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001. form	[Personally Identifiable Information] [partial] (1 page)	12/28/1995	b(6)

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2018-0758-F
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RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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Freedom of Information Act - [5 U.S.C. 552(b)]

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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

February 23, 1998

James P. Ahstrom, Jr., M.D.
H. Constance Bonbrest, M.D.
Co-Chairs of *Ad hoc* Committee on Needle Access
c/o Dean Devert
Illinois State Medical Society
20 N. Michigan, Suite 700
Chicago, IL 60602
312-782-1654 (ext 1156) fax 312-782-9212

Dear Colleagues:

This letter is intended to provide background information related to human immunodeficiency virus (HIV) prevention among injection drug users (IDUs) including recently adopted policies of the American Medical Association (AMA) and a variety of published articles and recommendations that emphasize the importance for HIV prevention of access to sterile syringes for IDUs.

(1) Policies Adopted at the June 25, 1997 Meeting of the House of Delegates of the American Medical Association

At the June 25, 1997 meeting of the AMA House of Delegates several new AMA policies were adopted.[1] Those policies relate to laws restricting the purchase and possession of syringes, syringe exchange programs, and drug use. Two of the new AMA policy positions are:

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

Best Statement

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

(2) United States Public Health Service *HIV Prevention Bulletin: Medical Advice for Persons who Inject Illicit Drugs*

On May 9, 1997, the Centers for Disease Control and Prevention (CDC), the Health Resources

and Services Administration, the National Institute on Drug Abuse, and the Substance Abuse and Mental Health Services Administration released a bulletin to update health care providers on medical advice that should be provided to persons who inject illicit drugs.[2]

The bulletin states that preventing drug abuse and providing effective substance abuse treatment for people who inject illicit drugs are the best ways to prevent drug-associated HIV transmission. The bulletin includes provisional recommendations that, to reduce the risks of HIV transmission and other health problems, individuals who continue to inject drugs should be advised to ***use sterile syringes to prepare and inject drugs*** and never reuse or share syringes and other equipment used to prepare drugs.

(3) American Medical Association *A Physician Guide to HIV Prevention*

In 1996, the AMA published *A Physician Guide to HIV Prevention*.[3] The AMA sent this guide to about two hundred thousand primary care physicians in the United States. The document provides guidance on a variety of HIV prevention measures. Pages 6 and 7 specifically deal with "Injecting Drug Use and HIV Prevention." That section includes the following statement:

> *Some patients are unwilling or believe themselves unable to abstain from injecting drugs. **Using new, sterile injection equipment each time drugs are injected eliminates the risk of acquiring HIV infection through injecting drugs. . .***

The section concludes with the following advice:

> *Primary care physicians can help their patients reduce HIV risk from injecting drugs by encouraging their patients to...*
>
> - *Abstain from using drugs and to seek treatment.*
> - *Use a new needle and syringe each time drugs are injected.*
> - *Have their own personal injection equipment that is never shared.*
> - *Share only needles and syringes that have been correctly cleaned.*
> - *Use condoms with sex partners who share injecting equipment.*

(4) U.S. Preventive Services Task Force *Guide to clinical preventive services*

This guide was produced for the United States Department of Health and Human Services by the U.S. Preventive Services Task Force.[4] On page 591, it includes the following recommendation:

> *. . . Patients with evidence of drug dependence should be referred to appropriate drug-*

treatment providers and community programs specializing in the treatment of drug dependencies. Persons who continue to inject drugs should be screened periodically for HIV infection and advised of measures that may reduce the risk of infections due to drug use: ***use a new sterile syringe with each use, never share or re-use injection equipment,*** *use clean (sterile, if possible) water to prepare drugs, clean the injection site with alcohol prior to injection, and safely dispose of syringes after use . . .*

(5) United States National Academy of Sciences Report on Sterile Needles and Bleach

In September 1995, the National Research Council and the Institute of Medicine of the National Academy of Sciences (NAS) published the report *Preventing HIV Transmission: the Role of Sterile Needles and Bleach.*[5] It includes the following statement:

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

(6) National Survey on the Regulation of Syringes and Needles

The January 1, 1997 issue of the *Journal of the American Medical Association* contained an article by Lawrence Gostin and colleagues entitled *Prevention of HIV/AIDS and Other Blood-Borne Diseases Among Injection Drug Users: A National Survey on the Regulation of Syringes and Needles.*[6] The article includes the following statements:

We report the results of a survey of laws and regulations governing the sale and possession of needles and syringes in the United States and its territories and discuss legal and public health proposals to increase the availability of sterile syringes, as a human immunodeficiency virus (HIV) transmission prevention measure, for persons who continue to inject drugs. ***Every state, the District of Columbia (DC), and the Virgin Islands (VI) have enacted state or local laws or regulations that restrict the sale, distribution, or possession of syringes.*** *Drug paraphernalia laws prohibiting the sale, distribution, and/or possession of syringes known to be used to introduce illicit drugs into the body exist in 47 states, DC, and VI. Syringe prescription laws prohibiting the sale, distribution, and possession of syringes without a valid medical prescription exist in 8 states and VI. Pharmacy regulations or practice guidelines restrict access to syringes in 23 states. We discuss the following legal and public health approaches to improve the availability of sterile syringes to prevent blood-borne disease among injection drug users: (1) clarify the legitimate medical purpose of sterile syringes for the prevention of HIV and other blood-borne infections; (2) modify drug paraphernalia laws to exclude syringes; (3) repeal syringe prescription laws; (4) repeal pharmacy regulations and practice guidelines restricting the sale of sterile syringes; (5) promote professional training of pharmacists, other health professionals, and law enforcement officers about the prevention of blood-borne infections; (6) permit local discretion in establishing syringe exchange programs; and (7) design community programs*

for safe syringe disposal.

