage ever.

These and other trends will serve as the backdrop to a session hosted in Boston today by the National Institute on Drug Abuse, which is mounting a campaign to fight drugs with the growing scientific understanding of addiction and treatment, not just the tools of the criminal justice system.

"The truth is that over the last 10 years, really, science has totally revolutionized our understanding of drug abuse and addiction and what we ought to be doing about it," said Alan I. Leshner, director of the national institute. "We know we have many effective tools in the clinical toolbox, many of which have been tested scientifically. Now the task is to use them."

About 500 participants, including Mayor Thomas M. Menino, are expected to attend the meeting at the Boston Marriott Copley Place. The event is cosponsored by Join Together, a Boston University School of Public Health-based national resource organization for communities fighting substance abuse, and other government and academia groups.

David Rosenbloom, director of Join Together, said he hopes the event will raise awareness about the benefits of treatment and treatment advances "so we can move toward understanding that this disease should be treated like other diseases."

At the meeting, Menino will highlight the progress made in his plan for providing drug education and treatment, announced last spring. "The criminal justice system has a role to play, but it's not the only answer," he said. "Treatment is the other important piece of the puzzle."

Recognizing that the weapons of law enforcement and criminal justice have produced discouraging results in the war on drugs when used alone, police, court, and prison officials themselves are turning to treatment as part of their armament.

For instance, the state Supreme Judicial Court appointed a task force to look at expanding drug treatment services for prisoners, said Rosenbloom, a member of the panel. "The judges of Massachusetts are now reviewing the role of courts in ordering treatment. Courts are not doing it enough," he said.

National studies have found that offering drug treatment to prisoners reduced by 70 percent the number who returned to crime and drug use after release, Leshner said. "There is more and more advocacy for treatment while people are in prison. The advocates are the criminal justice people," he said.

The latest drug abuse and treatment statistics - assembled in December for the National Institute on Drug Abuse but not yet widely disseminated - show that more than 2,600 people who overdosed on drugs or alcohol were taken to Boston-area emergency departments in the first six months of 1996, while 1,000 more showed up seeking detoxification.

From fiscal year 1993 to 1997, the homeless, Hispanics, and older residents made up a growing proportion of the approximately 30,000 annual admissions to state-funded substance abuse treatment programs in the Boston area.

Crack and cocaine remain the No. 1 illicit drug problem in the Boston area, but their use appears to have stabilized while heroin use is creeping up, said Thomas W. Clark of Boston-based Health and Addictions Research Inc., lead author of the report. The proportion of Massachusetts ninth- through 12th-graders who say they are marijuana users reached 33 percent in 1996, the highest rate since statistics were first kept in 1984.

Public health officials, moreover, are discouraged by the reluctance of communities to approve needle exchange programs to prevent the spread of the AIDS virus among intravenous drug users.

DRUG ARREST BREAKDOWN

PLEASE SEE MICROFILM FOR CHART DATA GLOBE STAFF CHART

GRAPHIC: CHART

LANGUAGE: ENGLISH

LOAD-DATE: April 2, 1998

8TH STORY of Level 1 printed in FULL format.

March 18, 1998, Wednesday, City Edition

SECTION: METRO/REGION; Pg. A1

LENGTH: 727 words

HEADLINE: Blacks' war with AIDS prompts call to arms

BYLINE: By Dolores Kong, Globe Staff

DATELINE: CAMBRIDGE

BODY:
Today, with AIDS the number one killer of young black men and women, nearly half of black Americans know someone who is infected or has died of the disease.

That finding was among the grim national statistics presented yesterday at a conference at Harvard University, prompting meeting organizers to call upon black leaders and government officials to do much more to stem the spread of the virus.

"Our community is at war, at war with a terrible disease - and equally at war with a sense of denial among our leadership," said Henry Louis Gates Jr., director of the W.E.B. DuBois Institute at Harvard.

"Let the message go out - business as usual simply cannot stand," said Mario Cooper, founder of Leading for Life, a New York advocacy group, and a member of the Harvard AIDS Institute International Advisory Council. "We are in a crisis."

