



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

DEC 16 1998

MEMORANDUM FOR THE PRESIDENT

I am writing this memorandum to give you notice that our latest Temporary Assistance for Needy Families (TANF) data indicates that States have a substantial amount of unspent TANF funds and to provide you with some initial information about some of the reasons for State delays in spending. While the early expenditure numbers do not have great significance given the early stage of TANF implementation and the unusually strong economy, it is important for us to carefully monitor these expenditures in the months ahead.

We intend to work with the Governors and State agencies to learn more about the reasons for low TANF expenditure levels, encourage further investments in working and hard-to-serve families, and develop guidance that will reduce State uncertainty about how they may use TANF and State maintenance-of-effort funds. Publication of the final TANF regulations (now pending at OMB) should also help States to move forward. In the meantime, it is important that we convey a consistent message about the importance of maintaining investments in low-income working families, the value of investments in "rainy day" funds, and the early nature of these figures.

Third-Quarter FY 1998 Data on State Expenditures.

The financial reports States submitted on their TANF program expenditures through the third quarter of FY 1998 show that States have not obligated about \$3 billion of the Federal funds available to them. This amounts to 24 percent of the block grant funds awarded to the States for the first three quarters of FY 1998. (If we include the amounts States carried over from FY 1997, we find that 26 percent of the total Federal funds available for expenditure through June of 1998 was unobligated.)

It is important to note that these figures reflect third-quarter data, meaning that we do not yet know what each State's spending was for the whole of FY 1998. Unfortunately, we do not have enough experience with this new program to make informed predictions of these amounts. For example, one factor that could affect the final State figures for 1998 would be variations in expenditure levels across quarters. Another could be a lag in reporting expenditures. In other words, because this was the first full year of TANF operation, we do not know how well the figures from the first three quarters represent the States' annual expenditure patterns.

Reasons for Delays in State Spending

Despite these limitations on the data, we have sought to improve our information about why some States have large reserves of unobligated funds by looking more carefully at the 12 States that have obligated the smallest portions of their available funds. These States, which represent 80% of the \$3 billion total, are: California, Florida, Kansas, Louisiana, Minnesota, New Jersey, New York, Oklahoma, Pennsylvania, Washington, West Virginia, and Wisconsin. As discussed below, the major reasons identified during further discussions include delayed adjustments to caseload reductions, the early nature of these reports, and State decisions to reserve funds.

1. To a significant extent, the spending shortfalls are attributable to the dramatic caseload reductions States have achieved. The unanticipated scale of these reductions (that is, many States did not expect or

Prepared by ACF/Oingley

12/17/1998/0042

budget for as great a decrease as they actually experienced), and the consequent time lag in adjusting to those reductions.

- California, Wisconsin, Florida, Oklahoma, and Minnesota all identified the scale of the caseload reduction as a reason for unexpended funds.
- Staff in one State reported that, in anticipation of caseload increases that it expected when it liberalized eligibility rules under TANF (to provide more benefits to working families), it had cut back on other services. Now that the State has in fact experienced dramatic reductions in caseload, it will increase expenditures on these services.

2. Second, in many States, the expenditure shortfalls reflect the fact that it is still early in TANF implementation. Decisions made during the last session of State legislatures may not yet be in effect. And where the first year of TANF experience has led to new ideas for investment, these new ideas may not be able to be implemented until the State legislature reviews them in the upcoming legislative session. For example:

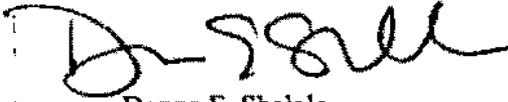
- California's Legislative Analysis Office expects an upturn in expenditures on work activities over the coming months as more individuals are enrolled in intensive activities. Expenditures are lagging because CalWORKS (which implements more stringent work requirements) just went into effect on January 1, 1998; counties did not begin enrolling large numbers of people until mid-year, and the most expensive services (such as case management, substance abuse services or other intensive services) do not kick in until several months into the program -- after individuals have gone through job search. California also will have grant increases taking effect in November 1998 and again in State fiscal year 1999/2000.
- Pennsylvania has budgeted for increases in child care spending (to be funded in part by a transfer from TANF) that were delayed until new child care regulations were finalized this month.
- West Virginia plans new spending for increased grant levels, increased school clothing allowance, and an increased transportation allowance; the State TANF agency also expects to seek State legislative approval for resources for Individual Development Accounts.

3. In some States, balances of unexpended funds also reflect State caution about moving forward in light of economic uncertainties and a focus on meeting the State spending (MOE) requirements before committing additional Federal dollars.

- A number of States mentioned their desire to be cautious about additional spending in case of future need. Florida's legislature passed legislation requiring the TANF agency to reserve \$250 million of its FY 1998 funds as a "rainy day reserve." To put this in perspective, its FY 1998 grant was \$576 million. Minnesota and New York also reported their intention to maintain rainy day funds.
- Some States appear to be reluctant to commit dollars for new expenditures without being sure that such a commitment can be sustained for several years into the future. Pennsylvania is holding enough TANF dollars unspent to be able to cover the costs of several years of transportation subsidies, in order to be sure that it can sustain this commitment to transportation.

- Some States are holding back on Federal spending in order to ensure that they meet the State spending (Maintenance of Effort or MOE) requirements in the statute. (Under the statute, States have limited flexibility to adjust their State contributions to the TANF program. Under the TANF MOE requirements, each fiscal year, they must contribute 75 or 80 percent of their historical contributions. However, they do not have to spend any specific share of their Federal TANF funds; they may reserve their Federal funds for future year spending without limitation. As a result, if program spending drops significantly, we expect to see this decline show up disproportionately in the Federal spending numbers.)
- 4. States appear to vary considerably in whether they have steps underway to invest the unexpended FY 1998 dollars. Some States do have detailed plans, including new and expanded investments in training and services, innovative strategies at State and local levels, grant increases, and transfers of TANF funds to the Social Services Block Grant or the Child Care and Development Block Grant. However, other States appear to be currently without a plan, not focused on the issue, or in the early stages of discussion.

Please let me know if there is any further information that would be useful to you.



Donna E. Shalala

Attachments

Tab A - TANF Expenditure Data

Tab B - Information on 12 States

Temporary Assistance to Needy Families (TANF) Program
 FEDERAL AWARD, TRANSFERS AND EXPENDITURES THROUGH 3RD QTR. FY 1994

Agency	1	2	3	4	5	6	7	8	9	10	11	12	13
	TRANSFERRED	TRANSFERRED	TRANSFERRED	AVAILABLE FOR	CASH AND WORK	WORK	CARD	ADMINISTRATIVE	TRANSITIONAL	EXPENDITURES	EXPENDITURES	EXPENDITURES	BALANCE
	30,000,000	30,000,000	30,000,000	30,000,000	30,000,000	30,000,000	30,000,000	30,000,000	30,000,000	30,000,000	30,000,000	30,000,000	30,000,000
Alabama	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Alaska	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000
Arizona	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000
Arkansas	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
California	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000
Colorado	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000
Connecticut	800,000	800,000	800,000	800,000	800,000	800,000	800,000	800,000	800,000	800,000	800,000	800,000	800,000
Delaware	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000
District of Columbia	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000
Florida	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000
Georgia	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000
Hawaii	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Idaho	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000
Illinois	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000
Indiana	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000
Iowa	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000
Kansas	900,000	900,000	900,000	900,000	900,000	900,000	900,000	900,000	900,000	900,000	900,000	900,000	900,000
Kentucky	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000
Louisiana	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000
Maine	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000
Maryland	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000
Massachusetts	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000
Michigan	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000
Minnesota	1,700,000	1,700,000	1,700,000	1,700,000	1,700,000	1,700,000	1,700,000	1,700,000	1,700,000	1,700,000	1,700,000	1,700,000	1,700,000
Mississippi	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Missouri	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
Montana	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000
Nebraska	800,000	800,000	800,000	800,000	800,000	800,000	800,000	800,000	800,000	800,000	800,000	800,000	800,000
Nevada	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000
New Hampshire	600,000	600,000	600,000	600,000	600,000	600,000	600,000	600,000	600,000	600,000	600,000	600,000	600,000
New Jersey	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000
New Mexico	700,000	700,000	700,000	700,000	700,000	700,000	700,000	700,000	700,000	700,000	700,000	700,000	700,000
New York	6,000,000	6,000,000	6,000,000	6,000,000	6,000,000	6,000,000	6,000,000	6,000,000	6,000,000	6,000,000	6,000,000	6,000,000	6,000,000
North Carolina	2,800,000	2,800,000	2,800,000	2,800,000	2,800,000	2,800,000	2,800,000	2,800,000	2,800,000	2,800,000	2,800,000	2,800,000	2,800,000
North Dakota	200,000	200,000	200,000	200,000	200,000	200,000	200,000	200,000	200,000	200,000	200,000	200,000	200,000
Ohio	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000
Oklahoma	600,000	600,000	600,000	600,000	600,000	600,000	600,000	600,000	600,000	600,000	600,000	600,000	600,000
Oregon	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000
Pennsylvania	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000
Rhode Island	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000
South Carolina	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000
South Dakota	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000
Tennessee	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000
Texas	4,500,000	4,500,000	4,500,000	4,500,000	4,500,000	4,500,000	4,500,000	4,500,000	4,500,000	4,500,000	4,500,000	4,500,000	4,500,000
Utah	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000
Vermont	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000
Virginia	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000
Washington	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000
West Virginia	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000
Wisconsin	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000
Wyoming	200,000	200,000	200,000	200,000	200,000	200,000	200,000	200,000	200,000	200,000	200,000	200,000	200,000

1. Percentages reported in other columns are the grant awards the States received through the third quarter of FY 94.
 2. Transfer percentages are based on the total amount awarded in Column 1. Expenditure percentages are based on the Total Expenditures reported in Column 11. Unfunded and Unobligated balances percentages are based on the Amount Available for TANF reported in Column 4.

DETAILED INFORMATION ON SPENDING SITUATION IN TWELVE STATES

California has experienced a 28 percent decline in caseload between January 1995 and August 1998 (going from 925,971 AFDC cases to only 669,237 TANF cases). State staff believes that the current surplus of TANF funds is an anomaly that will not continue. They expect program design changes will increase expenditures. Major changes did not occur until the State implemented the California Work Opportunity and Responsibility to Kids (CALWORKs) program on January 1, 1998. CalWORKs has more stringent work and other requirements than the State's original TANF program. Many counties did not begin enrolling large numbers until mid-year. The initial work activity for most individuals is attendance at job readiness/job search workshops, a relatively low cost CalWORKs component. Those who are not able to find employment immediately often face major barriers (e.g., substance abuse problems) and require more intensive case management and special services. The California Legislative Analysts Office (LAO) has reported that costs are expected to increase once all non-exempt individuals are enrolled in CalWORKs welfare-to-work activities. Also, grant increases became effective in November 1998 and a 2.2 percent cost-of-living increase in assistance will take effect in State fiscal year 1999/2000. Some additional areas in which TANF expenditures are expected to increase are: (1) effective January 1, 1998, California began using TANF funds to provide out-of-home care and other services for children under the jurisdiction of County Juvenile Probation Departments based on the provisions of the Title IV-A Plan in effect on September 30, 1995; (2) California provides TANF assistance to child welfare children who are placed with relatives, and the State is now looking to TANF to help fund kinship care payments for children who are placed with relatives; (3) the State transferred \$100 million in FY 1997 TANF funds to the Child Care and Development Fund and an additional \$183 million to the Title XX program in the fourth quarter of FY 1998; and (4) California is also transferring State MOE funds to the Southern California Tribal Chairmen's Association (SCTCA) TANF program that was implemented on March 1, 1998. However, even with these various planned activities that are likely to increase expenditures, it is still possible that California will have a pool of unspent funds. This is not viewed negatively by counties that are concerned about how potential economic downturns (e.g., fallout from the Asian economic crisis) could make it more difficult to recipients to find employment and result in TANF caseload increases. A question has also been raised about how California spends Federal and State funds. The State currently spends its Federal TANF funds first. In FY 1998, for example, the State reported very little MOE expenditures for the first three quarters of the fiscal year, but meets the 80 percent requirement when the entire fiscal years expenditures are reviewed. We have advised State staff verbally that its current practice of spending Federal dollars first is contrary to the Cash Management Improvement Act (CMIA) requirements. HHS is currently clarifying questions on CMIA with the Treasury Department and will issue written clarification to the Regions.

Florida has been using FY 1997 funds for much of its FY 98 program operations; through the third quarter of FY 98 it expended approximately \$80 million of its FY 1997 TANF grant. It will likely expend an additional \$35 million of FY 1997 funds during the last quarter of FY 98 in order to exhaust its left-over FY 1997 funds. Florida attributes its low TANF expenditure rate primarily to its declining caseload. However, since June 1998, Florida's rate of decline in caseload has become flat, and an upturn is possible. As a safeguard against unanticipated significant increases in caseload, the State Legislature passed legislation requiring the TANF agency to reserve \$250 million of its FY 1998 funds as a "rainy day reserve." Florida's use of FY 1998 Federal TANF funds is expected to increase during the fourth quarter because: all FY 1997 funds will have been either expended or obligated; it will likely transfer about \$56 million in expenditures previously reported against the FY 1997 grant to the FY 1998 grant; it is likely to report additional FY 1998 obligations of about \$51 million in previously unreported expenditures; and it will probably report an increase in transfers of about \$46 million by the first quarter of FY 99, raising its transfer level to approximately 15% of the total TANF allocation. These actions will reduce the State "surplus" to \$192 million, which is \$58 million below the States legislative mandate for a \$250 million reserve as a rainy day fund.

Kansas's caseload declined 31 percent between FY 1994 and FY 1997, which is the major reason for carryover. It has transferred funds, but could not transfer enough to prevent carryover.

Louisiana's caseload has declined by about 25 percent, from 60,226 in January 1997 (its TANF implementation date) to 45,871 in October 1998. Its 24-month time limit has not begun to affect a significant number of clients. (It will in January 1999.)

Minnesota reduced services to compensate for the liberalized eligibility rules that it implemented to provide more support for working families. However, it experienced higher reductions in its caseload and expenditures than expected. It will now increase services. Other factors affecting its expenditures are its decisions to maintain a "rainy day" reserve and spend MOE funds before spending Federal dollars. The State intends to increase its Federal expenditures in light of the amount available. It has closed out its FY 1997 grant and is working now on FY 1998 money.

New Jersey estimates that its unobligated balance of FY 1998 TANF funds will be \$124,258,000, or 31% of the funds available for TANF. It transferred over \$16 million to CCDF and over \$40 million to SSBG. State officials expect that it will expend the unliquidated balance in upcoming years. NJ also has questions about allowable claims under TANF, particularly concerning transportation and child care. It feels that the lack of final rules is an obstacle to States as they attempting to use TANF funds for innovative projects.

New York increased transfers of TANF funds to the SSBG and the CCDF in FY 1998. However, in FY 1998, expenditures on cash and work-based assistance were down 13 percent, and expenditures on work activities were down 23 percent. A small portion of New York's unobligated balance represents State Agency TANF administrative costs that have not

yet been reported for the third and fourth quarters of FY 1998. Another factor is the continued decrease in caseloads. With the funds, NY intends to build up a "rainy day reserve." It also intends to use the funds to implement a number of new initiatives in employment activities and in other areas.

Oklahoma has reduced its caseload 38 percent between October 1996 (its TANF implementation date) and October 1998 (from 34,901 cases to 21,644 cases). Expenditures on TANF payments were running \$10 million per month in 1996 and are now down to \$4.99 million as of October 1998.

Pennsylvania expects to increase its expenditure of TANF funds. Recently, it passed new child care regulations, which will permit the State to provide subsidized child care for TANF recipients under CCDF with funds transferred from TANF. The Commonwealth also created a job program for TANF recipients, called WorkNet, which will develop jobs and jobs training for recipients and will soon be operational. Also, PA has budgeted funds for transportation increases, but the Governor has not been willing to release the funds unless it is able to show a decline in the welfare caseload.

Washington's caseload continued to decline in FY 1998. This program has its roots in work search and unsubsidized employment, which are less costly to provide than education and training, subsidized employment, OJT, etc. At the same time, participation in Workfirst did not become mandatory for all welfare recipients until November 1998. Also, the decentralization of the Workfirst Program has resulted in some delays in spending at the local level. Another factor is the increasing amount of funding from sources other than TANF (such as DOL, DOT, HUD) to help with the transition from welfare to work.

West Virginia anticipates new spending. It is planning to transfer \$10 million to CCDF. It is also planning to increase its TANF grants by: increasing the basic payment by \$100, which will also automatically increase its 10 percent marriage incentive; increasing its annual school clothing allowance; and raising its transportation allowance from \$3.00 to \$8.00 a day. The TANF agency is also planning to ask its legislature to approve funds for individual development accounts.

Wisconsin has also experienced a declining caseload. The number of cash assistance cases has been declining gradually since March of 1998. The total caseload on cash assistance was 11,453 in April and was down to 10,580 families as of September. Also, the State is still spending FY 1997 TANF funds.



Grady
MEMORANDUM FOR THURGOOD MARSHALL, JR.

DATE: December 16, 1998

Forwarded herewith is a Memorandum for the President regarding the latest Temporary Assistance for Needy Families (TANF) data.

Mary Beth
Mary Beth Donahue

Attachment

- c: Bruce Reed
Asst to the President, DPC
- Jack Lew
Dir, OMB
- Cynthia Rice
Special Asst to the President, DPC
- Barbara Chow
Assoc to Dir, Human Resources, OMB

ADMINISTRATION FOR CHILDREN AND FAMILIES
Office of the Assistant Secretary, Suite 600
370 L'Enfant Promenade, S.W.
Washington, D.C. 20447

December 3, 1998

TO: The Secretary
Through: DS
 COS
 ES

FROM: Assistant Secretary
 for Children and Families

SUBJECT: Memorandum on Temporary Assistance for Needy
 Families Expenditures for the White House

Attached as requested is a memorandum to alert the White House about the amount of unobligated funds under the Temporary Assistance for Needy Families program.

We have also attached a table of the State expenditure information and a brief paper providing additional information on the situation in the 12 States that account for 80 percent of the unobligated funds. We would expect to share this supplemental information with the Office of Management and Budget and Domestic Policy Council staff upon transmittal of the memorandum.

Olivia A. Golden
Olivia A. Golden

- Attachments
Tab A - Memorandum for the President
Tab B - TANF Expenditure Data
Tab C - Information on 12 States

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

NOV 9 1993

MEMORANDUM FOR THE PRESIDENT

The Surgeon General's trip to East Africa to consider further ways to respond to the Embassy bombings in Kenya and Tanzania was most successful. As you will see in the attached report, Dr. Satcher was particularly concerned about both countries' capacity to respond to such emergencies in the future.

We have put together a package of assistance to assist the bombing victims, and will focus now on the possible establishment of a regional center for disaster management and injury control. This center could be a living memorial to those who perished in this tragic event.

I was very pleased with the excellent support that Dr. Satcher and his team received from the Department of State and USAID, especially in the field. We hope to continue this partnership as work goes forward and additional resources become available.



Donna E. Shalala

Enclosure

Proposed by [unclear] / Bart

11/10/93 [unclear]



OCT 22 1998

MEMORANDUM FOR THE PRESIDENT

You and the Secretary of Health and Human Services, Donna E. Shalala, requested that I visit Nairobi, Kenya and Dar es Salaam, Tanzania in response to the tragedy of the August 7, 1998 bombings of the U.S. Embassies in Kenya and Tanzania. The Department of Health and Human Services (DHHS) is working with our partners in the two countries and in the U.S. -- in the private and public sectors -- to address both immediate human needs and longer-term issues related to emergency preparedness and disaster response. The challenge is for United States Government (USG) to support the most urgent needs and to link emergency preparedness and disaster response to sustainable longer-term efforts. The tragedy which our nation shared with Kenya and Tanzania has serious physical and mental health consequences which an expert team, headed by myself, was able to witness and evaluate.

On August 7, 1998, the U.S. Embassies in Kenya and Tanzania were destroyed by high impact bombs. In Nairobi, 247 persons were confirmed dead, including 12 U.S. citizens and 32 foreign service nationals employed at the Embassy. More than 5,000 persons were injured. Thirteen U.S. citizens and 12 Kenyans were evacuated by air to third countries for hospital-based treatment. In Tanzania there were 11 persons killed and 85 injured (one American medivaced). The Office of Foreign Disaster Assistance (OFDA/USAID) has spent approximately \$3.2 million on various response measures such as search and rescue teams, donation of heavy equipment, air evacuation of survivors, and medical treatment. Additional immediate assistance came from other governments and private organizations.

In response to the request from you and the Secretary, I visited the two countries with an expert team (Tab A) to further the support from the USG. During our visit from September 28 to October 1, 1998, we viewed the bombing sites, toured facilities which responded to the disaster, met with the U.S. Ambassadors and Embassy staff and USAID Missions, and consulted with the leadership in the countries (Tabs B and C).

Many of the injured did not survive because of inadequate emergency response systems. Victims were dragged from the site and taken to hospitals in available vehicles by policemen, taxi drivers, and passerbys untrained in basic first aid. For example, simple measures to stop the loss of blood were not applied. At the hospitals, the lack of preparedness included the absence

of adequate plans for dealing with a large disaster with multiple casualties arriving at one time, inadequate equipment at the largest facilities, and lack of supplies. Blood banking and blood safety in both countries are very weak. Future USG facility construction must address prevention issues. In Tanzania, injuries sustained by flying glass were mitigated by use of shatter-proof glass at the Embassy. Flying glass in adjacent buildings in Nairobi, however, caused a great deal of injury. There is little if any system or plan for disasters. Finally, surveillance capacity is seriously lacking in both countries. Neither country has a capacity to set priorities because of the lack of basic health data.

The needs of the surviving victims, their families, and the community were also assessed. Plastic and reconstructive surgeons are needed to address scar revision and rehabilitation. Appropriate mental health response was also insufficient in the two countries. There were very few trained mental health professionals to deal with the psychological consequences of the bombing.

Our consultations suggest the need for two to three years of focused activities with the following outcomes:

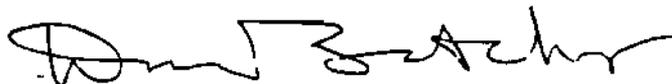
- (1) that most of the victims will have achieved rehabilitation and reintegration into the workforce;
- (2) that emergency preparedness and disaster response management capabilities will have been created and strengthened;
- (3) that blood banking services and blood safety will have been improved;
- (4) that the needs for training in public health surveillance and field epidemiology will have been assessed and some of those needs met.

DHHS agencies have developed a support package to respond to these needs. Agencies and Offices (Agency for Health Care Policy and Research, Centers for Disease Control and Prevention, Health Resources and Services Administration, Food and Drug Administration, Substance Abuse and Mental Health Services Administration, and Office of International and Refugee Health) have pledged technical expertise in the targeted areas. This response totals approximately \$1 million in cash and in-kind support for FY99. The needs which have been identified as a result of the bombings, however, cannot be adequately addressed by the resources which we have identified to date.

To enhance the DHHS response, we are working with our partners in the public and private sector (e.g., DOS, USAID, university hospitals, and U.S. and African NGOs). We are also working with USAID and DOS regarding the Supplemental Appropriation Request, submitted to Congress by DOS, to develop a partnership to coordinate the public and private sector responses.

RECOMMENDATIONS:

1. Support continued collaboration of DHHS with the Ministries of Health of Kenya and Tanzania.
2. Support the DHHS partnership with DOS and USAID, which will enhance the DHHS response.
3. Support the role of DHHS in global health matters including emergency medical response.



David Satcher, M.D., Ph.D.
Assistant Secretary for Health and
Surgeon General

Attachments

- Tab A - Expert Team and Staff
- Tab B - Institutions Visited
- Tab C - Persons met

Official Delegation

David Satcher, M.D., Ph.D.
Chief of Delegation
Assistant Secretary for Health and Surgeon General
U.S. Public Health Service
Washington, DC

Nils Daulaire, M.D.
President, Global Health Council
Washington, DC

Adel Mahmoud, M.D.
Department of Medicine
Case Western Reserve University School of Medicine
Cleveland, OH

Etienne Massac, M.D.
The Plastic Surgery Center
Howard University School of Medicine
Washington, DC

Betty Pfefferbaum, M.D., J.D.
Department of Psychiatry and Behavioral Sciences
University of Oklahoma College of Medicine
Oklahoma City, Oklahoma

Technical Support Staff

Stephen Blount, M.D., DHHS/CDC
RADM Roscoe M. Moore, Jr., D.V.M., Ph.D., DHHS/OS/OIRH
Ross Cox, DHHS/CDC
Kaye Hayes-Waller, DHHS/OSG
CAPT Nancy A. Hazleton, DHHS/OS/OIRH

TAB B

INSTITUTIONS VISITED

KENYA

Aga Khan Hospital

Kenyatta Memorial Hospital

American Embassy bomb site

TANZANIA

Aga Khan Hospital

Muhimbili Medical Center

American Embassy bomb site

SECRET

CONFIDENTIAL

SECRET

TAB C

PERSONS MET

KENYA

Ambassador Prudence Bushnell

Deputy Chief of Mission Michael W. Marine

USAID Mission Director Jonathan Conly

Greg Gottlieb, USAID Health and Population Office

Millicent Howard, USAID Health and Population Office

Paul Peterson, Regional Security Officer

Mr. Jackson Kalweo, Minister of Health

Mr. Sammy Mbovu, Permanent Secretary of Health

Dr. Julius Meme, Director of Medical Services

Dr. Khama Rogo, Chairman, Kenya Medical Association

Dr. Alice Mutungi, Vice-president, Kenya Women's Medical Association

Dr. Frank Njenga, Chairman, Operation Recovery

Dr. Augustine Muita, Director, Kenyatta National Hospital

Dr. David Silverstein, Nairobi Hospital and personal physician to the President of Kenya

Mr. Noorali Momin, Director, Aga Khan Hospital

Representatives from the following locally based NGOs:

Adventist Development & Relief Agency (ADRA)

Kenya Red Cross

Catholic Relief Services

National Christian Council of Kenya

Kenya Society for the Blind

Oasis Counseling Services

International Federation of Red Cross & Red Crescent Societies

International Medical Corps

AMREF (African Medical Relief Foundation)

TANZANIA

Ambassador Charles Stith

Deputy Chief of Mission John Lange

John DiCarlo, Regional Security Officer

Monica Stein-Olson, Acting Director, USAID

Dr. Diana Putman, USAID Health and Population team leader

Robert Cunnane, USAID Health and Population Office

Michael Mushi, USAID Health and Population Office

Dr. Soter Da Silva, contract Embassy physician

Dr. Javier Suarez, Regional Medical Officer for Psychiatry

Mrs. M.J. Mwaffisi, Permanent Secretary, Ministry of Health

Dr. Yusuf Hamed, Director of Hospital Services, Ministry of Health

Mr. Kwayu, Deputy Permanent Secretary, Office of the Prime Minister

Mr. Simon Muro, Disaster Management Unit, Office of the Prime Minister

Mrs. Maria Bilia, Disaster Management Unit, Office of the Prime Minister
Professor Sanwel Maselle, Director General, Muhimbili Medical Center
Ms. Lisa Walker, Acting Medical Director, Aga Khan Hospital
Dr. Nazir Thawer, Administrative Director, Aga Khan Hospital
Dr. Iqbal, Director of Surgery, Aga Khan Hospital
Dr. U. Grob, Muhimbili Orthopedic Institute
Dr. Darius Bukonya, AMREF Country director
Mr. A.O. Kimbisa, Secretary General, Tanzanian Red Cross
Mr. Santiago Bernal, Plan International
Dr. Kilonzo, Chief, Pyschiatric Unit, Muhimbili Medical Center



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary
Office of Public Health and Science

OCT 22 1998

Assistant Secretary for Health
Surgeon General
Washington, D.C. 20201

TO: The Secretary
Through: DS KTW
COS JED/10/29
ES 1-2

FROM: Assistant Secretary for Health and Surgeon General

SUBJECT: Memorandum for the President on the DHHS Response to the Embassy Bombings in Kenya and Tanzania -- ACTION

ISSUE:

This memorandum reports on the Surgeon General's trip to East Africa (September 28 to October 1, 1998) to respond to the Embassy Bombings in Kenya and Tanzania.

DISCUSSION:

You and the President requested that I visit Nairobi, Kenya and Dar es Salaam, Tanzania in response to the tragedy of the August 7, 1998 bombings of the U.S. Embassies in Kenya and Tanzania. The tragedy which our nation shared with Kenya and Tanzania has serious physical and mental health consequences which an expert team, headed by myself, was able to witness and evaluate.

BACKGROUND:

On August 7, 1998, the U.S. Embassies in Kenya and Tanzania were destroyed by high impact bombs. In Nairobi, 247 persons were confirmed dead. More than 5,000 persons were injured. In Tanzania there were 11 persons killed and 85 injured. Many of the injured did not survive because of inadequate emergency response systems. Surveillance capacity is seriously lacking in both countries, and neither country has a capacity to set priorities because of the lack of basic health data. The needs of the surviving victims, their families, and the community were assessed. Our consultations suggest the need for two to three years of focused activities. To enhance the DHHS response, we are working with our partners in the public and private sector, USAID and DOS regarding the Supplemental Appropriation Request, submitted to Congress by DOS, to develop a partnership to coordinate the public and private sector responses.

RECOMMENDATIONS:

That you sign the Memorandum for the President.

DECISION:

Approved _____ Disapproved _____ Date: NOV 9 1998

David Satcher, M.D., Ph.D.

Attachments: 2 Memorandums for the President

4/c



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

OCT 20 1998

MEMORANDUM FOR THE PRESIDENT

Marking National Breast Cancer Awareness Month, I am pleased to present to you *Breast Cancer: A Report on the Fight to Prevent, Cure, and Treat the Disease*

In these last five years, we have seen great strides toward the eradication of breast cancer. In 1993, at your request, I convened the Conference to Establish the National Action Plan on Breast Cancer (NAPBC). The NAPBC, a public-private partnership, serves as a catalyst for national efforts in six priorities areas identified through the conference, including biological resources, breast cancer etiology, hereditary susceptibility, clinical trials, information dissemination and consumer involvement. I also convened the Federal Coordinating Committee on Breast Cancer in 1994. The FCCBC, a liaison group to the NAPBC, fosters collaboration and cooperation in cross-cutting initiatives and reduces unnecessary duplication of effort in breast cancer programs.

As you read this report, I hope you will be pleased at the breadth of breast cancer activities across the Administration. While we have achieved much, we must recognize the work that lies ahead. Thank you for your continued leadership and commitment to this public health priority.

Donna E. Shalala

Attachment

Prepared by PHS/Fishback

10/27/1998/0006

IM 1998 0719 ~~3~~

Breast Cancer:
A Report on the Fight to
Prevent, Treat, and Cure the Disease



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary
Office of Public Health and Science

Assistant Secretary for Health
Surgeon General
Washington, D.C. 20201

DATE: October 20, 1998

TO: The Secretary
Through: DS _____
COS _____
ES _____

FROM: Assistant Secretary for Health and Surgeon General

SUBJECT: Transmittal Memorandum to the President from the Secretary for Health and Human Services: *Breast Cancer: A Report on the Fight to Prevent, Cure, and Treat the Disease* -- ACTION

ISSUE

Your review and signature is needed on a transmittal memorandum.

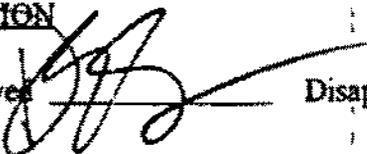
DISCUSSION

At the October 21 White House event recognizing breast cancer awareness month, you will present *Breast Cancer: A Report on the Fight to Prevent, Cure, and Treat the Disease*. A transmittal memorandum to accompany this report has been prepared for your review and signature.

RECOMMENDATION

I recommend that you approve this memorandum and provide your signature.

DECISION

Approved  Disapproved _____ Date OCT 20 1998

David Satcher, M.D., Ph.D.

Tab A - Transmittal Memorandum To the President



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

OCT 20 1998

MEMORANDUM TO THE PRESIDENT

This responds to your July 25, 1998, memorandum concerning cutting greenhouse gases through Energy Savings Performance Contracts. Specifically, you directed each executive agency to submit a memorandum detailing our efforts in this area.

As shown in the attachment to this memorandum, this Department has a very active energy conservation program. If we can be of any further assistance, your staff may call John J. Callahan, Assistant Secretary for Management and Budget, on (202) 690-6396.

A handwritten signature in black ink, appearing to read "Donna E. Shalala".

Donna E. Shalala

Attachment

7/29/1998 0011

DHHS Response to President Clinton's July 25, 1998, Memorandum to Executive Department and Agency Heads Concerning Energy Consumption

1. Your agency's accomplishments in reducing energy consumption since 1985, and your plans to reduce energy consumption 30 percent below 1985 levels by 2005, in compliance with Executive Order 12902;

The Department of Health and Human Services (HHS) consumed 7,417,804 million British thermal units (MMBtu) of energy at a cost of 69.8 million dollars in FY 1997. The energy consumption on a square foot basis equaled 289.9 MMBtu per thousand square feet (KSF). This represents a one percent decrease from the FY 1985 energy consumption baseline. The FY 1998 energy consumption, based on three quarters of actual data and one quarter of estimated data, is 7.4 percent below the FY 1985 baseline at 270.7 MMBtu per KSF.

In FY 1995, HHS drastically expanded its Departmentwide energy management program to enable us to develop a unified, structured approach and to expedite the energy conservation activities of the eight HHS Operating Divisions (OPDIVs) that manage real property throughout the nation. Each year the program continues to grow, involving more and more facilities and employees. In FY 1995, at the inception of the program, HHS reported energy consumption in 22.6 million square feet of facilities at a rate of 267 MMBtu per KSF. In FY 1997, the total HHS square footage reported increased by 13 percent to 25.6 million. This is a clear indication that the HHS energy management program has been effective in increasing the number of facilities engaged in energy conservation activities. However, the addition of these energy intensive facilities that predominately includes laboratory and hospital space, has negatively impacted the overall HHS rate of energy consumption.

According to our FY 1997 data, the National Institutes of Health (NIH) represents 64 percent of all energy consumed by HHS and 46 percent of the total HHS square footage. Therefore, any change in NIH energy usage will have a significant affect on the agency's data. When the inordinate effect NIH has on the overall HHS consumption is analyzed, NIH has increased energy consumption by 16 percent as compared to the FY 1985 baseline, while the other HHS OPDIVs have decreased energy consumption by 13 percent.

Therefore, HHS energy program officials have placed an emphasis on developing a centralized energy program at NIH involving all levels of management. The Director of the NIH Division of Engineering Services, realizing the need for an extensive and structured program, has assigned a civil/environmental engineer to assist the NIH energy engineer with the management and implementation of the NIH energy program. This program includes a consortium of energy program coordinators and a "stakeholders group" which consists of key personnel involved in energy, water and infrastructure projects throughout the main campus. The group meets at least monthly to discuss current and future projects in order to maintain a cohesive energy efficiency effort.

We are fine tuning each of our components energy management plans, in order to fully meet the Executive Order (EO) 12902 energy targets, and are continuing to search for resources that can be specifically earmarked for energy projects. However, we will also rely more on energy savings performance contracts (ESPC) to meet our energy mandates. In FY 1997 and 1998, several HHS

facilities entered into ESP-type contracts and are evaluating the energy contractors' recommendations for conservation projects. The outlook for FY 1999 is promising, as many more HHS facilities are expected to sign ESP-type contracts or are in the process of investigating the benefits and impact of this contracting mechanism.

The office responsible for energy conservation Departmentwide is the Division of Policy Coordination (DPC), located within the Office of Facilities Services, Assistant Secretary for Management and Budget. DPC continues to support the Departmentwide energy management program by providing both technical and administrative assistance to the OPDIVs on all energy related issues. Each year, the DPC broadens the scope of the Department's energy management program and implements new features that educate HHS energy personnel and increase energy awareness for all employees. The standard features of the program are the publication of energy newsletters, engineering analysis, recommendation of efficiency projects, coordination of an annual energy seminar, and provision of energy consultation services. Recent new features include the coordination of Earth Day and Energy Awareness Month expositions in HHS facilities, organization of OPDIV involvement in the EPA Federal Energy Star Buildings Program, development of a water conservation project in an HHS facility, and establishment of an HHS Energy Awards Program. These enhancements were extended into FY 1998 and new aspects of the HHS energy program will be developed in FY 1999 to advance energy efficiency in the OPDIVs, and to meet the EO 12902 energy reduction goals.