Finally, it is important to emphasize that deregulation of syringe sale and possession should constitute only one component of a comprehensive, well-financed strategy to impede the dual epidemics of drug use and HIV/AIDS. A realistic and sound national program must devote sufficient resources for expanded access to high-quality treatment for drug and alcohol dependency; education and counseling regarding the harms of illicit drugs; effective community efforts to discourage drug use; crime prevention in schools and communities; rehabilitation for offenders; and support and community activities for families and young people. Ultimately, both law enforcement and public health seek the same end--to promote the health and safety of the population through a comprehensive program designed to prevent HIV/AIDS and drug dependency.

(7) 1996 Survey of Syringe Exchange Programs in the United States

In June 1997, the CDC *Morbidity and Mortality Weekly Report* published the results of a survey of syringe exchange programs (SEPs) in the United States. Of 101 known SEPs, 87 participated in a survey carried out by the Beth Israel Medical Center in New York City. Those 87 programs were operating in 71 cities in 28 states and one territory. For the period January–December 1996, 84 SEPs reported exchanging approximately 14 million new, sterile syringes for used syringes (median 36,017 syringes per SEP).[7]

I hope these materials will be of use to you and the Illinois State Medical Society. If I can be of further assistance, please contact me at 404-639-5200.

Sincerely yours,

T. Stephen Jones, M.D.
Associate Director for Science
Division of HIV/AIDS Prevention
National Center for HIV, STD, and TB Prevention

Attachments

cc:
David Holtgrave, Ph.D.
Chet Kelley
William Longdon

References:

1. Lundberg GD. New winds blowing for American drug policies. (Editorial) *J Amer Med Assn* 1997;278:946-7.

2. United States Public Health Service. HIV prevention bulletin: medical advice for persons who inject illicit drugs. May 8, 1997, Atlanta, Georgia and Rockville, Maryland.

3. American Medical Association. A physician guide to HIV prevention. 1996. Chicago, Illinois.

4. U.S. Preventive Services Task Force. Guide to clinical preventive services, 2nd ed. Baltimore: Williams & Wilkins, 1996.

5. Normand J, Vlahov D, and Moses LE, eds. (1995). Preventing HIV Transmission: The Role of Sterile Needles and Bleach. Washington DC: National Academy Press.

6. Gostin LO, Lazzarini Z, Jones TS, Flaherty K. Prevention of HIV/AIDS and other blood-borne diseases among injection drug users: A national survey on the regulation of syringes and needles. J Am Med Assoc 1997;277:53-62.

7. CDC. Update: Syringe exchange programs--United States, 1996. MMWR 1997;46:565-8.

June 23, 1997

NOTE TO: SANDRA THURMAN, DIRECTOR, NATIONAL OFFICE OF AIDS POLICY
FROM: PETER HARTSOCK, NIH/NIDA

Re: SYRINGE EXCHANGE PROGRAMS--MMWR UPDATE

The attached report in the June 20, 1997 MMWR should be of interest both because it summarizes the latest U.S. syringe exchange program (SEP) trends and because this work was developed by NIDA in conjunction with Dr. Don Des Jarlais and was funded by NIDA.

Three years ago I ran the concept by Des Jarlais of using SEPs as an epidemiologic tool (as a complement to SEPs being used as an intervention tool) to monitor and study patterns of drug use and AIDS risk behavior in active drug users. The result was a grant that Des Jarlais and I developed which was recently funded and which has produced the findings that went into the attached MMWR report.

This study will continue to monitor all the SEPs that are members of the North American Syringe Exchange Network (NASEN) and will produce annual "state-of-the-art" reports of SEPs in the U.S. It will also do a number of other things as described in the project application's abstract page which I have attached.

I will keep you posted as more information comes out.

ISSUES - Needle
Ex - MMWR
Update

Korea — Continued

nutrient supplementation for children, continuing general food aid, and restoring essential public health services, especially vaccination and water-chlorination programs.

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2. Food and Agricultural Organization and World Food Program, United Nations. FAO/WFP crop and food supply assessment mission to the Democratic People's Republic of Korea, December 1996. Rome, Italy: United Nations, Food and Agricultural Organization and World Food Program, 1997.
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4. Yasukawa T. Travel report summary: Democratic People's Republic of Korea, March 10–April 2, 1997. Geneva, Switzerland: World Health Organization, Division of Emergency and Humanitarian Action, 1997.
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9. World Health Organization. The world health report, 1996. Geneva, Switzerland: World Health Organization, 1996.

Update: Syringe-Exchange Programs — United States, 1996

As of December 1996, approximately one third (36%) of the 573,000 cases of acquired immunodeficiency syndrome (AIDS) among adults reported to CDC were directly or indirectly associated with injecting-drug use (*1*). Syringe-exchange programs (SEPs) are one of the strategies for preventing infection with human immunodeficiency virus (HIV) among injecting-drug users (IDUs). The goal of SEPs is to reduce the transmission of HIV and other bloodborne infections associated with drug injection by providing sterile syringes in exchange for used, potentially contaminated syringes. This report summarizes a survey of U.S. SEPs regarding their activities during 1995 and 1996 and compares the findings with those during 1994 and early 1995 (*2*). The findings indicate continued expansion in the number and activities of SEPs in the United States.*

In November 1996, the Beth Israel Medical Center (BIMC) in New York City, in collaboration with the North American Syringe Exchange Network (NASEN), mailed questionnaires to the directors of 101 SEPs in the United States that were members of NASEN. Although the number of SEPs in the United States is unknown, most are be-

*Single copies of this report will be available until June 20, 1998, from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231 or (301) 217-0023.

