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 - Programs - Alexandria, VA

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

REV. GERALD O. GLENN
DIRECTOR

COMMONWEALTH of VIRGINIA

Department of Juvenile Justice
Eighteenth Judicial District Court Service Unit

Lillian Brooks
COURT SERVICES DIRECTOR

DISTRICT OFFICE
520 King Street
Alexandria, Virginia 22314
(703) 838-4144
Fax (703) 838-6492
TDD 1-800-828-1120
(VA Relay Center)

SERVING:
Alexandria City

FAX COVER SHEET

CONFIDENTIAL

DATE: 5/15/98

TO: Todd Summers

DEPT/FIRM: Office of Nat'l Aids Policy

PHONE: (202) 456-2437

FAX NO: (202) 456-2438

TODD
FYI,
I wrote the Alexandria paper.
M L

IMPORTANT NOTICE:

"The information contained in this fax message and accompanying documents is intended only for the personal and confidential use of the recipient(s) named above. This message may be a communication which, as such, is privileged and confidential. If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please notify us immediately by phone and return the original to us by mail. Thank you."

FROM: Lillian Brooks

DEPT/FIRM: Court Services

PHONE: 703/838-4144

FAX NO: 703/838-6492

RE: Alexandria & Va Reports

TOTAL NUMBER OF PAGES INCLUDING COVER PAGE: _____

COMMENTS: Thanks for Dr. Beilenson's testimony - I am forwarding to the City Manager.

_____ *Please Confirm Receipt*
_____ *No Confirmation Necessary*

Needle Exchange Prevents AIDS: The Case For Alexandria, Virginia

---

Alexandria Task Force on AIDS

March 1998

Table of Contents

Executive Summary 1

Current Injection Drug Use HIV/AIDS Statistics 2

New Infections 2

Current Federal Laws 3

Current State/Local Law 4

Why Is Injecting Drug Use a Problem? 4

What Does the Research Say? 4

Why are Needle Exchange Programs So Controversial? 5

Who Supports Needle Exchange Programs? 9

Visions for the Future 9

Membership, Alexandria Task Force on AIDS 12

Executive Summary

The Alexandria Task Force on AIDS (ATFA) is charged by its charter to provide advice and guidance to the Alexandria City Council on policy issues which affect the lives of people living with HIV and to provide recommendations on how to prevent the spread of HIV in Alexandria. In this role, the Alexandria Task Force on AIDS submits this paper to the City Council for discussion and consideration. This paper is intended to let the citizens and elected officials in Alexandria know of the benefit that a syringe availability program in Alexandria could have and to begin the dialogue which is necessary to address this critical issue. For the purposes of this paper, a needle exchange program, as part of a comprehensive HIV prevention program, involves the exchange of sterile needles for dirty, possibly HIV-infected needles, one-for-one, and in which referral to substance abuse treatment is offered. Programs may also offer condoms and HIV prevention education literature to participants.

It is important to state that the Alexandria Task Force on AIDS is not, at this time, calling for a needle exchange program in Alexandria. A full debate on this issue has not yet occurred in Alexandria, and the Task Force members themselves are not in agreement. However, the Task Force believes that such a dialogue should occur sooner rather than later. ATFA would like to provide the Council and the public an opportunity to learn more about needle exchange programs and how they could prevent hundreds of new HIV infections in Alexandria and in Virginia, and in the next few years, save lives and untold health-care dollars.

ATFA believes that an informed community makes good public health decisions and that it is necessary to provide accurate information to ensure that the debate surrounding the issue of needle exchange is conducted in a productive manner based on facts and not hyperbole. This paper is intended to add to that discussion.

It is clear from the research, both in the private sector and in that conducted by the Federal government, that needle exchange programs are effective in reducing HIV-infection in needle using individuals. The research shows that programs do not increase drug use among participants, that more needles do not end up in the streets, and that many programs are effective in referring individuals into drug treatment. Clearly, however, needle exchange programs are more than just the science. Community values, norms and concerns must be taken into account. This paper addresses the science as well as the major concerns expressed by citizens about needle exchange programs.