In addition to the efforts of the HHS energy management program, the OPDIV energy personnel are working hard to implement energy and water efficiency projects under the extremely heavy workloads. By the end of FY 1997, twenty-nine percent of the total HHS square footage had undergone comprehensive energy audits and many low cost or no cost measures have been implemented. The OPDIVs have started entering into GSA Area Wide Public Utilities Contracts and local utility contracts to implement the remaining high cost, favorable payback projects.

Other energy efficiency actions being taken by the OPDIVs include procurement of deregulated natural gas, application of solar energy technologies and passive design strategies in new construction and renovations, conversion of vehicles from gasoline to CNG fuels, design of new buildings using the latest energy efficient technologies, increased energy management training of personnel, and installation of a ground-source thermal water closed loop HVAC system to eliminate natural gas boilers.

DPC has worked hard to develop an agency-wide energy management program designed to meet the needs of the OPDIVs with the ultimate goal of achieving the EO 12902 energy reductions. The actions taking place in the OPDIVs reflect the program's success in establishing awareness and momentum in energy and water efficiency. This increased awareness has intensified the analysis of energy consumption which in turn has led to some progressive energy projects in the Department.

2. *Your agency's plans to use ESPCs and other tools, as well as your plans to achieve ENERGY STAR labels for your facilities, as part of your increased attention to saving money through energy efficiency and renewable energy;*

The Department's program to use alternative financing tools is a two part approach. The first aspect is to educate the OPDIVs on alternative financing options. HHS is accomplishing this through meetings with facility managers, articles in HHS energy newsletters, seminars for energy management personnel, and dissemination of pertinent information.

The second step is for the OPDIVs to determine other alternative financing mechanisms that may be used for their facilities. Because of the diversity of building types and functions, OPDIVs operate their real property somewhat autonomously in most arenas. Therefore, it is important that the OPDIVs have input into the strategy used when it comes to alternative financing. A specific agency time line for involvement in ESP-type contracts and interagency partnerships will be developed. The OPDIVs are aware of the FY 2005 deadline for 30 percent reduction in energy consumption and are working on alternative financing vehicles to help them meet this goal.

In addition to the above, in FY 1999 we are planning to issue a directive to all OPDIVs concerning implementation of ESPC projects. DPC will conduct briefings on the directive with each OPDIV and will involve budget, finance, contracts, and facilities management personnel. ESPC teams of budget, contracting, and energy management personnel will then be developed to promote ESPC projects within each OPDIV. Additional ESPC training will be provided as necessary.

The following is a list of sites that have signed alternative financing vehicles or are in the process thereof:

1. Frederick Cancer Research and Development Center, National Institutes of Health
Frederick, Maryland - Signed in FY 1997 (for approx. 1 million square feet)
Basic Order Agreement with Allegheny Power
Total Project Cost: \$2.7 million Total Savings: \$6.9 million Period: 15 years
Contact Information: Dennis Dougherty (301) 846-1087
2. Centers for Disease Control and Prevention Cincinnati Region
Cincinnati, Ohio - Signed in FY 1997 (three buildings - approx. 325,000 square feet)
GSA Area Wide Public Utilities Contract
Total Project Cost: \$2.3 million Total Savings: \$3.2 million Period: 10 years
Contact Information: Rich Crane (513) 533-8301
3. Centers for Disease Control and Prevention Atlanta Region
Atlanta, Georgia - Signed in FY 1997 (75 buildings - over 1 million square feet)
GSA Area Wide Public Utilities Contract
Total Project Cost: TBD Total Savings: TBD Period: TBD
Contact Information: Ken Bowen (404) 639-3303

4. National Center for Toxicology Research, Food and Drug Administration
Jefferson, Arkansas - Signed in FY 1998 (approx. 1 million square feet)
GSA Area Wide Public Utilities Contract
Total Project Cost: TBD Total Savings: \$9.0 million Period: 8 years
Contact Information: Bruce Rice (870) 543-7351

Facilities expected to sign alternative financing agreements in FY 1999:

1. National Institutes of Health Main Campus (one building)
Bethesda, Maryland
Utility ESPC
Contact Information: Van Nguyen (301) 496-6278

2. Module One, Food and Drug Administration
Laurel, Maryland
Utility ESPC
Contact Information: Jag Sarpal (301) 827-7017

3. Aberdeen Area, Indian Health Service
Northwestern U.S.
DOE Super ESPC
Contact Information: John Rodgers (206) 615-2461

4. Parklawn Building, Program Support Center
Rockville, Maryland
Utility ESPC
Contact Information: Glenn Phillips (301) 443-6340

HHS has notified the OPDIVs about the EPA Energy Star Buildings Program and is strongly recommending their participation in the program. In FY 1999, each OPDIV will be expected to sign a memorandum of understanding (MOU) with EPA and DOE, that commits them to the Energy Star program and will then begin the process of identifying facilities to receive Energy Star ratings. DPC will assist the OPDIVs in identifying facilities and applying for Energy Star ratings through its energy management program. The agency has established a goal to achieve the Energy Star rating in five buildings during FY 1999 and ten additional buildings in FY 2000. It should be noted, however, that only a fraction of the HHS buildings are dedicated solely to office space, thereby limiting our resources for participation in the program.

3. Your proposals on how to expand the Federal Government's use of these tools, for inclusion in our request to the Congress for extending ESPC beyond the year 2000;

HHS estimates that each ESP-type contract signed reduces annual energy consumption by approximately 15 to 25 percent for that particular building/facility. Based on current statistics, extending the authority to use ESPCs beyond the year 2000 could save HHS an additional \$12.2 million and 1,298,116 MMBtu by FY 2005 (assuming that we can implement ESPC financing affecting 70 percent of HHS square footage).

Expanding the use of ESPCs to other areas such as water conservation and leased buildings would also enable HHS to save additional taxpayer dollars. HHS square footage is predominantly dedicated for laboratories and hospitals, which tend to use large amounts of water as compared to office buildings. Implementing projects that would allow us to eliminate the waste of water and the need to heat water mechanically could drastically reduce utilities bills for many of our facilities.

HHS has also seen the impact of energy efficient technologies in new design and construction. A 250,000 square foot NIH laboratory is currently being built that has employed several energy efficient technologies in its design. It is expected that the energy consumption of the new laboratory will be as much as 40 percent less than a comparable design without the energy efficient technologies. These savings translate to roughly one million dollars or four dollars per square foot. The ability to alternatively finance energy efficient technologies in new design could facilitate this magnitude of savings in most new construction.

4. Your strategy for encouraging use of ESPCs and other financing mechanisms to install renewable energy production systems — such as those called for in the Million Solar Roofs Initiative.

To date, the HHS process of identifying and accomplishing cost-effective renewable projects has come from DPC's energy management program. Based on information received from the various HHS facilities, DPC has identified several facilities with renewable energy options and is working with the National Renewable Energy Laboratory (NREL) and FEMP's Technology Specific Super ESPC contractor for photovoltaics to implement such projects. In FY 1999, DPC will engage the OPDIV energy coordinators and facility managers in this process to expedite the implementation of renewable energy technologies. We intend to make renewable energy application one of the objectives of the OPDIV ESPC teams (see response to # 2). The use of alternative financing will be the primary means of funding renewable energy projects.

The energy management program will continue to place emphasis on renewable energy and educate personnel through the energy newsletters, seminars, expositions, awareness events, and informative mailings. In FY 1999, HHS will add renewable energy as a category to its energy and water management awards program.

Facilities that we project will incorporate renewable energy technologies in FY 1999:

1. Whiteriver Hospital, Indian Health Service
Whiteriver, Arizona
DPC, NREL, and the DOE photovoltaic ESPC contractor are working to develop an energy savings performance contract to replace a decommissioned solar field at the Whiteriver Health Center in Whiteriver, Arizona. When operational, the solar field reduced fuel oil consumption by as much as 60 percent.
2. Cherokee Indian Hospital, Indian Health Service
Cherokee, North Carolina
DPC is also being assisted by NREL on the renovation of a solar hot water system at the IHS

Cherokee Indian Hospital in Cherokee, North Carolina. Many of the tubes used by this parabolic collector system have broken and cannot be replaced by the original manufacturer. Replacements are being investigated to return the system to its original design.

3. **Acoma Cononcito Laguna Hospital, Indian Health Service
San Fidel, New Mexico**

The IHS Acomita Canoncito Laguna Hospital is planning to install solar lighting in FY 1999.

HHS will support the Million Solar Roofs initiative to the greatest extent possible. In FY 1999, the HHS Office of the Secretary, Assistant Secretary for Management and Budget will send a letter to the OPDIV heads about the initiative and the importance of renewable energy applications. This will secure upper management involvement and increase the attention on renewable energy. DPC will then work with the OPDIVs and facilities with the greatest potential to identify new renewable energy applications. The OPDIV ESPC team will provide assistance to the facility in applying alternative financing mechanisms to install new projects. DPC also plans to include the Million Solar Roofs initiative in the agenda for the 1999 HHS Energy Seminar.

All HHS facility managers have been made aware of the ability to procure renewable energy products through the GSA Federal Supply Schedule. We will continue to publicize this message through the communication tools of the HHS energy management program.



OCT - 2 1998

MEMORANDUM

TO: The Secretary
Thru: DS DS
COS WJ 10/9
ES _____

FROM: John J. Callahan *John J. Callahan*
Assistant Secretary for Management and Budget

SUBJECT: Response to President's July 25, 1998 Memorandum on Cutting Greenhouse Gases
-- Action

Attached for your signature is a memorandum to the President in response to his July 25, 1998, directive concerning cutting greenhouse gases through Energy Savings Performance Contracts (ESPC). Specifically, each executive agency was requested to submit a memorandum documenting accomplishments related to energy conservation in general and our current and planned use of ESFCs.

We are pleased to be able to report to the President that HHS has an active energy conservation program in place. In FY 1995, HHS expanded its Departmentwide energy management program to enable us to develop a unified, structured approach and to expedite the energy conservation activities of the eight HHS Operating Divisions (OPDIVs) that manage real property. ASMB provides both technical and administrative assistance to the OPDIVs on all energy related issues. The standard features of the program are the publication of energy newsletters, engineering analysis, recommendation of efficiency projects, coordination of an annual energy seminar, and provision of energy consultation services. Recent additions to the program include the coordination of Earth Day and Energy Awareness Month expositions in HHS facilities, dissemination of information relating to ESPCs, organization of OPDIV involvement in the EPA Federal Energy Star Buildings Program, development of a water conservation project in an HHS facility, and establishment of an HHS Energy Awards Program. These enhancements were extended into FY 1998 and new aspects of the HHS energy program will be developed in FY 1999.

The FY 1998 energy consumption, based on three quarters of actual data and one quarter of estimated data, is 7.4 percent below the FY 1985 required baseline figures. While reductions have fluctuated from year-to-year, this equates to millions of dollars being saved over the life of the program, with particular emphasis being placed on energy conservation from FY 1995 on. For example, with inflation factors considered, we realized a \$1.8 million actual savings for FY 1997 when compared to FY 1994 data. Estimated savings for FY 1998 are an additional \$3.6 million.

ESPC authority allows agencies to contract with private energy service companies to retrofit federal buildings with no up-front payments by the individual agency. Although an expanded Departmentwide initiative is planned for this year, HHS already has several ESP-type contracts in place, and several more planned throughout the OPDIVs.

Please note that, to provide structure to the memoranda to the President, the Department of Energy provided a suggested format to follow when developing our responses. We have structured our input in the manner suggested.

Please have your staff call Peggy Dodd, Director, Office of Facilities Services, if there are any questions concerning this material.

Attachments

P0-4-8
L/C



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

OCT 7 1998

MEMORANDUM FOR THE PRESIDENT

We are writing to update you on the implementation of the Executive Order on the Protection of Children from Environmental Health Risks and Safety Risks. This Executive Order made environmental health risks and safety risks to children a priority for the Federal government and established a Task Force, co-chaired by us, to lead the response in identifying and assessing those health and safety risks that may disproportionately affect children.

The Executive Order's directive for a comprehensive research agenda on children's environmental health has led to two significant accomplishments that will help protect children from environmental threats. First, the Department of Health and Human Services (HHS) and the Environmental Protection Agency (EPA) have jointly provided \$10 million in Fiscal Year 1998 to establish Centers for Children's Environmental Health and Disease Prevention Research. These Centers are unique because they will fill research data gaps as well as translate scientific findings into strategies to intervene in and prevent environmentally related diseases in children. Secondly, the Task Force is nearing completion of an Internet-accessible database that will track all relevant federally funded research, identify research gaps, and provide public access. This database will allow the Task Force to assess the status of children's environmental health research and develop an agenda for future research investments.

The Task Force is now prepared to move ahead and address specific threats to children in which environmental factors play a role and which we believe warrant the Administration's attention. Accordingly, it has identified four priority areas: asthma, unintentional injuries, childhood cancer, and developmental disorders. The Task Force envisions pursuing a comprehensive FY 2000 initiative focusing on these priority areas that would reach across the entire Federal government, where appropriate. Due to the seriousness and prevalence of the disease, asthma will be the immediate initiative of focus, but we are actively developing initiatives for unintentional injuries, childhood cancers, and developmental disorders as well.

Asthma is reaching epidemic proportions among American children today, impacting over 5 million children and disproportionately affecting poor and minority children in urban communities. Asthma rates increased 160 percent for children under 5 years of age from 1980 to 1994. The health implications of asthma are significant-150,000 children are hospitalized each year. Children with asthma miss twice as many school days as other children and asthma has become the leading cause of school absenteeism. In 1990, the cost to society of asthma was estimated at \$6.2 billion; in 1996, a different analysis found the cost of asthma to be \$14 billion. Together with proper medical care, measures to control indoor and outdoor environmental exposures could reverse these troubling trends.

Prepared by P. O. / Bart

10/8/1998/0017

The impacts of the other three priority areas are also important. Unintentional injuries are the leading cause of childhood mortality. Cancer continues to be the leading cause of disease-related mortality for children 1-14 years of age. Developmental disorders, which include birth defects and learning disabilities, are also a leading cause of childhood morbidity and mortality.

We will continue to keep you apprised of the details of these initiatives over the next few months. The Task Force believes that through better implementation and new investments the Federal government can take action that will show immediate and long term results in protecting our nation's children from environmental health risks and safety risks.



Donna E. Shalala
Secretary
Department of Health and Human Services

Carol M. Browner
Administrator
Environmental Protection Agency



Assistant Secretary for Health
Surgeon General
Washington, D.C. 20201

AUG 20 1998

TO: The Secretary
Through: DS RL
COS Med 4/2
ES LR

FROM: Assistant Secretary for Health and
Surgeon General

SUBJECT: Memorandum for the President on the Progress for the Task Force on
Environmental Health Risks and Safety Risks to Children--ACTION

ISSUE

This memorandum requests your signature on the Memorandum for the President on the progress of the Task Force on Environmental Health Risks and Safety Risks to Children.

DISCUSSION

The Task Force on Environmental Health Risks and Safety Risks to Children, established in April 1997 by Executive Order 13045, is co-chaired by you and EPA Administrator Browner. The Task Force reports to the President (in consultation with other White House offices), and the membership comprises nine departments and relevant White House offices.

At the second Task Force meeting, you and Administrator Browner requested that a progress report be sent to the President. The memorandum (attached at Tab B) informs the President that the Task Force has identified four priority areas (asthma, unintentional injuries, cancer, and developmental disorders) and is developing FY 2000 initiatives.

OPHS staff worked with EPA's Office of Children's Health Protection in developing this memorandum for the President. However, others in Administrator Browner's office wanted to include a focus on EPA's regulatory activities. We believe this has been resolved. The attached memorandum acknowledges the accomplishments of the multiagency Task Force and highlights the priority areas that may be part of an FY 2000 budget proposal but does not focus on the broader EPA environmental activities.

LL-4
4/c



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

AUG 31 1998

MEMORANDUM FOR THE PRESIDENT

The UN General Assembly has designated 1999 as the International Year of Older Persons. During this year, the world community will come together to proclaim the International Year of Older Persons and promote the theme "Towards a Society of All Ages" which acknowledges that aging permeates all of our lives regardless of where we are in the life cycle.

We are all members of an aging global society. The rapid increase in the numbers of older persons worldwide represents a social phenomenon without historical precedent. The world's older population is expected to approach 1.2 billion, defined by the UN as persons over 60, by the year 2025. Within the United States, one in five Americans - about 70 million people - will be age 65 and older by 2030 - as compared to one in eight today. The absolute number of older Americans will double from 32 million now to about 65 million.

The International Year of Older Persons offers us the unique opportunity to honor older people and to acknowledge the contributions that they continue to make to society. During this special commemorative year, we will pause to reflect on how rapidly the world population is aging, honor the past, and imagine what our world will be like in the next millennium. It is also a time to consider the advantages of active aging, where we recognize that aging begins at birth and successful aging and longevity reflect the decisions individuals, communities and societies make over the entire life course.

The United Nations will inaugurate the International Day of Older Persons on October 1, 1998. I would like to request that you issue the attached proclamation on or before October 1 honoring America's older persons, the contributions they have made to our great nation, and in turn, the world community.

Donna E. Shalala
Secretary

9/3/1998/005/2

Prepared by AOA/Harold

A+A-L.B.
P-C.D

International Year of Older Persons, 1999

By the President of the United States of America

A Proclamation

Longevity is one of the great achievements of the twentieth century. The rapid increase in the numbers of older people worldwide represents a social phenomenon without historical precedent. The world's older population, defined by the United Nations as persons over 60, is expected to approach 1.2 billion by the year 2025.

America is fortunate to be among the growing number of nations blessed with the gift of longevity. By 2030, one in five Americans-- approximately 70 million people--will be aged 65 and older as compared to one in eight today. The absolute number of older Americans will double from 32 million now to about 65 million over the same period.

In October 1992, the UN General Assembly recognized "humanity's demographic coming of age" by adopting a resolution declaring 1999 as the International Year of Older Persons. The United States joins with other members of the UN in proclaiming 1999 as the International Day of Older Persons and in opening the International Year on October 1, 1998, the International Day of Older Persons.

As we open the International Year of Older Persons, let us honor older persons around the globe and acknowledge the contributions they make to society as tradition-bearers, as parents and grandparents, as workers, as caregivers, as volunteers in their communities, and as role models for younger generations. Let us also reflect on our swiftly changing world demographics and envision how differently our world will look in the next millennium.

The theme of the International Year of Older Persons is "Towards a society for all ages". This theme recognizes that longevity is relevant to all of our lives, regardless of where we are in the life cycle, and that successful aging is a product of the long-term, life-long decisions made by individuals and societies. Long life

is a gift we must cherish and a responsibility for which we must prepare. Let us, therefore, take time during this very special year to determine what our preferred future will be in a context of longevity, and then let us set out to ready America by developing the policies and programs that will make this desired future a reality. We must all work together to prepare for the aging of our societies and to ensure that in the 21st century, human longevity is marked by older adults living healthy, satisfying, productive lives.

NOW, THEREFORE, I, WILLIAM J. CLINTON, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States of America, do hereby proclaim 1999 as the International Year of Older Persons. I call upon Government officials, businesses, communities, volunteers, educators, and all the people of the United States to observe this year with appropriate programs and activities.

IN WITNESS WHEREOF, I have hereunto set my hand this , in the year of our Lord nineteen hundred and ninety-eight, and of the Independence of the United States of America the two hundred and twenty second.



August 31, 1998

MEMORANDUM FOR ANNE MCGUIRE

Attached is a memorandum for the President requesting issuance of the Presidential Proclamation for International Year of Older Persons, October 1, 1998 - October 1, 1999.



Kevin Thurm

Attachments



JUL 31 1998

Washington, D.C. 20201

TO: The Secretary
Through: DS KTaw
COS (1167) 6/19
ES _____

FROM: Assistant Secretary for Aging

SUBJECT: PRESIDENTIAL PROCLAMATION FOR INTERNATIONAL YEAR OF
OLDER PERSONS, OCTOBER 1, 1998-OCTOBER 1, 1999 — ACTION

ISSUE

I request that you approve the attached draft proclamation acknowledging the International Year of Older Persons, scheduled to begin on October 1, 1998, and sign the attached memorandum to the President asking that he issue the proclamation on or before October 1.

BACKGROUND

In October 1992, the UN General Assembly recognized "humanity's demographic coming of age" by adopting a resolution to observe 1999 as the International Year of Older Persons. In 1996, AoA accepted the responsibility as the lead focal point and coordinating agency for the federal government's observance of the Year. A Federal Ad Hoc Committee has been formed, made up of over 30 federal agencies and Cabinet Departments to observe the International Year of Older Persons, which has as its theme "Towards a Society of All Ages" which recognizes that aging permeates all of our lives regardless of where we are in the life cycle. This Committee has met twice as a group, several planning subcommittee have been formed, and we are also coordinating our activities with Brookdale Center on Aging-based U.S. Committee to Celebrate the International Year of Older Persons. This Committee is coordinating public and private sector activities at both the national and grassroots level. Many events are being planned at the federal, state and local level throughout the nation, and the Administration on Aging will be hosting several events with its federal partners in Washington, D.C. including an international conference as well as some media events still being planned.

98-0613

The United Nations will officially inaugurate the International Day of Older Persons on October 1, 1998 which will officially launch the International Year of Older Persons. October 1 will recognize the vital links that connect nations across the globe and the responsibility we all share in preparing for our own longevity within our families, our communities, our nation and the world.

RECOMMENDATION

In order to demonstrate the Administration's continued commitment to national aging policy issues as well as our recognition as a nation of the global aging phenomenon, I would like to recommend that you request that the President sign and issue the attached proclamation designating the launching of the International Year of Older Persons on or before October 1.

DECISION

I recommend that you approve the attached memorandum to the President requesting that he issue a formal proclamation designating 1999 as the International Year of Older Persons, and approve the attached draft Presidential proclamation.

Approved Memo

Disapproved Memo Date AUG 24 1998

Approved Proclamation

Approved Proclamation Date AUG 24 1998


Jeanette C. Takamura

2 Attachments:

Tab A - Memorandum for the President

Tab B - Draft Proclamation



AUG 6 1998

MEMORANDUM FOR THE PRESIDENT

Recent media reports have suggested that commercial health plans (primarily for-profit HMOs) are withdrawing from participation in Medicaid managed care. At your request, we have evaluated these reports over the past several weeks by speaking to a wide variety of researchers, plan officials, and state and federal regulators and by reviewing research on this issue. Our review generally supports the conclusion that some commercial plans have withdrawn from Medicaid, but that their withdrawal has had little or no effect on access to managed-care coverage in most areas. The number of local and Medicaid-only health plans participating in Medicaid continues to grow, and for now these health plans are assuring adequate capacity for the continued expansion of Medicaid managed care. The growing dominance of Medicaid-only health plans, however, raises important policy issues about Medicaid beneficiary access to mainstream health care.

Below we discuss the participation of commercial health plans in Medicaid, the reasons for its decline, and some of the policy implications for beneficiary access and quality of care.

Commercial Plan Participation in Medicaid

Recent media reports of plans leaving the Medicaid market (including articles in the *Wall Street Journal* 4/7/98 and the *New York Times* 7/6/98) have focused on commercial health plans, plans whose primary business is non-Medicaid. Although we cannot yet confirm this trend with program data, anecdotal reports and our review of the issue generally support the conclusion that some commercial plans are pulling out of the Medicaid market. Some plans have left the market entirely while others have left states that they view as unreliable business partners.

The Medicaid managed care market is still evolving. Overall, enrollment in full-risk managed care plans was about 25 percent of all Medicaid beneficiaries in 1996, up from about 5 percent in 1991. Between 1993 and 1996, the number of managed care plans serving Medicaid beneficiaries more than doubled, with the largest increase occurring in Medicaid-only plans (plans in which Medicaid beneficiaries comprise 90-100 percent of total enrollment). Medicaid-only plans include those established by public hospitals and other Federally Qualified Health Centers, as well as those that are subsidiaries of commercial plans, provider-sponsored plans, and new plans that have been specifically created to capture the Medicaid managed care market. According to a 1997 survey by the National Association of Public Hospitals, approximately three-fourths of the urban safety-net hospitals surveyed have formed their own health plans, primarily to serve the Medicaid population.

The number of commercial plans serving Medicaid also grew rapidly during this period, increasing from 102 plans in 1993 to 199 plans in 1996. Commercial health plans initially viewed the Medicaid market as a complementary line of business to their other commercial operations. Many chose to expand into this market at a time when plans were vigorously competing for overall market share.

More recently, however, some commercial plans have begun to question the financial advisability of continued participation in Medicaid. Commercial plans that have left Medicaid (entirely or in selected states) have cited concerns over low payment rates, high administrative burdens, and high

Prepared by AS^D/Varrault

8/10/98/0015

volatility in enrollment as reasons for their declining interest in Medicaid. Perhaps more importantly, the market analysts that follow these publicly traded HMOs have begun to raise questions about the potential risk to plan profits posed by Medicaid participation. The understanding appears to be growing among plans that the Medicaid market is very different from the commercial market and that participation in Medicaid requires significant investments in developing new systems and new provider relationships that may not be rewarded by the low payment rates available in many states.

The pattern of withdrawals varies across the country. In some states, commercial participation appears to be stable. In other states, large commercial plans (predominantly those that are publicly traded) are beginning to question whether their future participation in Medicaid is viable. Specific examples of withdrawals of commercial plans over the last two years have been identified in at least 11 states (California, Connecticut, Delaware, Florida, Georgia, Maryland, Massachusetts, Missouri, New Jersey, New York, and Ohio). Precise numbers are difficult to obtain because of mergers and consolidation in the managed care industry.

These withdrawals do not appear to be causing problems for access to managed-care coverage in most areas, although no systematic quantitative data have been collected to date. (In one state, Georgia, some managed-care enrollees will have to shift to fee-for-service Medicaid, at least temporarily.) Even as some large commercial plans leave the Medicaid managed care market, local health plans and plans serving primarily Medicaid beneficiaries are replacing them in most areas, and the overall number of these plans has been growing. Many of these plans have developed outreach programs, networks, and management systems that may be more appropriate for the Medicaid population and have shown a willingness to meet the special Medicaid requirements imposed in some states. The potential implications of the growing dominance of these Medicaid-only plans is discussed later in this memo.

Reasons for Decline in Commercial Plan Participation

Although the Medicaid population has health and behavioral characteristics distinct from the general population, many commercial HMOs believed they could provide coverage by expanding their existing business and building on their infrastructure and organizational systems. Rates would typically be set by the government rather than the market, but health plans believed that Medicaid was plagued by inefficient utilization patterns that, if corrected, would allow them to make a return on investment.

Large managed health plans withdrawing from the Medicaid market over the past year or two cite several reasons for their decisions:

- better understanding of the business;
- low capitation rates; and
- burdensome contract requirements.

Commercial health plans have learned that covering the Medicaid population is not simply an expansion of current business, but rather a new and different line of business. The health and

behavioral needs of the population and the nature of the program (e.g., monthly eligibility) require distinct systems to be successful. Participation in Medicaid often also requires health plans to form relationships with new groups of providers (including safety-net providers) that have traditionally served Medicaid patients. As a result, the cost of covering the Medicaid population can be much higher than many health plans had initially projected.

Many health plans contend that when states set capitation rates, they do not reflect costs or demand, (although they sometimes involve competitive bidding). Under federal law, capitation rates in the Medicaid managed care market cannot exceed the amount of money that would have been spent to provide a comprehensive benefit package in Medicaid fee-for-service (FFS). This constraint has two components, each of which may contribute to suppressing capitation rates. The first is the low reimbursement rates the Medicaid program has historically paid in FFS. A 1991 study by the Physician Payment Review Commission showed that average Medicaid physician fees were about 62 percent of Medicare's (which in turn were lower than those in the private sector). The second is any under-utilization of services in FFS, resulting from both low physician participation in Medicaid and the less organized system of care delivery characteristic of FFS medicine.

Over time, plans have perceived Medicaid capitation rate increases as inadequate. In fact, in about half the states where we have information, rates have been cut, in some instances up to 10 percent to 15 percent over several years. A number of health plans argue that capitation rates (or least the annual adjustments after rates are first calculated) are often arbitrary; they do not reflect an actuarial analysis of an organization's true costs of serving this population. A number of HMO officials and financial analysts view states' rate-setting procedures as primarily "political." Plans are doubtful of their ability to raise capital or to make an adequate return on their investment over the long run.

Health plans also perceive Medicaid contracting requirements as more onerous than those imposed by private employers and Medicare. As purchasers, Medicaid agencies are looking both to ensure access to the range of Medicaid benefits and to monitor quality. As states learn how to design comprehensive contracts, their contracts with health plans increasingly include provisions for services particularly relevant for the Medicaid population – such as screening for elevated lead levels, medical and mental health care for children in the child welfare and juvenile justice systems, and asthma management programs and assessment. In addition, Medicaid agencies purchasing a managed care benefit package seek to ensure that adequate, quality health care is delivered to beneficiaries through various reporting requirements such as: utilization/encounter data, including hospital inpatient days; quarterly quality assurance reports; and patient satisfaction surveys. While there is significant overlap in requirements between Medicaid and either Medicare or large employer health plan contracts, there are a number of provisions unique to Medicaid. Although these differences appear largely to be the result of Medicaid managed care contracts conforming to the Medicaid benefit package, health plans believe that some of the requirements are arbitrary or poorly thought out.

Most states' experience with Medicaid managed care is only a few years old. As a result, they are still learning, for example, what contract requirements are an effective means of ensuring quality or access. A recent foundation-funded study of contract requirements, along with growing experience

nationwide, has the potential to bring some stability. But in the meantime, the uncertainty plans often face in negotiations adds to the perception that states are inflexible business partners.

We should note that HCFA will soon be promulgating a proposed rule to implement additional consumer protections, quality assurance standards, and other regulatory requirements stemming from the Balanced Budget Act. Whether commercial plans view these provisions as an added burden or as an impetus toward greater uniformity among states remains to be seen.

Medicaid's structure also creates challenges for health plans. The most frequently cited example is the "churning" in Medicaid enrollment, that is, beneficiaries cycling on and off Medicaid. Churning hinders health plans' ability to provide comprehensive care, particularly cost-effective preventive services such as prenatal care, as Medicaid beneficiaries may not be enrolled in a health plan for a sufficient period of time for outreach and managed care education to take place. For example, one plan recounted the experience of Medicaid beneficiaries enrolling in the seventh month of their pregnancy. This problem is partially addressed in the Balanced Budget Act through requirements for guaranteed eligibility. Another complexity is created in states where Medicaid contracts are written at the county level, generating additional management and reporting obligations for health plans. These structural challenges may contribute to the perception that Medicaid managed care is an arduous undertaking for commercial plans, particularly those with no previous Medicaid experience.

For all plans, there is a substantial investment associated with succeeding in Medicaid managed care (particularly if there is broad choice). Plans will not make that investment without reason to believe they will be able to form a long-term business relationship with a state. State practices that plans perceive to be arbitrary or political discourage that investment, particularly for commercial plans for which this population is not critical to their market share. Other practices that appear on their face to be reasonable also may discourage commercial plans, because they do not assure adequate return on investment. Examples of such state practices include permitting a large number of plans to compete in each area (which may lead to inadequate enrollment in any one plan), or establishing auto-assignment methods, used when beneficiaries fail to choose a plan, that favor certain plans (usually public plans operated by safety-net providers).

Policy Implications

States have two central and sometimes competing goals for Medicaid managed care. First, they are looking to control their costs, expecting that plans will use resources more wisely. Second, states may view managed care in Medicaid as a means of improving access, which may mean either more utilization or better providers. The second goal might be addressed in two different ways - by seeking to mainstream Medicaid beneficiaries and by requiring contracting plans to address the special needs of the Medicaid population and the unique benefits and other requirements of the program itself.

Recent experience in Medicaid, however, suggests that these goals are difficult to achieve simultaneously. For example, ensuring that payments to safety-net providers are sufficient to maintain their financial status sometimes conflicts with efforts to reduce costs. The withdrawal of

some commercial plans, if it continues, raises questions about whether Medicaid managed care can provide access to mainstream providers.

Mainstreaming as a Policy Goal

For years, a key debate in fee-for-service Medicaid has been whether beneficiaries have access to an adequate range of providers and, specifically, to the same providers that serve other Americans. Research suggests that so-called "Medicaid mills" have arguably contributed to poorer health outcomes.

This same issue now arises in Medicaid managed care. Some argue that having the same health plan card as anyone else can be empowering to the beneficiary and avoid the stigma of welfare status. The concern raised by reports of commercial plans leaving this market is that mainstream plans (particularly national plans) will not participate in Medicaid managed care unless conditions are favorable – thus jeopardizing the goal of mainstreaming.

At the same time, there is an issue of whether commercial plans, for which the Medicaid population is only one line of business, in fact make the same effort to serve the special needs of this population as plans created specifically to serve this population. In addition, there is evidence that some commercial plans essentially operate a separate, smaller provider network within their plans for Medicaid beneficiaries – achieving the goal of mainstreaming in name only.

The Role of Medicaid-Only Plans

Given the apparent trend toward more reliance on Medicaid-only plans, it is important to understand the ability of these plans to serve the Medicaid population. Even if withdrawals by commercial plans do not persist, changes made by the Balanced Budget Act (i.e., elimination of the need to get a waiver if less than 25 percent of a plan's enrollment is non-Medicaid) may accelerate the growth of Medicaid-only plans. Little research has been done to date on these plans, although some work has been funded by private foundations.

Medicaid-only plans may have particular strengths. They can be designed to meet the specific needs of Medicaid enrollees and, because of their focus on Medicaid, can develop particular expertise in diagnosing and treating conditions that disproportionately affect the Medicaid population. They also may be more likely to invest in enabling services, such as transportation and translation services, that assist Medicaid beneficiaries in obtaining needed services.

Furthermore, Medicaid-only plans are likely to be operated by or contract with the same providers that have traditionally served beneficiaries under fee-for-service Medicaid. In particular, they often collaborate actively with – or are owned or sponsored by – safety-net providers. In short, these providers are located in the communities where beneficiaries live and have the cultural competencies appropriate for this population.

There are questions, however, about the long-range viability of Medicaid-only plans, specifically about their ability to cope with the same low payment rates and regulatory requirements faced by

other plans. These plans lack the ability to cross-subsidize from other lines of business, creating a potentially greater risk of insolvency. Some of these organizations may survive only as a result of special protections — for example, special tax status, lower financial requirements, or government subsidies — that can avert insolvencies or their consequences.

Medicaid-only plans also face other challenges. Because they tend to be smaller than other plans, they have a harder time spreading fixed costs, such as the investment in information systems that are important for internal management, Medicaid reporting requirements, and performance measurement. Their smaller size may also make them more vulnerable to fluctuations in the Medicaid rolls. Because they are often newer entrants to the market, some may lack administrative or other needed expertise.

Conclusion

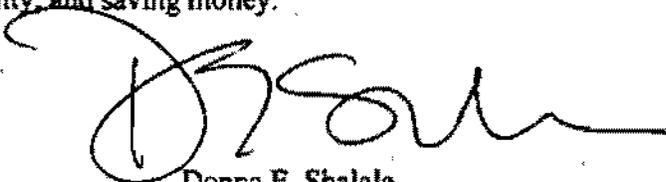
Although we cannot yet quantify the magnitude of the drop-off in commercial health plan participation in Medicaid, there are certainly growing numbers of plans choosing not to participate in selected geographical areas. This trend may not affect significant numbers of Medicaid managed care enrollees, either because these plans have low enrollment or because other managed care options are available to affected beneficiaries. However, as the interest of commercial plans in Medicaid wanes, the prospects of using managed care to mainstream Medicaid beneficiaries clearly become more limited. Whether or not the Medicaid population can be better served by Medicaid-only plans is a question that remains to be answered.