At the conference, "The Untold Story: AIDS and Black Americans," organizers and health officials released a national survey of blacks on the epidemic, and highlighted the latest US statistics. While the AIDS death rate for blacks is starting to decline with new treatments, it remains high and is not falling as rapidly as among whites.

Blacks are much more likely than Americans overall to know someone who is infected with HIV or has died of AIDS, to be very worried about becoming infected, and to consider AIDS a more urgent problem now than it was a few years ago, according to the survey by the Henry J. Kaiser Family Foundation, a California-based health philanthropy.

For instance, 49 percent of blacks surveyed said they know someone affected by AIDS, while 35 percent of all Americans surveyed did. Fifty percent of blacks said they are very worried about becoming infected, while 24 percent of all Americans said so.

"African-Americans are clearly very, very concerned about the AIDS epidemic, in a way that is very personal and close to home," said Dr. Sophia Chang, director of HIV programs for the Kaiser Family Foundation, which cosponsored the conference with the DuBois and AIDS institutes at Harvard.

The survey, with a margin of error of plus or minus 4 percent, interviewed 811 black adults and compared their responses to an earlier sample of all Americans.

Federal statistics paint an equally alarming picture. For instance, blacks now make up more than 40 percent of the new AIDS cases, while they constitute only about 12 percent of the US population, according to data presented by Dr. Helene Gayle of the US Centers for Disease Control and Prevention.

For black men between 25 and 44, AIDS pulled ahead of homicide as the leading killer in 1990; for black women of the same age, AIDS edged out cancer in 1993. In 1996, the last year for which numbers are available, nearly 150 young black men in 100,000 died from AIDS, compared with about 50 young white men in 100,000. The AIDS death rate for young black women was about 50 per 100,000, compared with the rate for young white women of less than 10 per 100,000.

The numbers also show that intravenous drug use accounts for a bigger share of AIDS cases among blacks than all Americans, with IV drug use causing 36 percent of cases among black men and 46 percent among black women, compared with 22 percent of cases among all men and 44 percent among all women.

But while IV drug use has been a large contributor to the AIDS epidemic in the black community, conference organizers yesterday blamed the Clinton administration for failing to support programs to exchange dirty needles for clean ones.

Meanwhile, in Washington yesterday, Clinton's own advisers, the Presidential Council on HIV/AIDS, unanimously voted no confidence in the administration's commitment to slowing the epidemic, citing the failure to back needle exchange as an example.

Barbara Gomes Beach, executive director of Boston's Multicultural AIDS Coalition, which was invited to attend the Harvard conference, agreed yesterday with the need to highlight the statistics, but she criticized the organizers for not reaching out to the local community more, both for the conference and in the fight against AIDS.

"AIDS is not a class issue," she said. "I certainly would invite all of those gentlemen to partner with local community agencies who are here on the front lines doing that kind of work. We certainly need that kind of exposure to help us."

GRAPHIC: PHOTO, HENRY LOUIS GATES JR. / 'Our community is at war'

LANGUAGE: ENGLISH

LOAD-DATE: March 18, 1998

The Gate www.sfgate.com Return to regular view

Ban on Funding For Needle Swap Expected to End
White House decision is imminent, sources say

Louis Freedberg, Chronicle Washington Bureau
Saturday, April 11, 1998

URL: http://www.sfgate.com/cgi-bin/article.cgi?file=/chronicle/archive/1998/04/11/MN89399.DTL

Under intense pressure from scientists, public health experts, activists and its own AIDS advisers, the Clinton administration is moving to lift a 10-year- old ban on using federal funds for needle exchange programs, according to key individuals close to the issue.

Although the administration's official stand is that it is still studying the matter, a range of AIDS organizations and key individuals say they have been assured a decision is imminent -- and they are anticipating that the ban will be lifted.

``We have reason to be optimistic that the administration will lift the ban, because it will fit comfortably within their perspective of research, prevention and care of people with AIDS,'' said Representative Nancy Pelosi, D-San Francisco. ``I know they are committed to stop the spread of AIDS, and I am confident they won't let politics stand in the way of that.''