Current Injection Drug Use HIV/AIDS Statistics

As detailed in Table 1, as of December 1997, 82 individuals in Alexandria have contracted AIDS through injection drug use (IDU). Another 118 Alexandrians have contracted HIV through IDU. Statewide, 1,804 Virginians have contracted AIDS through IDU drug use, and another 2,101 have contracted HIV through IDU. These numbers do not include individuals who may have had multiple risk exposure categories, such as men who have sex with men and inject drugs, or women who inject drugs and have sex with an injection drug user or bisexuals. Between 1996 and 1997, there was an 120% increase in the number of HIV cases attributed to IV drug use in Alexandria, from 5 to 11 cases.[1]

Table 1

Number and Percent of HIV and AIDS Cases Attributed to Injection Drug Use

Virginia		Alexandria	
AIDS	HIV	AIDS	HIV
1,804	2,104	82	118
17.8%	20.7%	12.0%	21.0%

New Infections

A General Accounting Office report indicates that up to one-third of IV drug use related cases of AIDS could have been prevented if needle exchange programs were in place in the U.S[2]. Thus, given that more than 240 Alexandrians with AIDS or HIV contracted HIV through injection drug use behavior, **More than 60 Alexandrians may not have become HIV infected had a needle exchnage program been in place in Alexandria.**

Given that the average lifetime cost of treating an AIDS patient is estimated to be approximately

---

1 Virginia Department of Health, Bureau of STD/AIDS, Surveillance Quarterly, January 1998 and Surveillance Quarterly Reports, 1996 and 1997.

2 *Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy*; U.S. General Accounting Office, March 1993; GAO/HRD-93-60. P. 12.

$149,000[3], approximately $894,000 in medical/care expenses could be saved by preventing these individuals from becoming HIV infected. It is impossible to estimate the cost of human suffering and emotional toll that the loss of these individuals have on loved ones, or the economic toll on loss of wages, productivity, and so forth. While it is possible that short term cost associated with enhanced referrals to substance abuse treatment programs could occur, the long term benefits of reduced infections and increased treatment of substance abusers should be considered. Changing from a punitive response to injection drug use to that of treatment of drug abusers is important.

Current Federal Laws

Currently, federal law prohibits the use of **Federal** funds to support and/or implement needle exchange programs -- **no Federal laws prohibit needle exchange programs from operating at the state or local level. State and local laws alone govern this activity.** The Congress has enacted statutory prohibitions against the use of federal funds for needle or syringe exchange programs until March 31, 1998. After that date such projects may proceed to use Federal funds if 1) the Secretary of Health and Human Services determines that needle exchange programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs, and 2) the project is operated in accordance with criteria established by the Secretary for preventing the spread of HIV and for ensuring that the project does not encourage the use of illegal drugs. This provision is consistent with the goal of allowing the Secretary maximum authority to protect public health while not increasing the overall number of needles and syringes in communities.

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

---

3 *The Hopkins HIV Report*, Johns Hopkins University AIDS Service, Vol. 9, Number 3, May 1997. Average lifetime cost of $149,000 starting from a CD4 count of approximately 500 cells/mm for Medicaid insured patients seen at Johns Hopkins University.

Current State/Local Law

Currently, the Commonwealth of Virginia does not allow needle exchange programs to operate in Virginia, regardless of the funding source. Sections 54.1-3466 to 54.1-3472 specify that distribution of needles is restricted to licensed pharmacists or others who have received a license or a permit from the Board of Pharmacy. Physicians, dentists, podiatrists, veterinarians, funeral directors, and embalmers do not need permits. [4]

Why Is Injecting Drug Use a Problem?

Transmission of HIV infection through injection drug use has a cascading effect: infections spread from the injection drug user to their needle sharing partners, and to the sexual partners of injection drug users, who may or may not inject drugs themselves. Women who have children may then pass the virus to their children during childbirth or during breast feeding. Individuals may engage in sexual and drug use activities with individuals they do not know are infected, and thus contract HIV. It is important to note that the stereotypes of who use a needle exchange program is not necessary accurate. For example, according to several studies, needle exchange participants are more likely to be male, are somewhat less likely to be African-American, and are older. The median age of program users ranged from 33 - 41 years, and mean duration of drug use ranged between 7 and 20 years. One-half of needle exchange programs (NEP) clients had never been in drug treatment[5]

What Does the Research Say?

The preponderance of research suggests that needle exchange programs lower the rates of multi-person use of syringes; offer a referral source of social services, health care and drug abuse treatment; and serve as a conduit to HIV testing and counseling, health education, and condom

---

4 Information provided by the Virginia Department of Health, Division of STD/AIDS on December 1, 1997.

5 Center for AIDS Prevention Studies, School of Public Health, University of California, Berkeley and the Institute for Health Policy Studies, University of California, San Francisco, 1993.

distribution[6,7,8,9]. Research also shows that needle exchange programs reduce the number of HIV infected needles/syringes.[10] In fact, the U.S. General Accounting Office confirmed the research as early as 1993 in their report to the chairman of the House of Representative's Select Committee on Narcotics Abuse and Control.[11]

In a later report published by the National Research Council, it stated that the "data concludes that syringe exchange programs constitute a vital component of a comprehensive strategy to prevent infectious disease," and that syringe exchange programs reduce the number of contaminated syringes in circulation, which lowers a major risk factor for infectious disease transmission.[12]

Why are Needle Exchange Programs So Controversial?