Syringe-Exchange Programs — Continued

lieved to be members of NASEN. From November 1996 through April 1997, BIMC contacted SEP directors to conduct structured telephone interviews based on the mailed questionnaires. SEP directors were asked about when the SEP began; the number of syringes[†] exchanged during 1995; and, for 1996, legal status, services provided, and the number of syringes exchanged.

Of the 101 SEPs, 87 (86%) participated in this survey. Of these, 51 began operating before 1995; 22, in 1995; and 14, in 1996. These 87 SEPs reported operating in 71 cities in 28 states and one territory[§]; 44 (51%) of the SEPs were located in four states (California [17], Washington [11], New York [10], and Connecticut [six]). In eight cities, at least two SEPs were reported operating. In the 1994–1995 survey, 60 SEPs reported operating in 46 cities and in 21 states (*2*).

Of the 73 SEPs operating in 1995, 70 reported exchanging approximately 11 million syringes. In 1996, of the 87 SEPs that provided information about the number of syringes exchanged, 84 reported exchanging approximately 14 million syringes (median: 36,017 syringes per SEP) (Table 1). The 10 most active SEPs (i.e., those that exchanged ≥500,000 syringes)[¶] exchanged approximately 9.4 million (69%) of all syringes exchanged. The SEP in San Francisco reported exchanging the largest number of syringes (1,461,096) in 1996. During 1996, a total of 50 SEPs (57%) reported exchanging ≤55,000 syringes each; of these, 23 (46%) exchanged <10,000 syringes each.

All 87 SEPs provided IDUs with information about safer injection techniques and/or use of bleach to disinfect injection equipment. Other services included referral of clients to substance-abuse treatment programs (84 [97%]), instruction in the use of condoms and dental dams to prevent sexual transmission of HIV and other sexually transmitted diseases (STDs) (84 [97%]), and STD-prevention education (70 [81%]). Health services offered on-site included HIV counseling and testing (35 [40%]), primary health care (15 [17%]), tuberculosis (TB) skin testing (23 [26%]), and STD screening (17 [20%]).

[†]For this report, the term "syringes" refers to both syringes and needles.

[§]California (17 SEPs); Washington (11); New York (10); Connecticut (six); Illinois and Michigan (three each); Massachusetts, Puerto Rico, Texas, and Wisconsin (two each); and one each in Colorado, Florida, Indiana, Louisiana, Maryland, Minnesota, Missouri, New Hampshire, New Jersey, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, and Tennessee. Twenty-four SEPs asked that their location not be reported.

[¶]New York (two); Bridgeport, Connecticut; Chicago; Los Angeles; Oakland, California; Philadelphia; San Francisco; Seattle; and Tacoma, Washington (one each).

TABLE 1. Number and percentage of syringe-exchange programs (SEPs) and number and percentage of new syringes provided by SEPs, by size of program — United States, 1996

	SEPs		Total syringes exchanged	
Size of SEP*	No.	(%)	No.	(%)
< 10,000	23	(27)	64,737	(<1)
10,000– 55,000	27	(32)	810,247	(6)
55,001–499,999	24	(29)	3,658,060	(26)
≥500,000	10	(12)	9,407,628	(68)
Total	**84**	**(100)**	**13,940,672**	**(100)**

*Based on the number of syringes exchanged in 1996.

Syringe-Exchange Programs — Continued

SEPs were defined as legal if they operated in a state that had no law requiring a prescription to purchase a hypodermic syringe (i.e., a prescription law) or had an exemption to the state prescription law allowing the SEP to operate; illegal-but-tolerated if they operated in a state with a prescription law but had received a formal vote of support or approval from a local elected body (e.g., city council); and illegal-underground if the SEP operated in a state with a prescription law but had not received formal support from local elected officials. In 1996, a total of 46 (53%) SEPs were legal, 20 (23%) were illegal but tolerated, and 21 (24%) were illegal-underground. Legal SEPs were more likely than illegal ones to offer on-site HIV counseling and testing (29 [63%] of 46 legal versus eight [20%] of 41 illegal) and TB skin testing (19 [41%] of 46 versus three [7%] of 41). The three SEPs that did not refer clients to substance-abuse treatment were illegal-underground programs.

Reported by: D Paone, EdD, D Des Jarlais, PhD, J Clark, Q Shi, MS, Beth Israel Medical Center; M Krim, PhD, American Foundation for AIDS Research, New York. D Purchase, North American Syringe Exchange Network, Tacoma, Washington. Div of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, CDC.

Editorial Note: Among IDUs, multiperson use of syringes (i.e., "sharing") is the primary mechanism of transmission of HIV, hepatitis B and C, and other bloodborne infections related to injection of illicit drugs (*3*). Multiperson use occurs when an IDU prepares or injects drugs using a syringe borrowed, rented, and/or lent by another IDU. In addition, equipment and water used to prepare drugs for injection can become contaminated with blood remaining in previously used syringes.

In May 1997, the Public Health Service** released provisional recommendations for persons who continue to inject drugs (*4*). These recommendations include advice that drug users who cannot stop injecting drugs use only sterile syringes to prepare and inject drugs and other steps to prevent bloodborne infection transmission. If IDUs adhere to these recommendations, the number of syringes required would be substantially greater than that currently provided through SEPs and other sources. Because of the costs of large-scale expansion of SEPs, these services alone probably could not meet the demand for sterile syringes (*5*).

The findings in this report indicate an expansion in the number of SEPs and in the scope of activities since 1994 (*2*). During 1994–1996, there were increases in the number of SEPs participating in the surveys (58% [from 55 to 87]) and in the numbers of cities (52% [from 46 to 71]) and states (38% [from 21 to 29]) with SEPs. Although the number of syringes exchanged increased by 75% (from 8 million to 14 million) from 1994 to 1996, most SEPs exchanged relatively small numbers of syringes, and the 23 least active SEPs exchanged a mean of 2815 syringes per program. If less active SEPs are located in communities with large numbers of IDUs, their impact on the overall availability of sterile syringes will probably be limited.