Dr. Scott Hitt, a Los Angeles physician and the chairman of President Clinton's advisory council on AIDS, said he believes an announcement could be made within a week.

About 100 communities -- approximately 30 of them in California -- run needle exchange programs without federal funds. The San Francisco AIDS Foundation runs the largest in the nation, using a combination of city and private funds to hand out 2.2 million needles a year.

State and federal laws require a public health emergency to operate a needle exchange program, forcing the Board of Supervisors to make such a declaration every two weeks since the program started in 1993.

Lifting the ban would allow San Francisco to spend federal AIDS prevention funds on needle exchanges and free up funds for other programs. It would also allow many other communities that do not have a needle exchange program to initiate one.

``There could certainly be a financial benefit to San Francisco, and it would certainly benefit hundreds of other programs around the country that do not have the kind of support that San Francisco has,'' said Regina Aragon, policy director of the San Francisco AIDS Foundation.

According to authoritative estimates, more than half of new cases of HIV infection are related to drug use. Some experts argue that at least 14,000 new cases of HIV could be prevented each year if needle exchange programs were widely in place across the nation.

The congressional ban imposed in 1988 gives the secretary of health and human services the authority to lift the ban if there is sufficient scientific evidence to meet two criteria: needle exchange programs reduce the spread of HIV, and they do not encourage drug use.

As late as this week, a spokesman for Health and Human Services Secretary Donna Shalala said the administration is not yet convinced that needle exchange programs do not promote drug use.

PRESSURE ON SHALALA

As frustration at the administration's inaction mounted, the president's advisory council

approved a resolution of ``no confidence" last month in the administration, marking an embarrassing rebuke to a president who has prided himself on his efforts to fight the AIDS epidemic. Hitt sent a sharply worded letter to Shalala saying that her failure to lift the ban represented an ``abdication" of her responsibilities.

On Thursday, council members held a conference call to decide whether to approve an even tougher resolution calling on Shalala to resign. But they decided to hold off after administration officials said a decision on the ban was imminent -- although they didn't provide details about what the decision would be.

But those close to the controversy believe the administration will lift the ban in light of the mountain of scientific evidence demonstrating the efficacy of needle exchange programs. Scientific panels and reports commissioned by the National Institutes of Health, the Centers for Disease Control and Prevention, the National Academy of Sciences, as well as the American Medical Association and the American Public Health Association have come to similar conclusions.

Within the administration, the emotional debate among Clinton's top advisers on AIDS and drug policy has led some officials to wryly refer to the conflict as ``czar wars."

On the one side is Clinton's ``drug czar," retired General Barry McCaffrey, who insists that handing out clean needles to drug users would send the message that the government is condoning drug use. He has been supported in that view by a combination of conservative Republicans and some Democratic representatives of cities with large African American populations.

THE `AIDS CZAR'

On the other side is ``AIDS czar" Sandra Thurman, head of Clinton's Office of National AIDS Policy, although she downplayed her differences with McCaffrey.

``We are not warring," said Thurman. ``General McCaffrey is every bit as committed to stopping the AIDS epidemic as I am."

At the same time, she said ``We have convincing evidence that the criteria (needed to lift the ban) have been met."

On Wednesday, a major obstacle appeared to be removed when the authors of the only major study suggesting that needle exchange programs lead to increased drug use contended that their research in Montreal and Vancouver had been misinterpreted by McCaffrey and others.

Some AIDS advocates say they are skeptical of administration assurances that it is moving on the issue, saying they have heard the same thing too many times before.

``Until the decision is made, it is premature to say we have a victory here," said San Francisco's Aragon. ``This is not an easy thing for the administration to do, and I would caution my colleagues not to be overly optimistic."

But others believe the administration is finally ready to act. ``I don't think it will be much longer now," said Daniel Zingale, executive director of AIDS Action in Washington, D.C. ``They understand where the science comes down on this issue."

 Page A1