Regardless of the type of plan, payment rates based on historically low fee-for-service payment may not provide adequate flexibility to improve access in ways that proponents of Medicaid managed care have envisioned. Ideally, additional services can be financed by savings due to greater efficiency and avoidance of unnecessary services, such as costly emergency room care. Whether this can be accomplished in practice is uncertain given the historical access deficiencies of Medicaid. These issues will become even more difficult as greater numbers of more costly populations (i.e., the disabled and the elderly) join Medicaid managed care. Further study of capitation rates (both methodologies and levels) will be important.

Viewed against the backdrop of all the concerns outlined here, the significant adjustments to managed care models that health plans are compelled to make to meet Medicaid program requirements and beneficiary needs must be recognized. HCFA will soon be promulgating a proposed rule to implement additional consumer protections, quality assurance standards, and other regulatory requirements stemming from the Balanced Budget Act, which may add to the administrative burden for health plans. This rule will amplify the difficult tradeoffs between the goals of assuring quality and protecting rights of beneficiaries on the one hand, and the objective of ensuring broad plan participation and choice on the other.

The Department will continue to analyze these issues further to ensure that decisions made by commercial health plans do not have an adverse impact on access to health care for Medicaid beneficiaries. One component of this effort will be increased surveillance, including factors such as what types of plans are participating, how much choice is available, and how these patterns vary by

state and market area. A second component will be research on some of the underlying issues discussed in this memo (e.g., plan capitation payments and the characteristics of Medicaid-only plans). Finally, additional consideration will be given to the overall goals of the Medicaid program and Medicaid managed care initiatives in particular, with attention to the tradeoffs between improving access, assuring quality, and saving money.

A handwritten signature in black ink, appearing to read 'D. Shalala', with a large, stylized initial 'D'.

Donna E. Shalala



August 6, 1998

MEMORANDUM FOR ERSKINE BOWLES

The President requested an evaluation of recent media reports which suggested that commercial health plans are withdrawing from participation in Medicaid managed care.

A review and evaluation of these reports have been completed as the President requested. Attached is Secretary Shalala's memorandum to the President advising him of our findings.

Elizabeth Sumay For
Mary Beth Donahue

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410



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

June 19, 1998

MEMORANDUM FOR THE PRESIDENT

FROM: Donna E. Shalala *Donna E. Shalala*

SUBJECT: Interagency Task Force on Children's Health Insurance Outreach

I am pleased to submit to you the report of the Interagency Task Force on Children's Health Insurance Outreach. The report was prepared in collaboration with seven other Federal agencies. It presents our plans for reaching out to the community to enroll uninsured children in State health insurance programs. The plans fall into three broad areas: educating the workforce; educating families; and coordinating cross-agency and public-private efforts to identify and enroll children.

Prepared by 401/10/98

Donna E. Shalala



JUN 19 1998

TO: The Secretary
Through: DS
COS MEU 6/19

FROM: Administrator
Health Care Financing Administration

SUBJECT: Report to the President: Interagency Task Force on Children's Health Insurance Outreach

On Monday, June 22, at the Family Reunion Conference in Nashville, Tennessee, the President will announce, among other things, the release of the Interagency Task Force on Children's Health Insurance Outreach Report. As you know, this report will be submitted to the President by the Secretary of HHS in collaboration with the seven other Cabinet Secretaries, covers a wide range of activities and programs surrounding outreach to families and children.

Attached for your information is the executive summary of the Report, that highlights the three themes identified by the Task Force: educating the workforce about children's health; encouraging the workforce to, in turn, educate families about State health insurance programs; and coordinating both cross-agency and public-private efforts to identify and enroll children in these programs.

In addition, I have also included a draft of the directive that the President will sign and issue on Monday as well. The directive instructs the Departments to move forward with these important outreach efforts.

I hope this information will be helpful. Thank you for your continued commitment to the success of this effort and the Children's Health Insurance Program as a whole.

Nancy-Ann Min DeParle

REPORT TO THE PRESIDENT:

**INTERAGENCY TASK FORCE ON
CHILDREN'S HEALTH INSURANCE OUTREACH**

Submitted By:

The Secretary of Health and Human Services

In Collaboration with:

The Secretary of Agriculture
The Secretary of Education
The Secretary of Housing and Urban Development
The Secretary of the Interior
The Secretary of Labor
The Commissioner of Social Security
The Secretary of Treasury

June 1998



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

JUN 10 1998

MEMORANDUM FOR THE PRESIDENT

I want to provide you with some background information regarding recent coverage in the press on the New Jersey family cap policy (see attached Washington Post and New York Times articles). According to press accounts, the findings of an evaluation indicate that the policy has resulted in an increase in the number of abortions among welfare recipients. The National Organization for Women (NOW) Legal Defense Fund, the American Civil Liberties Union, the Catholic Conference of New Jersey, and other groups are concerned about the possible increase in abortions and have also questioned whether the State of New Jersey is trying to alter the findings.

Background

Under 1992 Aid to Families with Dependent Children waivers, the New Jersey Department of Human Services (DHS) implemented a family cap policy, which eliminates benefit increases for additional children conceived while a family is receiving welfare benefits. The State is continuing the family cap under Temporary Assistance to Needy Families (TANF). A draft Rutgers University evaluation of the New Jersey family cap indicates a rise in the number of abortions among welfare recipients over the time that the policy has been in effect. NOW and others who have spoken out on the issue speculate that the State is trying to alter the findings. This speculation is based on the fact that the State has asked Rutgers to revise the report to address methodological concerns.

HHS Analysis of the Rutgers Evaluation

HHS shares the State of New Jersey's concerns about the methodology of the Rutgers study. We believe that the evaluation results to date are inconclusive with respect to whether the family cap caused an increase in abortions because of possible methodological flaws in the study. Since the Department provided a portion of the funds for the evaluation, we have made extensive comments to the New Jersey DHS regarding methodological problems. Our most significant concerns are as follows:

- The evaluation may not have sufficiently controlled for factors other than the family cap and these other factors may have contributed to the reported increases in abortions. If the group changed its behavior for reasons other than the family cap, the results could be biased. This is particularly possible in this evaluation because the composition of the group studied changed over time as individuals entered and exited the welfare rolls.
- Some of the assumptions made in the evaluation were unrealistic. For example, the evaluation established a baseline for comparing changes in the number of abortions. This baseline assumed that, absent the family cap, the number of abortions would have fallen

200/45 6/10/98/0029

among welfare recipients until eventually they would equal zero within a few years. Any abortions above this baseline were assumed to be a result of the family cap policy. This unrealistic assumption could lead to overstating the number of abortions attributable to the family cap policy.

- In general, we feel the authors overstated the strength of their findings and did not discuss sufficiently the measurement problems inherent in social science research. The family cap policy was implemented with a large degree of publicity and as part of a comprehensive package of policy changes. This makes it difficult to identify accurately those families who believed they were affected at any specific time, and to estimate the impacts of each policy intervention. Furthermore, it is difficult to identify all the factors that affect childbearing decisions or to disentangle precisely how much of an effect is attributable to each factor.

Rutgers is currently revising the evaluation and results are expected during the month of June. The New Jersey DHS is planning to have a panel of researchers review the revised report to comment on its methodological soundness. The revised results could show either increased or decreased impact on abortions. There may continue to be disagreement among researchers as to whether the current or revised draft of this report supports a finding that the family cap policy caused an increase in abortions.


Donna E. Shalala

Attachments

Report Tying Abortion To Welfare Is Rejected

New Jersey Officials Question Its Validity

By TAMAR LEWIN

A team of Rutgers University researchers hired by the New Jersey government to examine the effects of the state's new welfare policy found that it has contributed to an increase in abortions, but the state has rejected the findings, and asked for revisions of the report.

In a December report, commissioned by the State Department of Human Services and the Federal Department of Health and Human Services and obtained by The New York Times, the Rutgers researchers said the welfare overhaul provision known as the family cap, which was enacted in 1983 and cuts off extra benefits from welfare recipients who have additional children, has caused some women to abort their pregnancies.

"The Family Development Program does appear to exert a small but non-trivial effect on abortion rates, adding about 260 abortions per year over what would be expected due to trend and population composition changes," the report said. There were 21,860 abortions in New Jersey in 1986.

The Rutgers findings are likely to add new fuel to the nationwide debate over welfare because 20 other states have imposed family caps similar to New Jersey's.

Welfare recipients generally have abortions at a higher rate than other women. In New Jersey, in the quarter ending December 1985, the abortion rate for the welfare population was 27 per 1,000 compared with 4 per 1,000 for all New Jersey women of child-bearing age. And although the abortion rate in New Jersey, and nationwide, declined between 1981 and 1986, the abortion rate among New Jersey's welfare recipients rose during the same period. By 1986, the Rutgers report found, the gap had widened further, with 19 abortions per 1,000 women receiving welfare, compared with 3 per 1,000 women in the general population.

But the state has not accepted those findings, calling the report a draft that needs substantial revision.

In a May 14 letter to the research team, the Department of Human Services said the document should be labeled a draft, criticized the methodology and asked for a reworking that would explain all the difficulties of determining whether it was the welfare policy that had caused the increase in abortions. The letter also questioned the validity of studying the behavior of the welfare population before and after the law changed, since the changes themselves may have altered that population, causing some recipients to get off welfare, and other people to avoid it.

But the lawyers challenging the family cap provision contend that the state's response reflects political problems, not methodological ones.

"We think this is a final report that the state is trying to cover up by

saying it's a draft," said Martha Davis, a lawyer with the NOW Legal Defense and Education Fund, one of the groups challenging the family cap. "And we think the real reason for their objections is concern about what legislators will do if they see the conclusions the Rutgers researchers have drawn."

Jacqueline Tenazza, a spokeswoman for the State Department of Human Services, denied that interpretation. Rather, she said, the state is committed to understanding what effects the family cap has had, and is concerned about the release of draft findings based on a methodology that the state says is flawed.

"This is just a draft," she said. "Neither of the two clients, us or Health and Human Services in Washington, has approved it, and it's not final until it's approved. We want to make sure that what we get is good social science research that is clear about the effects of the policy."

The question of how welfare recipients' reproductive decisions are affected by a family cap, removing any financial incentive to have more children, has been one of the most hotly argued issues in the debate over welfare.

Some conservatives have argued that family caps help discourage welfare recipients from having more babies than they can support, and prevent long-term welfare dependency. But in an unusual political alliance, the Roman Catholic Church and conservative Christian groups joined with advocates for the poor to argue against family caps, on the ground that they would encourage abortion and increase child poverty by forcing welfare families to stretch their meager benefits too far.

New Jersey's family cap went into effect in 1983, under a Federal waiver allowing the state to conduct welfare experiments. Two years later, the Federal welfare overhaul bill opened the way for any state to adopt such a policy, and family caps are now in effect in 20 other states.

"The Rutgers findings have very serious implications for children in every state that has instituted a family cap," said Regina Purcell, a spokeswoman for the Catholic Conference of New Jersey. "It's important to remember not only the number of babies that were aborted due to the family cap, but also the number of children born who were denied assistance. As of December, more than 25,000 children in New Jersey had been denied cash assistance because of the family cap."

Last year, Ms. Davis's group, along with the American Civil Liberties Union of New Jersey and Gibson Del Deo, a New Jersey law firm, filed suit charging that the family cap violated the state constitution by interfering with women's reproductive rights and treated children differently depending on their birth status.

In late February, in the course of

preparing a summary judgment motion in the case, Ms. Davis said, the lawyers asked the state whether the final report from Rutgers, which had been long scheduled for release in December, was available.

A lawyer in the Attorney General's office gave them a copy of the December report, which they shared with representatives of the Catholic Church and others who oppose the family cap at a May 11 meeting. Ms. Davis said the lawyers challenging

those rules might have been without the welfare changes, and the suggestion that the welfare changes may have caused the difference. And it said that the researchers need not redo the study, but should submit a revised version making clear the difficulties of determining causality.

Michael Carnahan, the lead researcher on the \$1 million evaluation project, declined to discuss the specifics of the December report or the reworking now under way.

"We have three different studies of the family cap, this pre/post research, a cost-benefit analysis, and another using an experimental group and a control group," he said. "All I can say is that the final reports on all three, which are not that far off, will present the most comprehensive view possible of the effects of the family cap."

The lawyers challenging the family cap are convinced that the policy encourages abortions, both from the Rutgers research and from interviews with welfare recipients.

"We showed the report to outside experts, including statisticians and economists, and they agreed that it shows that the family cap is causing women to have abortions," said Lenora Lapides, legal director of the New Jersey A.C.L.U. "In a state where there's been this strong effort to cut back on access on abortion, there's a real irony here. This state now has two choices, they can backpedal and try to change the study. Or with the Governor leading, they can take the high road and reconsider the policy."

Adding new fuel to a continuing debate over welfare.

the cap had also asked for, and been granted, permission to talk to the Rutgers researchers.

But, she said, on May 14 — the same day the department's letter went out to the researchers — the Attorney General's office called to say that the report was only a draft and to withdraw permission to talk to the researchers.

"This is a report filed in December, and there was plenty of time for back and forth about the methodology before May," Ms. Davis said. "The timing, together with the fact that this was in no way labeled a draft, as an earlier interim report had been, lead us to conclude that something else was going on here."

Ms. Tenazza said there were no political machinations involved; discussions of the methodology had gone on since the report was filed, she said, and the May 14 letter only reflected continuing discussions. And she said that the lawyer for the Attorney General's office who gave out the report was simply unaware that it was a draft.

"It was an oversight, and it should not have been released," Ms. Tenazza said. "This is very complicated, very important social science research, and there are many serious concerns about methodology. We're not confident that there is any methodology that would result in establishing a cause-and-effect relationship. That's one thing we've learned through this process."

The letter questioned the researchers' use of trends in abortion and birth rates to estimate what

N.J. Study Links Abortion Rise To Welfare Cap

By JUDITH HAVENARTH
Washington Post Staff Writer

A research team from Rutgers University has concluded that New Jersey's welfare law increased abortions among the state's approximately 85,000 welfare families by about 240 a year, but state officials have disputed the report and sent it back for revisions, state officials and opponents of the policy said yesterday.

New Jersey became the first state in 1991 to pass a controversial "family cap," which denies additional benefits to mothers who have more children while on the welfare rolls. Such families lost \$64 a month as a result of the policy.

The family cap was designed to send a powerful signal to mothers to postpone having children they can't support. An unusual coalition of Catholics, conservative family groups and liberal advocates argued against it, saying it would raise the abortion rate and increase child poverty.

In a report to the state and the federal Department of Health and Human Services in December, researchers from Rutgers and Princeton universities concluded that the family cap, which has been adopted by 21 other states, had a "small but non-trivial effect on abortion rates... over what would be expected due to trends and population composition changes."

While the abortion rate was going up among welfare mothers by about 6 percent, it declined for the general population.

The report was disclosed to the NOW Legal Defense and Education Fund and the American Civil Liberties Union by a state lawyer during routine pretrial document exchanges in a suit the groups filed against the policy. The conclusions were shared with representatives of the Catholic Church on May 12. On May 14, the state sent a nine-page letter to the researchers disputing their methodology and requesting revisions.

"The state is backing away from the findings because they don't like the conclusions the researchers came up with," said Martha Davis, legal director of the NOW Legal Defense and Education Fund. "In no way was this a draft," she said. "It shows the real conflict when the states have a political agenda and are trying to influence this kind of research."

But a New Jersey Department of Human Services spokeswoman sharply disputed the advocates' conclusions. Jacqueline Tenora said, "We have a lot of concerns about the way the number was derived because there were a lot of changes in the workload during the period they were studying."

A spokesman for the federal Department of Health and Human Services said the report was a draft "that is still being worked on." Its \$250,000 cost was paid by HHS and the Kaiser Foundation.

Welfare child cap boosts abortions

TRENTON, N.J. (AP) — A research study has concluded that New Jersey's policy of holding welfare benefits level when recipients have additional children has contributed to an increase in abortions.

And critics of the policy say state officials, who commissioned the study, are now trying to play it down because they don't like the results.

The \$1 million study by Rutgers University was commissioned by the state Department of Human Services and the federal Department of Health and Human Services. Researchers were asked to examine the effects of New Jersey's "family cap," which was the first of its kind in the nation when it was enacted in 1992.

Twenty other states have since instituted family caps similar to New Jersey's, and the Rutgers report is likely to fan the fire of debate over welfare reform.

The December 1997 report, obtained yesterday by the Associated Press, said the new welfare policy "does appear to exert a small but non-trivial effect on abortion rates." The researchers estimated that the number of abortions in the state was about 240 higher per year than it would have been without the welfare change.

"We were concerned that this law could cause an increase in abortions," Marie Eady, a spokeswoman for New Jersey Right to Life said. "If the Rutgers study is accurate, our fears have been confirmed."

State officials have rejected the report's findings, declaring it a "draft" and asking for a revision.

But groups that are challenging the cap in court say the report was not labeled a draft when it was distributed to them in February as part of their preparations for trial.

"We think this is a final report that the state is trying to cover up by saying it's a draft," Martha Davis, a lawyer with the National Organization for Women's Legal Defense and Education Fund, said in yesterday's editions of the New York Times. "And we think the real reason for their objections is concern about what legislators will do if they see the conclusions the Rutgers researchers have drawn."

Miss Davis' group, along with the American Civil Liberties Union of New Jersey, sued the state last year, charging that the family cap violated the state constitution by interfering with women's reproductive rights and treating children differently depending on their birth status.

Other opponents to the cap include the Roman Catholic Church and conservative Christian groups that believe the cap encourages abortions.

State officials say their concerns are methodological, not political.

WELFARE AND ABORTION: Denying additional aid to welfare recipients who have more children — a policy in effect in 20 states — could increase abortions, a controversial New Jersey report says. The preliminary finding by researchers at Rutgers University, disputed by state officials, poses a potential dilemma for lawmakers who voted for the "family cap" policy. The impact on abortions was slight, an estimated 140 more per year; New Jersey had about 21,000 in 1996. But it could prompt abortion foes to seek repeal of the provision in states that adopted it under the 1996 federal welfare reform law. — Richard Wolf



JUN 10 1998

MEMORANDUM FOR ANNE MCGUIRE

Attached is a memorandum for the President on the recent reports in the New York Times and Washington Post on the evaluation of the New Jersey Family Cap. The evaluation is being conducted by Rutgers University and was partially funded by this Department. Findings reported in the papers indicated that abortions went up among welfare recipients a result of the family cap. However, both the State of New Jersey and HHS believe there are methodological flaws with the current evaluation that bring the findings into question.

Mary Beth Donahue
Chief of Staff

Attachments



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

April 10, 1998

MEMORANDUM TO THE PRESIDENT

Subject: Scientific Basis for Policy on Needle Exchange Programs

I am transmitting to you the scientific report which is the basis for the memorandum on needle exchange programs that I forwarded to you last weekend. Included in the current document is the recommendation to me from the Department's senior scientists who have responsibility for this issue.

Donna E. Shalala



April 10, 1998

MEMORANDUM TO THE SECRETARY

SUBJECT: Review of Scientific Data on Needle Exchange Programs

At your request, we have reviewed the scientific studies on the effectiveness of syringe and needle exchange programs. Attached is our review. It includes:

- o Appendix A: The Department's February 1997 Report to Congress
- o Appendix B: Recent data analysis completed since February 1997
- o Appendix C: Summary document reviewing the scientific literature by outcome measures of interest
- o Appendix D: Data summary specifically addressing the criteria established by Congress as conditions for federal funding for needle exchange programs

After reviewing all of the research, we have unanimously agreed that there is conclusive scientific evidence that needle exchange programs, as part of a comprehensive HIV prevention strategy, are an effective public health intervention that reduces the transmission of HIV and does not encourage the use of illegal drugs. In addition, when properly structured, needle exchange programs can provide a unique opportunity for communities to reach out to the active drug injecting population and provide for the referral and retention of individuals in local drug treatment and counseling programs and other important health services.

Therefore, based on the scientific data, we strongly recommend that you certify that needle exchange programs are effective in reducing the transmission of HIV and do not encourage the use of illegal drugs, and that the Congressional test regarding the use of Federal HIV prevention funds for needle exchange programs has been met.

NEEDLE EXCHANGE PROGRAMS IN AMERICA: REVIEW AND EVALUATION OF SCIENTIFIC RESEARCH

Introduction

In September 1996, the Committee on Appropriations for the Departments of Labor, Health and Human Services, Education and Related Agencies requested the Secretary of the Department of Health and Human Services to provide a review of the scientific research on needle exchange programs. In response to that request, the Department provided a report to Congress in February 1997 with an overview of the status of scientific research on needle exchange programs, including a compilation of relevant studies and abstracts pertinent to the efficacy of needle exchange programs in reducing HIV transmission and their effect on utilization of injection drugs.

The February 1997 report included two extensive summaries (National Academy of Science/Institute of Medicine 1995, and University of California at Berkeley/San Francisco 1993) evaluating the research literature on the effectiveness of needle exchange programs for the prevention of HIV transmission among injection drug users and their effect on utilization of illegal drugs. An earlier report by the General Accounting Office (1993) reviewed the results of studies addressing the effectiveness of needle exchange programs in the United States and abroad, with an assessment of the credibility of a forecasting model developed at Yale University that estimates the impact of a needle exchange program on the rate of new HIV infections. The conclusion provided in the February 1997 report stated that needle exchange programs can be an effective component of a comprehensive strategy to prevent HIV and other blood borne infectious diseases in communities that choose to include them, and that needle exchange programs can have an impact on bringing difficult to reach populations into systems of care that offer drug dependency services, mental health, medical and support services.

Since the completion of the February 1997 report to Congress, a number of researchers have published data in peer-reviewed journals or presented research findings at national conferences. The National Institutes of Health also published an NIH Consensus Development Statement, Interventions to Prevent HIV Risk Behaviors, in March 1997. That document summarized the proceedings of an NIH Consensus Development Conference, which evaluated the available scientific information regarding the effectiveness of interventions designed to prevent HIV transmission, including needle exchange programs.

Consistent with the February 1997 report to the Congress, this report is limited to those studies conducted in the United States, with the exception of the inclusion of Canadian research data from Vancouver and Montreal. The National Academy of Sciences/Institute of Medicine previously reviewed the unpublished data from Montreal, now published in final form. Other international studies are not reviewed here, as drug use patterns are highly context sensitive in terms of both social, cultural and economic factors and findings could not be generalized to the U.S. population.

This report builds upon the February 1997 report to Congress, expanding on that summary to include newly available data and the implications for policy.

HIV Transmission Through Injection Drug Use

The consequences of injection drug use have become the driving force in the HIV epidemic in the United States. Half of all new infections are caused by the sharing of injection equipment contaminated with HIV, either due to injection drug use or through unprotected sex with an injection drug user or birth to a mother who herself, or whose partner, was infected with HIV through drug use. The proportion of AIDS cases and new HIV infections attributable to injection drug use has been rising steadily. Over 75% of new HIV infections in children result from injection drug use by a parent. The impact has been most devastating in communities of color, which accounted for 65% of newly reported AIDS cases between July 1996 - June 1997.

The primary goal of needle exchange programs is to reduce the transmission of HIV and other blood borne infections, such as hepatitis B (HBV) and hepatitis C (HCV), associated with drug injection by providing sterile needles in exchange for potentially contaminated ones. Researchers from Yale University empirically demonstrated that provision of sterile syringes results in removing from circulation contaminated syringes that could potentially be re-used, thereby decreasing the transmission risk associated with sharing contaminated equipment. In addition to exchanging syringes, needle exchange programs are effective access points for populations with multiple high risk behaviors for HIV infection to receive other services. Many needle exchange programs provide an array of other services including referrals to drug treatment and counseling, HIV testing and counseling, and screening for sexually transmitted diseases and tuberculosis. There are more than 100 needle exchange programs now operating in 71 cities and 28 states and one territory in the United States.

Summary of Research Findings on Needle Exchange Programs

This section summarizes in brief the primary research findings regarding needle exchange programs. A more extensive review of the studies included in the February 1997 DHHS Report to the Appropriations Committee can be found at Appendix A; an analysis of those studies completed since February 1997 is provided at Appendix B. A summary table of needle exchange research studies examining specific outcomes of interest is provided at Appendix C. A subset of this table identifying those studies reporting on the two criteria established in the Public Law 105-78 Appropriations legislation is provided at Appendix D.

Empirical Studies in the United States Needle exchange programs have been implemented in low, moderate and high HIV prevalence sites in an attempt to reduce the spread of HIV and other blood borne infectious diseases among injection drug users. A discussion of some of the methodological issues pertinent to studies on needle exchange is provided later in this document.

In brief, findings from a comprehensive review of the literature indicate that needle exchange programs: increase the availability of sterile injection equipment and reduce the proportion of contaminated needles in circulation (Kaplan and Heimer 1992, Kaplan 1994, and Heimer et al. 1993); reduce drug-related risk behaviors such as multi-person re-use of syringes (Hagan et al. 1991 and 1993, Guydish et al. 1993, Oliver et al. 1994, Paone et al. 1994, DesJarlais et al. 1994, Watters et al. 1994, Singer et al. 1997, and Vlahov et al. 1997); increase drug treatment referrals (Heimer 1994) and entry into drug treatment (Hagan et al. 1993, Singer et al. 1997, and Vlahov et al. 1997); have successfully referred participants to drug treatment with resulting high drug treatment retention rates and reduced HIV risks (Broner and Vlahov 1997); have shown small improvements in reducing sexual risk behaviors among needle exchange participants (Watters et al. 1994, DesJarlais et al. 1994, and Paone et al. 1994); have maintained low prevalence of blood borne HBV and HCV infections (Heimer et al. 1993, DesJarlais et al. 1995, Hagan et al. 1994, and Paone et al. 1994); have reduced HIV seroprevalence rates in certain cities (Hurley, Jolley and Kaldor 1997); and have reduced the rate of new blood borne infections like HIV and HBV among program participants (Hagan et al. 1991 and 1995, and DesJarlais et al. 1996). Additional information on the study design and findings of the studies listed above can be found in the summary documents at Appendices C and D.

Empirical Studies in Canada Two recent observational studies from Vancouver (Strathdee et al. 1997) and Montreal (Bruneau et al. 1997) reported a higher incidence of HIV among injection drug users participating in needle exchange than non-exchange participants. In Vancouver, HIV seroprevalence was estimated to be stable at 1%-2% among the injection drug using population from 1988, when the needle exchange program was established, through 1993. In 1994, a rapid expansion of the HIV epidemic took place, with a baseline seroprevalence of 23.2% observed in a prospective cohort study of injection drug users. Preliminary analysis from this cohort study found an HIV incidence rate of 18.6 per 100 person years. This study reported on a number of behavioral and social risk factors associated with HIV seropositive status, including a high level of injectable cocaine use, prostitution and longer histories of injection drug use. The presence of multiple behavioral risk factors confounded the ability to isolate participation in needle exchange as a predominant or predictive factor for HIV infection. Subsequent 1997 data from this cohort have showed a decline in HIV incidence to 4.4 per 100 person years.

An observational cohort study of injection drug users was conducted in Montreal. In a baseline assessment of HIV seroprevalence, individuals who attended a needle exchange program reported higher frequencies of risk behaviors associated with drug injection and more frequent involvement in prostitution activities. In a prospective HIV seroincidence analysis, HIV incidence among persons attending the needle exchange program was 7.9 per 100 person years, compared to 3.1 per 100 person years among non-attenders. As in the Vancouver study, demographic, behavioral and social factors were identified that in aggregate defined the high risk profile of those persons also attending needle exchange programs. A more complete review and analysis of these two studies is provided at Appendix B.

Synthesis Reports

Institute of Medicine

In 1995, the National Academy of Sciences/Institute of Medicine published a report, Preventing HIV Transmission: The Role of Sterile Needles and Bleach, reviewing the cumulative body of scientific literature available at that time. A summary of the conclusions of the NAS/IOM panel on the scientific assessment of needle exchange program effectiveness is provided as follows:

“On the basis of its review of the scientific evidence, the panel concludes:

- o needle exchange programs increase the availability of sterile injection equipment. For the participants in a needle exchange program, the fraction of needles in circulation that are contaminated is lowered by this increased availability. This amounts to a reduction in an important risk factor for HIV transmission.
- o The lower the fraction of needles in circulation that are contaminated, the lower the risk of new HIV infections.
- o There is no credible evidence to date that drug use is increased among participants as a result of programs that provide legal access to sterile equipment.
- o The available scientific literature provides evidence based on self-reports that needle exchange programs do not increase the frequency of injection among program participants and do not increase the number of new initiates to injection drug use.
- o The available scientific literature provides evidence that needle exchange programs have public support, depending on locality, and that public support tends to increase over time.” p.4

The IOM concluded that “needle exchange programs should be regarded as an effective component of a comprehensive strategy to prevent infectious disease.” (p.4)

NIH Consensus Development Statement

In March 1997, the National Institutes of Health published the Consensus Development Statement on Interventions to Prevent HIV Risk Behaviors, summarizing the proceedings of a Consensus Development Conference. A panel of non-Federal experts evaluated the available scientific information regarding behavioral interventions to reduce risk for HIV/AIDS. Presentations of scientific data were made to the panel by distinguished researchers, including ongoing evaluation studies of needle exchange programs. Specific behaviors and community contexts that produce elevated risks for HIV infection were reviewed, as well as the spectrum of available interventions to reduce behavioral risks. After reviewing the data on needle exchange programs, the panel concluded that these programs have beneficial effects on reducing behaviors

such as multi-person re-use of syringes. They reported that "studies show a reduction in risk behaviors as high as 80% in injecting drug users, with estimates of a 30% or greater reduction of HIV." (p.11) The panel also concluded that the preponderance of evidence shows either a decrease in injection drug use among participants or no changes in their current levels of use.

University of California at Berkeley and San Francisco Study for the CDC

In 1993 the University of California published a review and analysis of the literature on needle exchange programs to answer a number of research questions, including the effect of needle exchange programs on HIV infection rates and HIV risk behaviors. Study findings reported included the following: needle exchange programs served as a bridge to other health services, particularly drug abuse treatment; needle exchange programs generally reached a group of injecting drug users with long histories of drug injection and limited exposure to drug abuse treatment; there was no evidence that needle exchange programs increased the amount of drug use in participants or changes in overall community levels of drug use; needle exchange programs did not result in an increase in the number of discarded syringes in public places; the rates of HIV drug risk behaviors were reduced in needle exchange participants; needle exchange programs were associated with reductions in hepatitis B among injection drug users; and, the data were too limited at that time to draw conclusions about needle exchange programs and reductions in HIV infection rates.

Summary of New Research Findings

Since completion of the Department of Health and Human Services' February 1997 report to the Congress on needle exchange programs, several scientific studies have added new data on the effects of needle exchange programs, corroborating and expanding knowledge about the role needle exchange programs play in reducing HIV transmission. In addition, these new data continue to demonstrate that needle exchange programs do not encourage drug use, and in fact will increase referrals into drug treatment for hard-to-reach populations. A more complete description of these studies is provided at Appendix B.

In a study by Vlahov et al. (1997), reductions in high risk drug use behaviors and an increase in enrollment in drug treatment were observed in a cohort participating in the needle exchange program. In a study by Brooner et al (in press), a high rate of acceptance of substance abuse treatment and retention in treatment was demonstrated among injection drug users referred from needle exchange programs, despite greater severity of drug use and high risk behaviors for HIV and psychosocial problems in this group. Hurley et al (1997) identified decreased HIV seroprevalence among 29 cities with needle exchange programs compared to 52 cities without these programs, with cities selected according to the availability of HIV prevalence data for their injection drug using population for 2 or more years. Two studies from Canada reported increased HIV incidence among injection drug users also using needle programs, but the design of these studies and the behavioral characteristics of the study populations limit the

generalizability of the findings to the United States populations. Subsequent data from one Canadian study (Vancouver) has shown a significant decrease in HIV incidence since publication of the first study.

Methodological Considerations

In reviewing the scientific data on needle exchange, it is relevant to note the wide range of methodologic approaches utilized and the impact of these study design choices on the conclusions drawn. As was noted in the 1995 report by the National Academy of Sciences/Institute of Medicine, some of the studies that examine needle exchange and bleach distribution programs have various limitations including inadequate sample size, improper controls and problematic measures including self-reporting instruments. In behavioral research, these study designs and instruments are the best available tools to describe complex behaviors. In addition, multiple behavioral risk factors, including drug choices such as cocaine, confound the ability to isolate cause and effect relationships for HIV transmission among injection drug users. This whole body of research is burdened by these constraints.

Nevertheless, as the NAS/IOM report states "... the limitations of individual studies do not necessarily preclude us from being able to reach scientifically valid conclusions based on the entire body of literature available. The situation resembles the exploration of the relationship between cigarette smoking and lung cancer; virtually every individual study was vulnerable to some particular objection, yet collectively those studies justified a compelling conclusion. It was essential for the panel first to distinguish between studies of high quality and those of lesser quality, and then to weigh the credibility of the findings, according to their completeness and soundness. Using this approach, the panel based its conclusions on the pattern of evidence provided by a set of high-quality studies, rather than relying on the preponderance of evidence across less scientifically sound studies." p. 3-4

Maximizing the Public Health Benefits of Needle Exchange Programs

In assessing the public health benefits gained from needle exchange programs, certain characteristics have consistently emerged from the research data that confirms the unique role that needle exchange programs can play as part of the public health response to an epidemic driven by injection drug use. To ensure that federal dollars are maximized in this effort, a careful consideration of those factors most predictive of public health benefit must be heeded. To this end, it is critical that no reduction in drug treatment capability occur, as substance abuse treatment remains the long term strategy for reducing injection drug use and the associated risk of HIV transmission. Needle exchange programs are appropriately supported as an HIV prevention activity in those communities that choose to develop them. Other important factors include local support of health department leaders and affected communities for needle exchange as a necessary component of a broader, comprehensive HIV prevention plan. Those programs which consistently provide referral to medical and drug treatment afford the greatest opportunity

to reduce HIV infection and decrease injection drug use. Concerns among communities have highlighted the need for appropriate disposal of hazardous wastes. Where collection and disposal of used syringes has been implemented, and syringes are provided on a replacement basis only, community support has been achieved. Those programs that operate in accordance with state and local laws, or which are granted waivers from applicable laws, have shown the greatest success in linking together the range of medical and drug treatment services needed by their clients. Finally, there is an important role for ongoing evaluation of needle exchange programs to maximize their effectiveness in reaching high risk populations and providing the means for injection drug users to eliminate or reduce both their risks for HIV and injection drug use.

Public Health Implications

The scientific data now available have established the utility of needle exchange programs in reducing new HIV infections with no evidence of increasing injection drug use. The data supports the unique role needle exchange programs can play in creating an access point into social services, drug treatment and medical care for the population most responsible for new HIV seroconversions. This role as a conduit into care is amplified in that needle exchange programs offer, at multiple points in time, repeated opportunities for prevention intervention as well as an ongoing opportunity to develop trusting relationships between professional staff and the injection drug-using population. This is often the most significant social connection in an active drug user's life and creates a foundation with which future interventions may depend. In addition to the immediate replacement of a contaminated needle with a clean one, we see the efficacy of a needle exchange program as dependent on its relationship to a constellation of services that are directed at identifying high risk populations and creating formal conduits into care.

The public health need to target high risk populations most responsible for driving HIV seroconversion rates is evident. Our understanding of how HIV moves through communities must be structured into responses to epidemiologic surveillance data that describe modes of transmission. This includes allowing States and localities to coordinate their resources and target them to those population groups that cannot stop participating in high risk behaviors. However, federal funding is only appropriate for those programs that provide the critical linkages with drug treatment and health care services and incorporate the spectrum of prevention services that have proven effective HIV prevention tools.

We remain committed to exploring through research those factors that affect the demonstrated utility of needle exchange programs in curtailing transmission of HIV in communities and the relative effects on drug use and entry into drug treatment.