The findings in this report are subject to at least two limitations. First, the extent of SEP activity is probably underestimated because of incomplete participation in this survey of U.S. SEPs and the possible existence of SEPs that are not members of NASEN. Second, because the definition of legal status did not include the local status of drug paraphernalia laws, legal barriers to SEPs may be underestimated (*6*).

**CDC, the Health Resources and Services Administration, the National Institute on Drug Abuse of the National Institutes of Health, and the Substance Abuse and Mental Health Services Administration.

Syringe-Exchange Programs — Continued

Existing laws and regulations in many U.S. communities substantially limit the sale of sterile syringes and needles and establish criminal penalties for possession of syringes for persons who inject illicit drugs (*6*) and may reduce the likelihood that IDUs will be able to obtain sterile syringes from legal sources (e.g., pharmacies). In May 1997, in efforts to prevent HIV transmission among IDUs, the legislatures in Maine and Minnesota removed criminal penalties for possession of ≤10 syringes to permit the legal operation of SEPs and increase IDUs' use of sterile syringes from legal sources.

References

1. CDC. HIV/AIDS surveillance report, 1996. Atlanta, Georgia. US Department of Health and Human Services, Public Health Service, 1997:1–39. (Vol 8, no. 2).
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4. CDC/Health Resources and Services Administration/National Institute on Drug Abuse/Substance Abuse and Mental Health Services Administration. HIV prevention bulletin: medical advice for persons who inject illicit drugs. Atlanta: US Department of Health and Human Services, Public Health Service, 1997.
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Department of Health and Human Services — Public Health Service — Application

504653

APPL NO:1 R01 DA09536-01A2 | COUNCIL: 05/96
DUAL: | RCVD:01-02-96
IRG: NIDA-J

1. TITLE OF PROJECT *(Do not exceed 56 characters, including spaces and punctuation.)*
Epidemiology of U.S. Syringe Exchange Participants

2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT ☐ NO ☒ YES *(If "Yes," state number and title)*
Number: PA 94-0077 Title: Survey Research on Drug Use and Associated Behaviors

3. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR

3a. NAME *(Last, first, middle)*	3b. DEGREE(S)	3c. SOCIAL SECURITY NO.
Des Jarlais, Don C.	BA MA PhD	(b)(6)

3d. POSITION TITLE: Director of Research

3e. MAILING ADDRESS *(Street, city, state, zip code)*:
Beth Israel Medical Center
Chemical Dependency Institute
~~First Avenue and 16th Street~~
New York, NY 10003
Fed Ex Address:
215 Park Ave, South, 15th Floor

3f. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT: Chemical Dependency Institute

3g. MAJOR SUBDIVISION:

3h. TELEPHONE AND FAX *(Area code, number and extension)*
TEL: 212-387-3803
FAX: 212-387-3897

E-MAIL ADDRESS: dcdesjarlais@eworld.com

4. HUMAN SUBJECTS	4a. If "Yes," Exemption no. or Pending	4b. Assurance of compliance no.	5. VERTEBRATE ANIMALS	5a. If "Yes," IACUC approval date	5b. Animal welfare assurance no.
☐ No ☒ Yes	IRB approval date ☐ Full IRB or ☐ Expedited Review		☒ No ☐ Yes		

6. DATES OF PROPOSED PERIOD OF SUPPORT *(month, day, year—MM/DD/YY)*		7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD		8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT	
From: 7/1/96	Through: 6/30/98	7a. Direct Costs ($)	7b. Total Costs ($)	8a. Direct Costs ($)	8b. Total Costs ($)
		$414,152	$594,124	$738,297	$1,073,538

9. APPLICANT ORGANIZATION
Name: Beth Israel Medical Center
Address: First Avenue and 16th St.
New York, NY 10003

10. TYPE OF ORGANIZATION
Public: → ☐ Federal ☐ State ☐ Local
Private: → ☒ Private Nonprofit
Forprofit: → ☐ General ☐ Small Business

11. ORGANIZATIONAL COMPONENT CODE

12. ENTITY IDENTIFICATION NUMBER: 13-5564934
Congressional District: 18

13. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE
Name: Nina Peyser, MBA
Title: Executive Director
Address: Grants Manangement & Research Support
Beth Israel Medical Center
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New York, NY 10003
Telephone: 212-387-3883
FAX: 212-387-3897
E-Mail Address: Nina_Peyser@BIMC.edu

14. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION
Name: Thomas Killip, MD
Title: Executive VP of Medical Affairs
Address: Beth Israel Medical Center
First Avenue and 16th St.
New York, NY 10003
Phone: 212-420- 4010
FAX: 212-387- 2881
E-Mail Address:

15. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR ASSURANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application.

SIGNATURE OF PI / PD NAMED IN 3a. *(In ink. "Per" signature not acceptable.)* — DATE

16. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Service terms and conditions if a grant is awarded as a result of this application. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.

SIGNATURE OF OFFICIAL NAMED IN 14 *(In ink "Per" signature not acceptable.)* — DATE 1/28/97

SUBMITTED TO DR. PETER HARTSOCK, NIDA/DEPR/CRB

DD Principa

DESCRIPTION. State the application's broad, long-term objectives and specific aims, making reference to the health relatedness of the project. Describe concisely the research design and methods for achieving these goals. Avoid summaries of past accomplishments and the use of the first person. This description is meant to serve as a succinct and accurate description of the proposed work when separated from the application. If the application is funded, this description, as is, will become public information. Therefore, do not include proprietary/confidential information. **DO NOT EXCEED THE SPACE PROVIDED.**

Program Announcement #94-0077 "Survey Research on Drug Use and Associated Behaviors" from the NIDA Division of Epidemiology and Prevention Research calls for innovative research to improve survey methods for assessing drug use behaviors in the U.S. Though politically controversial, syringe exchange (SE) programs are increasingly being used as a community based intervention to reduce HIV transmission among injecting drug users in the U.S. The number of U.S. SEs has increased from 33 to 38 in the last two years. Systematic surveys of SE participants could contribute greatly to the epidemiology of both injecting drug use and risk for HIV infection in the nation. We will conduct methodological research to lay a foundation for such systematic surveys.