Many individuals have understandable concerns about the perceived message and safety of needle exchange programs. It is important to address these concerns and acknowledge that it is appropriate for people to be concerned about the message the government and the community send, whether a program adds to, or decreases the safety of its citizens, and whether such

---

6 Watters, JK. *Syringe and needle exchange as HIV/AIDS prevention for injection drug users*. Journal of the American Medical Association, 1994; 271:115:20.

7 Kaplan EH, Heimer K. *HIV prevalence among intravenous drug users; model-based estimates from New Haven's legal needle exchange*. Journal Acquired Immune Deficiency Syndrome. 1992:5:163-169.

8 Hartgers C., Buning Ed, van Santen GW, Vester AD, Coutinho RA. *The impact of the needle and syringe-exchange programme in Amsterdam in injecting risk behavior*. Journal Acquired Immune Deficiency Syndrome. 1989;3:571-576.

9 Lurie P, Reingold AL, Bowser B, et. Al. *The Public Health Impact of Needle Exchange Programs In the United States and Abroad*. San Francisco: University of California, Institute for Health Policy Studies; 1993, vol.1.

10 *Prevention of HIV/AIDS and Other Blood-Borne Diseases Among Injection Drug Users*. Journal of the American Medical Association; January 1, 1997, page 7.

11 *Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy*. U.S. General Accounting Office, March 1993; GAO/HRD 93-60.

12 As summarized in *Prevention of HIV/AIDS and Other Blood-Borne Diseases Among Injection Drug Users*. Journal of the American Medical Association; January 1, 1997, page 7.

programs add to overall quality of life of a city.

The main concerns are:

1) Distributing clean needles sends a signal that society tolerates drug use.

2) Needle exchange programs may increase drug use by having more needles available on the streets.

3) Needle exchange programs may increase the number of used, dirty needles on the streets, thus posing a hazard to the public, especially children.

4) Individuals may not want a needle exchange program in their backyard, regardless of its success rate.

5) Individuals are concerned that drug users from other jurisdictions will come to Alexandria to participate in a NEP.

Let us examine each of these concerns individually.

#1 **Distributing clean needles sends a signal that society tolerates drug use. Why else would we give drug users free needles to use to shoot up?**

The main purpose of needle/syringe exchange programs is to prevent the transmission of HIV by preventing/reducing the sharing of HIV contaminated needle/syringes between an individual who is HIV infected and someone who is not. Secondary purposes include preventing the spread of other diseases, such as Hepatitis, and serving as a referal to substance abuse counseling/treatment. Needle exchange programs are based on the principle of "harm reduction." Harm reduction in the context of HIV/AIDS and injection drug use simply states that "users are unlikely, in the short term, to stop injection, and therefore should be encouraged to engage in safer-injecting practices".[13] Needle exchange programs send the message that society views life as valuable, and that society wants to prevent the destruction of life from AIDS. Needle exchange programs send a message to drug users that someone cares for them, especially considering that most needle exchange programs offer referral to drug treatment centers. Public health officials are simply saying that if you make the decision to inject drugs, at least take precautions

---

13 Ted Meyers, Rhonda Cocerill, et.al., *The Role of Policy in Community Pharmacies' Response to Injection Drug Use: Results of a Nationwide Canadian Survey*. AIDS and Public Policy Journal, Summer 1996.

and prevent yourself from becoming infected with HIV, and get into treatment. A similar argument was that condoms will increase sexual activity among young people. Yet, numerous research studies have shown that making condoms available within the context of an HIV prevention program for youth does not increase sexual activity, and in fact, delays sexual activity.[14]

#2 **Needle exchange programs may increase drug use by having more needles available on the streets.**

As documented earlier, numerous reports show that needle exchange programs do **not** increase the number of needles on the street.[15] Needle exchange programs exchange clean needles for used needles. Thus, if an individual has 10 dirty needles/syringes to exchange, they receive no more than 10 clean needle/syringes in exchange. Needle exchange programs may in fact reduce the number of needles/syringes given that some individuals will go into substance abuse treatment/counseling and thus discontinue their injection drug use.[16] In some localities, given the educational/referral aspects of needle exchange programs, up to 30 percent of individuals who are in drug treatment were referred to treatment through a needle exchange program. Thus, NEP may in fact, reduce drug use. In addition, just as has happened with "bottle bill deposit laws," needles may become a commodity and thus be exchanged.