Attachments

- Appendix A: 1997 Report to Congress
- Appendix B: Analysis of Recent Data
- Appendix C: Summary Tables of Research Studies
- Appendix D: Summary of Data by Statutory Criterion



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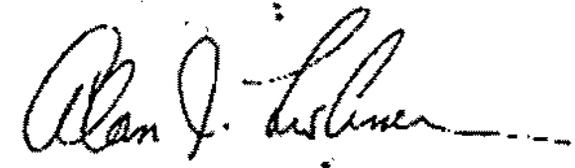
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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20251

FEB 18 1997

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

Dear Senator Specter:

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

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

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

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

Page 2 - The Honorable Arlan Specter

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

Sincerely,

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

Donna E. Shalala



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

P0-473

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FEB 18 1997

The Honorable Tom Harkin
Ranking Minority Member
Subcommittee on Labor, Health
and Human Services, and Education
Committee on Appropriations
United States Senate
Washington, D.C.

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

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

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

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

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

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

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

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

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

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

I. Review of Published Studies

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

Report of the U.S. General Accounting Office

The U.S. General Accounting Office (GAO) was requested by the Chairman of the House Select Committee on Narcotics Abuse and Control to: (1) review the results of studies addressing the effectiveness of needle exchange programs in the United States and abroad, (2) assess the credibility of a forecasting model developed at Yale University that estimates the impact of a needle exchange program on the rate of new HIV infections, and (3) determine whether federal funds can be used in support of studies and demonstrations of needle exchange programs.

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

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

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

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

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

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

Report of the University of California

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

The Executive Summary of the report is provided below:

***How and Why did Needle Exchange Programs Develop?**

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

How do Needle Exchange Programs Operate?

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

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

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

How Much Does it Cost to Operate Needle Exchange Programs?

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

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

Who Are the IDUs Who Use Needle Exchange Programs?

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

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

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

What Are the Community Responses to Needle Exchange Programs?

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

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

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

Do Needle Exchange Programs Affect the Number of Discarded Syringes?

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

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

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

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

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

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

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

Do Needle Exchange Programs Affect HIV Infection Rates?

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

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

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

Report of the National Academy of Sciences

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

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

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

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

Scientific Assessment of Program Effectiveness

* On the basis of its review of the scientific evidence, the panel concludes:

- o Needle exchange programs increase the availability of sterile injection equipment. For the participants in a needle exchange program, the fraction of needles in circulation that are contaminated is lowered by this increased availability. This amounts to a reduction in an important risk factor for HIV transmission.
- o The lower the fraction of needles in circulation that are contaminated, the lower the risk of new HIV infections.
- o There is no credible evidence to date that drug use is increased among participants as a result of programs that provide legal access to sterile equipment.
- o The available scientific literature provides evidence based on self-reports that needle exchange programs do not increase the frequency of injection among program participants and do not increase the number of new initiates to injection use.
- o The available scientific literature provides evidence that needle exchange programs have public support, depending on locality, and that public support tends to increase over time.* Preventing HIV Transmission: The Role of Sterile Needles and Bleach, Executive Summary, page 4.

Other Recent Studies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Current Federally Supported Research on Needle Exchange Programs

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

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

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

III. National Survey on the Regulation of Syringes and Needles

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

Summary

This review provides the Committee with an overview of the current status of knowledge regarding the impact needle exchange programs may have on the seroprevalence of HIV and their impact on drug use and behavior of needle exchange participants. Overall these studies indicate that needle exchange programs can have an impact on bringing difficult to reach populations into systems of care that offer drug dependency services, mental health, medical and support services. These studies also indicate that needle exchange programs can be an effective component of a comprehensive strategy to prevent HIV and other blood borne infectious diseases in communities that choose to include them.

IV. Appendices

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

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

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

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

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

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

GAO

Report to the Chairman, Select
Committee on Narcotics Abuse and
Control, House of Representatives

March 1993

NEEDLE EXCHANGE PROGRAMS

Research Suggests Promise as an AIDS Prevention Strategy





Supported by the
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service



AGENCY B

THE PUBLIC HEALTH IMPACT OF NEEDLE EXCHANGE PROGRAMS IN THE UNITED STATES AND ABROAD

Volume 1

SCHOOL OF PUBLIC HEALTH,
UNIVERSITY OF CALIFORNIA, BERKELEY

INSTITUTE FOR HEALTH POLICY STUDIES
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

PREPARED FOR THE CENTERS FOR DISEASE CONTROL AND PREVENTION

October 1993

ANNEX C

PREVENTING

HIV

TRANSMISSION

The Role of
Sterile Needles
and Bleach

NATIONAL RESEARCH COUNCIL • INSTITUTE OF MEDICINE

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HIV Incidence among Injecting drug users in New York City syringe-exchange programmes

Don C Des Jarlais, Michael Marmor, Denise Fennie, Stephen Titus, Qiduo Shi, Theresa Perlis, Benny Jose, Samuel R Friedman

Summary

Background There have been no studies showing that participation in programmes which provide legal access to drug-injection equipment leads to individual-level protection against incident HIV infection. We have compared HIV incidence among injecting drug users participating in syringe-exchange programmes in New York City with that among non-participants.

Methods We used meta-analytic techniques to combine HIV incidence data from injecting drug users in three studies: the Syringe Exchange Evaluation (n=280), in which multiple interviews and saliva samples were collected from participants at exchange sites; the Vaccine Preparedness Initiative cohort (n=133 continuing exchangers and 188 non-exchangers, in which participants were interviewed and tested for HIV every 3 months; and very-high-seroprevalence cities in the National AIDS Demonstration Research (NADR) programme (n=1029), in which street-recruited individuals were interviewed and tested for HIV every 6 months. In practice, participants in the NADR study had not used syringe exchanges.

Findings HIV incidence among continuing exchange-users in the Syringe Exchange Evaluation was 1.58 per 100 person-years at risk (95% CI 0.54, 4.65) and among continuing exchange-users in the Vaccine Preparedness Initiative it was 1.38 per 100 person-years at risk (0.23, 4.57). Incidence among non-users of the exchange in the Vaccine Preparedness Initiative was 5.26 per 100 person-years at risk (2.41, 11.49), and in the NADR cities, 6.23 per 100

person-years at risk (4.4, 8.6). In a pooled-data, multivariate proportional-hazards analysis, not using the exchanges was associated with a hazard ratio of 3.35 (95% CI 1.29, 8.65) for incident HIV infection compared with using the exchanges.

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

Introduction

The provision of sterile injection equipment (syringe exchanges or pharmacy sales) has been the main method for reducing HIV infection among injecting drug users (IDUs) in most industrialised countries.¹ After nearly a decade of research on legal injection equipment for preventing HIV infection, there is no evidence that such programmes are associated with increased illicit drug injection,² whereas that participation is associated with lower rates of drug-injection HIV-risk behaviour.^{3,4} To date, however, there has been no direct evidence that participation is associated with a lower risk of incident HIV infection for the individual IDU.⁵

New York City had rapid transmission of HIV among drug injectors, between 1978 and 1984, with seroprevalence reaching about 50%.⁶ A small-scale pilot syringe-exchange programme was started by the City Department of Health in 1988, although this programme was discontinued by a new mayor in 1990.⁷ Community activists then opened a number of "underground" exchanges. In 1992, the New York State Health Department permitted legal operation of five community exchanges. These exchanges expanded rapidly, providing services to about 36 000 IDUs by September, 1995, and exchanging 1.75 million syringes in 1994.

We report on incident HIV infections among IDUs in community-based syringe-exchange programmes in New York City from 1992 to 1995. We have reported on reductions in HIV risk behaviour among participants.^{8,9}

Lancet 1996; 348: 987-91

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(Mo.D.361) EVALUATION OF THE BALTIMORE NEEDLE EXCHANGE PROGRAM: PRELIMINARY RESULTS

Vlahov D, Junge, Benjamin, Beilenson P*, Brookmeyer RS, Cohn S, Armenian H. The Johns Hopkins School of Public Health; *Baltimore City Health Department.

Objective: To evaluate the first year of the Needle Exchange Program (NEP) for injection drug users (IDUs).

Methods: All participants between 8/12/94 and 8/11/95 who underwent enrollment interviews on sociodemographic and drug use practices. A systematic sample was interviewed at initial, two week and six month follow-up visits about needle acquisition, use and disposal practices during the 2 weeks before each interview. Data were analyzed using paired T-tests. In a community cohort (the ALIVE Study) demographics and HIV seroconversion rates were compared between participants who used vs. did not use the NEP.

Results: During the first year, 2965 IDUs enrolled in the NEP of whom 87% were African-American, 72% were male, 56% had < 12 years of education, 92% were unemployed and 90% injected | 1/day, the median age was 38 years old. Within the ALIVE cohort, NEP users were more likely to inject | 1/day, otherwise IDUs not enrolled in NEP were statistically similar. Of the 2965, 55% returned at least once to exchange, and 7% were high volume exchangers (> 50/visit); among high volume exchangers injection frequency and needles exchanged were similar. In the interviewed subset, there was a significant decrease (p < .05) of injections on the street, frequency of injection, needle sharing, use of galleries, and discarding needles on the street in the 2 weeks prior and subsequent to enrollment. These changes were sustained at the six month visit. **Conclusion:** This NEP has recruited a large number of IDUs and preliminary data suggest that the NEP attracts high risk IDUs, and that a reduction in HIV risk drug use is observed.

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[Tu.C.2523] NEEDLE EXCHANGE USE AMONG A COHORT OF DRUG USERS

Schoenbaum, Ellie E*, Hartel DM, Gourevitch MN. Montefiore Med Center, Albert Einstein College of Medicine, Bronx, New York, USA.

Objective: To prospectively study injection behaviors among IDU who did and did not utilize a local needle exchange in the Bronx, New York City.

Methods: Starting in 1985, IDUs attending a methadone maintenance program were enrolled in a prospective study of HIV-related risk behaviors. Since 1989, when a needle exchange opened near the methadone program, data were collected regarding the number and percent of needles obtained at the needle exchange. By end of 1993, 12.6% had died and 23.7% were lost to follow-up.

Results: Of 904 IDUs who injected between 1985 -1993, 21.9% used the needle exchange. Male gender (ORadj 1.57), HIV seropositivity (ORadj 1.39) and younger age (ORadj/10 yrs of age 1.66) were independently associated with needle exchange use. The percent injecting declined each year, preceding the needle exchange opening and concurrent with its operation (from 64.6% in 1985 to 43.6% in 1993). The proportion of active injectors using the needle exchange increased from 38/398 (9.6%) in 1989 to 140/251 (55.8%) in 1993. Among the 329 IDU who injected in 1988, the year before the exchange opened, 53/124 (42.7%)($p < .001$) who went on to use the needle exchange and 168/205 (81.9%)($p < .001$) non-users stopped or decreased injecting by 1993. Needle exchange users reported less needle sharing than non-users ($p < .05$ in 1993). HIV infected and uninfected IDUs were equally likely to decrease or stop injecting.

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

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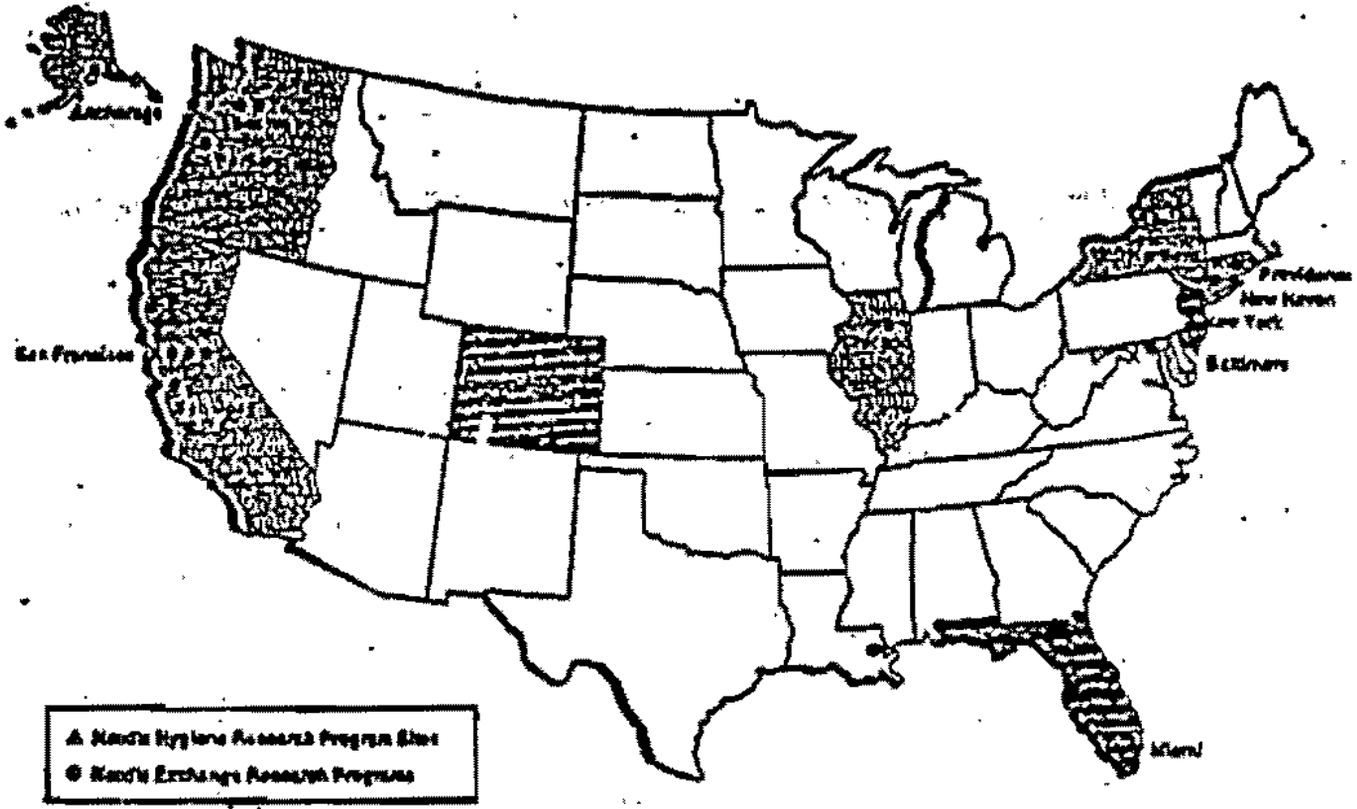
Final Report
First Year of the Pilot Needle Exchange Program
in Massachusetts

October 1995

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NIDA'S NEEDLE HYGIENE AND NEEDLE EXCHANGE EVALUATION RESEARCH PROGRAM PORTFOLIO 1992-PRESENT

NEEDLE HYGIENE AND NEEDLE EXCHANGE EVALUATION RESEARCH PROGRAM SITES



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Needle Hygiene Research Program Grantees

Michael Clatts, Ph.D., New York, NY; Steve Koertes, Ph.D., Denver, CO; Clyde B. McCoy, Ph.D., Miami, FL.

**NEEDLE EXCHANGE PROGRAMS:
ANALYSIS OF SCIENTIFIC DATA COMPLETED**

SINCE FEBRUARY 1997

NEEDLE EXCHANGE PROGRAMS: ANALYSIS OF SCIENTIFIC DATA COMPLETED SINCE FEBRUARY 1997

On February 18, 1997, the Secretary provided a report to the Committee on Appropriations reviewing all published studies on needle exchange programs in the United States and the status of federally-supported research. Since completion of that report, a number of researchers have published data in peer-reviewed journals or presented research findings at national conferences. The National Institutes of Health published a Consensus Development Statement, Interventions to Prevent HIV Risk Behaviors, in March 1997. Additional data have been submitted in abstract form to the 12th World AIDS Conference to be held in Geneva in the summer of 1998, but peer-review has not been completed at this time.

This report will review this recent body of data relevant to the issues of efficacy of needle exchange programs in reducing HIV transmission and their effect on utilization of illegal drugs. Consistent with the February 1997 report to Congress, this analysis will be limited to those studies undertaken in the United States, with the exception of inclusion of the Canadian research data from Vancouver and Montreal. The National Academy of Sciences/Institute of Medicine previously reviewed the data from Montreal, and it is included here in published form. Scientific data relevant to needle exchange programs reviewed during the NIH Consensus Development Conference which was published in March 1997 overlaps with the Department of Health and Human Services' February 1997 report to the Appropriations Committee. The conclusions drawn from the NIH Consensus Development Conference are reviewed.

NIH Consensus Statement: Interventions to Prevent HIV Risk Behaviors Volume 15, Number 2 February 11-13, 1997

The purpose of the consensus conference was to examine what is known about behavioral interventions that are effective with different populations in different settings for the two primary modes of HIV transmission: unsafe sexual behavior and nonsterile injection practices.

The consensus statement concluded that the scientific evidence shows that needle exchange program participants have a decrease in needle sharing, a decrease in drug use among participants, an increase likelihood of entering drug treatment programs, and in the vast majority of studies reviewed, there was no increase in used needles discarded in public places. The consensus conference summary conclusion was that needle exchange programs are an effective public health intervention for decreasing seroconversions in injection drug users and do not increase drug use.

Paone D, Des Jarlais D, Clark J et al. Update: Syringe-Exchange Programs - United States, 1996. Morbidity and Mortality Weekly Review 1997; Vol 46, No. 24: 565-568.

This report summarizes a survey of needle exchange programs in the United States regarding their activities during 1995 and 1996. A questionnaire was mailed to 101 syringe exchange

programs who were members of the North American Syringe Exchange Network, followed by a structured telephone interview. Eighty seven needle exchange programs participated in the survey (86% response rate), operating in 71 cities in 28 States and one territory. Fifty one syringe exchange programs began operating before 1995, with an additional 22 starting in 1995 and 14 in 1996.

In 1996, 84 needle exchange programs reported exchanging approximately 14 million syringes. Approximately 9.4 million syringes (69%) were exchanged in the 10 most active needle exchange programs. Fifty needle exchange programs (57%) reported exchanging 55,000 fewer syringes apiece, with 23 programs exchanging fewer than 10,000 syringes each. Data on the number of syringes exchanged was not available from 3 programs.

Ninety seven percent of needle exchange program respondents (84 programs) provided client referral to substance abuse treatment programs. Instruction to reduce sexual transmission of HIV and other STDs was provided by 97% of needle exchange programs. Health services offered on-site included HIV counseling and testing (40%), primary health care (17%), tuberculosis skin testing (26%) and STD screening (20%). All programs provided injection drug users information about safer injection techniques and/or use of bleach to disinfect injection equipment.

Fifty three percent (46) of needle exchange programs operated legally, in that they operated in a State without a law requiring a prescription to purchase a hypodermic syringe or had an exemption to the State prescription law allowing the needle exchange program to function. Twenty three percent (20) of needle exchange programs were defined as illegal-but-tolerated, as they operated in a State with a prescription law but had received a formal vote of support or approval from a local elected body. Twenty four percent (21) of needle exchange programs were defined as illegal underground programs. The legal needle exchange programs were more likely than illegal ones to offer on-site HIV counseling and testing (63% of legal vs. 20% of illegal needle exchange programs) and TB skin testing (41% of legal programs vs. 7% of illegal programs). The three needle exchange programs that did not refer clients to substance abuse treatment programs were illegal underground programs.

Vlahov D, Junge B, Brookmeyer R et al. Reductions in High-Risk Drug Use Behaviors Among Participants in the Baltimore Needle Exchange Program. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* 1997; 16:400-406.

Using systematic sampling, a subset of needle exchange program enrollees was recruited to participate in an evaluation study of injection practices among needle exchange program clients. The study hypothesis was that participation in a needle exchange program should reduce the frequency of high risk injection practices, contributing to a reduced risk for acquiring blood borne infections. All participants (2965) of the Baltimore needle exchange program were given a brief interview by needle exchange program staff at their first visit, covering demographic information and drug injection behavior for the previous 6 months. A subset of 422 (14.2%)

recruited into the evaluation study were statistically similar to the larger cohort with respect to most demographic and drug use variables; however, the evaluation group were more likely to be female (33.2% vs 26.9%), had a higher proportion of daily speedball (heroin mixed with cocaine) injectors (72.1% vs 64.3%), and had initiated injection drug use at a younger age (20.1 years vs. 20.8 years old). A follow-up interview at 2 weeks was completed by 335 (79.4%), and at 6 months by 221 (66%). Demographic and drug use characteristics of those returning at 2 weeks were similar to the original evaluation group, with the exception that drop-outs were 10% more likely to have used a needle after someone else. Comparison of the 221 clients studied at 6 months with the 114 who did not return were statistically similar with respect to demographic and drug use variables.

Drug use patterns and related behaviors before and after enrollment were compared for the 335 participants who completed the baseline and 2-week follow-up interviews. After joining the needle exchange program, the proportion of evaluation participants who injected at least daily declined (97% vs 88%, $p < .001$). Declines were observed in the use of syringe previously used by another person (20% vs 11.7%, $p < .001$), lending one's used syringe to a friend (27.7% vs 20.1%, $p = .003$), sharing cookers (60.5% vs 42.5%, $p < .001$), and sharing cotton (45.8% vs 33.5%, $p < .001$).

Injection frequency and syringe use variables were also examined. The mean injections per day decreased from 5.9 in the two weeks before enrollment to 4.9 in the two weeks after enrollment in the needle exchange program (mean change = -1.09, 95% confidence interval = -1.5, -0.68). The mean number of injections per syringe was 12.4 in the 2 weeks before and 8.5 in the 2 weeks after entry into the needle exchange program (mean change = -3.98, 95% CI -5.85, -2.11), and the median injections per syringe decreased from 6 to 4.3.

Regarding related practices, declines were reported in the proportion of evaluation participants who discarded needles in a street, alley, sewer or gutter (28.2% vs 15.6%, $p < .001$) and in the garbage or a dumpster (42.2% vs 29.1%, $p < .001$) at baseline and at 2 weeks. Injection settings also changed significantly, with declines in injections performed in friends' places (53.2% vs 41.7%, $p < .001$); streets, parks and restrooms (24% vs 16.2%, $p < .001$), empty houses and abandoned buildings (38.1% vs 21.6%, $p < .001$); and shooting galleries (22.9% vs 12.4%, $p < .001$).

Regarding experience with drug treatment, at baseline 5.9% of the injection drug user enrolled in the needle exchange program reported that they were in treatment. Two weeks after enrollment, 9.6% needle exchange participants reported having been in treatment, increasing to 15.9% reporting being in treatment at 6 months.

Data for participants completing the 6-month interview showed a sustained reduction in the proportion engaging in high risk injection practices at the 6-month visit. With the exception of syringe backloading ($p = .238$), all other behavioral changes from baseline to 6 months were statistically significant with $p < .001$. The number of daily injections decreased from 5.6 to 4.1

from baseline to 6 months ($p < .001$). The number of syringes used per day increased from 1.1 to 1.6 ($p < .001$). Accordingly, the mean number of injections per syringe declined substantially from 12.4 at baseline to 8.5 at 2 weeks, and 3.6 at the 6-month follow-up visit (median numbers 6.0, 4.3, and 2, respectively).

Baseline HIV seropositivity in the evaluation group was 29.9% at enrollment, and slightly higher among the subgroup of 335 returning at 2 weeks (32.5%). It is important to note that the difference was not statistically significant, and does not reflect any change in infection status given the smaller size of the returning group and the short two week time interval. This reflects the change in drop outs and is not indicative of an alteration in the baseline seroprevalence. HIV seropositive persons were more likely than HIV seronegative persons to be older, unemployed, to share cookers and cotton, and to inject at a shooting gallery.

Study design issues of note include the reliance on self-report and the absence of an external comparison group. To study the concern that self-reported data may reflect distortion based on concern for socially acceptable responses, the authors undertook a supplemental analysis of those injection drug users who reported no decrease in injection frequency. Among this subgroup of injection drug users who admitted continuing a socially undesirable risk behavior, the levels of decline for other drug-use related variables measured were similar to the overall evaluation group. This result increases the confidence that behavioral change, not socially conditioned responses, were responsible for the observed findings.

Hurley SF, Jolley DJ, and Kaldor JM. Effectiveness of Needle Exchange Programmes for Prevention of HIV Infection. *Lancet* 1997; 349:1797-1800.

An ecological study design was used to compare changes HIV seroprevalence over time among injecting drug users in 29 cities with needle exchange programs and 52 cities without needle exchange programs. The purpose of the design was to overcome methodological limitations of observational studies reliant on self-reported behavior. Cities were included in the analysis if HIV seroprevalence had been measured in injecting drug users in 2 or more calendar years, and basic information on needle exchange program implementation was available. Forty four of the study cities were in North America (54%), 32% in Europe, and 12.4% were in Asia and the South Pacific. The data from this study are included in this series due to the proportion of data coming from North America and the perspectives offered by the alternative study design. Of the North American cities, 17 had needle exchange programs and 27 did not.

Data from 214 published studies, and unpublished data from the CDC on HIV seroprevalence among injection drug users entering treatment between 1988-1993, were used in this study. The term HIV seroprevalence survey was defined as a measurement of HIV seroprevalence among injection drug users in a single city at a single point in time. The rate of change of HIV seroprevalence over time was estimated by regression analysis. Average slopes, or the rate of

change in HIV seroprevalence, were calculated for cities with established needle exchange programs during the period spanned by the surveys and those without needle exchange programs.

In the study cities, 1046 surveys of HIV seroprevalence involving 332,892 drug users had been done between 1980 and 1993, with 75% conducted in drug treatment centers. Some serum specimens had been collected and stored, and analyzed when HIV tests became available. The regression model showed that seroprevalence increased on average by 5.9% per year in the 52 cities without needle exchange programs, and decreased by 5.8% per year in the 29 cities with needle exchange programs ($p=.004$).

Study design issues limiting the analysis include different protocols used to collect seroprevalence data among diverse populations; however, it is unlikely that a systematic error would exist across cities with and without needle exchange programs. Selection of the cities studied may also reflect a bias in that decisions were made to conduct HIV seroprevalence surveys. HIV seroprevalence may also have remained low in some of the cities with needle exchange programs irrespective of their operation, and implementation of other HIV prevention strategies potentially confounds the study findings. Nevertheless, a plausible explanation for the differences in HIV prevalence across cities is that needle exchange programs lead to a reduction in HIV incidence in injection drug users.

Brooner R, Kidorf M, King V et al. Drug Abuse Treatment Success Among Needle Exchange Participants. Abstract Presented at APHA, Oct 1997. Accepted for publication Pub Health Rep: Special Supplement (Summer 1998)

New admissions to a Baltimore outpatient opioid substitution program were classified by their referral source (needle exchange program $n=82$, standard referral $n=243$) and followed for 3 months to assess early treatment response. Data on demographic characteristics, substance use and other psychiatric disorders were collected for each participant as well as prior history of treatment. Current psychiatric and substance use diagnoses were made using the Structured Clinical Interview for DSM-III-R (SCID). Dimensional data on severity of drug use and psychosocial impairment was obtained using the Addiction Severity Index-Fifth Edition (ASI). Outcome measures included retention in treatment rates, self-reported drug use and injection frequency, self-reported illegal activities for profit, and weekly urine tests for drugs. All patients admitted to this community-based drug treatment program received routine opioid agonist treatment and weekly individual and group counseling.

Patients in the needle exchange group were referred by the Baltimore City Needle Exchange Program. Out of a total of 160 out-of-treatment opioid abusers who were offered referral and guaranteed admission to the treatment program, 82 (51%) presented to the treatment program for admission. There were no significant demographic differences between the 82 referrals who entered treatment and the 78 referrals who did not seek admission.

There were significant differences in demographic characteristics, self-reported drug use patterns and psychosocial problems between the needle exchange program-referred group and standard referral group. Compared to baseline information for individuals in the standard referral group (SRS), the needle exchange program-referred group were older (40.6 yrs vs. 37.6 yrs, $p=.001$), more likely to be African American (85.4% vs. 49.8%, $p<.001$), had a greater proportion of men (69.5% vs 43.6%, $p<.001$) and higher rates of unemployment (93.9% vs 71.2%, $p<.001$). Significantly more referrals from needle exchange had cocaine dependence (74.1% vs 41.1%, $p<.001$) and reported remarkably higher rates of heroin and cocaine use than SRS referrals (for heroin 28.8 days vs. 17.2 days, $p<.001$). The needle group also reported significantly more days of injecting drugs (26 vs. 14 days, $p<.001$) and sharing of injection equipment (5.1 vs 1.8 days, $p=.01$). Needle exchange program referrals also reported higher severity scores for drug use, alcohol use and legal difficulties compared to SRS referrals (all p -values $<.001$). Needle exchange program referrals also reported spending more days in the past month engaged in illegal activity than SRS referrals (12.1 vs 3.2 days, $p<.001$) and earning more illegal income during this period (\$637 vs \$181, $p=.001$).

Retention rates at the completion of 13 weeks of treatment were 88% for the standard referral group and 76% for the needle exchange program group ($p=.004$); these rates compare favorably to published data on retention rates among new admissions to opioid substitution programs in the greater Baltimore area. Self-reported data comparing pre-treatment baseline data with data collected after 30 days of treatment showed significant short-term reductions in opioid and cocaine use, number of days engaged in illegal activity, and number of days injecting all drugs (all p values $<.01$). Patients in the needle exchange program group also had significant reductions in the amount of illegal income and number of days sharing injection equipment. There was a significantly higher proportion of opioid and cocaine-positive urine specimens among the needle exchange program referral group, but there were comparable reductions in opioid positive urine specimens between months 1 and 3 for the needle exchange program group (9%) and the SRS group (11%).

This data documented that significant acceptance of referral, and retention in drug treatment with an opioid agonist component, can be achieved among injection drug users referred from needle exchange programs, in the face of greater severity of drug use, high risk behaviors for HIV, and psychosocial problems common among this population. Limitations of the study design include use of self-report, self selection among those accepting referral to treatment, lack of self-reported data for 2 and 3 month follow-up intervals, and limited sample size.

CANADIAN STUDIES

Vancouver, British Columbia

One published study, one study in press, and one abstract presented at the 5th Conference on Retroviruses and Opportunistic Infections in February 1998 reporting on the Vancouver Injection

Drug Use Study are reviewed here. The study by Strathdee et al. reports on HIV incidence among a cohort of injection drug users and risk factors associated with HIV infection. The characteristics of the users of the Vancouver needle exchange program were further defined in a follow-up report by Archibald et al. The abstract by Raboud et al. describes a computer simulation model which could predict the outbreak of HIV in the Vancouver Injection Drug Use Study that was observed after years of stable incidence rates, coincident with a switch from heroin to injection cocaine among the injection drug using population.

Strathdee SA, Patrick DM, Currie SL et al. Needle Exchange Is Not Enough: Lessons From the Vancouver Injecting Drug Use Study. AIDS 1997;11:F59-F65.

Between May 1996 and February 1997, a cohort of 1006 injection drug users were continuously recruited for a study of HIV and hepatitis C (HCV) incidence and prevalence, and associated risk behaviors. Study participants provided blood samples for HIV and HCV antibody testing, and underwent an interviewer-administered questionnaire at baseline and semi-annually. The questionnaire collected data on risk behaviors, demographic information, non-injection and injection drug use practices, substance abuse treatment history, self-reported frequency of HIV tests, sexual behavior and condom use, incarceration, housing, and a variety of mental health and social issues. Information on needle exchange program attendance was also collected as: a) ever attended needle exchange program, and b) frequent use of needle exchange program (i.e. more than once a week) or less frequent use of needle exchange programs (i.e. less than once a week). Referrals were provided for medical care, HIV/AIDS care, available drug and alcohol treatment, and counseling at each study visit.

Prevalence study Prior baseline estimates of HIV prevalence in 1988 among the Vancouver injection drug using population was 1-2%, which remained stable until 1994. For the injection drug using study cohort, baseline HIV prevalence was 23.2%; HCV prevalence was 88%. HIV positive injection drug users were more likely to be women ($p = .02$), significantly more likely to have less than a high school education, unstable housing, and to reside in a downtown Vancouver neighborhood which is the poorest district in Canada. HIV positive injection drug users were also significantly more likely to be established injection drug users (> 2 years), more likely to report engaging in commercial sex work, and more likely to inject with others. The most frequently injected drug among the cohort was cocaine, with HIV positive injection drug users reporting cocaine use more commonly than HIV seronegative injection drug users ($p < .001$). The proportion of HIV-positive and HIV-negative injection drug users who reported lending and borrowing used needles in the previous 6 months were nearly identical; almost one-half (45%) reported sharing other injection paraphernalia. HIV-positive injection drug users were more likely to have ever attended needle exchange programs (96% vs 91%, $p = .01$), and to attend needle exchange programs on a more regular basis, i.e. more than once a week (81% vs 71%, $p = .002$), compared with HIV-negative injection drug use.

Multiple logistic regression was used to identify independent predictors of HIV-positive serostatus. Behavioral variables independently associated with positive HIV serostatus were commercial sex work, borrowing used needles, injecting with others, being an established injection drug user, and attending a needle exchange program more than once per week. Sociodemographic variables independently associated with positive HIV serostatus were unstable housing and low education.

Incidence. At the time of the first follow-up, 83% of the initially enrolled cohort returned. Of the 257 individuals who were seronegative at baseline, 24 HIV seroconversions had occurred yielding an estimated HIV incidence of 18.6 per 100 person years. The small number of new seroconversions precluded formal statistical analysis, but similarities with the larger HIV positive cohort included the proportion who were established injection drug users, most commonly injected cocaine, resided in unstable housing (primarily single room occupancy hotels), and the proportion who were women. Needle exchange programs were the most frequent source of syringes for all but one new HIV seroconverter.

Study design and context considerations include the possibility of self-selection bias among those returning for follow-up, if individuals suspecting an HIV exposure disproportionately returned. While cocaine injection was not an independent risk factor for HIV, cocaine was more commonly the drug of choice for HIV-positive injection drug users and is commonly associated with more frequent injections. The estimated 6000-10,000 injection drug users in Vancouver, conservatively estimated to have 2.5 injections per day, exceeded the capacity of the needle exchange program to provide sterile injection equipment. The finding that frequent needle exchange program attendance was independently associated with HIV prevalence should not be interpreted as a causal, as the majority of subjects attended needle exchange programs at least once. The absence of significant change in HIV prevalence between 1988, when the needle exchange program was established, and 1994 is relevant.

NOTE: The HIV incidence rate in the injection drug use cohort was 18.6 per 100 person years between December 1996 to June 1997. Since June 1997, the incidence rate has been stable at 4.4 per 100 person years. Personal Communication from S. Strathdee.

Archibald CP, Ofner M, Strathdee S et al. Factors Associated with Frequent Needle Exchange Program Attendance in Injection Drug Users in Vancouver, Canada. In Press. JAIDS.

A case control study to identify factors associated with frequent needle exchange program attendance was conducted among a community of injection drug users in Vancouver. Cases (n=89) were defined as those injection drug users with a newly positive HIV test result after January 1994 and who had a negative HIV test result within the prior 18 months. Controls (n=192) were HIV seronegative injection drug users who had two HIV-negative test results during the same period. Participants were recruited through street outreach, HIV testing

sites, local health care providers and inner city service agencies. A questionnaire was used by trained interviewers to collect participant responses on the following issues, focused on the interval between the two HIV tests: demographic information, drug injection and sexual behavior, needle exchange program attendance, history of incarceration, mental health, and social factors such as housing and source of income. Information on needle exchange program attendance included if the injection drug user had attended the fixed site needle exchange programs, mobile van, and the average frequency of their visits to either during the inter-test interval. Logistic regression analysis was used to examine the effects of a range of variables on needle exchange program attendance.

Of 274 participants providing information on frequency of needle exchange program attendance, 31% (84) attended the needle exchange programs daily, 27% (75) once every 2 to 6 days, 15% (42) once per week, 9% (25) one to three times per month, and 8% (23) did not use the needle exchange programs in the inter-test interval. Frequent attendees of the needle exchange programs were more likely to cite the needle exchange program as their main source of needles; about one fourth of participants reported difficulty obtaining new needles.

Cocaine was the drug of choice among study participants, with 90% of injection drug users reporting cocaine injection during the inter-test interval; 70% injected heroin during this time. For men and women, frequent needle exchange program attendance was associated with injecting any drug >4 times/day ($p < .001$), injecting cocaine >4 times/day ($p < .004$), and borrowing used needles ($p = .003$ for women). For women, four additional variables were associated with frequent needle exchange program attendance: having a nonlegal source of income ($p = .03$), living in unstable housing ($p < .001$), using shooting galleries ($p = .003$), and not having a regular heterosexual sex partner ($p = .02$).