Potential underreporting of HIV risk behavior is perhaps the most critical aspect of future surveys of SE participants. Preliminary data suggest that SE program staff can collect data without high underreporting, and that audio computer-assisted structured interviewing (CASI) can reduce underreporting. In a 2x2 factorial design with random assignment of subjects to data collection conditions, we will compare potential underreporting of risk behavior in 1. face-to-face interviews conducted by independent researchers; 2. face-to-face interviews conducted by SE program staff; 3. in audio CASI interviews administered by independent researchers; and 4. in audio CASI interviews administered by SE program staff. Data on changes in HIV risk behavior and on current levels of HIV risk behavior will be obtained from 800 subjects from 4 different SE programs.

In addition to the rapid growth in SE programs in the U.S., substantial organizational change is also occurring among individual programs. We will conduct two annual surveys of all identifiable SE programs in the U.S. Cluster analysis will be used to identify basic "types" of SE programs and changes in U.S. SE programs over time. We will produce annual "state-of-the-art" reports of SE programs in the country. These organizational studies will both provide the context for interpreting epidemiologic data collected from SE participants and provide needed information for developing sampling strategies for future national surveys of SE participants.

From our previous experience in SE research and from the experience in this proposal, we will prepare a "state-of-the-art" monograph on collecting epidemiologic data from SE participants. The monograph will also address collecting biological samples from SE participants for potential HIV and hepatitis testing.

PERFORMANCE SITE(S) *(organization, city, state)*

Beth Israel Medical Center
New York, NY 10003

Lower East Side NEP
New York, NY

Research Triangle Institute
Research Triangle Park, NC

Chicago Recovery Alliance
Chicago, IL

Point Defiance AIDS Projects
Tacoma, WA

Minority AIDS Project
Los Angeles, CA

KEY PERSONNEL. See instructions on Page 11. *Use continuation pages as needed* to provide the required information in the format shown below.

Name	Organization	Role on Project
Don C. Des Jarlais	Beth Israel Medical Center	Principal Investigator
Denise Paone	Beth Israel Medical Center	Co- Investigator
Judith Milliken	Beth Israel Medical Center	Project Supervisor
Qiuhu Shi	Beth Israel Medical Center	Biostatistician
Samuel R. Friedman	National Development and Research Institutes (NDRI)	Consultant
Holly Hagan	The Raven Study - Seattle-King County Depart. of Health	Consultant
Peter Lurie	University of California-S.F.	Consultant
Bruce Rapkin	Beth israel Medical Center	Consultant
Heather G. Miller	Research Triangle Institute	Senior Scientist
Charles F. Turner	Research Triangle Institute	Director
Philip C. Cooley	Research Triangle Institute	Manager

Update: Syringe-Exchange Programs — United States, 1996

As of December 1996, approximately one third (36%) of the 573,000 cases of acquired immunodeficiency syndrome (AIDS) among adults reported to CDC were directly or indirectly associated with injecting-drug use (*1*). Syringe-exchange programs (SEPs) are one of the strategies for preventing infection with human immunodeficiency virus (HIV) among injecting-drug users (IDUs). The goal of SEPs is to reduce the transmission of HIV and other bloodborne infections associated with drug injection by providing sterile syringes in exchange for used, potentially contaminated syringes. This report summarizes a survey of U.S. SEPs regarding their activities during 1995 and 1996 and compares the findings with those during 1994 and early 1995 (*2*). The findings indicate continued expansion in the number and activities of SEPs in the United States.*

In November 1996, the Beth Israel Medical Center (BIMC) in New York City, in collaboration with the North American Syringe Exchange Network (NASEN), mailed questionnaires to the directors of 101 SEPs in the United States that were members of NASEN. Although the number of SEPs in the United States is unknown, most are be-

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Syringe-Exchange Programs — Continued

lieved to be members of NASEN. From November 1996 through April 1997, BIMC contacted SEP directors to conduct structured telephone interviews based on the mailed questionnaires. SEP directors were asked about when the SEP began; the number of syringes[†] exchanged during 1995; and, for 1996, legal status, services provided, and the number of syringes exchanged.

Of the 101 SEPs, 87 (86%) participated in this survey. Of these, 51 began operating before 1995; 22, in 1995; and 14, in 1996. These 87 SEPs reported operating in 71 cities in 28 states and one territory[§]; 44 (51%) of the SEPs were located in four states (California [17], Washington [11], New York [10], and Connecticut [six]). In eight cities, at least two SEPs were reported operating. In the 1994–1995 survey, 60 SEPs reported operating in 46 cities and in 21 states (*2*).

Of the 73 SEPs operating in 1995, 70 reported exchanging approximately 11 million syringes. In 1996, of the 87 SEPs that provided information about the number of syringes exchanged, 84 reported exchanging approximately 14 million syringes (median: 36,017 syringes per SEP) (Table 1). The 10 most active SEPs (i.e., those that exchanged ≥500,000 syringes)[¶] exchanged approximately 9.4 million (69%) of all syringes exchanged. The SEP in San Francisco reported exchanging the largest number of syringes (1,461,096) in 1996. During 1996, a total of 50 SEPs (57%) reported exchanging ≤55,000 syringes each; of these, 23 (46%) exchanged <10,000 syringes each.