#3 **Others worry that needle exchange programs may increase the number of used, dirty needles on the streets, thus posing a hazard to the public, especially children.**

As discussed in #2, most needle exchange programs trade dirty needles with clean ones, one-for-one; no additional needles are put on the street[17]. Because a used syringe in a city with an NEP now has value, it is plausible that the discarding of syringes would decrease much the same way as "bottle bills" have decreased discarded bottles and can.[18]

---

14 American Jounal of Public Health (1997;87:556-558, 544-546); New York Times, September 30, 1997

15 GAO, 1993; Lurie, 1993, JAMA, 1994; JAMA, 1997, Kaplan, 1989..

16 Center for AIDS Prevention Studies, School of Public Health, University of California, Berkeley and the Institute for Health Policy Studies, University of California, San Francisco, 1993.

17 Center for AIDS Prevention Studies, School of Public Health, University of California, Berkeley and the Institute for Health Policy Studies, University of California, San Francisco, 1993.

18 Ibid.

#4 **Some people many not want a NEP in their back yard, regardless of it success rate.**

Because of the need to go where the user is, needle exchange programs operate in areas where drug use is already occurring so access to those who can benefit is assured. Drug use/abuse is already occurring in several areas in Alexandria, as evidenced by reports in local newspapers and police concerns. Since needle exchange programs are part of a comprehensive HIV prevention efforts, which includes referral to drug treatment, a neighborhood may actually see a decrease in drug using activity. Since fewer than 15 percent of IDUs are in drug treatment on any given day, any activity which can assist in referrals to drug treatment is beneficial.[19]

#5 **Some are concerned that individuals from other jurisdictions will come to Alexandria to participate in a NEP.**

Concerns exist that individuals from other jurisdictions, such as the District, will come to Alexandria to participate in a needle exchange program. The District of Columbia currently has a needle exchange program in operation. Anecdotal information has shown that injection drug users do not travel great distances in order to exchange dirty needles for clean ones, and in fact, convenience and ease of access to a program is often a key determinant to its success. Thus, many programs offer several different sites in a community where individuals can exchange needles. As with all consumers, IDUs want programs which are easily accessible, quick to use, and cause minimal disruption to their daily routine.

Currently, the City of Alexandria reports a 2 week to 1 month waiting period for substance abuse treatment. Currently, Alexandria has 110 methadone treatment slots.[20] Thus, right now for those who are not in treatment, clean-needle programs are an effective intervention strategy which could be employed to protect people from contracting HIV from injection drug use behaviors. This includes the sexual partners of injection drug users and children of infected mothers, many who may not know that they are at risk of HIV infection since they do not know that their partner is an injection drug user. In addition, there are a number of young adults and

---

19 Center for AIDS Prevention Studies, School of Public Health, University of California, Berkeley and the Institute for Health Policy Studies, University of California, San Francisco, 1993.

20 Conversation with the Alexandria Mental Health, Mental Retardation and Substance Abuse Agency, February, 1998.

others who experiment with injecting drugs for a while and then stop, never injecting again. Consider the difference access to clean needles could make for them. The uninfected person who stops using illicit drugs has a lifetime before him or her. The HIV-infected person who stops injecting drugs still faces a life threatening disease ahead of them.

Who Supports Needle Exchange Programs?

Currently, there are more than 130 legal and illegal needle exchange programs operating in the United States, including Washington, D.C., Baltimore, San Francisco, Seattle, San Diego, Portland, Philadelphia, and programs operated by the States of New Mexico and Hawaii[21]. Needle exchange programs, as an important component of a comprehensive HIV prevention strategy which includes referral to drug treatment, has been endorsed by many prominent Congressional and national organizations, including (but not limited to):

- National Academy of Science
- American Medical Association
- American Bar Association
- American Public Health Association
- National Association of State and Territorial AIDS Directors
- Association of State & Territorial Health Officials
- National Association of County and City Health Officers
- U.S. Conference of Mayors
- State of Virginia HIV Prevention Planning Council
- Congressional Black Caucus
- Congressional Hispanic Caucus
- National Black Caucus of State Legislators

Visions for the Future

In order to implement needle exchange programs, communities must bridge the gap between perception and reality, working with all segments of a community to ensure that those most concerned about the health and safety of a community are well informed and have facts on which to make their decisions.[22] Needle exchange programs are unique in that in order for many of

---

21 Washington Times, Metropolitan Section, February 26, page 3.

22 Summarized from *Prevention of HIV/AIDS and Other Blood Borne Diseases Among Injection Drug Users*. Journal of the American Medical Association. January 1, 1997, page 8.

them to operate, strong working relationships must be developed between the program and the community.