After adjusting for HIV serostatus, residence in Vancouver, and use of a mobile needle exchange program van in multi variate analysis, frequent cocaine injection was the only variable significantly related to needle exchange program attendance for men (adjusted odds ratio (AOR) 3.9; 95% confidence interval (CI) 1.8 - 8.3). Variables independently associated with needle exchange program attendance among women were: frequency of any drug injection (AOR=5.5, CI 1.7-17), shooting gallery attendance (AOR=1.5, CI 2.2-66), and having a nonlegal source of income (AOR=3.4; CI 1.0-12).

Study design and context issues include reliance on self reported data with a recall period of up to 18 months, artificially establishing an HIV prevalence of 32% among the study population due to the case control design, potential under representation of male injection drug users who have sex with men, and limitation to those injection drug users with at least two HIV tests in the prior 18 months. The prevalence of cocaine use is a probable factor in the increased demand for needles, consistent with the observation that men who were frequent needle exchange program attendees were four times more likely to be frequent injectors of cocaine. The study design does not determine the effect of needle exchange program attendance on behavior, but it does document that the Vancouver needle exchange program appears to attract high risk persons. The

finding that needle exchange programs attract high risk injection drug users could explain a paradoxical association between needle exchange program attendance and HIV prevalence and incidence, as sharing patterns and injection frequency among this population contribute to HIV risk independently of needle exchange program utilization.

Raboud JM, Thorne AE, Strathdee SA et al. Explosive HIV Epidemics in Injection Drug Users - What are the Causes and Controls? Abstract presented at 5th Conference on Retroviruses and Opportunistic Infections, Chicago, IL February 1998.

The purpose of this study was to determine the role of various factors in explosive outbreaks of HIV among injection drug users in cities such as Vancouver, where incidence rapidly increased to 18.6/100 person years following a long stable period with annual rates of 1%-2%. Computer simulations were run to study the effects of the following factors on the rates of HIV seroprevalence and seroincidence among injection drug users: number of needle-sharing partners, rate of change of partners, pattern of social networks in the injection drug user community, and high rates of infectivity in the first 3 months after seroconversion (acute phase of infection). Infectivity in the acute phase was set at 50-100 fold relative to the chronic phase, based on acute phase viral load data collected at the BC Center for Excellence in HIV/AIDS in Vancouver. The outbreak of HIV was simulated by approximately doubling the contact rates among injection drug users, as likely occurred when injection drug users switched from heroin to cocaine injection use in 1994. This effect was observed in the model only when a high rate of infectivity was postulated for the acute viral infection stage; reducing infectivity (as would occur with aggressive screening and antiretroviral therapy) limited the epidemic significantly. The presence of a "core group" of high risk individuals and the number of concurrent needle-sharing partners were also very influential.

Montreal, Quebec

Bruneau J, Lamothe F, Franco E et al. High Rates of HIV Infection Among Injection Drug Users Participating in Needle Exchange Programs in Montreal: Results of a Cohort Study. American Journal of Epidemiology 1997; 146 No.12:994-1002

A cohort of 1599 active injection drug users were recruited for an observational study of the association between use of needle exchange programs and baseline HIV seroprevalence and cumulative HIV seroincidence. Participants were recruited on an ongoing basis between September 1988 - January 1995 from a hospital detoxification unit, community-based social service agencies and city outreach workers. Injection drug users were eligible if they had injected drugs within the last 6 months. Participants completed a baseline questionnaire-based interview that included Sociodemographic characteristics, knowledge and attitudes concerning HIV infection, drug use, and sexual behavior, and had an HIV test performed. A similar questionnaire and repeat HIV test was included at a first follow-up visit at 3 months and at 6

month follow-up visits thereafter. Data were analyzed using three risk assessment scenarios: seroprevalence analysis, seroincidence analysis, and a nested case control study. Adjusted odds ratios were calculated to address the potential confounding effects of drug utilization and sexual practices.

Seroprevalence analysis Baseline HIV seroprevalence among the full cohort of 1599 was 10.7% (171 HIV+). The majority of subjects were male (79.7%); mean age at entry was 32.2 years, although women were slightly younger with mean age of 28.9 yrs. Half of the women reported involvement in prostitution. Most participants reported consumption of multiple drugs lasting an average of 9.1 years, with cocaine the drug of choice for 64.2% of subjects; 82% reported having injected drugs in the previous month. Differences between needle exchange program attenders and non-attenders were analyzed, with needle exchange program attenders defined as subjects who reported having obtained equipment from a needle exchange program at least once in the 6 months prior to study enrollment. Needle exchange program attenders were significantly more likely to be HIV seropositive, younger, of lower income, and to have been in treatment for addiction less frequently. Needle exchange program attenders also reported higher frequencies of risk behaviors related to drug injection and more frequent involvement in prostitution activities. The odds ratio for HIV seropositive status associated with participation in needle exchange programs was 3.0 (95% confidence interval 2.2-4.5). Further adjustment for potential confounders reduced the magnitude of the association but consistent risk elevation was observed for needle exchange program attenders.

Seroincidence analysis The study cohort used for the seroincidence analysis included 974 HIV-negative subjects with a mean follow-up period of 21.7 months (median 15.4 months). Subjects differed from those initially seronegative persons (377) who were lost to follow-up on the following parameters: proportion of male subjects (81% vs. 74% lost to follow-up), cocaine as drug of choice (64% vs 57%), sharing in last 6 months (78% vs 68%), having two or more sharing partners in the last month (23% vs 17%), getting syringes and needles at the drug dealer (57% vs 33%), franco phones (80% vs 72%) and declaring a lower income (11.5% vs 21%). Subjects lost to follow-up more often reported sharing with an HIV-positive partner (11% vs 7%). There were 89 incident cases of HIV seroconversion during follow-up for an overall incidence was 5.1 /100 person years. Among needle exchange program attenders, incidence was 7.9/100 person years (95% CI 6.0-10.2), and 3.1/100 person years among non-needle exchange program attenders (95% CI 2.1-4.4). The cumulative probability of HIV seroconversion for persons using a needle exchange program in the 6 months prior to study enrollment remained significant after adjustment for potential confounders.

Nested case-control analysis The case-control analysis was done using 88 new seroconversion cases (1 was dropped due to matching difficulties) and 320 matched controls. Substantial HIV risk elevations among needle exchange program users were observed for both those persons obtaining their intravenous equipment exclusively from the needle exchange program and those also obtaining equipment from other sources (i.e. friends, pharmacies, drug dealers, shooting galleries). The consistency of reported needle exchange program attendance was also evaluated

for an effect on HIV seroconversion; consistent attenders were defined as those who reported some needle exchange program attendance at all visits, and intermittent attenders were those reporting needle exchange program attendance at some but not all visits. Compared with non-attenders and intermittent attenders, consistent needle exchange program attenders were more likely to identify cocaine as their drug of choice (84.6%), had injected more often in the last month (76% with 30 injections or more), and had more sharing partners in the last month. There was a clear tendency for risks of seroconversion to increase with frequency of needle exchange program use over time; this remained significant only among consistent needle exchange program users and for males only after adjustment for potential confounders.

Study considerations include the observational study design which is not structured to address a possible causal relationship between needle exchange program attendance and HIV infection. Possible limitations include reliance on self-reported data, subject recruitment relying heavily on informal word-of-mouth advertisement which may have over sampled high-risk individuals, and different baseline HIV prevalence among groups of injection drug users. Limitations on the number of needles exchanged per visit may have underestimated the need for clean equipment among this population with substantial cocaine use. The ready availability of clean equipment through neighborhood pharmacies may also have resulted in needle exchange programs attracting existing core groups of marginalized, high risk individuals.

Note: Commentary on the Bruneau study by Lurie, and Bruneau's response are included in this same journal issue.

Discussion

The empirical data reviewed by the GAO report (1993), CDC/UCSF (1993), NAS/IOM (1995), NIH Consensus Conference (1997) and the department's review of 1997 and 1998, indicate that needle exchange programs are an effective component of a comprehensive HIV prevention strategy that will limit the spread of HIV and other blood borne diseases. The data presented in the aforementioned articles increase the Department's confidence that needle exchange programs can be an effective component of a comprehensive HIV prevention strategy. Studies reviewed in the February 1997 report to Congress indicate that needle exchange programs significantly reduce HIV seroincidence, and reduce Hepatitis B and Hepatitis C. In addition, these studies demonstrate that needle exchange participants reduce needle sharing and thereby reduce the circulating time of used syringes in a given community.

The data reviewed in this analysis indicates that where formal links are created between a needle exchange program and drug treatment, with dedicated slots available, injection drug users referred by a needle exchange program are more likely to enter drug treatment and be retained. In addition short term reduction in high risk behavior were more likely in the needle exchange program referred group. These data demonstrate the enhanced ability to decrease new HIV seroconversions when needle exchange programs are implemented in concert with drug and

medical services and are a solid component of a comprehensive HIV prevention plan. It is critical to keep in mind, that injection drug users are not only themselves at risk for HIV, but they are a bridge to other populations, their sexual partners and their children. Data showing an increased incidence of HIV in needle exchange users demonstrates the ability to target the highest risk populations, even when compounded by the use of cocaine. When that same cohort is followed over time incidence moves down for needle exchange program participants (Strathdee, HIV incidence 18.6 per 100 person years declining to 4.4 per 100 person years).

Targeting the injection drug using population may well become a priority for those States and municipalities where injection drug use is driving their epidemics. Needle exchange programs are often the only prevention intervention available to impacted States and cities that are successful at creating an interface with this most difficult to reach population. The preponderance of evidence clearly shows HIV transmission is preventable in injecting drug user populations when exchange programs are linked to drug treatment and medical care. These "linked" needle exchange programs demonstrate higher rates of referral, entry and retention.

NEEDLE EXCHANGE PROGRAMS: AN UPDATED REVIEW OF RESEARCH ON THE EFFECTS OF NEPs

Findings from 27 published studies of Needle Exchange provide data on the following endpoints/outcomes:

- ▶ Characteristics of US Needle Exchange Programs
- ▶ Risk of HIV and other blood borne infections in IDUs
- ▶ Risk behaviors associated with HIV in IDUs
- ▶ Protective behaviors against HIV among IDUs
- ▶ Discarding of dirty needles on the streets
- ▶ Initiation of drug injection by non-IDUs
- ▶ Linking IDUs to drug treatment

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NIDA/DEPR/CRB

Prepared 2/17/97

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Includes studies published since Secretary's report 02/18/97

**Revised 2/25/98 to

**Include updated summaries of Strathdee et al., 1997 and Bruneau et al., 1997

Reviewed and revised 4/6/98

Table 1.1: US Needle Exchange Programs Characteristics

Author/Purpose	Sample/Design	Results/Findings	Comments
<p>*Paone, Des Jarlais, et al., 1997, MMWR, 46:565-568.</p> <p>Identify activities of US NEPs for 1995/96</p>	<p>National survey of all 101 NEP programs that were members NASEN in 1996</p>	<ul style="list-style-type: none"> - 84 NEPs exchanged 14 Million syringes - 97% refer to Tx - 97% provide info on sexual risk - 81% provide STD prevention ed. - 40% testing & counseling - 26% TB testing - 20% STD screening - 17% primary health care 	<ul style="list-style-type: none"> - Current estimate of 120 NEP - 53% operate legally - NEPs provide ancillary services

Table 1.2: Effects of NEP Legal Status on Referrals to Drug Treatment.

Author/Purpose	Sample/Design	Results/Findings	Comments
<p>Paone et al., 1996</p> <p>To describe characteristics of US NEPs.</p>	<p>Review of 60 NEP programs in U.S. (46 cities in 21 states)</p>	<p>Provided formal referrals to drug treatment</p> <ul style="list-style-type: none"> • 79% of legal programs (26 of 33) • 48% of illegal programs (13 of 27) 	<p>Fully legal status was associated with providing formal referrals to drug treatment services, always having a sufficient syringe supply, having funding for biohazardous waste disposal, and having longer hours of operation.</p>

Table 1.3: HIV Infection Rates (11 studies: 3 found significant reductions in HIV seroincidence, 1 found no seroincidence associated with NEP participation, 1 found increases in HIV incidence, 3 found reductions in seroprevalence, and 2 found stable seroprevalence, and 2 found increases in seroprevalence)¹

Authors/Purpose	Sample/Design	Results/Findings	Comments
Heimer et al., 1992 To assess the prevalence rates of HIV in needles/syringes used by New Haven IDU.	1,860 randomly selected needles distributed and returned to the needle exchange Prospective open cohort	HIV seroprevalence rates <ul style="list-style-type: none"> • Pre-NEP: prevalence at 68% • NEP in 1st 2 months: prevalence at 64% • NEP after 4 months: prevalence stable at 43% (reflecting a 33% decrease) 	Independent reviews of model support conclusions about HIV infections averted by NEP.
Kaplan & O'Keefe, 1993; Kaplan, 1994 Estimate change in seroincidence rate among IDUs following their enrollment in New Haven NEP	Randomly selected syringes Mathematical models using unique Syringe Tracking and Testing System	HIV seroincidence: <ul style="list-style-type: none"> • 33% reduction among program participants • 0.7 to 1.6 infections prevented per 100 person years 	
Kaplan & Heimer, 1994, 1995 Provide more accurate estimates (Maximum likelihood model) of change HIV incidence rates among IDUs who use NEP.	2,813 tested needles that were distributed and returned between November 1990 and June 1992 Maximum likelihood change point model applied to empirical data gathered in Syringe Tracking and Testing System	HIV seroincidence <ul style="list-style-type: none"> • Incidence rate of 1.63 per 100 person years among program participants which was found not to differ from zero which means that the best estimate of new infection among needle exchange participant is zero 	

Table 1.3 continues on next 3 pages.

¹Note: One of the 11 studies (i.e., Bruneau et al., 1997) examined both Incidence and Prevalence of HIV, making total number of finding equal to 12.

Table 1.3: HIV Infection Rates (Continued)

Authors/Purpose	Sample/Design	Results/Findings	Comments
<p>Watters, 1994</p> <p>To examine change in HIV risk behaviors and prevalence among IDUs between 1986 & 1992.</p>	<p>5,956 IDUs recruited from street settings and detoxification clinics</p> <p>Ecological study with 13 semiannual cross-sectional surveys over 6.5 years, 1986-1992</p>	<p>HIV seroprevalence rates</p> <ul style="list-style-type: none"> • Needle exchange was implemented in 1988 • HIV prevalence rate doubled between 1986 and 1987 and remained stable between 1987 and 1992 (12%) 	<p>Cross-sectional data</p>
<p>Des Jarlais et al., 1994</p> <p>Examine trends HIV risk behaviors & HIV prevalence among IDUs between 1984 & 1992.</p>	<p>1,115 IDUs admitted to drug detoxification program</p> <p>Ecological study with 2 randomly selected cross-sections, 1984 and 1992</p>	<p>HIV seroprevalence rates</p> <ul style="list-style-type: none"> • Stable HIV prevalence at slightly more than 50% 	<p>Cross-sectional data</p>
<p>Des Jarlais et al., 1996</p> <p>Compare HIV incidence among IDUs who use NEPs with that among IDUs who do not participate.</p>	<p>2,630 IDUs from</p> <ul style="list-style-type: none"> • Syringe Exchange Evaluation (SEE) • Vaccine Preparedness Initiative (VPI) • National AIDS Demonstration Research (NADR) <p>Meta-analytic technique combining HIV incident data across 3 studies</p>	<p>HIV seroincidence</p> <ul style="list-style-type: none"> • SEE: among continuing NEP users, incidence was 1.58 per 100 person years at risk (pyar) • VPI: among continuing NEP users, incidence was 1.38 per 100 pyar; among non-NEP users, incidence was 5.26 per 100 pyar • NADR: among non-NEP users, incidence was 6.23 per 100 pyar • Pooled 3-study data indicate that non-NEP use was associated with a 3.35 greater risk of HIV infection 	<p>Causal link can not be made between NEP use and seroincidence.</p> <p>Data does show that NEP participation is protective of HIV seroconversion</p> <p>Dose response relationship between NEP participation and HIV infections averted.</p>

<p>*Hurley, Jalley, & Naidor, 1997, 349:1797-1800.</p> <p>Compare changes over time in HIV seroprevalence among IDUs for cities with and without NEPs.</p>	<p>Ecological study of 81 cities across Europe, Asia, and North America</p>	<p>Seroprevalence among increased ^{decreased} by 5.0% per yr in the 52 cities without NEPs, and decreased by 5.8% per yr in cities with NEPs.</p> <p>The average prevalence rate was 11% lower in cities with NEPs.</p>	<p>Cities in Europe, Asia, and the US with NEPs report seroprevalence decrease.</p> <p>Due to the study design, no causal link between the presence of NEP and HIV prevalence reductions can be made.</p>
<p>*Strathdee, et al., 1997, AIDS, 11:F59-F65.</p> <p>Describe HIV prevalence and incidence among prospective cohort of IDUs</p>	<p>1,006 IDUs were recruited through street outreach. Prospective cohort study with baseline, semi-annual data collection.</p>	<p>Predictors of HIV + status were: - low education, unstable housing, commercial sex, borrowing needles, injecting with others, and frequent NEP attendance.</p> <p>- 23 of the 24 HIV Seroconverters reported NEP as their most frequent source of needles and only 5 reported having difficulty accessing sterile syringes.</p>	<ul style="list-style-type: none"> • Despite availability of NEPs, high incidence was reported • NEP user most frequently report cocaine use • Comprehensive services such as counseling & testing, drug treatment appear not to have been &/or insufficient to prevent HIV • Study is epidemiologic in nature, was not intended to evaluate NEP (92% of study participant attended NEP) • Can not establish causal relationship between NEP use and HIV infection. • Comprehensive services such as counseling & testing, drug tx appear not to be available or insufficient to prevent HIV infection.

<p>*Bruneau et al., 1997, Am J of Epidemiol, 146:994-1002.</p> <p>Assess the association between risk behaviors and HIV seroprevalence and incidence among IDUs in Montreal.</p>	<p>1,599 IDUs were recruited to participate in this open prospective cohort study.</p> <p>Data analyses included:</p> <ul style="list-style-type: none"> - Cross-sectional analyses of baseline data to assess association of NEP use and serostatus, - Cohort analyses of NEP use at baseline as predictor of conversion, - Nested case-control analysis of NEP use during follow-up as predictor of conversion. 	<ul style="list-style-type: none"> - NEP users were 2.2 times more likely to be positive at baseline. - The cohort analysis showed that the cumulative probability of HIV conversion was found to be 33% for NEP users versus 13% for Nonusers. - Nested case-control study revealed that consistent NEP users was associated with seroconversion (odds ratio = 10.5). 	<p>NEP users were at higher risk at baseline than non-NEP users.</p> <p>Study was not designed or intended to evaluate NEP.</p> <p>Epidemiologic study.</p> <p>No causal link between NEP participation and HIV infection can be made.</p>
<p>*Lurie & Drucker, 1997, The Lancet, 349:605-608.</p> <p>Estimate the number of HIV infections that could have been averted (and associated cost) between 1987 and 1995 in the US had NEPs been implemented.</p>	<p>Implement a mathematical model using empirical data from available epidemiological data from the US and Australia.</p>	<ul style="list-style-type: none"> - Estimates that between 4,304 and 9,666 HIV infection could have been averted between 1987 and 1995. - The cost to the health care system for treating these preventable infections range between 244 to 538 million. 	<p>Estimates are based on mathematical modeling which make stringent assumptions (it is appropriate to use empirical estimate from Australia to estimate US experience).</p>
<p>*Singer et al., 1997</p> <p>To assess the effect of environmental changes on HIV risk behaviors and prevalence among IDUs.</p>	<p>3,050 randomly selected needles r Prospective open cohort with pretest and posttest measures returned to NEP</p>	<p>HIV seroprevalence rates:</p> <ul style="list-style-type: none"> > Baseline NEP: prevalence at 58% > NEP after 2.5 years: prevalence relatively stable at <40% 	

Table 1.4: Hepatitis B (HBV) and Hepatitis C (HCV) Infection Rates (2 studies: 2 found significant reductions)

Authors/Purpose	Sample/Design	Results/Findings	Comments
<p>Hagan et al., 1991</p> <p>To report on HBV incidence and determination of risk behaviors for observed new HBV infections.</p>	<p>All incident HBV cases among IDUs, 1985-90</p> <p>CDC HBV case reports: sentinel surveillance pre-post needle exchange</p>	<p>Outbreak of HBV among IDU in 1985 (40 incident cases) dropped rapidly a few months following the opening of the NEP to 9 incident cases in 1990</p>	<p>Low HIV prevalence site. NEP began in Amsterdam to reduce risk of hepatitis.</p>
<p>Hagan et al., 1993</p> <p>To examine the association between syringe exchange use and hepatitis B and C in IDUs.</p>	<p>Cases:</p> <ul style="list-style-type: none"> • 28 HBV IDUs • 20 HCV IDUs <p>Controls:</p> <ul style="list-style-type: none"> • 38 No-HBV IDUs • 26 No-HCV IDUs <p>Case control study</p>	<ul style="list-style-type: none"> • Non-NEP use associated with a 5.5 greater risk of HBV • Non-NEP use associated with a 7.3 greater risk of HCV 	<p>Low HIV prevalence area.</p>

Table 2.1: Reductions in Injection Frequency (9 studies: 4 had significant reductions, 3 had mixed findings, and 2 were not significant)

Authors/Purpose	Sample/Design	Results/Findings	Comments
Guydish et al., 1993 To evaluate potential negative effects of the San Francisco NEP	35,460 drug treatment admissions of which 24,120 were IDUs Ecological cross-sectional study. Data on records 2 years preceding NEP (1987-1988) and 2 years following NEP implementation.	Decrease significant and stable not significant: Proportion (%) of IDUs in various categories of frequency of injection in last 30 days <ul style="list-style-type: none"> Decrease % of IDU injecting 2-3 times a day (before NEP 41% vs after NEP 28%) Stable % of IDUs injecting once a day or less (before NEP 17% vs after NEP 17%) Increase % of IDUs more than 3 times a day (before NEP 40.7% vs after 55.4%) 	
Hagan et al., 1993 To assess the potential effectiveness of the Tacoma NEP	204 needle exchange participants Retrospective cohort study (pre-post measure)	Decrease not significant: Mean monthly injection frequency <ul style="list-style-type: none"> Stable injections at 155 a month prior to first use of NEP and 152 a month while participating in NEP 	
Walters et al., 1994 To evaluate a syringe exchange in San Francisco.	5,644 IDUs recruited from street settings and detoxification clinics Ecological cross-sectional study using 11 semiannual cross-sectional surveys over 5.5 years (12/86-6/92)	Median daily frequency of injection declined: <ul style="list-style-type: none"> from 1.9 to 0.7 injections per day 	
Paone et al., 1994 To evaluate NYC lower East side NEP.	1,752 IDUs, randomly selected needle exchange participants Multiple random cross-sections of NEP participants with recapture feature using retrospective data collection over 8 months (10/92-6/93)	Mean monthly frequency of injections declined: <ul style="list-style-type: none"> from 95.2 to 85.6 times per month. 	
Oliver et al., 1994 Evaluate NEP in Portland, OR.	<ul style="list-style-type: none"> 83 participants attending NEP ≥ 4 times 32 participants attending > 4 times Prospective cohort study with pre-post measures	Mean monthly frequency of injection <ul style="list-style-type: none"> Frequent NEP attenders: Baseline 28.7 reduced to Follow-up 8.9 Infrequent NEP attenders: Baseline 33.0 reduced to Follow-up 30.7 	

<p>Des Jarlais et al., 1994</p> <p>Examine trends HIV risk behaviors & HIV prevalence among IDUs between 1984 & 1992.</p>	<p>1,115 IDUs admitted to drug detoxification program</p> <p>Ecological study with 2 randomly selected cross-sectional samples, 1984 and 1992</p>	<p>Decrease significant and stable not significant</p> <p>Mean Frequency of Injection per month</p> <ul style="list-style-type: none"> • Decrease cocaine injections per month (55 vs 43) • Stable heroin injections per month (46 vs 44) • Stable speedball injections per month (43 vs 41) 										
<p>Hagan et al., 1994</p> <p>To update the evaluation of Tacoma NEP.</p>	<p>426 needle exchange participants</p> <p>Retrospective cohort study</p>	<p>Decreases not significant (OR=.83, p>.05)</p> <p>Proportion of IDUs who inject < 37 times per month and injectors who inject ≥ 37 times per month</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th></th> <th style="text-align: center;">Pre-exchange</th> <th style="text-align: center;">Post-exchange</th> </tr> </thead> <tbody> <tr> <td>< 37 per month</td> <td style="text-align: center;">42.2%</td> <td style="text-align: center;">46.9%</td> </tr> <tr> <td>≥37 per month</td> <td style="text-align: center;">57.8%</td> <td style="text-align: center;">53.1%</td> </tr> </tbody> </table>		Pre-exchange	Post-exchange	< 37 per month	42.2%	46.9%	≥37 per month	57.8%	53.1%	
	Pre-exchange	Post-exchange										
< 37 per month	42.2%	46.9%										
≥37 per month	57.8%	53.1%										
<p>Schoenbaum, Hartel, and Gourevitch, 1996, AIDS, 10:1729-1734.</p> <p>To compare prospectively injection behaviors of IDUs in methadone Tx who did and did not use local NEP.</p>	<p>904 IDUs who injected between 1985 and 1993 and attended a methadone treatment program in the Bronx were recruited. Bronx NEP opened in 1989.</p> <p>Prospective study.</p>	<p>Among active IDUs, there were declines in the proportion of IDUs who injected 30 or more times per month. That proportion decreased for NEP participants from 72% in 1989 to 49% in 1993 compared with reductions of 70% to 45% among nonusers of NEP.</p>	<p>Study documents more substantial reductions in injection frequency and sharing among methadone Tx participants who also used NEP compared to IDUs in Tx who did not use NEP while in Tx..</p> <p>Ongoing injection drug use while in methadone treatment is documented in this study and others in the literature.</p> <p>NEP and TX are compatible interventions.</p>									

<p>* Singer et al., 1997 To assess the effect of environmental changes on HIV risk behaviors and prevalence among IDUs.</p>	<p>213 non participants Prospective cohort study with pretest and posttest measures</p>	<p>Mean monthly frequency of injection * IDU injecting < 5 times/day at baseline; increase of 57 injections at posttest * IDU injecting > 5 times/day at baseline; decrease of 90 injections at posttest</p>	
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Table 2.2: Reductions in Multiperson Reuse of Works (8 studies: 7 had significant reductions, 1 had mixed findings)

Authors/Purpose	Sample/Design	Results/Findings	Comments
Guydish et al., 1993 To evaluate potential negative effects of the San Francisco NEP	35,460 drug treatment admissions of which 24,120 were IDUs Ecological cross-section study. Data on records 2 years preceding NEP (1987-1988) and 2 years following NEP	Percent of IDUs who report sharing in 30 days before admission to methadone detoxification clinic (n=5,532) • Decreased steadily over time (36.5% in 1987; 30.1% in 1988; 29.2% in 1989; 24.8% in 1990) • NEP implemented in 6/88	
Hagan et al., 1993 To assess the potential effectiveness of the Tacoma NEP	204 needle exchange participants Retrospective cohort study (pre-post measure)	Mean monthly frequency of rented or borrowed syringe • Pre-NEP 56/month, while in NEP 30/month (p<.05) Mean monthly frequency of lending used syringe • Pre-NEP 100/month, while in NEP 62/mo (p<.05)	
Watters et al., 1994 To evaluate a syringe exchange in San Francisco.	5,644 IDUs recruited from street settings and detoxification clinics Ecological cross-sectional study using 11 semiannual cross-sectional surveys over 5.5 years (12/86-6/92)	Proportion of IDUs who reported sharing, last 30 days • Frequent NEP users (i.e., used > 25 times in last year) were 0.71 times less likely to report sharing than those who used NEP less often or not at all	
Paone et al., 1994 To evaluate NYC lower East side NEP.	1,752 IDUs, randomly selected needle exchange participants Multiple random cross-sections of needle exchange participants with recapture feature using retrospective data collection over 8 months (10/92-6/93)	Percentage of injection episodes that involved using a previously used works: • Pre-NEP 11.6%, while in NEP 3.9% Percent IDUs who used used works: • Rented or bought: Pre-NEP 22%, while in NEP 6% • Borrowed: Pre-NEP 29%, while in NEP 12%	

Table 2.2 continues on next page.

<p>Oliver et al., 1994 Evaluate NEP in Portland, OR.</p>	<ul style="list-style-type: none"> • 83 participants attending NEP ≥ 4 times • 32 participants attending < 4 times <p>Prospective cohort study with pre-post measures</p>	<p>Percentage of IDUs who shared prior to using NEP compared to percentage who did while using NEP:</p> <ul style="list-style-type: none"> • 9% decrease sharing (65% vs 56%) • 6% decrease renting (9% vs 3%) • 13 % decrease borrowing (20% vs 7%) 																						
<p>Hagan et al., 1994 To update the evaluation of Tacoma NEP.</p>	<p>426 needle exchange participants Retrospective cohort study (pre-post NEP measure)</p>	<ul style="list-style-type: none"> • Proportion not using a used syringe in month & those who did at least once (OR=.36, p<.05). • Proportion not passing on a used syringe in month and those who did at least once (OR=.33, p<.05). <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th></th> <th style="text-align: center;"><u>Pre-exchange</u></th> <th style="text-align: center;"><u>Post-exchange</u></th> </tr> </thead> <tbody> <tr> <td>Re-used syringe</td> <td></td> <td></td> </tr> <tr> <td>None</td> <td style="text-align: center;">42%</td> <td style="text-align: center;">68%</td> </tr> <tr> <td>At least once</td> <td style="text-align: center;">57%</td> <td style="text-align: center;">33%</td> </tr> <tr> <td>Passed used syringe</td> <td></td> <td></td> </tr> <tr> <td>None</td> <td style="text-align: center;">28%</td> <td style="text-align: center;">54%</td> </tr> <tr> <td>At least once</td> <td style="text-align: center;">72%</td> <td style="text-align: center;">46%</td> </tr> </tbody> </table>		<u>Pre-exchange</u>	<u>Post-exchange</u>	Re-used syringe			None	42%	68%	At least once	57%	33%	Passed used syringe			None	28%	54%	At least once	72%	46%	
	<u>Pre-exchange</u>	<u>Post-exchange</u>																						
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At least once	72%	46%																						
<p>Des Jarlais et al., 1994</p>	<p>1,115 IDUs admitted to drug detoxification program Ecological study with 2 randomly selected cross-sectional samples, 1984 and 1992</p>	<p>Decrease significant for one behavior and not significant for another:</p> <ul style="list-style-type: none"> • Negative correlation (-.67) between NEP use and using used needles (p<.02) • Negative correlation (-.44) between NEP use and passing needles (p<.11) 																						
<p>*Singer et al., 1997 To assess the effect of environmental changes on HIV risk behaviors and prevalence among IDUs.</p>	<p>315 needle exchange participants Prospective cohort study with pretest and posttest measures</p>	<p>Percentage of NEP users who share needles:</p> <ul style="list-style-type: none"> • 74% do not share at baseline, 16% discontinued or decreased needle sharing at posttest <p>Percent of NEP users who share injection equipment:</p> <ul style="list-style-type: none"> • 14% do not share at baseline, 37% discontinued or decreased sharing injection equipment at posttest • NEP use < 2 yrs: mean decrease of 10 times/month • NEP use ≥ 2 yrs: mean decrease of 48 times/month 																						

Table 2.3: Increases in Needle Disinfection (2 studies: 2 found significant increases)

Author/Purpose	Sample/Design	Results/Findings	Comment
<p>Hagan et al., 1993 To assess the potential effectiveness of the Tacoma NEP</p>	<p>204 needle exchange participants Retrospective cohort study (pre-post measure)</p>	<p>Mean monthly frequency of used bleach to disinfect syringe <ul style="list-style-type: none"> Used bleach: Pre NEP 69 per mth During NEP 105 per mth ($p < .05$) </p>	
<p>Oliver et al., 1994 Evaluate NEP in Portland, OR</p>	<p>77 needle exchange participants Prospective cohort study with pre-post measures (baseline and six month follow-up)</p>	<p>Percentage of IDUs who cleaned their needles. Percentage of IDUs who re-used works without cleaning. Compared cleaning prior to attending NEP with behavior while using NEP: <ul style="list-style-type: none"> 14% increase in % who cleaned (65% vs 51%) 11% Decrease in % who re-used works without cleaning (12% vs 23%) </p>	

Table 2.4: Entry into Drug Treatment (4 studies: 4 found significant effects)

Authors/Purpose	Sample/Design	Results/Findings	Comments
<p>Hagan et al., 1993 To assess the potential effectiveness of the Tacoma NEP</p>	<p>530 patients admitted to methadone treatment Ecological, all drug treatment admissions during 17-month period</p>	<p>Health Dept. methadone referral source for all patients during study period <ul style="list-style-type: none"> • NEP was the largest referrals source (43%) followed by self-referrals (38%), other outreach (8%), and other source (13%) </p>	
<p>Heimer & Lopes, 1994 To report on the increase in drug treatment associated with opening of NEP</p>	<p>1,512 IDUs using New Haven's NEP Prospective open cohort, compared treatment entry during first 7.5 mths (1990) to 11 mths experience 2-3 yrs later.</p>	<p>Number of monthly drug treatment entries <ul style="list-style-type: none"> • Drug treatment entries doubled (14.4 to 28.8 persons per month) </p>	
<p>*Singer et al., 1997 To assess the effect of environmental changes on HIV risk behaviors and prevalence among IDUs.</p>	<p>315 needle exchange participants Prospective open cohort with pretest and posttest measures</p>	<p>After using NEP for more than 6 months, 58% report having enrolled in detox or drug treatment</p>	
<p>*Vlahov et al., 1997 To determine whether enrollment in NEP was associated with short-term reduction in risk behaviors.</p>	<p>221 IDUs in NEP Prospective study, baseline and 2 follow-ups (at 2 weeks and at 6 months)</p>	<p>Drug treatment participation tripled between baseline (5% of NEP users in treatment) and 6-month followup (15% of NEP users in treatment)</p>	

Table 2.5: Unsafe Disposal of Injection Equipment (2 studies: 1 found significant reduction, 1 not significant)

Authors/Purpose	Sample/Design	Results/Findings	Comments
<p>Oliver et al., 1994</p> <p>Evaluate NEP in Portland, OR</p>	<p>77 needle exchange participants</p> <p>Prospective cohort study with pre-post measures (baseline and six month follow-up)</p>	<p>Percentage of IDUs who used syringes and threw away:</p> <ul style="list-style-type: none"> • 14% decrease in % IDUs who used syringes and threw them away (54% vs 40%) <p>Mean number of syringes found on street per month:</p> <ul style="list-style-type: none"> • Before NEP implementation: 5.2 • After NEP implementation: 1.9 	
<p>*Doherty et al., 1997</p> <p>Examine effect of NEP on quantity of discarded needles.</p>	<p>Random sample of city blocks in high areas of drug use</p> <p>Prospective study with pre-post needle exchange implementation measures</p>	<ul style="list-style-type: none"> • At 2 month follow-up, no increase in discarded syringes following NEP implementation • At 2 year follow-up, the number of discarded syringes was reduced 	

Table 2.6: Increases in Mean Age of NEP Users Indicate NEP Did Not Encourage New IDUs (2 studies: 1 found significant increase, 1 had some significant increase)

Authors/Purpose	Sample/Design	Results/Findings	Comments
<p>Guydish et al., 1993</p> <p>To evaluate potential negative effects of the San Francisco NEP</p>	<p>35,460 drug treatment admissions; 24,120 IDUs 11,340 non-IDUs</p> <p>Ecological cross-section study. Data on records 2 years preceding NEP (1987-1988) and 2 years following NEP.</p>	<p>IDUs</p> <ul style="list-style-type: none"> ▸ Mean age at admission increased steadily over time ▸ Mean age at first injection remained stable over time <p>Non-IDUs</p> <ul style="list-style-type: none"> ▸ Pre-NEP, 31.6% switched to injection by time of 2nd treatment admission ▸ Post-NEP, 35.4% switched to injection by time of 2nd treatment admission (not significant) 	
<p>Watters et al., 1994</p> <p>To evaluate a syringe exchange in San Francisco.</p>	<p>5,644 IDUs recruited from street settings and detoxification clinics</p> <p>Ecological cross-sectional study using 11 semiannual cross-sectional surveys over 5.5 years (12/86-6/92)</p>	<p>1987: Mean age of IDUs was 38.5 years 1992: Mean age of IDUs was 41.6 years</p> <p>The mean age of youngest NEP participants did not significantly over the 5.5 year study</p>	

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CRITERIA 1

Section 505(1) The Secretary of Health and Human Services determines that exchange projects are effective in preventing the spread of HIV ... (PL 105-78)

Table 1.1: HIV Infection Rates (11 studies: 5 found significant reductions in HIV seroincidence, 2 found increases in HIV incidence, 3 found stable seroprevalence, and 2 found reductions in seroprevalence)

Author/Year	Study Design	Results/Findings	Conclusions
Heimer et al., 1992 To assess the prevalence rates of HIV in needles/syringes used by New Haven IDU.	1,860 randomly selected needles distributed and returned to the needle exchange Prospective open cohort	HIV seroprevalence rates <ul style="list-style-type: none"> • Pre-NEP: prevalence at 68% • NEP in 1st 2 months: prevalence at 64% • NEP after 4 months: prevalence stable at 43% (reflecting a 33% decrease) 	Independent reviews of model support conclusions about HIV infections averted by NEP.
Kaplan & O'Keefe, 1993; Kaplan, 1994 Estimate change in seroincidence rate among IDUs following their enrollment in New Haven NEP	Randomly selected syringes Mathematical models using unique Syringe Tracking and Testing System	HIV seroincidence: <ul style="list-style-type: none"> • 33% reduction among program participants • 0.7 to 1.6 infections prevented per 100 person years 	
Kaplan & Heimer, 1994, 1995 Provide more accurate estimates (Maximum likelihood model) of change HIV incidence rates among IDUs who use NEP.	2,813 tested needles that were distributed and returned between November 1990 and June 1992 Maximum likelihood change point model applied to empirical data gathered in Syringe Tracking and Testing System	HIV seroincidence <ul style="list-style-type: none"> • Incidence rate of 1.63 per 100 person years among program participants which was found not to differ from zero which means that the best estimate of new infection among needle exchange participant is zero 	

Table 1.1 continues on next 3 pages.