All 87 SEPs provided IDUs with information about safer injection techniques and/or use of bleach to disinfect injection equipment. Other services included referral of clients to substance-abuse treatment programs (84 [97%]), instruction in the use of condoms and dental dams to prevent sexual transmission of HIV and other sexually transmitted diseases (STDs) (84 [97%]), and STD-prevention education (70 [81%]). Health services offered on-site included HIV counseling and testing (35 [40%]), primary health care (15 [17%]), tuberculosis (TB) skin testing (23 [26%]), and STD screening (17 [20%]).

[†]For this report, the term "syringes" refers to both syringes and needles.
[§]California (17 SEPs); Washington (11); New York (10); Connecticut (six); Illinois and Michigan (three each); Massachusetts, Puerto Rico, Texas, and Wisconsin (two each); and one each in Colorado, Florida, Indiana, Louisiana, Maryland, Minnesota, Missouri, New Hampshire, New Jersey, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, and Tennessee. Twenty-four SEPs asked that their location not be reported.
[¶]New York (two); Bridgeport, Connecticut; Chicago; Los Angeles; Oakland, California; Philadelphia; San Francisco; Seattle; and Tacoma, Washington (one each).

TABLE 1. Number and percentage of syringe-exchange programs (SEPs) and number and percentage of new syringes provided by SEPs, by size of program — United States, 1996

Size of SEP*	SEPs		Total syringes exchanged	
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Total	84	(100)	13,940,672	(100)

*Based on the number of syringes exchanged in 1996.

Syringe-Exchange Programs — Continued

SEPs were defined as legal if they operated in a state that had no law requiring a prescription to purchase a hypodermic syringe (i.e., a prescription law) or had an exemption to the state prescription law allowing the SEP to operate; illegal-but-tolerated if they operated in a state with a prescription law but had received a formal vote of support or approval from a local elected body (e.g., city council); and illegal-underground if the SEP operated in a state with a prescription law but had not received formal support from local elected officials. In 1996, a total of 46 (53%) SEPs were legal, 20 (23%) were illegal but tolerated, and 21 (24%) were illegal-underground. Legal SEPs were more likely than illegal ones to offer on-site HIV counseling and testing (29 [63%] of 46 legal versus eight [20%] of 41 illegal) and TB skin testing (19 [41%] of 46 versus three [7%] of 41). The three SEPs that did not refer clients to substance-abuse treatment were illegal-underground programs.

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Editorial Note: Among IDUs, multiperson use of syringes (i.e., "sharing") is the primary mechanism of transmission of HIV, hepatitis B and C, and other bloodborne infections related to injection of illicit drugs (*3*). Multiperson use occurs when an IDU prepares or injects drugs using a syringe borrowed, rented, and/or lent by another IDU. In addition, equipment and water used to prepare drugs for injection can become contaminated with blood remaining in previously used syringes.

In May 1997, the Public Health Service** released provisional recommendations for persons who continue to inject drugs (*4*). These recommendations include advice that drug users who cannot stop injecting drugs use only sterile syringes to prepare and inject drugs and other steps to prevent bloodborne infection transmission. If IDUs adhere to these recommendations, the number of syringes required would be substantially greater than that currently provided through SEPs and other sources. Because of the costs of large-scale expansion of SEPs, these services alone probably could not meet the demand for sterile syringes (*5*).

The findings in this report indicate an expansion in the number of SEPs and in the scope of activities since 1994 (*2*). During 1994–1996, there were increases in the number of SEPs participating in the surveys (58% [from 55 to 87]) and in the numbers of cities (52% [from 46 to 71]) and states (38% [from 21 to 29]) with SEPs. Although the number of syringes exchanged increased by 75% (from 8 million to 14 million) from 1994 to 1996, most SEPs exchanged relatively small numbers of syringes, and the 23 least active SEPs exchanged a mean of 2815 syringes per program. If less active SEPs are located in communities with large numbers of IDUs, their impact on the overall availability of sterile syringes will probably be limited.

The findings in this report are subject to at least two limitations. First, the extent of SEP activity is probably underestimated because of incomplete participation in this survey of U.S. SEPs and the possible existence of SEPs that are not members of NASEN. Second, because the definition of legal status did not include the local status of drug paraphernalia laws, legal barriers to SEPs may be underestimated (*6*).

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Syringe-Exchange Programs — Continued