Here is what some communities have been doing to address the issue of HIV transmission among injection drug users.

1. Clarifying in the public eyes the legitimate medical purpose of needle and syringe exchange programs, including educating community leaders, police agencies, etc.

   It is clear that many individuals do not fully understand the purpose or functions of needle exchange programs. The public health community (including pharmacists), and local elected leaders, must be able to clearly articulate the benefits to the individual and to society that needle exchange programs provide. Dialogue, including that with the local law enforcement agencies and community leaders, must occur.

2. Seeking to modify drug paraphernalia laws.

   State and local laws which limit the establishment of legitimate needle exchange program must be modified to allow for controlled programs to operate without fear of prosecution. Most programs work with local officials including the police department to adopt rules which exempt individuals who are participating in a bonafide needle exchange program from being prosecuted for possession of syringes.

3. Seeking to amend syringe prescription laws.

   Laws which make it illegal to purchase syringes over the counter, without a prescription, limit the availability of individuals to obtain clean needles.

4. Seeking to amend restrictive pharmacy regulations and practice guidelines.

   Laws must be modified which allow greater access to the purchase of clean needles and syringes.

5. Promoting professional training of individuals so that they are aware of the issues surrounding needle exchange and will be willing to support a program.

   It is important to have pharmacists and other professions understand the value and mechanics of needle exchange programs. Thus, special efforts must be undertaken to educate them on needle exchange programs and their operations.

6. Stressing the need to permit local discretion in establishing syringe exchange programs.

   Clearly, local option is the most appropriate manner to address needle exchange

programs. A community in Southwest Virginia which has very few injection drug related HIV-cases may not be willing to allow a program in that community. However, they should not have veto authority over a community in Central Virginia where injection drug use HIV cases are significant. Local option is key and provides a particular community the ability to decide what is best for that community.

7. Working with the police department and public health officials to design programs for safe syringe disposal.

Any successful program will have in place strict safeguards for the safe disposal of needles that are exchanged. Clearly, working with the local health department to design disposal protocols will be required. Needle programs are intended to reduce the number of HIV infected needles in circulation, and disposal of dirty needles is of paramount concern. Most programs have strong working relationships with their local police department, and many have representatives on the program advisory board as means to ensure information exchange and that the police department's concerns are addressed.

Membership

Alexandria Task Force on AIDS

Chair: **Nathan Monell, Nothern Virginia AIDS Ministry**
Vice Chair: **Diane Hall, Alexandria Gay and Lesbian Community Association**

Bradley Buster, Citizen at Large
Barbara Clancy, Citizen at Large
Emilie Deady, Visiting Nurses Association
Helen Donovan, Alexandria Public Health Advisory Commission
James H. Dunning, Sheriff
J. Vincent Guss, Pastoral Representative, INOVA Alexandria Hospital
Beth Hoyas, Citizen at Large
Ian Larsen, American Red Cross
Jean Mayhan, alternate, Alexandria Public Health Advisory Commission
Brent Minor, Citizen at Large
Matthew Murguía, Citizen at Large
Susan Osborn, Hospice of Northern Virginia
Albert C. Pierce, Citizen at Large
Francine Proulx, Hopkins House
Gregory Reid, Whitman Walker of Northern Virginia
Richard Reno, Human Rights Commission
Katherine Riddile, Student, T.C. Williams High School
Michele Ross, Alexandria City Public Schools
Peter Schultze, Citizen at Large
Sharon Selby, INOVA Alexandria Hospital
Carlos Vega-Matos, Alexandria Community Services Board

Regular Attendance From:

Alexandria Mental Health Mental Retardation and Substance Abuse Agency
Office on Women
Alexandria Detention Center

Source: Virginia Department of Health
Division of STD/AIDS
Richmond, Virginia

NEEDLE EXCHANGE PROGRAMS
WHITE PAPER

January 1998

Introduction

More than half a million cumulative cases of AIDS have been reported to the Centers for Disease Control and Prevention (CDC). Injecting drug use (IDU) constitutes the second largest transmission category, with one of the most significant proportionate increases in cases during the last 15 years. The percentage among drug users rose from 12% of all reported AIDS cases in 1981 to nearly 29% in 1995.

Needle-borne spread of HIV/AIDS also affects the drug user's sexual and needle-sharing partners and the children of HIV-infected mothers. Nearly 72% of all heterosexual cases of AIDS reported in the United States involve persons who have had sexual contact with an injecting drug user. The connection between pediatric AIDS and drug use is even more significant. Seventy-nine percent of all children born infected with HIV have a mother who either was an injecting drug user or had sexual relations with an injecting drug user.