Table 1.1: HIV Infection Rates (Continued)

Author(s)	Study Design	Results/Finding	Conclusion
Watters, 1994 To examine change in HIV risk behaviors and prevalence among IDUs between 1986 & 1992.	5,956 IDUs recruited from street settings and detoxification clinics Ecological study with 13 semiannual cross-sectional surveys over 6.5 years, 1986-1992	HIV seroprevalence rates <ul style="list-style-type: none"> • Needle exchange was implemented in 1988 • HIV prevalence rate doubled between 1986 and 1987 and remained stable between 1987 and 1992 (12%) 	Cross-sectional data
Des Jarlais et al., 1994 Examine trends HIV risk behaviors & HIV prevalence among IDUs between 1984 & 1992.	1,115 IDUs admitted to drug detoxification program Ecological study with 2 randomly selected cross-sections, 1984 and 1992	HIV seroprevalence rates <ul style="list-style-type: none"> • Stable HIV prevalence at slightly more than 50% 	Cross-sectional data
*Hurley, Jolley, & Kaldor, 1997, 149:1797-1800. Compare changes over time in HIV seroprevalence among IDUs for cities with and without NEPs.	Ecological study of 81 cities across Europe, Asia, and North America	Seroprevalence among increased by 5.9% per yr in the 52 cities without NEPs, and decreased by 5.8% per yr in cities with NEPs. The average prevalence rate was 11% lower in cities with NEPs.	Cities in Europe, Asia, and the US with NEPs report seroprevalence decrease. Due to the study design, no causal link between the presence of NEP and HIV prevalence reductions can be made.

<p>Des Jarlais et al., 1996</p> <p>Compare HIV incidence among IDUs who use NEPs with that among IDUs who do not participate.</p>	<p>2,630 IDUs from</p> <ul style="list-style-type: none"> • Syringe Exchange Evaluation (SEE) • Vaccine Preparedness Initiative (VPI) • National AIDS Demonstration Research (NADR) <p>Meta-analytic technique combining HIV incident data across 3 studies</p>	<p>HIV seroincidence</p> <ul style="list-style-type: none"> • SEE: among continuing NEP users, incidence was 1.58 per 100 person years at risk (pyar) • VPI: among continuing NEP users, incidence was 1.38 per 100 pyar; among non-NEP users, incidence was 5.26 per 100 pyar • NADR: among non-NEP users, incidence was 6.23 per 100 pyar • Pooled 3-study data indicate that non-NEP use was associated with a 3.35 greater risk of HIV infection 	<p>Causal link can not be made between NEP use and seroincidence.</p> <p>Data does show that NEP participation is protective of HIV seroconversion</p> <p>Dose response relationship between NEP participation and HIV infections averted.</p>
<p>*Stratbuck, et al., 1997, AIDS, 11:F59-F65.</p> <p>Describe HIV prevalence and incidence among prospective cohort of IDUs</p>	<p>1,006 IDUs were recruited through street outreach. Prospective cohort study with baseline, semi-annual data collection.</p>	<p>Predictors of HIV + status were:</p> <ul style="list-style-type: none"> - low education, unstable housing, commercial sex, borrowing needles, injecting with others, and frequent NEP attendance. - 23 of the 24 HIV Seroconverters reported NEP as their most frequent source of needles and only 5 reported having difficulty accessing sterile syringes. 	<ul style="list-style-type: none"> • Despite availability of NEPs, high incidence was reported • NEP user most frequently report cocaine use • Comprehensive services such as counseling & testing, drug treatment appear not to have been &/or insufficient to prevent HIV • Study is epidemiologic in nature, was not intended to evaluate NEP (92% of study participant attended NEP) • Can not establish causal relationship between NEP use and HIV infection. • Comprehensive services such as counseling & testing, drug tx appear not to be available or insufficient to prevent HIV infection.

<p>*Bruneau et al., 1997, Am J of Epidemiol, 146:994-1002.</p> <p>Assess the association between risk behaviors and HIV seroprevalence and incidence among IDUs in Montreal.</p>	<p>1,599 IDUs were recruited to participate in this open prospective cohort study.</p> <p>Data analyses included:</p> <ul style="list-style-type: none"> - Cross-sectional analyses of baseline data to assess association of NEP use and serostatus, - Cohort analyses of NEP use at baseline as predictor of conversion, - Nested case-control analysis of NEP use during follow-up as predictor of conversion. 	<ul style="list-style-type: none"> - NEP users were 2.2 times more likely to be positive at baseline. - The cohort analysis showed that the cumulative probability of HIV conversion was found to be 33% for NEP users versus 13% for Nonusers. - Nested case-control study revealed that consistent NEP users was associated with seroconversion (odds ratio = 10.5). 	<p>NEP users were at higher risk at baseline than non-NEP users.</p> <p>Study was not designed or intended to evaluate NEP.</p> <p>Epidemiologic study.</p> <p>No causal link between NEP participation and HIV infection can be made.</p>
<p>*Singer et al., 1997</p> <p>To assess the effect of environmental changes on HIV risk behaviors and prevalence among IDUs.</p>	<p>1,050 randomly selected needles r</p> <p>Prospective open cohort with pretest and posttest measures returned to NEP</p>	<p>HIV seroprevalence rates:</p> <ul style="list-style-type: none"> * Baseline NEP: prevalence at 38% * NEP after 2.5 years: prevalence relatively stable at <40% 	

Table 1.3: Expert reports (2 studies: 2 found significant reductions)

Author(s)	Methodology	Results/Conclusions	Reference
<p>GAO, 1993</p> <p>To assess the effectiveness of NEP in reducing HIV infection rates.</p>	<p>Reviewed all publications on the topic.</p>	<p>The report stated the following, based on a thorough review of the only study at the time that reported HIV incidence findings (Kaplan and O'Keefe, 1993):</p> <p>"Based on our expert consultant review, we found the model to be technically sound, its assumptions and data values reasonable and the estimated 33% reduction in new infections defensible."</p>	
<p>NRC/TOM</p> <p>To evaluate the effectiveness of NEP programs.</p>	<p>Reviewed all published and unpublished studies of NEPs.</p>	<p>The report states:</p> <p>"For the participants in a needle exchange program, the fraction of needles in circulation that are contaminated is lowered by this increased availability. This amounts to a reduction in an important risk factor for HIV transmission. The lower the fraction of needles in circulation that are contaminated, the lower the risk of new HIV infections."</p>	

CRITERIA 2

**Section 506(1) The Secretary of Health and Human Services
determines that exchange projects ... do not encourage the use
of illegal drugs (PL 105-78)**

Table 2.1: Increases in Mean Age of NEP Users Indicate NEP Did Not Encourage New IDUs (2 studies: 1 found significant increase, 1 had some significant increase)

Author(s)/Year	Sample/Design	Findings/Conclusions	Comments
Walters et al., 1994 To evaluate a syringe exchange in San Francisco.	5,644 IDUs recruited from street settings and detoxification clinics Ecological cross-sectional study using 11 semiannual cross-sectional surveys over 5.5 years (12/86-6/92)	1987: Mean age of IDUs was 38.5 years 1992: Mean age of IDUs was 41.6 years The mean age of youngest NEP participants did not significantly over the 5.5 year study	
Guydish et al., 1993 To evaluate potential negative effects of the San Francisco NEP.	35,460 drug treatment admissions: 24,120 IDUs 11,340 non-IDUs Ecological cross-section study. Data on records 2 years preceding NEP (1987-1988) and 2 years following NEP.	IDUs <ul style="list-style-type: none"> • Mean age at admission increased steadily over time • Mean age at first injection remained stable over time Non-IDUs <ul style="list-style-type: none"> • Pre-NEP, 31.6% switched to injection by time of 2nd treatment admission • Post-NEP, 35.4% switched to injection by time of 2nd treatment admission (not significant) 	

Table 2.2: Reductions in Injection Frequency (9 studies: 5 had significant reductions, 2 had some significant reductions, 2 not significant)

Author/Year	Sample/Design	Results/Findings	Significance
Watters et al., 1994 To evaluate a syringe exchange in San Francisco.	5,644 IDUs recruited from street settings and detoxification clinics Ecological cross-sectional study using 11 semiannual cross-sectional surveys over 5.5 years (12/86-6/92)	Median daily frequency of injection declined: • from 1.9 to 0.7 injections per day	
Paone et al., 1994 To evaluate NYC lower East side NEP.	1,752 IDUs, randomly selected needle exchange participants Multiple random cross-sections of NEP participants with recapture feature using retrospective data collection over 8 month (10/92- 6/93)	Mean monthly frequency of injections declined: • from 95.2 to 85.6 times per month.	
Oliver et al., 1994 Evaluate NEP in Portland, OR.	• 83 participants attending NEP ≥ 4 times • 32 participants attending > 4 times Prospective cohort study with pre-post measures	Mean monthly frequency of injection • Frequent NEP attenders: Baseline 28.7 reduced to Follow-up 8.9 • Infrequent NEP attenders: Baseline 33.0 reduced to Follow-up 30.7	
*Singer et al., 1997 To assess the effect of environmental changes on HIV risk behaviors and prevalence among IDUs.	233 NEP participants Prospective cohort study with pretest and posttest measures	Mean monthly frequency of injection • IDU injecting < 5 times/day at baseline: increase of 57 injections at posttest • IDU injecting ≥ 5 times/day at baseline: decrease of 90 injections at posttest	

Table 2.2 continues on next 2 pages.

Table 2.2: Reductions in Injection Frequency (Continued)

Author(s) / Purpose	Sample / Design	Results / Findings	Comments									
Guydish et al., 1993 To evaluate potential negative effects of the San Francisco NEP	35,460 drug treatment admissions of which 24,120 were IDUs Biological cross-sectional study. Data on records 2 years preceding NEP (1987-1988) and 2 years following NEP implementation.	Decrease significant and stable not significant: Proportion (%) of IDUs in various categories of frequency of injection in last 30 days <ul style="list-style-type: none"> Decrease % of IDU injecting 2-3 times a day (before NEP 41% vs after NEP 28%) Stable % of IDUs injecting once a day or less (before NEP 17% vs after NEP 17%) Increase % of IDUs more than 3 times a day (before NEP 40.7% vs after 55.4%) 										
Des Jarlais et al., 1994 Examine trends HIV risk behaviors & HIV prevalence among IDUs between 1984 & 1992.	1,115 IDUs admitted to drug detoxification program Ecological study with 2 randomly selected cross-sectional samples, 1984 and 1992	Decrease significant and stable not significant: Mean Frequency of injection per month <ul style="list-style-type: none"> Decrease cocaine injections per month (55 vs 43) Stable heroin injections per month (46 vs 44) Stable speedball injections per month (43 vs 41) 										
Hagan et al., 1993 To assess the potential effectiveness of the Tacoma NEP	204 needle exchange participants Retrospective cohort study (pre-post measure)	Decrease not significant: Mean monthly injection frequency <ul style="list-style-type: none"> Stable injections at 153 a month prior to first use of NEP and 152 a month while participating in NEP 										
Hagan et al., 1994 To update the evaluation of Tacoma NEP.	426 needle exchange participants Retrospective cohort study	Decreases not significant (OR=.83, p>.05) Proportion of IDUs who inject < 37 times per month and injectors who inject ≥ 37 times per month <table border="1"> <thead> <tr> <th></th> <th>Pre-exchange</th> <th>Post-exchange</th> </tr> </thead> <tbody> <tr> <td>< 37 per month</td> <td>42.2%</td> <td>46.9%</td> </tr> <tr> <td>≥ 37 per month</td> <td>57.8%</td> <td>53.1%</td> </tr> </tbody> </table>		Pre-exchange	Post-exchange	< 37 per month	42.2%	46.9%	≥ 37 per month	57.8%	53.1%	
	Pre-exchange	Post-exchange										
< 37 per month	42.2%	46.9%										
≥ 37 per month	57.8%	53.1%										

<p>Schoenbaum, Hartzel, and Gourevitch, 1996, AIDS, 10:1729-1734.</p> <p>To compare prospectively injection behaviors of IDUs in methadone Tx who did and did not use local NEP.</p>	<p>904 IDUs who injected between 1985 and 1993 and attended a methadone treatment program in the Bronx were recruited. Bronx NEP opened in 1989.</p> <p>Prospective study.</p>	<p>Among active IDUs, there were declines in the proportion of IDUs who injected 30 or more times per month. That proportion decreased for NEP participants from 72.4% in 1989 to 49% in 1993 compared with reductions of 70% to 45% among nonusers of NEP.</p>	<p>Study documents more substantial reductions in injection frequency and sharing among methadone Tx participants who also used NEP compared to IDUs in Tx who did not use NEP while in Tx.</p> <p>Ongoing injection drug use while in methadone treatment is documented in this study and others in the literature.</p> <p>NEP and TX are compatible interventions.</p>
<p>*Vlahov et al., 1997</p> <p>To determine whether enrollment in NEP was associated with short-term reduction in risk behaviors.</p>	<p>221 IDUs in NEP</p> <p>Prospective study, baseline and 2 follow-ups (at 2 weeks and at 6 months)</p>	<p>Significant reductions were reported in the mean number of injections per syringe and mean number of injections per day at follow-up (from 5.9 to 4.9 per day).</p>	

Table 2.3: Entry into Drug Treatment (4 studies: 4 found significant effects)

Author(s) / Purpose	Sample / Design	Results / Findings	Conclusions
Hagan et al., 1993 To assess the potential effectiveness of the Tacoma NEP	530 patients admitted to methadone treatment Ecological, all drug treatment admissions during 17-month period	Health Dept. methadone referral source for all patients during study period • NEP was the largest referrals source (43%) followed by self-referrals (38%), other outreach (8%), and other source (13%)	
Heimer & Lopes, 1994 To report on the increase in drug treatment associated with opening of NEP	1,512 IDUs using New Haven's NEP Prospective open cohort, compared treatment entry during first 7.5 mths (1990) to 11 mths experience 2-3 yrs later.	Number of monthly drug treatment entries • Drug treatment entries doubled (14.4 to 28.8 persons per month)	
*Singer et al., 1997 To assess the effect of environmental changes on HIV risk behaviors and prevalence among IDUs.	315 needle exchange participants Prospective open cohort with pretest and posttest measures	After using NEP for more than 6 months, 58% report having enrolled in detox or drug treatment	
*Vlahov et al., 1997 To determine whether enrollment in NEP was associated with short-term reduction in risk behaviors.	221 IDUs in NEP Prospective study, baseline and 2 follow-ups (at 2 weeks and at 6 months)	Drug treatment participation tripled between baseline (5% of NEP users in treatment) and 6-month followup (15% of NEP users in treatment)	

Table 2.4: Expert reports (2 studies: 2 found significant reductions)

Author(s)	Methods	Results/Findings	Conclusions
<p>GAO, 1993</p> <p>To assess the effectiveness of NEP in reducing HIV infection rates.</p>	<p>Reviewed all publications on the topic.</p>	<p>The report states: "One concern surrounding needle exchange programs is whether they lead to increased injection drug use. Seven of the nine projects looked at this issue, and five had strong evidence for us to report on outcomes. All five found that drug use did not increase among users; four reported no increase in frequency of injection and one found no increase in the prevalence of use."</p>	
<p>NRC/IOM</p> <p>To evaluate the effectiveness of NEP programs.</p>	<p>Reviewed all published and unpublished studies of NEPs.</p>	<p>The report states: "There is no credible evidence to date that drug use increased among participants as a result of programs that provide legal access to sterile equipment. The available scientific literature provides evidence based on self-reports that needle exchange programs do not increase the frequency of injection among program participants and do not increase the number of new initiates to drug use."</p>	

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

410
80-4-3

April 4, 1998

MEMORANDUM FOR THE PRESIDENT

SUBJECT: Policy on Needle Exchange Programs

This memorandum summarizes the scientific data on needle exchange programs as a public health intervention and the relevant statutory provisions now in place.

Based on a comprehensive review of the available scientific data, I plan to certify: 1) the statutory test in the Labor/HHS Appropriations bill for use of federal HIV prevention dollars from the Centers for Disease Control and Prevention (non-drug treatment funds) has been met; and 2) as part of a comprehensive public health program including referrals for drug treatment, State and local communities may, at their option, use such HIV prevention funds to support locally designed needle exchange programs. This certification will not affect or reduce any federal substance abuse treatment dollars; nor will it weaken our national commitment to expanding opportunities for substance abuse treatment. In fact, this decision will increase referrals into drug treatment for hard-to-reach populations.

Background The proportion of AIDS cases and new HIV infections attributable to injection drug use has been rising dramatically and the consequences of intravenous drug use have become the driving force in the HIV epidemic. Half of all new HIV infections are caused by the sharing of injection equipment contaminated with HIV. For adults, infection is either due to injection drug use or through unprotected sex with an injection drug user. For too many innocent children HIV transmission occurs at birth from a mother who herself, or whose partner, was infected with HIV through drug use. The impact has been most devastating in communities of color, which accounted for 65% of newly reported AIDS cases between July 1996-June 1997.

There are more than 100 needle exchange programs currently operating in the United States supported by State, local or private funds in an effort to reduce HIV transmission rates among injection drug users. Many programs actively refer injection drug users to substance abuse and medical treatment. To date, because of Congressionally imposed limits, federal funds have supported only research on needle exchange, not the programs themselves.

Existing scientific evidence including studies reviewed by the Institute of Medicine and additional research published since the Department's February 1997 report to the Congress, strongly supports the role of needle exchange programs as an effective public health intervention.

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Nelson/CDC

These studies document the effectiveness of needle exchange programs in engaging injection drug users in drug treatment and reducing their risk of HIV infection without showing an increase in community-level drug use.

There is also broad-based support for needle exchange as a prevention strategy among numerous groups including the American Medical Association, American Nurses Association, American Public Health Association, Association of State and Territorial Health Officials, American Academy of Pediatrics, American Psychological Association, United States Conference of Mayors, National Urban League, and the American Bar Association, as well as the Congressional Black and Hispanic Caucuses.

Current Law There are three statutes that currently constrain the use of federal funds for needle exchange programs: (1) The Labor/HHS Appropriations bill permits funding of needle exchange if the Secretary of HHS determines that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs (a moratorium on federal funding expired on March 31, 1998); (2) The Substance Abuse and Mental Health Services Administration (SAMHSA) block grant prohibits the use of federal drug treatment funds unless the Surgeon General determines needle exchange programs are effective in reducing the spread of HIV and the use of illegal drugs; (3) The 1996 reauthorization of the Ryan White CARE Act contains a flat prohibition on the use of Ryan White treatment funds to support needle exchange programs.

Scientific Data Over the last few years, major scientific agencies of the Department of Health and Human Services have conducted an ongoing, exhaustive examination of the peer-reviewed published data on needle exchange programs. In the past year, new data regarding the effects of needle exchange programs on reducing the frequency of injection drug use, and the role these programs can play in increasing the number and success of referrals into drug treatment for this hard-to-reach population, has reached a threshold that firmly establishes the value and effectiveness of these programs. In addition, the National Institutes of Health is funding research projects which continue to generate data and have the capacity to identify any emerging trends.

There is now a conclusive body of evidence that needle exchange programs reduce the level of HIV infection among needle exchange program participants, with the best results observed in those programs which provide strong linkages to risk reduction counseling, substance abuse and medical treatment. Leading federal scientists¹ have reviewed the literature and are concluding in a

¹ David Satcher, M.D., Ph.D., Surgeon General and Assistant Secretary for Health; Margaret Hamburg, M.D., Assistant Secretary for Planning and Evaluation; Harold Varmus, M.D., Director, National Institutes of Health; Claire V. Broome, M.D., Acting Director, Centers for Disease Control and Prevention; Nelba Chavez, Ph.D., Administrator, Substance Abuse and Mental Health Services Administration; Eric P. Goosby, MD., Director, Office of HIV/AIDS Policy; Anthony Fauci, M.D., Director, National Institute of Allergy and Infectious Diseases; Alan Leshner, Ph.D., Director, National Institute on Drug Abuse; Helene Gayle, M.D., M.P.H., Director, National Center for HIV, STD and TB Prevention, CDC.

memorandum to me that the scientific evidence is now sound enough to certify that the statutory test has been met for the use of federal prevention funds from the Centers for Disease Control and Prevention. These programs have also proven to be of critical value in reaching disenfranchised, hard-to-reach, often poor and minority populations who are not able to access substance abuse treatment, and to curtail the spread of HIV in their social networks. This has particularly broad ramifications for African American and Hispanic women, who account for 78% of new AIDS cases among women and are often unknowingly exposed through heterosexual contact with an intravenous drug user. Similarly, over 75% of new HIV infections in children result from intravenous drug use by a parent.

Regarding drug use patterns, the evidence substantiates that both the sharing of injection equipment, and the frequency of injection by an individual, are reduced among participants of needle exchange programs. In addition, recent data indicate that needle exchange programs have considerable success in increasing access to, entry into, and retention rates in drug treatment for the chronically-addicted individuals who are the most frequent users of needle exchange programs.

In our review, we have given special attention to the concern that needle exchange programs might increase community-level drug use or promote a new drug habit among young people. In a March 1997 report on an NIH Consensus Development Conference completed after our initial review went to Congress, leading private sector scientists reached consensus on the efficacy of needle exchange programs as an essential component in the public health strategy for reduction of HIV transmission among injection drug users. They definitively stated that the use of prevention resources for needle exchange programs was justified on the merits of the scientific evidence and that needle exchange programs do not encourage drug use². Reviewing this report and more recent studies, the Department's top scientists³ have now concluded: (1) there is no empirical evidence that the presence of needle exchange programs results in an increase of drug use at the community level. (2) There is no known scientific data to support the concern that needle exchange programs confound our message to young people that drug abuse is harmful. In fact, a large number of studies have shown that needle exchange program participants are overwhelmingly older, chronically addicted individuals with a long histories of injection drug use. There is no evidence that young people or new users are being recruited into drug use as a result of these programs. Ongoing federal studies of drug use patterns and needle exchange programs are well poised to quickly identify any new trends in this regard.

²National Institutes of Health. Interventions to Prevent HIV Risk Behaviors. NIH Consensus Statement, 1997 February 11-13; 15 (2) US Department of Health and Human Services, Washington, D.C.

³Ibid, page 2.

Action Steps On the basis of overwhelming scientific evidence: (1) I plan to make the determination that needle exchange programs are effective public health measures to prevent the spread of HIV through injection drug use and do not encourage the use of illegal drugs.

(2) Centers for Disease Control and Prevention HIV prevention funds would now be available for use at the option of local decision makers and grantees under limited and specific conditions which maximize the public health benefit both to HIV/AIDS prevention and drug treatment, and require evidence of community support.

Consistent with the direction of the Labor/HHS Appropriations Conference Report language, the criteria would be:

- o only HIV prevention funds administered by CDC may be used, not substance abuse treatment dollars;
- o review and approval by the State health officer, or local health officer if the grantee is a city or organization, to certify that there is support for needle exchange programs as part of a comprehensive HIV prevention effort responsive to the jurisdiction's HIV epidemic;
- o grantees certify that programs are mandated to provide referral to appropriate health, social services and drug treatment programs;
- o grantees certify that needles are provided only on a replacement basis, not distribution;
- o grantees certify compliance with established standards for hazardous waste disposal;
- o grantees certify that needle exchange programs are consistent with State or local legal requirements; and
- o grantees must collaborate with ongoing federally supported research and evaluation, and provide information on reducing the risk of transmission of HIV.

Substance abuse treatment programs provide the critical long term response to HIV transmission among injection drug users. However, research findings demonstrate that the immediate risk of HIV transmission and expansion of the epidemic among vulnerable communities due to injection drug use can be effectively reduced through carefully designed needle exchange programs. The use of federal funds for needle exchange programs would remain entirely at the option of State or local grantees, with no federal program targeted to this purpose. We are mindful that there may be public concerns around implementation of needle exchange programs at some local levels, and we will help those jurisdictions to address these concerns by providing scientific and other relevant information, if requested. But the choice of whether or not to include needle exchange programs in an HIV/AIDS prevention strategy would be made at the local level.

Conclusion There is strong scientific evidence that needle exchange programs are an effective public health intervention to reduce the spread of HIV and are wholly consistent with our national strategy to reduce the use of illegal drugs. The use of federal HIV prevention funds to support local needle exchange programs must be coupled with strict requirements that such programs have the support of appropriate State and local health officials and the communities they represent; that needle exchange programs are consistent with State and local laws; that needle exchange programs are part of comprehensive programs directly linked to drug treatment and prevention programs; and that funding for needle exchange programs not represent any diminution of support for drug abuse prevention and treatment efforts.



Donna E. Shalala
Secretary

The Public and the War on Illicit Drugs

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

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

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DURING THE PAST YEAR several groups and individuals holding diverse views have called for a reexamination of the nation's overall policies for reducing the use of illicit drugs.¹⁻⁴ Among these was a group of distinguished physicians, medical educators, and public health professionals interested in refocusing the nation's drug policies toward a greater emphasis on drug prevention and treatment.⁵

These new initiatives, aimed at encouraging a national dialogue on the future direction of America's drug policies, occur almost a quarter of a century after President Nixon launched the first War on Drugs. Since then, steps to reduce illicit drug use have been a high priority for presidents, the Congress, private-sector leadership groups, health professionals, and almost every civic, professional, and political organization in our society.

Extensive public policy efforts have come in response to the perceived seriousness and scope of the nation's illicit drug

problems. The impact of these problems on our society can be seen in a number of key indicators. Annually, illicit drugs lead to approximately 11 000 related deaths,⁷ direct government expenditures of \$27 billion (1991 data [the last year for which both state and federal expenditures are available]),⁸ and over half a million drug-related episodes in hospital emergency departments.⁹ In addition, nearly 900 000 people receive drug-related rehabilitation treatment each year,¹⁰ and law enforcement efforts produce more than 1 million arrests.¹¹ The scale of these problems, the attention they have received in the media, and the scope of the nation's response have likely shaped Americans' attitudes and views on the direction of future drug policy. They also engendered a number of broad controversies that will involve members of the medical and public health communities in the years ahead.

As health professional and other experts become more involved with a reexamination of the nation's drug-related policies and enmeshed in many of the related controversial issues, it is important for them to understand the nature, extent, and rationale for the American public's current views on this critical subject. This article provides perspective through an analysis of public opinion surveys conducted between 1978 and the present.

This article addresses 4 issues that are seen as important background information for health professionals interested in America's drug policy. First, where do Americans get their information about the extent of the nation's illegal drug problem and what are their experiences with it? Second, what worries Americans most about the country's illicit drug problems? Third, why do Americans think individuals use illegal drugs? Fourth, what are the public's views on various policy proposals to respond to the nation's drug problems, and what are their implications for the future? In addition, the article examines what Americans think about 2 medically related issues that have been the subject of recent policy debates—the exchange of sterile needles and syringes for the used ones of injection drug users and the legalization of marijuana for medical treatments.

DATA AND METHODS

The data reported in this article are drawn from a review of more than 100 national opinion surveys, including more than 2 500 questions conducted between 1951 and 1997. From this review, data from 47 opinion surveys were drawn for this

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The views expressed are solely those of the authors, and no official endorsement by the sponsor is intended or should be inferred.

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Table 1.—Relationship Between Illicit Drug Use and American Concerns for the Drug Problem

	1979	1985	1988	1990	1991	1993	1994	1996
Used illicit drugs in past month, %*	14.1	12.1	7.7	8.7	8.8	8.9	8.0	8.7
Persons aged 12-17 y who used drugs in past month, %*	16.3	13.2	8.1	7.1	8.8	8.7	8.2	8.0
Average yearly ranking on most important problem list†	12	12	5	2	5	9	6	8
Persons who said we are spending too little on drug addiction, %‡	83	71	66	60	63	63	61	

*Data for 1979 through 1994 from Substance Abuse and Mental Health Services Administration; Office of Applied Studies (SAMHSA).¹¹ Data for 1988 from SAMHSA.¹² †Data from Gallup poll.¹³ ‡Data from Davis and Smith.¹⁴

article from the POLL database at the Roper Center for Public Opinion Research, Storrs, Conn; from the General Social Surveys 1972-1996 machine-readable data file,¹¹ which is available from the Roper Center; and from the Harris subscription service. In addition, findings from a 1997 Harris poll containing drug policy-related questions developed by the authors are included in this review.¹²

Only a limited number of findings from these surveys are reported in this article. The findings that were selected were chosen on the basis of 4 criteria: (1) their relevance to key policy decisions on the issue of illegal drug use; (2) when several poll questions addressed the same issue, the pattern of public response had to be consistent; (3) questions with obviously biased or confusing phrasing were excluded; and (4) when only 1 measure of public opinion was provided for an issue, that measure was the most recent available.

Data in Table 1 on "the most important problem facing the nation" are yearly averages calculated by the authors from surveys by the Gallup Organization,¹³ which asked the question multiple times within a given year. Because there was no General Social Survey in 1979, the percentage in Table 1 saying that too little is being spent dealing with drug addiction for the year 1979 is an average of the percentage giving this response in the General Social Survey for the years 1978 and 1980. For this question, we have excluded those who said "don't know" or for whatever reason did not give a response. This was done so that these data would be compatible with that readily available on the World Wide Web.¹¹ (The response categories in Table 6 for 1990¹⁴ were reformulated by the authors out of the 7 choices the respondents were offered to make them consistent with the data shown for 1995.)

All of the surveys reported here, with 1 exception, were conducted using either face-to-face or over-the-telephone interviews. That exception was a self-administered mail survey.¹⁵

When interpreting these findings, it should be recognized that all surveys are subject to sampling error. Results differ from what would be obtained if the whole population of adults in the United States had been interviewed. This size of sampling error varies with the number of people interviewed and the magnitude of difference in the responses to each question. The sampling error for a survey of 800 respondents is approximately plus or minus 4 percentage points; for a survey of 1500 respondents it is plus or minus 3 percentage points.

Telephone surveys underrepresent groups in the population less likely to have telephones, particularly people with low income. In 1990, an estimated 5% of households in the United States were without telephone service.

THE ISSUES

1. Where do Americans get their information about the extent of the nation's illegal drug problem, and what are their experiences with it?

Americans see the use of illicit drugs as a major problem facing the country (82%).¹⁶ However, its relative ranking as a major issue can vary from 1 year to the next.

Each year, Americans are asked in national surveys to identify the single most important problem facing the country. They can select any issue; usually up to 15 problem areas are identified by different segments of the public. In 6 of the 8 years shown in Table 1,^{11,12,13} the category "drugs" has ranked among the top 10 single most important problems. It ranked among the top 5 problems in each year from 1988 through 1991.¹³

In addition, in recent years many Americans have chosen a related issue, crime, as the nation's most important problem. It has ranked among the top 5 public concerns since 1979.¹³ Today, a majority (56%) of the public perceives these 2 issues as linked: they believe that illicit drugs are one of the most important causes of crime.¹⁷

Also it is significant that the relative ranking of drugs among most important problems does not correspond to trends in self-reported illicit drug usage. In fact, the issue as a national problem ranked lowest in 1979,¹³ when 25 million people (14.1% of the population older than 12 years) reported using illicit drugs in the past month.¹⁸ However, it ranked highest as a national problem in 1990¹³ when 14 million people (5.7% of the population older than 12 years) reported using illicit drugs in the past month.¹⁸

This year-to-year variation appears to be related to 2 factors. The first is that other major issues, such as health care, the economy, the federal deficit, or education, emerge on the national agenda and compete for the public's attention. Second, the public has relatively little firsthand experience with the extent of the problems associated with drug use. In fact, 81% of Americans say drug abuse has never been a cause of problems in their own family.¹⁹ The majority of Americans (68%) report getting most of their information about the seriousness of the illicit drug problems from the news media, mainly television.²⁰

Studies show that news reports about illicit drug use and related crimes significantly increased during the 1980s, and peaked in the latter half of 1986 following the cocaine-related death of University of Maryland basketball star, Len Bias.²¹⁻²⁴ The increase in media coverage occurred in a period when the overall use of illicit drugs declined for the population as a whole.¹⁸ However, this was a period when the news media paid more attention to track cocaine use and its health and criminal consequences.²²⁻²⁴

In addition to the year-to-year variation, public concerns about illegal drug problems vary by whether or not they are asked about the country as a whole or their own local community. Survey findings show that 82% of the public thinks that illegal drug use is a big problem for society, but only 27% see it as such for their own local community.¹⁶ Even among groups more likely to worry about these problems, such as parents of teenagers and the teenagers themselves, there is much more concern about the illicit drug problem nationally than in their own schools and local communities (Table 2).²⁵ The most dramatic finding is that while only 6% of parents of teenagers

Table 2.—Parents' and Teenagers' Perception of the Seriousness of the Drug Abuse Problem*

	Parents: Crisis	Parents: Serious Problem	Teenagers: Crisis	Teenagers: Serious Problem
Your neighborhood	8	15	2	9
Local schools	8	44	6	23
Your community	9	41	9	27
Across the country	43	54	22	70

*Data (percentages of parents and teenagers holding the views) from ABC/Washington Post drug poll.¹²

Table 3.—Americans' Views of the Dangers of Various Substances*

	% Saying Very Dangerous
Heroin	99
Cocaine	96
Cigarettes	62
Marijuana	47
Alcohol	44

*Data from Gallup/CNN/USA Today poll.¹³

report that the illegal drug problem is a crisis in their own neighborhood, and 8% in their local schools, 43% still call it a "crisis" across the country.

2. What worries Americans most about the country's illicit drug problem?

Americans report that they worry about the effect of illicit drugs for the following 4 reasons: (1) linkage to high rates of crime, (2) negative effect on the national character, (3) morality, and (4) harmful health consequences for communities and individuals.