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References

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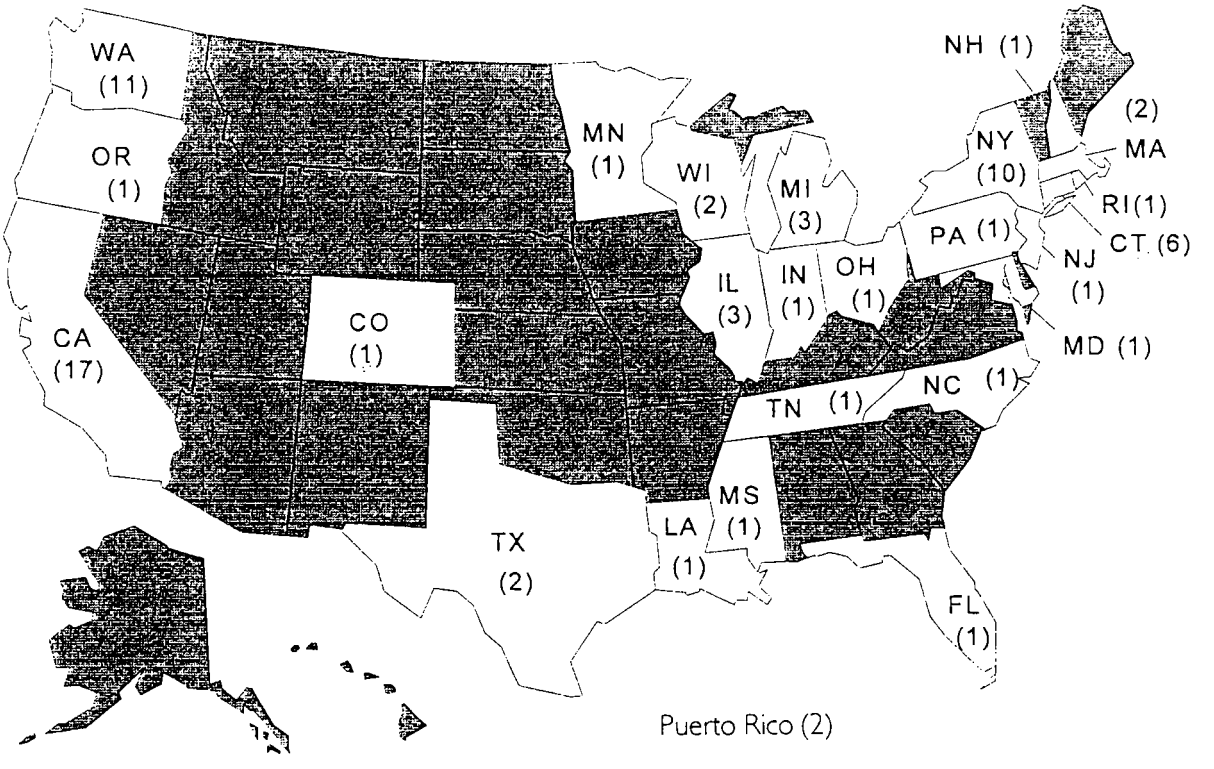
SEPs Participating in Beth Israel Survey in 1996



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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

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Pages 392–398

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

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

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

IDU-Associated AIDS Cases Reported in 1995

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

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

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

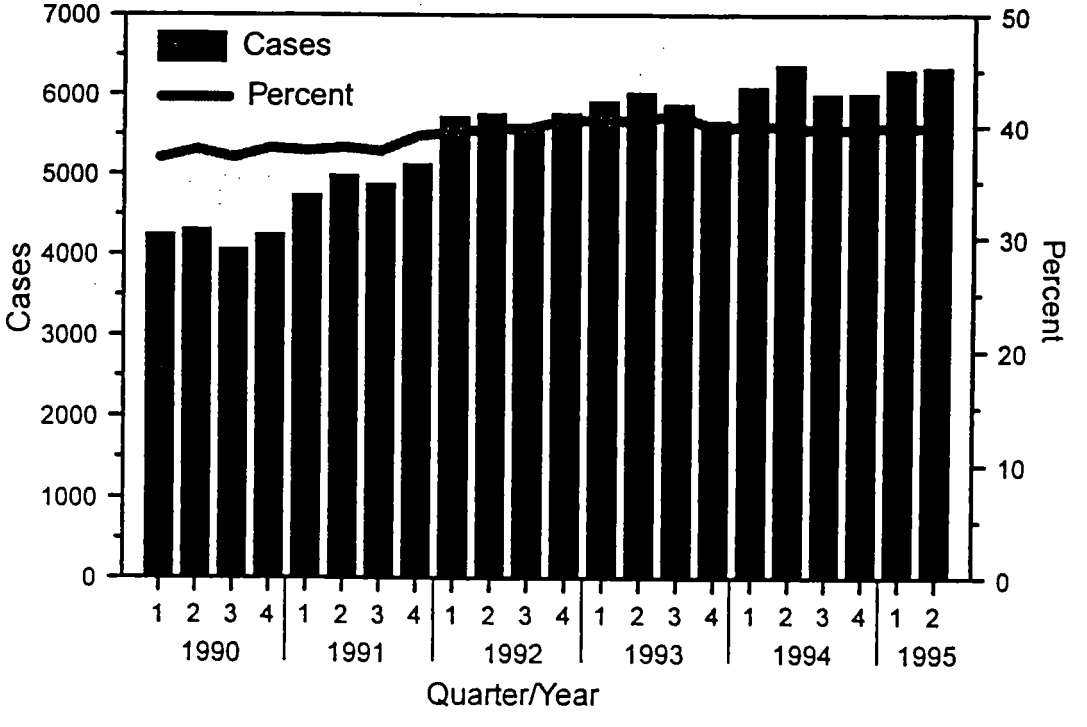
When analyzed by sex and sexual orientation, 66% (7125 of 10,777) of AIDS cases reported among women and 85% (14,985 of 17,686) among heterosexual men with an identified exposure category were IDU-associated. In comparison, 10% (3425 of 34,096) of AIDS cases among MSM had a history of injecting-drug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