In Virginia, as of October 31,1997, nearly 31% (3,073) of all HIV cases and 28.5% (2,757) of all AIDS cases are related to injecting drug use. Pediatric cases of HIV and AIDS associated with IDU constitute 34.8% (112) and 42.9% (161) respectively.

One of the reasons injecting drug use is regarded as an effective means of transmitting HIV is because the initial injector draws a small amount of blood into the needle (which is invisible to the naked eye), which is then passed along to the next person who injects not only the drugs but also the remaining blood directly into his blood stream. As a means of decreasing the negative consequences of injecting drug use, harm reduction strategies were developed. Harm reduction aims to reduce drug-related health and social problems among individuals, families, and communities. Harm reduction strategies can be employed among people who do not wish or are not yet ready to stop using drugs, those waiting for treatment, and people for whom traditional treatment has failed. The Virginia Department of Health, Division of STD/AIDS, for over ten years has funded numerous community-based organizations (CBOs) to provide HIV prevention/risk reduction education and one-on-one street outreach. Outreach workers not only provide information, they conduct assessments and make appropriate referrals, and occasionally distribute bleach kits.

Although the use of bleach reduces the risk of HIV transmission, it is not 100% effective and it does not kill the hepatitis viruses; therefore, many organizations, because of its ease and low-relative cost, have adopted syringe/needle exchange programs. The provision of sterile syringes has become the approach of choice to ensure that injecting drug users are using clean injecting equipment. It is also a way of linking drug users with other services.

Needle exchange programs have been highly controversial from an ethical and legal perspective. Law enforcement and community groups have expressed intense opposition to needle exchanges because they fear that they may encourage drug use and send out the wrong message about the use of drugs. The public health community has observed that needle exchanges may well reduce the rate of needleborne transmission of HIV and other infections. Although NEPs are very controversial, Beth Israel Medical Center in New York conducted a survey of 101 known NEPs in the United States. Eighty-seven programs returned surveys indicating they operate in 28 states, 71 cities, and one territory. When questioned about their primary sources of funding 45% reported they receive state funding, 33% receive city/county monies, 15% receive private funds, and 4% receive donations.

Forty-six of the NEPs were defined as legal. These NEPs either operated in states that had no law requiring a prescription to purchase a hypodermic syringe, or had an exemption to the state presciption law which allowed the NEP to operate. Twenty were illegal but tolerated; these NEPs operated in a state with a prescription law but had received formal suppport from local elected officials. Twenty-one NEPs were defined as illegal/underground; operating in states with prescription laws, without having received either an exemption to the state law or formal support from local officials.

Legal Barriers to Needle Exchange Programs

Currently, Virginia law does not allow an agency to initiate a needle exchange program (NEP). Virginia code, sections 54.1-3466 to 54.1 - 3472 specify that distribution of needles is restricted to licensed pharmacists or others who have received a license or a permit from the Board of Pharmacy. Physicians, dentist, podiatrist, veterinarians, funeral directors, and embalmers do not need a permit. In addition, it is a misdemeanor for any person to possess controlled paraphernalia such as hypodermic syringe, needle or other instruments for the administration of controlled dangerous substances.

Since 1988, Congress has passed at least six laws that contain provisions prohibiting or restricting use of federal funds for needle exchange programs and activities. These provisions are contained in:

- The Comprehensive Alcohol Abuse, Drug Abuse, and Mental Health Amendments Act of 1988
- The Health Omnibus Programs Extension of 1988
- The Ryan White Comprehensive AIDS Resources Emergency Act of 1990
- The Departments of Labor, Health, and Human Services, and Education, and Related Agencies Appropriations Act of 1990, 1991, and 1993

However, in 1992 Congress passed a measure that allows the surgeon general to lift the funding ban if research shows that needle exchange programs reduce the spread of HIV without increasing illegal drug use.

Opponents Fear Needle Exchange Programs:

- will send out the wrong message and promote the use of drugs
- will tell drug users and their suppliers that an aggressive war on drugs is over
- will pose a safety hazard due to discarded syringes
- will be a burden to taxpayers
- may reduce number of persons seeking treatment
- will simply prolong drug use and remove any motivation to quit resulting in other health problems
- may be viewed by some African American church congregations as a cheap and cynical substitute for drug treatment programs

Opponents to NEPs include the following national organizations: The U.S Dept of Health and Human Services, Family Research Council, and the Police Foundation.

Proponents of Needle Exchange Programs State that:

- with more needles in circulation sharing is less likely
- clean syringes in exchange for used ones can help control the spread of HIV without increasing the amount of drugs taken by participants or raising the levels of drug abuse in the community

Proponents of NEPs include: The American Medical Association, the National Academy of Science, the Centers for Disease Control and Prevention, the American Public Health Association, the American Pharmacists Association, and the Medical Society of Virginia.