Surveys find that Americans see crime and illicit drugs linked as national problems, and many have changed their way of living in response to their concerns. Seven (78%) in 10 adults report that they are very concerned about the possibility of themselves or a family member being the victim of a crime committed by a drug user.¹⁴ In fact, 89% report that they have taken some security precaution, such as placing bars on windows or not going out alone at night, because of the perceived threat of drug-related crime.¹⁵

The public also believes that the use of illicit drugs is a moral issue and thinks of it as a phenomenon that negatively affects the character and values of the country. Nearly three quarters (72%) see drug use as changing the national character,¹⁶ and 60% believe that it represents a fundamental breakdown in the country's morals.¹⁷ Even in the case of marijuana, which is thought to be less harmful by the public than other illicit drugs (Table 3),¹⁸ 64% of adults describe its use as being morally wrong, and 51% think that it is morally wrong and should not be tolerated.¹⁹

When the public is given a list of 27 items that describe, in positive and negative terms, the characteristics of those who use cocaine, only 6 terms are selected by at least half. Of these, 4 have negative connotations: "no future" (63%), "loser" (56%), "lazy" (50%), and "self-centered" (50%). The 2 other characteristics were more of a medical nature: "nervous" (52%) and "depressed" (51%). A similar pattern of responses on the survey followed for marijuana users.²⁰

Similarly, the public sees the use of most illicit drugs as causing serious health consequences for communities and individual users. The public overwhelmingly views drugs such

Table 4.—Americans' Views of Why Some Americans Use Drugs*

	% Saying It is a Major Reason
Peer pressure	65
Poor parenting	64
Drug dealers trying to expand markets	60
Laws and courts not severe enough	48
Breakdown of religion and morality	45
Difficult social conditions	45
Drugs make some people feel better	42
Not enough being done to educate young people about risks of drugs	40
Influence of media, arts, and entertainment	21
Not enough clinics to treat people who want to stop	20

*Data from Louis Harris and Associates Inc poll.²¹

as cocaine and heroin as very dangerous substances for individuals to use (Table 3).²² When compared with other drugs, the use of crack cocaine is seen as the largest problem (66%) of all.²³ In addition, 89% of people surveyed believe that drugs make people "do worse at school, work, or athletics."²⁴ Most of the public sees marijuana use as having less serious consequences. Its risks are perceived to be at about the same level as cigarettes and alcohol (Table 3).²⁵ Though seen as less risky, today, 63% of parents of teenagers and 76% of teenagers themselves say that marijuana leads to the use of other, more serious types of drugs.²⁶

Coupled with all these factors, the public overwhelmingly (94%) believes that the illegal drug problem is not under control,²⁷ and more than half of Americans (58%) believe that it is getting worse over time.²⁸ Only 15% believe the country is making progress in this area.²⁹ In addition, the majority (68%) of the public expresses a great deal or a good amount of concern that some family member may become addicted to drugs.³⁰

3. Why do Americans think individuals use illegal drugs?

In a 1997 survey (Table 4)³¹ respondents were given a list of 10 possible reasons why some Americans might use illegal drugs. Only 8 factors were seen by a majority of Americans as a major reason for drug use. These included peer pressure, drug dealers trying to expand their markets, and poor parenting.³² Other surveys also show that poor parenting is seen as a significant factor by the public. Two thirds (66%) identify the disintegration of the family as a major cause,³³ and 58% say that parents should share all or most of the blame for the increase in teenage drug use that occurred between 1992 and 1995.³⁴

Though most Americans do not believe that the influence of the media, arts, and entertainment is a major cause of drug use,³⁵ Americans remain highly critical of their role in this area. Nearly 2 (63%) of 3 Americans said that the industry had "a great deal of influence" over the attitudes of children and teenagers toward drug use.³⁶ When asked about the effect of media reports, 47% think that media reports of heroin use, arrests, hospitalizations, and deaths of actors, rock stars, and fashion models have the paradoxical result of encouraging young people to use heroin. Only 10% think that this same news scares young people away.³⁷

Likewise, the majority of Americans do not believe that difficult social conditions are a major cause of drug use.³⁸ What is seen as the least important reason for individuals using

Table 5.—Public Support for Various Drugs Abuse Policies*

	Strongly Favoring Policy, %	Total Favoring Policy, %
More severe criminal penalties	49	84
Antidrug education in schools	45	80
Increase funding for police	37	67
Increase job training for at-risk youth	32	63
Antidrug education in communities	31	66
US military in US cities along the border	30	73
Increase mandatory drug testing at work	27	71
Surprise searches of school lockers	25	67
US military advisers in foreign countries	22	64
Death penalty for smugglers	22	60
Increase funding for treatment	19	77
Mandatory drug testing of high school students	19	64
US military in other countries to arrest drug traffickers	18	60
US aid to farmers in foreign countries not to grow drug crops	18	44
Aid to foreign governments to fight drug traffickers	17	54
Legalize all drugs	6	11
Death penalty for selling drugs to children†	Not asked	44
Legalize marijuana for personal use‡	Not asked	66
Death penalty for selling drugs to adults†	Not asked	17

*Data from Gallup/CNN/USA Today poll²² unless otherwise indicated.
 †Data from Yanakovic/TIME/CNN poll.²³
 ‡Data from CBS News poll.²⁴

illegal drugs is the lack of treatment programs for people who want to stop using drugs. Almost three quarters (72%) of the public did not see this as a major factor behind personal drug use.²²

4. What are the public's views on various policy proposals to respond to the nation's drug problem?

When looking at the future of American drug policy we see a paradox: most Americans (58%) do not see the nation's illegal drug problem getting better after years of increases in national spending,²⁵ and they see the War on Drugs as having failed thus far (75%).²¹ Yet, despite this assessment, they continue to support greater resources being expended in generally the same policy direction as has been followed in the past. Surveys over the last 20 years show that every time the public has been asked, a majority has responded by saying the nation is not spending enough money to deal with the problem of drug addiction (Table 1).¹¹ Not only do Americans say that more money should be spent dealing with addiction, they report that they are willing to pay more in taxes (66%) to support increased antidrug-related spending.²⁶

Because Americans are very concerned about illegal drug use, they tend to indicate support for most of the approaches posed to them as options for reducing the use and effects of illegal drugs. As shown in Table 5,^{22,23,24} among the approximately 19 policy choices they have been offered, there are 5 that are rejected by Americans: giving aid to farmers in foreign countries not to grow drug crops; giving aid to foreign governments to fight drug traffickers²⁷; legalizing marijuana for personal use;²⁸ the death penalty for drug sales²⁹; and legalizing all illicit drugs.²⁵ Among the choices that a majority of the public favors, some are a much higher priority than others.²²

The option that the largest share of the public say they strongly support is more severe penalties for the possession and sale of drugs.²² This corresponds with the public's perception that 1 major reason for drug use is the influence of dealers

Table 6.—Percentage Saying What Policy Would Do the Most to Reduce the Drug Problem in This Country

	1990*	1995†
Educate the young	20	40
Supply reduction	21	31
Punishing and convicting for drug crimes	41	21
Providing treatment programs	10	4
Legalization	4	Not asked
Don't know	4	Not asked
All equally	Not asked	2

*Data from Washington Post poll.¹⁴

†Data from Gallup/CNN/USA Today poll.²²

trying to expand their markets (Table 4).²² The second choice is antidrug education in schools.²² Similarly, this priority responds to the public's belief that peer pressure is a major cause of drug use.²² The third is increased funding for the police.²²

One question that has been raised in the media in the last few years, the legalization of all illicit drugs, is supported by a small portion (14%) of the public, and only 5% favor that option strongly.²⁵ The majority of the public (62%) believes that drug-related crime would actually increase if drugs were legalized.²¹ Just 25% said crime would decrease if drugs were legalized.²¹ Most Americans remain so concerned about the other dimensions of the drug problem that 3 (76%) of 4 would not favor legalizing cocaine and heroin, even if they believed it would lead to less crime.²³

The option of increased funding for drug treatment did not rank as a top issue on this list of priorities (Table 5).²² Compared with a number of other policies, this approach has lower salience with the American public. In drug treatment we see the widest gap between Americans' general support for a particular spending priority (77%), and those who say they strongly favor it (19%).²² In addition, public support for increased spending for drug treatment has declined from a high of 65% in 1990 to 53% in 1996.¹¹

However, even with this low salience, the public does think that drug treatment can make a major difference in some circumstances. A majority (59%) thinks that rigorous and closely supervised drug treatment for first-time offenders would make a major difference in reducing drug-related crime.²⁷ Close to a majority (49%) believe that making government-funded drug treatment available for everyone who seeks it and that providing drug treatment in prisons would be very effective in reducing drug-related crime.²⁷

In recent years there has been an increase in public support for antidrug education. In 1990¹⁴ and 1995²² opinion surveys (Table 6), Americans were asked what is the single most effective program or policy to affect the drug problem in this country. Over this period, there was a significant change in public opinion. Public support for drug education activities increased substantially (Table 6).^{14,22} On the other hand, the priority shown by the public for efforts aimed at punishing and convicting people for drug crimes declined.^{14,22}

5. What do Americans think about 2 medically related issues that have emerged that bridge medically related concerns and the broader drug policy debate?

The first is should public and community health programs be permitted to exchange sterile needles and syringes for the used ones of injection drug users in an attempt to decrease the risk of human immunodeficiency virus transmission? As of 1997, the majority of Americans (55%) reported that they were

not familiar with these types of programs.⁴² During the last few years public support for community programs to dispense clean needles has varied substantially from a high of 66% in 1995⁴³ to a low of 44% in 2 surveys in 1997.^{44,45} This variation in public opinion over this relatively short period suggests that Americans have not come to a firm judgment on this issue. It is also reflected in the fact that specific arguments about this issue can affect the direction of public opinion. If respondents were told that the American Medical Association and other medical and public health organizations have endorsed these programs, support rises to 50%.⁴⁶

The second issue, the legalized use of marijuana for medical purposes, has been discussed for over a decade. In early 1997,⁴⁷ separate surveys reported that 62%⁴⁸ and 60%⁴⁹ of the American public supported a policy where physicians should be able to prescribe marijuana to their seriously and terminally ill patients. Moreover, 58% said that physicians should be able to prescribe marijuana for medical uses in states where it is allowed by law, and that the federal government should not prosecute medical doctors who do so.⁵⁰ While opposing the use or legalization of marijuana for recreational purposes, the public apparently does not want to deny very ill patients access to a potentially helpful drug therapy if prescribed by their physicians. The public's support of marijuana for medical purposes is conditioned by their belief that marijuana would be used only in the treatment of serious medical conditions.⁵¹

COMMENT

What are the implications of these findings for a reexamination by health professionals of the nation's drug policies? First, this is an area where physicians and other health professionals can be influential. Even with the general lack of public confidence in leadership groups and institutions in society today, physicians and public health professionals remain trusted⁵² and are likely to be seen as an important source of information about drug policies, particularly in the areas of preventive education and treatment. As with smoking, physicians and other health professionals can have a long-term effect on how Americans think about the major public health consequences and implications of our current illicit drug policies and the priorities for the future.

Second, health professionals interested in this area will find there is growing public support for continued large-scale initiatives in public drug education and prevention. The result is a positive environment for health professionals and others to examine critically various current approaches to public drug education and to identify those that would be most effective. However, there remains considerable controversy among policymakers and professionals in this field over what kind of drug education is most effective.

Third, health professionals need to turn more of their attention toward the issue of drug treatment and public views on its efficacy and usefulness. Without a change in current public attitudes, garnering support for increased efforts in the drug treatment area would be difficult in the future. The public is ambivalent about drug treatment: they favor it, but not strongly. These views appear to relate to public concerns about its effectiveness at reducing crime, the use of illicit drugs, and to the stigma that is attached to those addicted to drugs. If health professionals are going to increase public support for drug treatment, Americans would have to be shown that it is important in the overall fight against the adverse consequences of drug use.

Fourth, national medical organizations and health professional groups can play an important role in helping the public come to judgment on the future direction of issues where drug policy conflicts with potentially helpful medical and public health policies. This finding highlights the importance of providing the public independent scientific assessments of the medical or public health consequences of these policies. As we have seen in the past, these issues are likely to be viewed individually and the public will evaluate each based on what they see as the trade-off between their medical and public health usefulness, and the risk that they may encourage an increase in illicit drug use and related crime.

Fifth, though Americans do not believe the War on Drugs is working, they do not want to abandon the effort nor the general direction of public policies. As a result, in a number of areas, health professionals would face substantial obstacles if they propose major changes in the nation's current drug policies. To gain public support, a proposal for major change must address 4 dimensions of public concern: the impact on crime, the national character, morals, and health. Thus, any new proposals for significant change in drug policy direction at the national level will require a lengthy period of debate before they might obtain public approval.

This finding is most true for the issue of legalization of some illicit drugs. Today, public beliefs in this area, particularly those that relate to morality, are very strongly held. Thus, in the immediate future it would be very difficult to achieve public support for the broader legalization of any currently illicit drugs, including marijuana.

Last, most members of the American public have very little direct experience with the illicit drug problem. Their views are largely shaped by the content and magnitude of media coverage on the issue. In the future, if health professionals want to change the direction of Americans' beliefs on particular drug policies they will have to devote significant resources to gaining media attention for their views.

On this issue, it is not only the news media that will influence future public opinion. The public is likely to be swayed by what they see on weekly television health and crime drama series, by large paid-for advertising campaigns, and by public service advertisements that espouse a particular drug policy viewpoint.

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DO AMERICANS THINK THE AIDS EPIDEMIC IS "OVER"?

MANY SEE PROGRESS IN FIGHT AGAINST THE DISEASE, YET SUPPORT STILL STRONG FOR SPENDING ON PREVENTION AND TREATMENT

Though Still Number One, AIDS Now Tied with Cancer As Nation's Most Urgent Health Problem

WASHINGTON, DC -- As new drugs have become available to help people with AIDS/HIV live longer, advocates have worried that the public will perceive the epidemic as "over," while others have questioned whether AIDS should receive special status among the nation's health concerns. Sixteen years since the beginning of the epidemic, a new survey finds that while Americans see growing progress in the fight against the disease, they also continue to view AIDS as an urgent health problem for the nation and still strongly support spending on prevention, research, and treatment.

According to a Kaiser Family Foundation survey released today, the public is far from thinking the AIDS epidemic is "over:" the vast majority -- 88 percent -- give an emphatic no. But, a majority of Americans (52%) now do see the country making progress in addressing the problems of AIDS. Only a third (32%) were as optimistic in 1995, when the Foundation surveyed Americans on AIDS/HIV. And, in 1994, it was just a quarter (23%), according to a Times Mirror survey. Even so, the public continues to rank AIDS among the most serious health concerns facing the nation; although, it is now seen as more comparable with other diseases. Today, the same percentages of Americans name AIDS (38%) as name cancer (38%) when asked what is the most urgent health problem facing the nation. Two years ago, AIDS was ranked first by 44 percent of the public, followed by cancer with 27 percent. In 1990, 49 percent of the public said AIDS, and 31 percent, cancer, according to a *Los Angeles Times* poll.

"After more than a decade of fighting this deadly disease, Americans are learning to live with AIDS. While the public continues to see AIDS as an urgent issue, it is no longer viewed as an emergent one," said Sophia Chang, MD, MPH, Director of HIV Programs, Kaiser Family Foundation.

Support for government spending to help pay for drug therapies for low-income people with AIDS is especially strong. Three quarters (73%) of Americans say the government should help pay for new AIDS treatments regardless of income-level; 20 percent say the responsibility should be left to individuals and their families. Two thirds (64%) support spending even when told it would result in higher costs to the government; 29 percent say the government cannot afford it.

-- more --

Overall, a majority (51%) of the American people say the government spends too little money on AIDS (32% say "about the right amount," 8% say "too much"). Forty percent (40%) say federal spending on AIDS is too low, as compared to what is spent on other health problems such as cancer and heart disease (35% say "about the right amount," 11% say "too high"). This is down from 1995, when 50 percent of Americans said not enough was spent on fighting the disease as compared to what is spent on other health concerns (31% said "about the right amount," 12% said "too high"). Still, there remain high levels of support today for spending in all areas of AIDS education, prevention, and treatment. When asked to choose a "top priority" for HIV spending, the public favors devoting resources to research to find an AIDS vaccine (47%), followed by HIV/AIDS education and other prevention efforts (32%).

The survey also finds that most people — 89 percent — think that by now all adults should know how to protect themselves from HIV infection, and 71 percent think those who become infected today are more responsible for their circumstances than those infected earlier. While public sentiment leans toward greater personal responsibility, the public's attitude toward people with AIDS is not punitive: a majority — 54 percent — do not think that adults with AIDS/HIV should have to pay more of their medical bills themselves than those infected years ago; 42 percent say should have to pay more today.

Trends in AIDS/HIV. For the first time this decade, in February of 1997, the Centers for Disease Control and Prevention (CDC) announced a decline in AIDS deaths in the United States. Deaths from AIDS among Americans, ages 13 and older, declined 23 percent between 1995 and 1996. Declines were reported in all geographic areas, among men and women, among all racial and ethnic groups, and in all risk and exposure categories. The number of Americans living with AIDS — almost a quarter of a million today — increased by 11 percent over the same time period. This increase in people living with AIDS comes at a time when new drug therapies are available to help treat the disease and lengthen life. Protease inhibitors, a class of drug commonly used in combination therapies to treat people with HIV/AIDS, was approved by the Food and Drug Administration for use in this country in December 1995. The use of zidovudine (AZT) to prevent the transmission of HIV from mother to child also appears to be having an impact. New AIDS cases as a result of mother to child transmissions were recently reported to have decreased by 43 percent between 1992 and 1996.

New Drug Therapies. More people today (86%) than two years ago (75%) know that drug therapies are available to help people with AIDS live longer. The public is also more aware today that certain drugs can be taken by pregnant women with HIV to help prevent transmission to their babies: 49 percent today, as compared to 30 percent in 1995.

Awareness about the availability of new drugs may be one reason the public sees progress in the fight against AIDS: 44 percent of Americans today say "a lot" of progress has been made in keeping people with AIDS alive longer, up from 24 percent in 1995. However, most people believe that the new drugs do not benefit everyone with AIDS/HIV: 79 percent say most people who want the treatments are not getting them, and 58 percent say they are not effective for most people who are taking them. The public also appears to have a realistic understanding of the high cost of the new drugs: 42 percent know the average monthly expense can be as high as \$1000; 30 percent think it is closer to \$500 per month.

In spite of greater awareness about the drug therapies, the percentage of Americans who report having been tested for HIV has remained relatively constant over the last two years. Currently, two out of five people (38%) say they have ever been tested for HIV, including 16 percent in the last year, about the same percentages as reported being tested in 1995. Just 20 percent of those surveyed say they have ever talked with a health care provider about getting tested for HIV; two thirds (66%) of whom say they brought the topic up themselves.

Needle Exchange. Over the two years the Foundation has surveyed the public on needle exchange, Americans have remained supportive of these programs, which offer clean needles to IV drug users in exchange for used needles, as an AIDS prevention measure. As of the end of November, 64 percent of the public favor needle exchange and 30 percent oppose. Earlier in the fall when the Foundation surveyed on needle exchange, 58 percent supported and 38 percent opposed such programs. Two years earlier, 66 percent supported needle exchange, and 30 percent opposed.

Public opinion on needle exchange, however, appears to be influenced by how the issue is presented. When presented with the major arguments for and against needle exchange (including the criticism that needle exchange programs give tacit approval of illegal drug use) the differences level out: in November, 48 percent support and 46 percent oppose. A few months earlier, 43 percent support and 53 percent oppose needle exchange when given these same arguments. Better knowledge of the scientific evidence on needle exchange, on the other hand, appears to increase support. After hearing that organizations such as the National Academy of Sciences have concluded that needle exchange programs reduce HIV infection among IV drug users without increasing their drug use, support for the programs in the most recent survey increases. Among the first group, those asked about needle exchange without arguments, support increases from 64 percent to 73 percent (20% still oppose); among those given both sides of the argument, support increases from 48 percent to 60 percent (32% still oppose). (This question was not asked in the earlier surveys.)

Today, a majority of Americans – 61 percent – think current law should be changed to allow state and local governments to decide for themselves whether federal funds should be used for needle exchange.

Other Prevention Efforts. Americans support efforts to encourage condom use to help stop the spread of HIV:

- 62 percent say the TV networks should accept condom advertising (33% say should not);
- 55 percent say when movies and TV shows deal with sexual relationships there should be more references to condoms (32% say there are enough references now); and
- 44 percent say condoms should be made available in high schools, and another 52 percent say only information about AIDS prevention should be provided (1% oppose both).

Parents, Kids, and AIDS

The theme for this year's World AIDS Day, held on Monday, December 1, was "Give Children Hope in a World with AIDS." According to the Kaiser Family Foundation survey, parents remain a worried group about AIDS, especially when it comes to their children: 52 percent of those with children 21 and younger say they are "very concerned" about their son or daughter becoming infected with HIV, and an additional 21 percent say they are "somewhat concerned." Close to half -- 46 percent say their concerns have heightened from just a few years ago. Most parents -- 57 percent -- say they need more information about what to discuss with their children about AIDS.

When it comes to other AIDS prevention efforts, parents are among the most supportive: 47 percent favor providing condoms in high schools; 64 percent say more references to condoms should be included in movies and television shows that deal with sexual relationships; and 66 percent think condom ads should be aired on network television. In total, 97 percent think some information about AIDS and how it is spread should be provided to teens in high school.

Methodology

The Kaiser Family Foundation's *1997 National Survey of Americans on AIDS/HIV* is a random-sample survey of 1205 adults, 18 years and older. It was designed by staff at the Foundation and conducted by telephone by Princeton Survey Research Associates (PSRA) between September 17 and October 19, 1997. Additional questions were asked as part of a national omnibus telephone survey of 1,009 adults conducted November 20-23, 1997. The margin of sampling error for both national samples are plus or minus 3 percent. The margin of sampling error may be higher for some of the sub-sets in this analysis.

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

Copies of the questionnaire and top line data for the findings reported in this release available by calling the Kaiser Family Foundation's publication request line at 1-800-656-4533 (Ask for #1346). Also available is the top line data from the Kaiser Family Foundation's *1995 National Survey of Americans on AIDS/HIV* (Ask for #1118).

CHART 12
**RESEARCH AND PREVENTION:
 TOP SPENDING PRIORITIES FOR AIDS**

Percent who say...

Percent who say government should spend money for...

Which one area should be the top priority for AIDS spending?

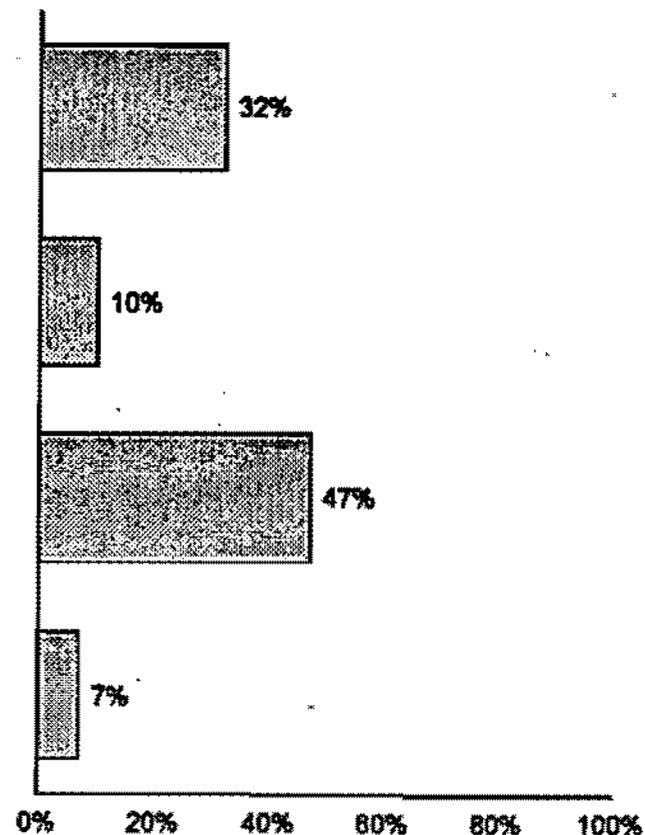
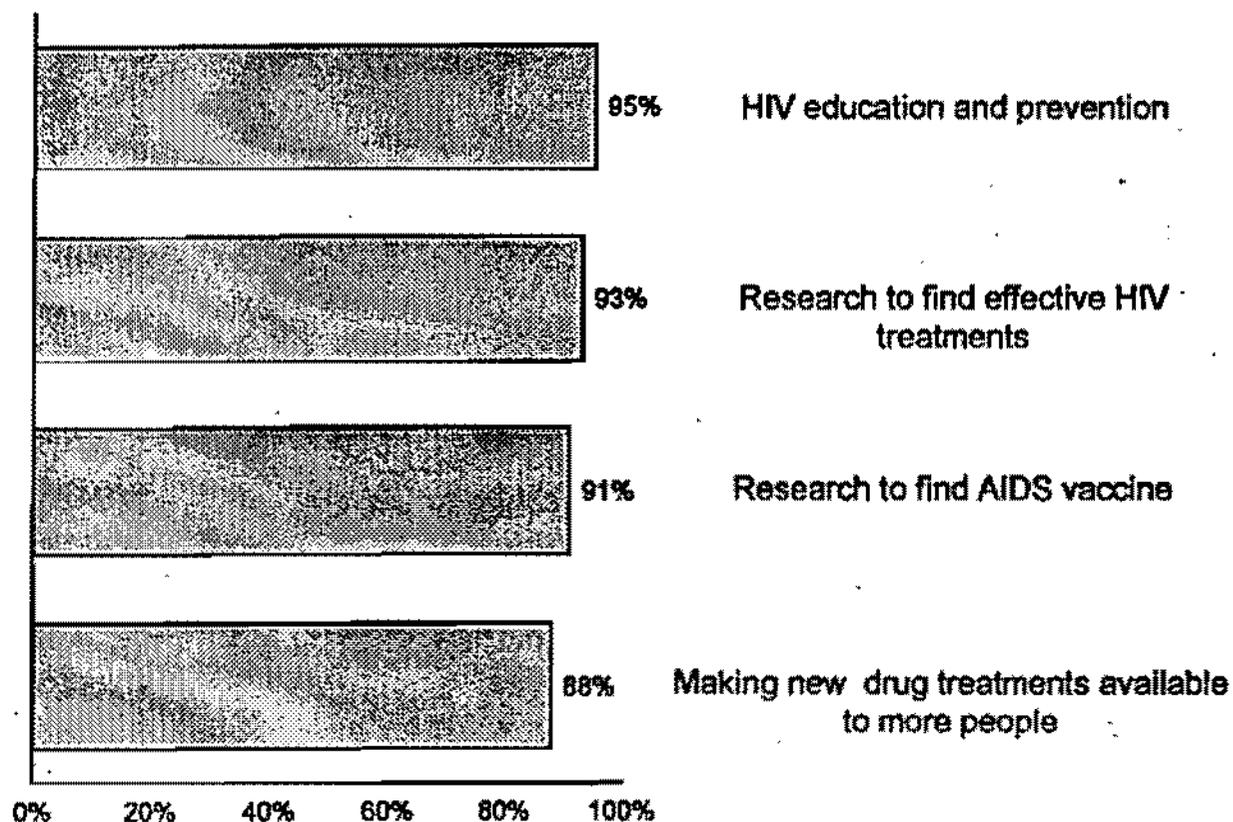
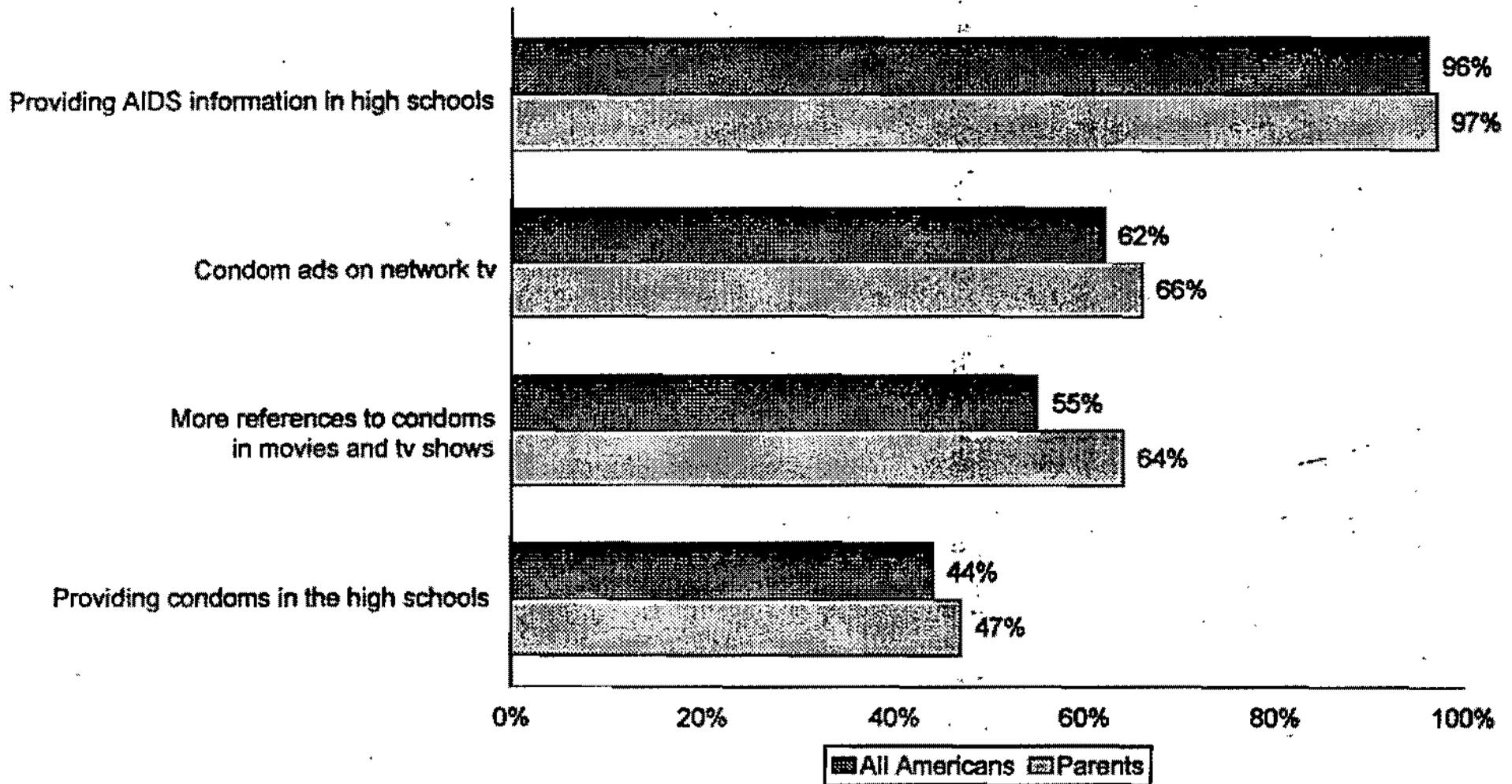


CHART 13

SUPPORT FOR PREVENTION STRATEGIES

Percent who support...



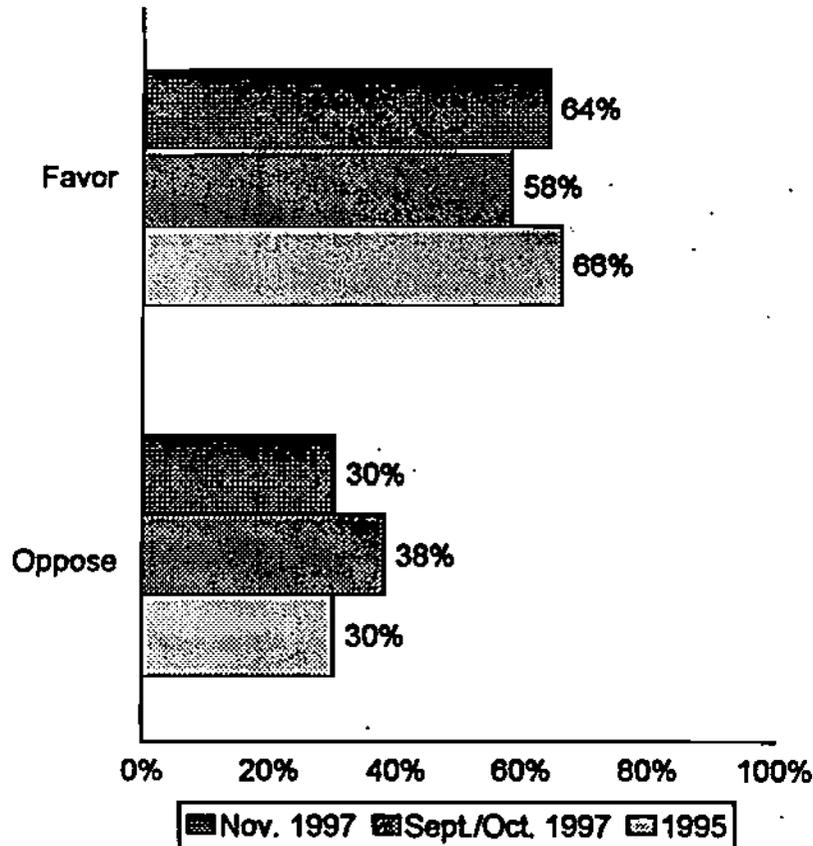
Sources: Kaiser Family Foundation 1997 Survey of Americans on AIDS/HIV;
Kaiser Family Foundation Omnibus Survey, November 1997.

CHART 14

MOST FAVOR NEEDLE EXCHANGE, BUT INFLUENCED BY HOW ISSUE PRESENTED

QUESTION VERSION 1:

"Do you favor or oppose needle exchange programs, which offer clean needles to IV drug users in exchange for used needles to help stop the spread of HIV?"



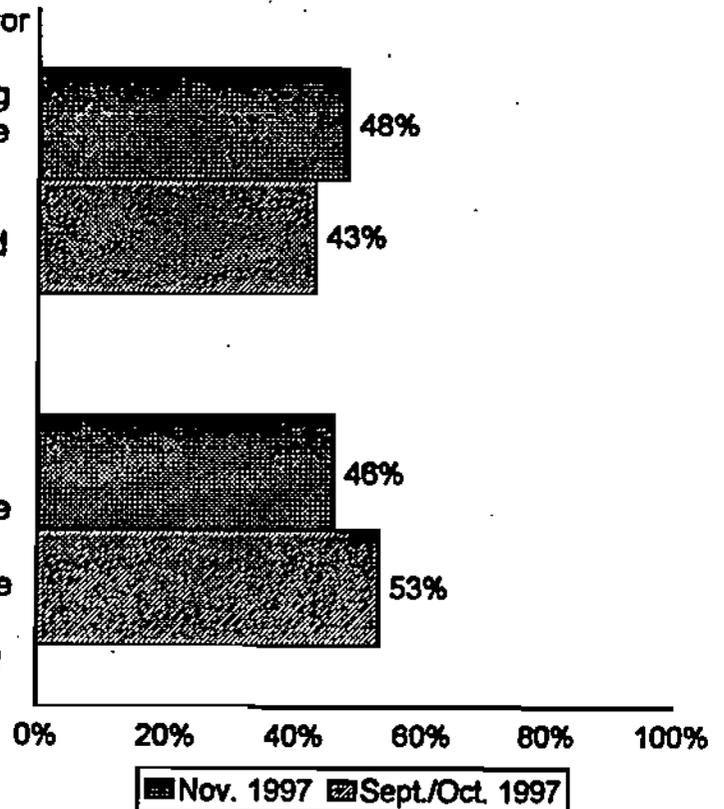
QUESTION VERSION 2:

Which one comes closer to your view?