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

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

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

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



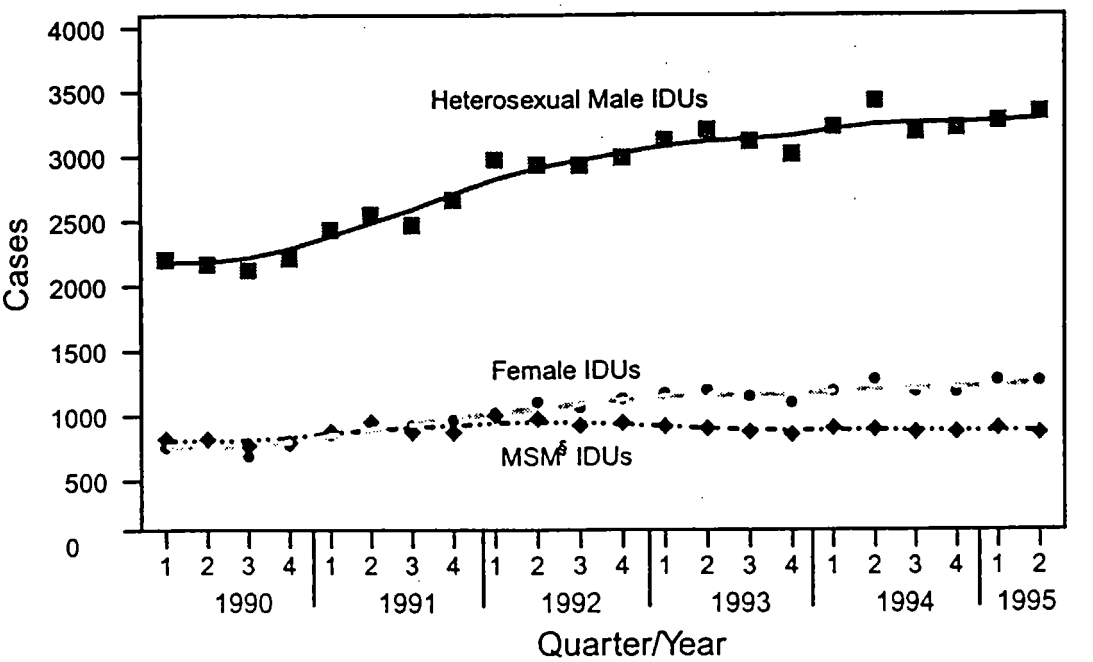
*Estimates are adjusted for delays in reporting and reclassification of cases initially reported without risk (*1*).

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

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

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

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



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†Points represent quarterly incidence; line represents "smoothed" incidence (*2*).
§Men who have sex with men.

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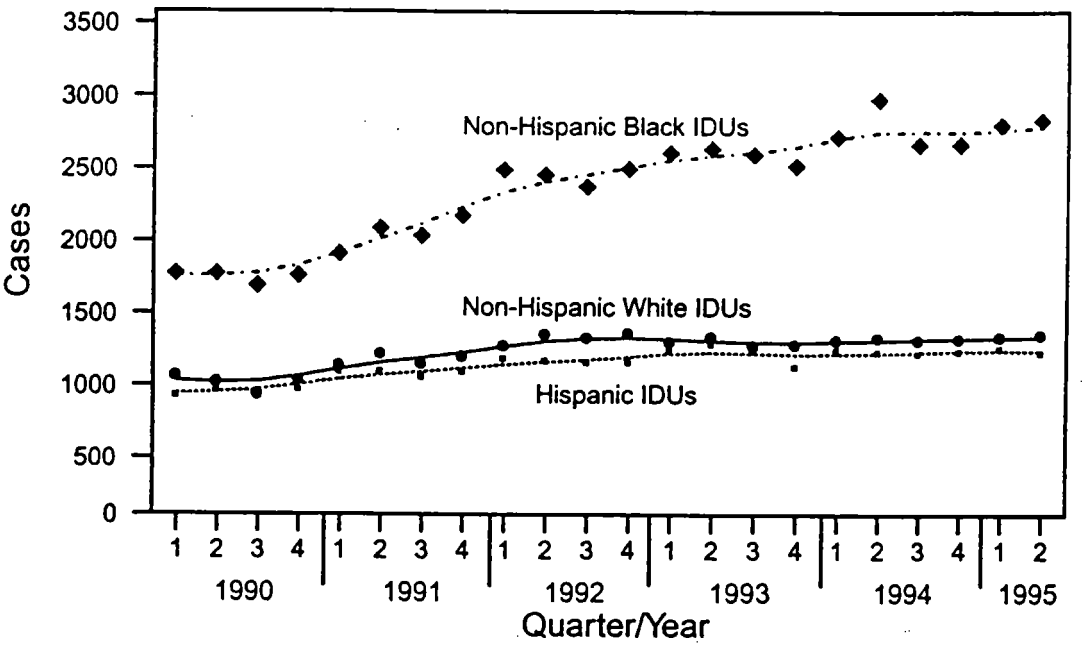

*Estimates are adjusted for delays in reporting and reclassification of cases initially reported without risk (*1*).
†Numbers for other racial/ethnic groups were too small for meaningful analysis.
§Points represent quarterly incidence; line represents "smoothed" incidence (*2*).

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

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

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

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

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

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

*Per 100,000 population.

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

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

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

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

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

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

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

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May 9, 1997

HIV PREVENTION BULLETIN: MEDICAL ADVICE FOR PERSONS WHO INJECT ILLICIT DRUGS

Dear Colleague:

Preventing drug use and providing substance abuse treatment for persons who inject illicit drugs are crucial to preventing many blood-borne infections, including human immunodeficiency virus (HIV). However, many drug users are not currently in substance abuse treatment programs because of multiple factors including the limited availability of these programs and the lack of readiness or willingness of some drug users to enter substance abuse treatment. Consequently, substantial numbers of drug users continue to inject drugs.

This bulletin summarizes new information on preventing transmission of HIV and other blood-borne infections among persons who inject drugs and updates prevention recommendations published in April 1993.* [1] The findings of a 1995 workshop on the use of sterile syringes by persons who inject drugs and several recent publications [2,3,4,5,6] indicate that persons who inject drugs should use sterile syringes** to prevent the transmission of HIV and other blood-borne infectious diseases. These conclusions should be considered by clinicians providing health care to persons who use or inject drugs and by public health professionals planning and carrying out HIV prevention programs for injection drug users (IDUs). Health professionals should inform IDUs that using sterile syringes is safer than reusing syringes, including syringes that have been disinfected with bleach. The information in this bulletin has been prepared for health professionals involved in programs serving persons who inject drugs. Separate educational materials will be prepared to inform drug injectors of these findings.

* Issued jointly by the Centers for Disease Control and Prevention, the National Institute on Drug Abuse of the National Institutes of Health, and the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration.

** The term "syringes" is used throughout this bulletin to refer to both syringes and needles.