Research Findings on Needle Exchange Programs:

In 1992, Connecticut's laws were changed to permit syringe purchase without a prescription and to allow possession without medical need of up to 10 syringes. In the article "Impact of Increased Legal Access to Needles and Syringes on Practices of Injecting Drug Users and Police Officers" researchers found decreases in self reported syringe-sharing and increases in purchasing by IDUs of sterile syringes from reliable sources; therefore, suggesting that the simultaneous repeal of both prescription and paraphernalia laws is an important HIV prevention strategy. (1)

According to the study "Syringe and Needle Exchange as HIV/AIDS Prevention for Injection Drug Users" researchers found that syringe exchange programs were rapidly adopted by injecting drug users. Health interventions associated with not sharing needles included use of the syringe exchange program and voluntary, confidential HIV testing and counseling. The data did not support the hypothesis that a syringe exchange program would stimulate increased drug abuse in terms of frequency of injecting or recruitment of new and/or younger users.(2)

Researchers Lurie and Drucker found that nearly 10,000 new HIV cases could have been prevented over the last 8 years with the use of needle exchange programs. At the Eleventh International Conference on AIDS, Lurie presented findings from studies showing that HIV infections among injecting-drug users, their sexual partners and their children could have been prevented between 1987 and 1995. The federal governments reluctance to use the harm-reduction method is expensive, ranging between $244 million and $538 million for HIV treatments over the last 8 years. If needle exchange programs are established now, an additional 5,150 to 11,329 infections could be prevented by the year 2,000. (3)

The Public Health Impact of Needle Exchange Programs in the United States and Abroad states that:

- Although quantitative data are difficult to obtain, those available provide no evidence that NEPs increase the amount of drug use by NEP clients or change in overall community levels of non-injecting and injecting drug use. This conclusion is supported by interviews with NEP clients and by IDUs not using the NEP, who did not believe that increased needle availability would increase drug use. (4)

- NEPs in the US have not been shown to increase the total number of discarded syringes and can be expected to result in fewer discarded syringes. (4)

- The majority of studies of NEP clients demonstrate decreased rates of HIV drug risk behavior, but not decreased rates of HIV sex risk behaviors. (4)

- Studies of the effect of NEPs on HIV infection rates do not, (in part due to the need for large sample sizes and the multiple impediments to randomization) provide clear evidence that NEPs decrease HIV infection rates. However, NEPs do not appear to be associated with increased rates of HIV infection. (4)

Multiple mathematical models suggest that NEPs can prevent significant numbers of infections among clients of the programs, their drug and sex partners, and their children. (4)

Preliminary Findings from an Evaluation Study of Baltimore's Needle Exchange Program:

- Discarded needles did not increase after the opening of their NEP. In fact, a well defined study looked at discarded needles around the two program sites compared to other high drug-use areas in the city and found no increase in the number of discarded needles in the areas surronding the exchange. (5)

- The average age of their needle exchange clients is 39 years old. Their records showed that only two of their 6,000 clients are under 18. (5)

- Needle sharing is reduced. Clients reported significant drops in the following unsafe drug behaviors after starting the NEP: a) using needles after someone else; b) using cotton after someone else; and c) letting a friend use your needle and syringe. (5)

- The goal of this program is to decrease the transmission of HIV. The program is showing a 39.7% decrease in HIV seroconversion among the injecting drug use population that is being served. (5)

The majority of the studies indicate that NEPs do not appear to increase injecting drug use; however, according to the study titled "High Rates of HIV Infection Among Injection Drug Users Participating in Needle Exchange Programs in Montreal" Canadian researchers have concluded that participants in needle-exchange programs in Montreal appear to have greater HIV seroconversion rates than non-participants. The researchers studied nearly 1,600 participants for an average of 21.7 months. The cohort study revealed 89 incident cases of HIV infection with a cumulative probability of HIV seroconversion of 33 percent for NEP users and 13 percent for non-participants. Furthermore, despite broad adjustment for confounders, the researchers note that risk elevations for HIV infection related to NEP participation were both "substantial and consistent." (6)

Recommendations:

State Health Officials- Report Recommends Strategies for HIV Prevention Among Injecting Drug Users.

The Association of State and Territorial Health Officials (ASTHO), representing the chief public health officials in each state and U.S. territory, announced on October 2, 1997 a report: " Preventing HIV Infection Among Drug Injectors: The Role of Sterile Syringes and Substance Abuse Treatment."

The recommendations outlined in the report include:

- Public health agencies should advocate for increased availability and access to alcohol and other drug treatment as a public health intervention to prevent the spread of HIV and other blood-borne pathogens.

- Public health agencies should endorse the importance of making sterile syringes available to injecting drug users in order to reduce the spread of HIV infection, including:

    1. supporting the deregulation of syringes through the removal of prescription requirements for syringe purchase and the removal of syringes from drug paraphernalia laws

    2. aggressively promoting federal and state funding for syringe exchange programs designed to increase the availability of sterile syringes

- Public health agencies should promote public health programs and alcohol and other drug program collaboration with pharmacist organizations, police organizations, and others.

Cost to Operate Needle Exchange Programs

According to the conclusions of "The Public Health Impact of Needle Exchange Programs in the United States and Abroad," NEPs in the United States and Canada vary greatly in their total budgets. The programs ranged from $18,628 to $403,464 with a median of $168,650. The median cost per syringe distributed was $1.35 and the median cost per hour open was $145. The median number of syringes distributed per hour was 205. Activist programs were the least expensive, government programs the most expensive, with CBO-run programs in between. Most of the cost of the more expensive NEPs was for items that did not add directly to services (e.g., staff supervision and rent) and for non-exchange services (e.g., drug referrals and counseling). The largest cost component was personnel, accounting for a median of 66% of total budgets. Syringe costs represented a median of 7% of total budgets.

Estimated Cost to Operate a Needle Exchange Program in Virginia

To examine the potential cost benefit of operating a needle exchange program in Virginia, a hypothetical example of a pilot NEP follows:

This needle exchange program operates five days a week out of one mobile van. The program covers the Richmond metropolitan statistical area (MSA) which includes 13 localities. The NEP is designed to reach about 200 IDUs (25% @ 814 potential IDUs*). In addition, this program operates on a "one-for-one" exchange basis. Clients of this program will receive risk/harm reduction education and referrals to drug treatment and HIV testing programs.

The following is an estimation of the cost to operate the program described above:

Personnel:		
	2 full-time Outreach Workers @ 18,000/per year	$36,000
	Data person (25% @ 15,000)	$ 3,750
	Supervisor (15% @ 25,000)	$ 3,750
Fringe		$ 8,700
Equipment:		
	Van	$ 11,000
Supplies:		
	Needles ($.15/per syringe x 365 days x 200 IDUs)	$ 10,950
Other:		
	Vehicle insurance and maintenace phone,beeper, office space, office supplies, and gas	$ 4,140
		$ 78,290

The annual cost of treating an individual with HIV without any complications is approximately $12,000. Between 1990 and 1995 about 75 IDUs were infected with HIV each year in the Richmond MSA. If we continue at this rate, the annual cost to treat 75 newly infected IDUs is $900,000. If Virginia were to initiate one NEP in the Richmond area, using the above calculations, $821,710 would be saved per year. If additional programs were implemented, cost savings would increase depending on the number of clients who were reached.

* The 1996 national household survey on injecting drug use estimates that .2% of the total population in the southern region are IDUs. The total adult population for the Richmond MSA area is 720,823 x .2% - 628 (IDUs already infected) = 814. According to The Public Health Impact of NEPs in the United States and Abroad, cities in the U.S. and Canada operating NEPs serve a median of 14.5% of the IDU population in those areas. We estimate reaching about 25% of the IDU population.

References:

1. Groseclose SL; Weinstein B; Jones TS; Valleroy LA; Fehrs LJ; Kassler WJ. "Impact of Increased Legal Access to Needles and Syringes on Practices of Injecting Drug Users and Police Officers—Connecticut, 1992-1993." Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology, 1995.

2. Watters JK; Estilo MJ; Clark GL; Lorvick J. "Syringe and Needle Exchange as HIV/AIDS Prevention for Injection Drug Users." Journal of the American Medical Association, 1994.

3. Lurie P; Drucker E. "An Opportunity Lost: HIV Infections Associated with the Lack of Needle Exchange Programme in the USA." Lancet, 1997.

4. The Public Health Impact of Needle Exchange Programs in the United States and Abroad. Prepared by the School of Public Health, University of California, Berkley and the Institute for Health Policy Studies, University of California, San Francisco. Prepared for the Centers for Disease Control and Prevention. 1993

5. Written Testimony of Dr. Peter Beilenson Baltimore City Health Commissioner to the Subcommittee on National Security, International Affairs and Criminal Justice of the Congress of the United States September 18, 1997.

6. Bruneau J; Lamothe F; Franco E. "High Rates of HIV Infection Among Injection Drug Users Participating in Needle Exchange Programs in Montreal." American Journal of Epidemiology 1997