"Some people favor offering clean needles to IV drug users in exchange for used needles because it helps reduce the spread of AIDS"

OR

"Others oppose needle exchange programs because they feel these programs send the message that it's okay to use illegal drugs"



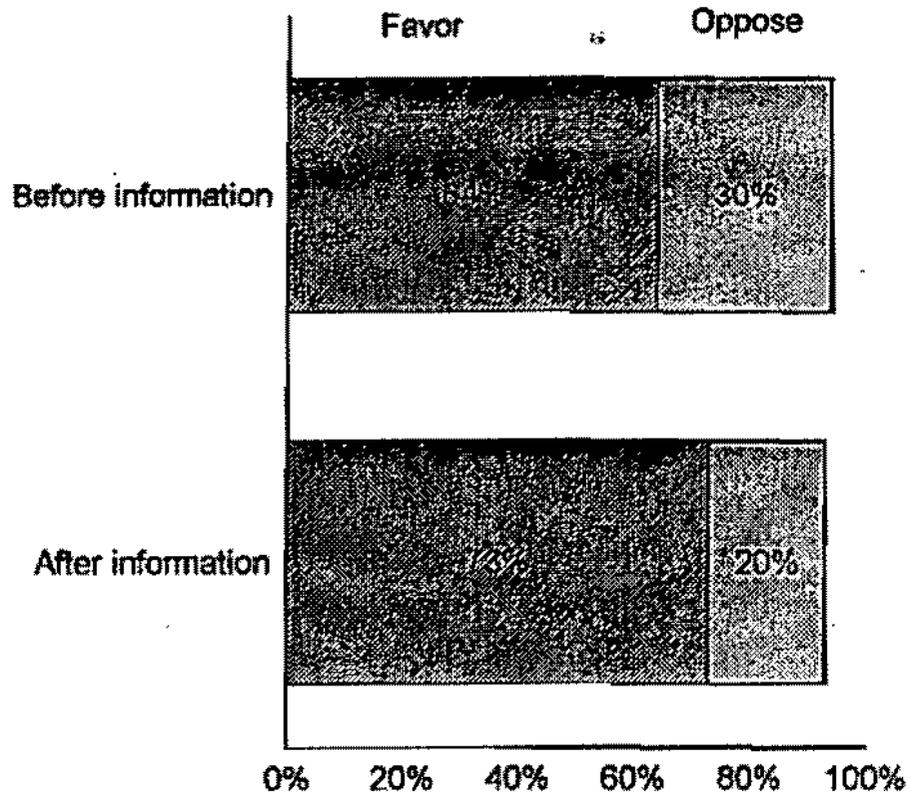
Sources: Kaiser Family Foundation Omnibus Survey, November 1997;
 Kaiser Family Foundation 1997 National Survey of Americans on AIDS/HIV;
 Kaiser Family Foundation 1995 National Survey of Americans on AIDS/HIV.

CHART 15

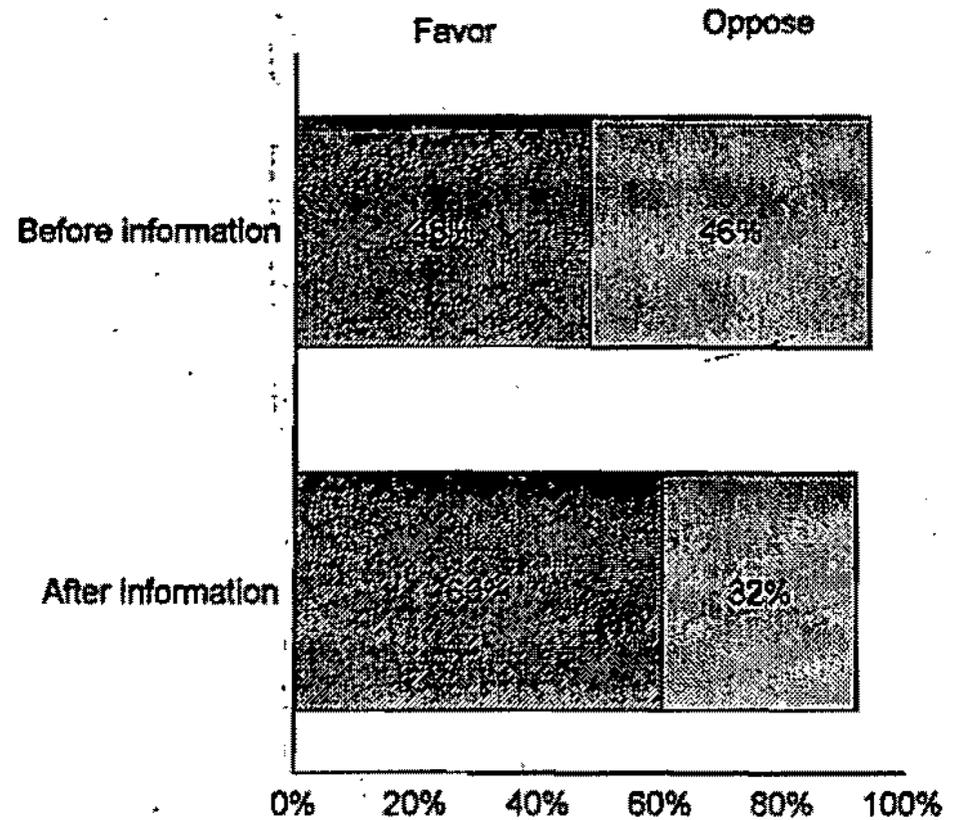
INFORMATION INFLUENCES VIEWS ON NEEDLE EXCHANGE

"Several different government agencies and independent scientific organizations, including the National Academy of Sciences, have concluded that needle exchange programs are effective at reducing HIV infections among IV drug users without increasing their drug use. Knowing this, would you now favor or oppose needle exchange programs?"

QUESTION VERSION 1



QUESTION VERSION 2



Source: Kaiser Family Foundation Omnibus Survey, November 1997.

CHART 16

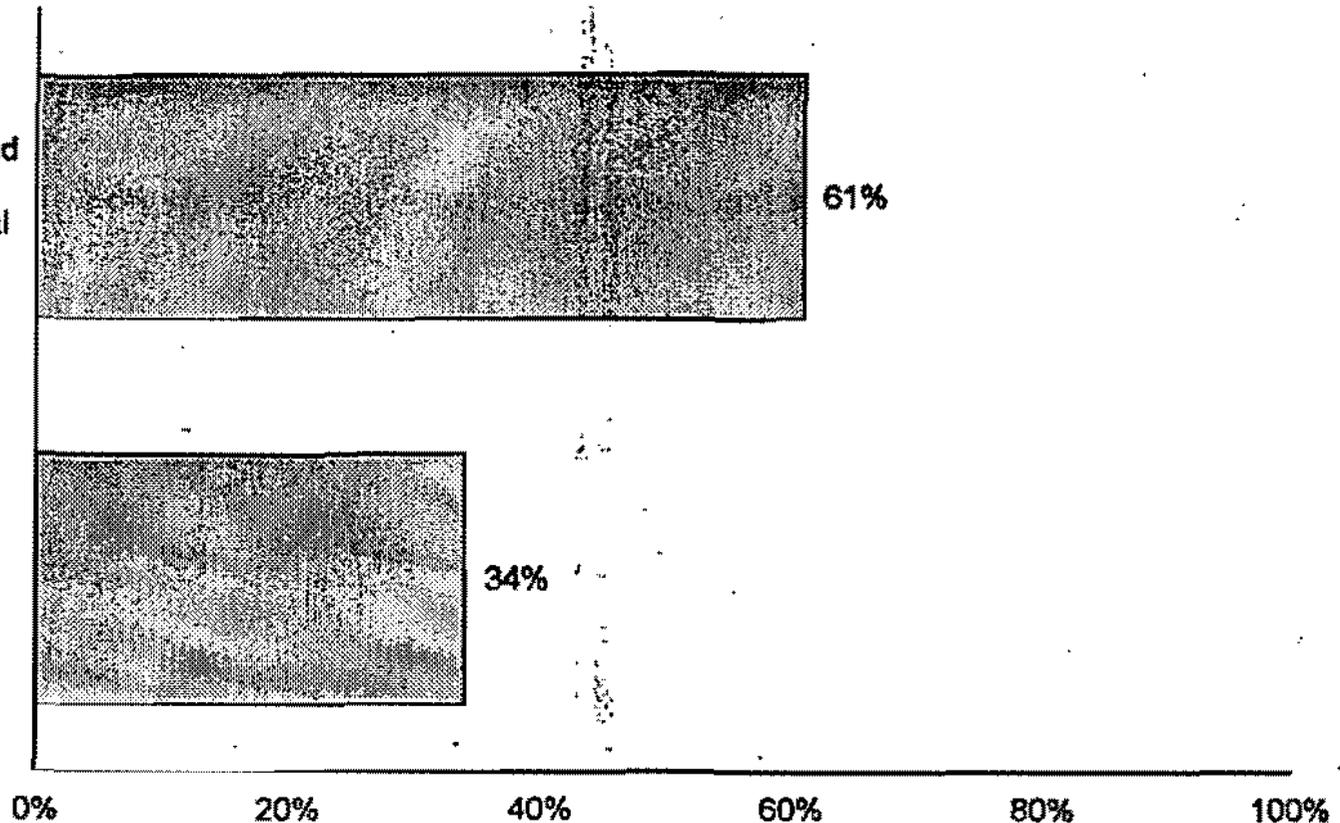
SUPPORT FOR STATE AND LOCAL DECISION-MAKING ON FUNDING FOR NEEDLE EXCHANGE PROGRAMS

"Currently, the federal government provides state and local governments with funding for a number of HIV prevention activities. However, these funds may not be used to support needle exchange programs. Which comes closer to your view?"

"The law should be changed. State and local governments should decide for themselves whether to use their federal funds for needle exchange programs."

OR

"The law should stay as it is. Federal funds should not be used for needle exchange programs."



FEEL-10-88 10:00 AM

The Secret ^{Has Seen} Congress of the United States
House of Representatives
Washington, DC 20515

February 9, 1998

The Honorable Donna Shalala
Secretary, Department of Health & Human Services
200 Independence Avenue, SW
Room 615-F
Washington, DC 20201

Dear Secretary Shalala,

As Chairs of the Congressional Black Caucus and the Hispanic Caucus, we urge you to make an immediate determination that needle exchange programs reduce the risk of HIV transmission and do not promote the use of illegal drugs. Having successfully preserved your authority from legislative attack, we strongly urge you to make available federal funds after the moratorium expires on March 31, 1998. We believe there is ample scientific data to make such a determination and exercise your authority. We are equally concerned that you exercise this authority expeditiously in order to avoid future efforts to codify a ban in the Fiscal Year 1999 Labor, Health and Human Services Appropriations bill or any other legislative "vehicle."

By issuing a determination immediately, you will help keep the focus of the debate on science and not politics. Congress would construe an immediate determination as a less political response than if you waited until the end of the Congressional moratorium. If some of our colleagues are successful in further restricting the use of federal funds, the Administration will be able to send the right public health message.

Needle exchange programs are a proven HIV prevention tool and will save lives, particularly among the constituencies we represent. Half of all new HIV infections are attributed to injection drug use. Among African Americans diagnosed with AIDS through June 1997, injection drug use accounted for 36% of the total cases in men and 46% of the total cases in women (compared with 9% for white men and 43% of white women). In 1996, of the Latinos diagnosed with AIDS, injection drug use accounted for 39% of the total cases in men and 51% of the total cases in women.

Minority populations are disproportionately affected by HIV/AIDS and this scientifically proven intervention is one way to stop this trend. Although overall AIDS deaths have declined since the first time the epidemic started, these declines have been much less dramatic for minority populations. AIDS is still the number one killer of African Americans and Latinos between the ages of 25 and 44. It is estimated that 33 American men, women, and children are infected with HIV every single day that would not be infected if comprehensive needle exchange was implemented in this country.

Minority communities recognize the importance of needle exchange programs because of their linkages to drug treatment services, primary health care, job counseling, psychosocial services, testing and counseling, and public assistance. These services are very important to minority populations who often do not receive services and referrals in other venues. As

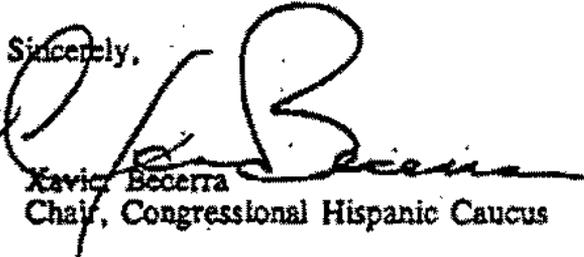
you stated in your February 1997 report, "needle exchange programs can have an impact on bringing difficult to reach populations into systems of care that offer drug dependency services, mental health, medical and support services."

Needle exchange programs have been proven to reduce the risk of HIV transmission without increasing the use of illegal drugs. Furthermore, needle exchange programs are also very cost-effective. The cost of a needle is only 10 cents compared to the \$119,000 lifetime cost of treating one HIV infected person. We appreciate your continued support in issues dealing with people living with HIV/AIDS. We look forward to your cooperation on this important matter.

Sincerely,



Maxine Waters
Chair, Congressional Black Caucus



Xavier Becerra
Chair, Congressional Hispanic Caucus

Congress of the United States
House of Representatives
Office of the Democratic Leader
Washington, DC 20515-6537

February 17, 1998

The Honorable Donna Shalala, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, DC 20201

Dear Madame Secretary:

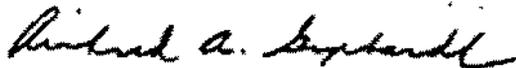
As you know, compromise language in the FY 1998 Labor-HHS-Education Appropriations Act preserves your authority to make a determination that would allow the use of federal funds for clean needle exchange programs. Your role in achieving that compromise helped keep the debate focused on science. While the compromise language prohibits the use of federal funds for needle exchange through March 31, your determination on the issue is not restricted. The language in the appropriations law also provides reasonable requirements for assuring that federal dollars, should their use become available, will be used wisely.

A clear and unequivocal message from you on this issue is critical at this time, should you be convinced, that based on the best available scientific evidence, needle exchange programs are effective in decreasing HIV transmission and do not encourage the use of illegal drugs — the conditions set forth in the Act that would allow federal funds to be used. If the Administration joins with the American Medical Association, the American Public Health Association, the American Academy of Pediatrics and AIDS organizations in recognizing needle exchange to be a scientifically sound and effective tool in our arsenal to fight the AIDS epidemic it would help maintain that focus should authorizing committees choose to address this issue further in the coming months.

Public health considerations on this issue must prevail over politics. I opposed the Hastert amendment to the House version of the appropriations bill last fall for precisely that reason. As the HIV and AIDS epidemic affects more women, more children, more communities of color and other difficult to reach populations, we must be willing to support local authorities in utilizing the most effective prevention tools. That is why I believe that your timely action on this matter can help convince many people who have opposed clean needle exchange programs in the past of the efficacy and necessity of those programs.

Thank you for all you have done in our battle against HIV/AIDS. I look forward to continuing to work with you in this fight.

Sincerely,



Richard A. Gephardt, M.C.
House Democratic Leader

**HR-38. HIV/AIDS**

As a result of the recent NGA Meeting, this policy may have changed. All policies will be updated shortly. Please check back later to see if this policy has been changed.

◀ [NGA Policy Index Page](#)

◀ [HR-37. PRIVATE SECTOR HEALTH CARE REFORM](#)

▶ [HR-39. ENCOURAGING MENTORING](#)

38.1 Preamble

The human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) are critical public health problems. No state has been untouched by the devastating human and economic costs of HIV and AIDS. U.S. Public Health Service and worldwide projections of future incidence are startling. Through June 1996, 548,102 AIDS cases have been reported in the United States. Since the beginning of the epidemic, 343,000 people have died of AIDS in this country. State and local governments have allocated significant financial resources to this problem. In a number of states, state and local funds far exceed federal support. Although encouraging progress has been made in slowing the spread of the disease, the Governors strongly believe that the magnitude of the HIV/AIDS epidemic calls for strong action by all levels of government, including continued support for HIV/AIDS prevention and tracking and for the reauthorized Ryan White CARE Act.

38.2 Education, Prevention, Counseling, and Testing

The Governors recognize that the federal government has made a significant contribution toward funding HIV/AIDS prevention activities. Although significant scientific progress has been made, an effective vaccine or a cure for the disease remains years away. In the absence of a vaccine or a cure, prevention efforts such as education, public information, HIV/AIDS counseling and testing, and personal responsibility are the most effective means available to prevent the disease from spreading further.

State health departments have the primary role in planning and coordinating HIV/AIDS prevention efforts. All states are engaged in HIV Prevention Community Planning with support from the U.S. Centers for Disease Control and Prevention (CDC). Since 1994, state and territorial health departments have been required to implement a planning process through which they collaborate with their communities to identify unmet needs and establish priorities for HIV/AIDS prevention programming. With federal support for prevention efforts, this planning process has given states the flexibility to design and implement targeted prevention programs at the state and local levels that meet state and locally determined needs and are consistent with community values. Federal restrictions or requirements on the use of available funding interfere with the ability of states to develop comprehensive prevention strategies.

Preventive efforts directed at young people—before they reach the age when they may engage in behaviors that place them at risk of infection—also are important. The nation's youth should be made aware of the risk of the possible spread of HIV/AIDS through sexual activity and the harm posed by contaminated needles. Information about HIV/AIDS should be an integral part of substance abuse prevention efforts.

It is also important to recognize the interrelationships between HIV/AIDS and other sexually transmitted diseases and combine efforts to combat further spread of disease. Although the Governors have initiated a variety of sexually transmitted disease prevention strategies, when HIV/AIDS is transmitted sexually, sexual abstinence is the only 100 percent effective means of prevention and should be

strongly reinforced among minors as a way to reduce the risk of contracting HIV/AIDS.

Finally, special education efforts must be made to ensure that all members of the medical and health care community are knowledgeable and have current information about HIV/AIDS prevention. Health providers must be more diligent in identifying people who are at risk or who are infected with HIV, particularly in populations such as women and adolescents who are not as frequently recognized as at risk. The Governors also recognize the importance of educating providers on the appropriate use of emerging treatments and primary prevention and care services within managed care settings.

Counseling and testing have been important components of the national education and prevention effort. Access to counseling services should be an integral part of the HIV/AIDS testing effort, both before and after testing and regardless of the test results. Counseling and testing represent major opportunities to encourage, on a one-to-one basis, the behavioral changes required to stop further spread of the HIV virus. Although counseling and testing remain important strategies to address this epidemic, the nation must continue to seek any and all strategies that will successfully reduce the transmission of HIV/AIDS. In order to increase early access to new HIV/AIDS treatments, it is critical that counseling and testing programs have the ability to link individuals to primary care services as soon as possible. Federal laws should not challenge or supersede state laws and preferences with respect to issues surrounding testing and reporting.

The social stigma associated with HIV/AIDS has created a particular problem for the prevention and control of the disease. Out of fear of discrimination, individuals with HIV and AIDS worry about being identified. Within the context of sound public health policy, states are encouraged to review their medical information and privacy laws and, where necessary or appropriate, update these statutes to safeguard the rights of tested individuals.

The Governors are concerned that individuals who test positive for HIV/AIDS may face discrimination, despite the fact that all medical evidence to date shows that HIV cannot be transmitted through casual contact. Progress has been made in ending AIDS discrimination, but clarification of or modifications in laws should be made, where necessary, to protect HIV-infected individuals from inappropriately being denied opportunities in areas such as employment and housing.

In addition to the range of very important prevention strategies already underway across the country, prevention activities centered around substance abuse and perinatal transmission are emerging as particular priorities.

38.2.1 Substance Abuse.

Transmission tied to injecting drug use continues to be a major cause of HIV infection. Thirty-six percent of the total number of AIDS cases reported to CDC are linked to injecting drug use. A key factor in containing the spread of HIV/AIDS is reducing the use of injection drugs. Programs should strive to eliminate the significant waiting time frequently facing those wishing to receive treatment for drug abuse. Yet the vast majority of drug users are not seeking treatment. Consequently, outreach should be extended to drug users who are not currently in treatment in order to get them into treatment, encourage them to be counseled and tested, and educate them about the dangers of high-risk behaviors. Additionally, appropriate models to attract drug users to treatment should be developed, with a particular emphasis on finding effective methods for reaching out to long-term abusers.

38.2.2 Pediatric AIDS.

The major cause of pediatric HIV/AIDS today is perinatal transmission of infection, although dramatic progress has already been made in reducing transmission rates. Recent findings released by CDC demonstrate a 27 percent reduction in perinatal transmission between 1992 and 1995. The Governors applaud this reduction and the scientific advances and voluntary prevention strategies that made it possible.

The Ryan White CARE Act, as reauthorized in 1996, includes a number of provisions focused on reducing perinatal transmission, including targeted caseload reductions. Failure to comply will cause a state's allocation of Title II funding to be eliminated. Vital treatment funding will be jeopardized as a result of prevention mandates. The Governors strongly oppose efforts to tie the receipt of federal funds to mandatory testing laws.

The Governors are strongly committed to reducing and eliminating HIV/AIDS in children through implementation of universal HIV counseling and voluntary testing guidelines for pregnant women. But mandatory postpartum testing, as set forth in the Ryan White CARE Act, will not in and of itself reduce the spread of HIV/AIDS to newborns. In fact, some states fear that mandatory testing could discourage at-risk women from seeking needed health care. Instead of this focus on mandatory testing, the Governors encourage federal support for the use of AZT during pregnancy, when infection can be prevented.

In an effort to comply with the targeted perinatal caseload reductions mandated by the Ryan White CARE Act, every state will be forced to redirect funds from other equally vital and more effective HIV/AIDS prevention activities. States will no longer be able to develop comprehensive prevention strategies to meet the particular needs of their communities. Instead, federal mandates will require states to focus available resources on one particular category of need. Unfortunately, the science of prevention is not so exact that there is any guarantee that any level of intervention will produce the desired result in any state. The Governors would like to work closely with Congress and the administration to develop prevention strategies that achieve the goal we all support of keeping babies healthy, without jeopardizing funding for other important HIV/AIDS prevention and treatment efforts.

The Governors support efforts to reduce the transmission of HIV/AIDS. They do not support the new perinatal transmission mandate imposed by Congress. In addition, the Governors are specifically concerned that because an alternative measure as required by the legislation has not been determined by CDC, it will be virtually impossible statistically for low-incidence states as defined by CDC to realize the required 50 percent reduction in perinatal transmission. For that reason, the Governors believe that while moving toward a more workable perinatal transmission prevention strategy for all states, low-incidence states should be held harmless from the caseload reduction requirements of the Ryan White CARE Act. The Governors also believe that future federal resources made available to reduce perinatal transmission should be targeted to high-incidence states.

38.3 Research

A comprehensive national education and prevention program, with significant federal leadership, must be a central component of the nation's fight against HIV/AIDS. At the same time, resources must be devoted to research—both to find a vaccine for HIV/AIDS as well as to develop effective, accessible, and affordable treatments and a cure for present and future HIV/AIDS patients. The federal government has the primary role to play in funding HIV/AIDS-related research activities. The Governors urge that money appropriated for HIV/AIDS research be used expeditiously and that funding provided for HIV/AIDS research not be made at the expense of other public health priorities.

In addition to the substantial commitment made by the federal government, private sector HIV/AIDS research has led to dramatic breakthroughs. The Governors applaud the pharmaceutical industry for the research and development efforts that have resulted in the creation of protease inhibitors and other useful drug therapies. The Governors urge increased coordination between federal and private sector efforts to ensure the most efficient use of research dollars. The Governors also urge the speedy dissemination of research results to the scientific community, as well as to practitioners, to ensure that research findings can be applied as expeditiously as possible. The Food and Drug Administration's expedited drug approval process has helped make new treatments available more quickly than in the past and should be continued.

38.4 Treatment

Over the next few years, the growing number of HIV/AIDS cases will place an increasing strain on the nation's health care delivery system. The estimated cost of treating a person with HIV/AIDS from the time of infection to death is \$119,000. Now is the time to begin the fiscal and capacity planning required to address these future health care delivery needs. This should include an assessment of the appropriate burden of HIV/AIDS health care costs that should be borne by the public and private sectors.

At the same time, we need to provide appropriate services to those individuals presently suffering from HIV/AIDS. Treatment needs are changing with the advent of promising multidrug combination therapies, which are helping many HIV/AIDS patients live longer and healthier lives. Treatment

protocols relating to chronic disease management of HIV/AIDS, developed in partnership among federal, state, and private efforts, will lead to changes in existing systems of care.

Adequately addressing patients' health care needs requires the establishment of a continuum of care, including inpatient and outpatient hospital services, care in nursing home and alternative residential settings, home care, hospice care, psychosocial support services, and case management services. Many state and local governments have led the way in providing health care services for people with HIV/AIDS; however, more research is required to determine the most humane and cost-effective way of providing HIV/AIDS-related care. Finally, as the nation moves toward networks of health care, efforts are needed to ensure that the prevention and treatment needs of people at risk for or infected with HIV/AIDS are adequately addressed in managed care settings. In addition, strategies must be developed that ensure that those in managed care arrangements also have access to other support services, such as social supports and home- and community-based services, so that the continuum of care is maintained.

38.5 Ryan White CARE Act

The Governors strongly supported the reauthorization of the Ryan White CARE Act. Funds provided through the act support a network of health care, support services in cities and states, and prescription drugs for people living with HIV infection and AIDS, especially the uninsured who would otherwise be without care. This program is a critical element in HIV/AIDS prevention, education, and treatment efforts by states.

However, despite strong support of the Ryan White CARE Act as a whole, certain provisions of the act are of concern to Governors. As previously mentioned, the perinatal transmission mandate restricts state flexibility to allocate limited federal funding. In addition, the AIDS Drug Assistance Program (ADAP) funding made available through the Ryan White CARE Act has not kept up with the increasing costs of the expensive new drug therapies. Accordingly, an increasing percentage of the cost of the new therapies is shifting from the federal government to the states. The Governors call on the federal government to work in partnership with states and the private sector to reduce the costs of treatment and to maintain funding that adequately reflects the growing cost of drug therapies.

ADAP services currently are delivered by states in a number of different, cost-effective ways, such as Minnesota's successful high-risk insurance pool for HIV/AIDS patients. The Governors believe that although many of these strategies are cost-effective, further study is needed to help states identify and learn from the best practices in the field.

The Governors also believe that CDC and the Health Resources and Services Administration should work very closely with states when determining whether a good-faith effort has been made to comply with the new mandate in the Ryan White CARE Act requiring states to notify the spouses of individuals with HIV infection. The Governors feel strongly that no state should lose access to its Ryan White CARE Act funds as this new mandate is implemented.

In implementing the Ryan White CARE Act and in confronting the HIV/AIDS epidemic more generally, the Governors believe that the best results will be achieved if the federal government, the states, private insurers, the medical and pharmaceutical industries, and interested members of our communities work together in close partnership.

*Time limited (effective Winter Meeting 1997–Meeting 1999)
Adopted Annual Meeting 1987; reaffirmed Winter Meeting 1992; revised Winter Meeting 1995 and
Winter Meeting 1997 (formerly Policy C-17).*

This policy appears in the volume *Policy Positions*, February 1997. (Washington, D.C.: National Governors' Association, 1997.) This volume includes policies adopted by the Governors at NGA's 1997 Winter Meeting. To order, contact NGA Publications at 301/498-3738.



THE UNITED STATES CONFERENCE OF MAYORS

1620 EYE STREET, NORTHWEST
WASHINGTON, D.C. 20006
TELEPHONE (202) 293-7330
FAX (202) 293-2352
TDD (202) 293-9445
URL: www.uscmayors.org/uscm

March 4, 1998

The Honorable Donna Shalala
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Shalala:

On behalf of the nation's mayors, I am writing to urge you to issue an immediate determination based on the scientific data that needle exchange programs are effective in reducing HIV transmission and do not encourage the use of illegal drugs. The mayors also urge you to exercise the waiver authority available to you beginning March 31, 1998 under the Labor, Health and Human Services Appropriations bill which would allow you to fund needle exchange programs.

The U.S. Conference of Mayors adopted policy at its annual meeting last June which recognizes the overwhelming scientific evidence that needle exchange is effective in preventing the spread of HIV and does not increase the use of illegal drugs. That policy resolution also recognizes needle exchange as one, vital component of a comprehensive HIV prevention program. It urges you to exercise the waiver authority available and calls for the utilization of federal funds by state and local public health officials for needle exchange programs, as part of a comprehensive prevention program.

We have worked closely with the Department of Health and Human Services on AIDS prevention initiatives for many years. We look forward to continuing that partnership and would be pleased to work with you to assure that federal funds can be used by local communities to support needle exchange programs as part of their comprehensive prevention efforts.

Sincerely,

J. Thomas Cochran
J. Thomas Cochran
Executive Director

- President: PAUL BELMONT, Mayor of Fort Worth
- Vice President: BRUCE COOPER, Mayor of San Antonio
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 - MARK H. MORAN, Mayor of New Orleans
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 - SYDNEY E. CHAPMAN, Mayor of Virginia Beach
 - JAMES P. FRYSON, Mayor of Edison
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 - MICHAEL S. SMITH, Mayor of Oklahoma
- Secretary:
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 - A. CALLETTI, Mayor of Houston
 - WELLS L. BROWN, Mayor of San Francisco
 - MAJORN CLAYTON, Mayor of Atlanta
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 - HELEN M. SCHWARTZ, Mayor of San Francisco
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THE UNITED STATES CONFERENCE OF MAYORS

1620 EYE STREET, NORTHWEST
WASHINGTON, D.C. 20006
TELEPHONE (202) 295-7350
FAX (202) 295-2552
TDD (202) 295-9445
URL: www.usmayors.org/uscm

March 4, 1998

TO: The Mayor
FROM: J. Thomas Cochran, Executive Director
RE: Federal Support for Needle Exchange Programs

I have sent a letter on behalf of the nation's mayors to HHS Secretary Donna Shalala urging her to issue an immediate determination based on the scientific data that needle exchange programs are effective in reducing HIV transmission and do not encourage the use of illegal drugs. I have also urged her to exercise the waiver authority available to her beginning March 31, 1998 under the Labor, Health and Human Services Appropriations bill which would allow you to fund needle exchange programs. I am writing to you as the mayor of a city which receives Ryan White Act CARE Title I funds to ask that you send a similar letter to the Secretary.

The U.S. Conference of Mayors adopted policy at the San Francisco annual meeting last June which recognizes the overwhelming scientific evidence that needle exchange is effective in preventing the spread of HIV and does not increase the use of illegal drugs. That policy resolution also recognizes needle exchange as only one, vital component of a comprehensive HIV prevention program. It urges the Secretary of Health and Human Services to exercise the waiver authority available and calls for the utilization of federal funds by state and local public health officials for needle exchange programs, as part of a comprehensive prevention program.

The Conference of Mayors has worked closely with the Department of Health and Human Services on AIDS prevention initiatives since 1983. We look forward to continuing that partnership and to working with the Department to assure that federal funds can be used by local communities to support needle exchange programs as part of their comprehensive prevention efforts.

- President: PAUL BELMONT, Mayor of New York
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Resolution No. 26

Submitted By:

The Honorable Willie Brown, Jr.
Mayor of San Francisco

The Honorable Richard Riordan
Mayor of Los Angeles

RATIONALE FOR NEEDLE EXCHANGE PROGRAMS

1. WHEREAS, as of December 1996, 581,429 persons have been diagnosed with AIDS since 1982; and
2. WHEREAS, one in 250 people in the United States is infected with human immunodeficiency virus (HIV), and every year an additional 40,000-80,000 Americans become infected with the AIDS virus; and
3. WHEREAS, AIDS is the leading cause of death among men and women between the ages of 25 and 44; and
4. WHEREAS, intravenous drug use is responsible for the greatest number of new AIDS cases among the heterosexual population; and
5. WHEREAS, by 1996, among children under the age of 13 with AIDS, 53 percent were born to women who contracted HIV through injection drug use or sex with a spouse or partner who used injection drugs; and
6. WHEREAS, the FY 1997 Labor, Health and Human Services, Education and Related Agencies appropriations legislation prohibits the use of Federal funds to "carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug unless the Secretary of Health and Human Services determines that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs;" and

7. WHEREAS, six federally funded studies, conducted independently by the National Commission on AIDS in 1991, the General Accounting Office in 1993, the University of California in 1993, the Centers for Disease Control and Prevention in 1993, the National Academy of Sciences in 1995 and the Office of Technology Assessment in 1995 report that needle exchange programs reduce HIV transmission and do not increase drug use; and
8. WHEREAS, the NIH Consensus Panel reviewed studies on the effectiveness of needle exchange programs and concluded that needle exchange programs do not increase syringe injecting behavior among current drug users, do not increase the number of drug users, and do not increase the amount of discarded drug paraphernalia. In addition, the NIH stated that "legislative restriction on [needle exchange programs] must be lifted. Such legislation constitutes a major barrier to realizing the potential of a powerful approach and exposes millions of people to unnecessary risk;" and
9. WHEREAS, the average lifetime cost of care is \$119,000 for one AIDS patient from diagnosis to death; and
10. WHEREAS, the average cost of a sterile syringe is less than 10 cents; and
11. WHEREAS, studies show reduction in risk behavior as high as 80 percent with estimates of a 30 percent or greater reduction of HIV among injecting drug users in needle exchange programs; and
12. WHEREAS, Secretary of Health and Human Services Donna Shalala, reported that "studies indicate that needle exchange programs can have an impact on bringing difficult to reach populations into systems of care that offer drug dependency services, mental health, medical and support services. These studies also indicate that needle exchange programs can be an effective component of a comprehensive strategy to prevent HIV and other blood-borne infectious diseases in communities that choose to include them;" and

13. WHEREAS, needle exchange programs can offer a bridge to drug treatment, HIV prevention information and medical and support services to hard to reach populations who might not otherwise receive such services; and
14. WHEREAS, there are 113 needle exchange programs in 29 states, the District of Columbia and Puerto Rico; and
15. WHEREAS, The U.S. Conference of Mayors reports that "the clock is ticking in terms of stemming the spread of HIV among drug users and the subsequent spread to their sexual partners and unborn children" and "it may be time to shift discussion to how effective prevention strategies, such as syringe exchange, can be implemented at the local level...;" and
16. WHEREAS, the Federal ban on funding for needle exchange impedes states and local communities from implementing HIV prevention strategies that have been scientifically proven effective,
17. NOW, THEREFORE, BE IT RESOLVED, that the Secretary of the Department of Health and Human Services, in recognition of the overwhelming scientific evidence that needle exchange is effective in preventing the spread of HIV and does not increase the use of illegal drugs, exercise the waiver authority provided under the FY 1997 Labor, Health and Human Services, Education and Related Agencies appropriations legislation; and
18. BE IT FURTHER RESOLVED, that needle exchange is only one, vital component of a comprehensive HIV prevention program, including information, medical treatment, substance abuse treatment and a broad range of complementary social services necessary to prevent the spread of HIV; and

SENT BY:

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- drug
not
19. BE IT FURTHER RESOLVED, that state and local public health officials, consistent with the scientific and public health evidence supporting needle exchange as an effective HIV prevention tool, may utilize appropriate Federal resources for needle exchange programs, as a part of a community's comprehensive HIV prevention plan.

Projected Cost: None

Scofflaws beware:
Parking checkers
going high-tech

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MILWAUKEE METRO AND STATE NEWS

Despite troubles,
state lottery has
plenty of fans

Page 5

MONDAY, MARCH 30, 1998

MILWAUKEE JOURNAL SENTINEL — FINAL EDITION

SECTION 8

Survey shows needle exchange support

Results seen as contrary
to political reluctance to use
tax money for programs

By MARILYN MARRINOW
in the Journal Sentinel and
elsewhere

Most Milwaukeeans support
needle exchange programs to

fight AIDS and think that tax
revenue should help pay for
them, according to a poll to be
released today, a day before the
ban on federal funding for such
programs expires.

The poll was done by the Uni-
versity of Wisconsin-Milwaukee-
Center's Institute for Survey and
Policy Research and was paid
for by the AIDS Resource Cen-

ter of Wisconsin, an AIDS ser-
vice agency that operates in most
of the state, except the Madison
area.

It's the first local survey on
the topic, and it echoes findings
of at least two recent nationwide
polls and scientific studies con-
cluding that such programs
don't encourage drug use but do
stem AIDS.

The UW-M poll of city resi-
dents shows 57% support of
needle exchange programs, 36%
oppose them, and 7% were un-
decided. The poll, conducted in
December, was of 409 randomly
selected adults, and the survey
has a margin of error of 4.9 per-
centage points.

Asked whether existing gov-
ernment AIDS prevention pro-

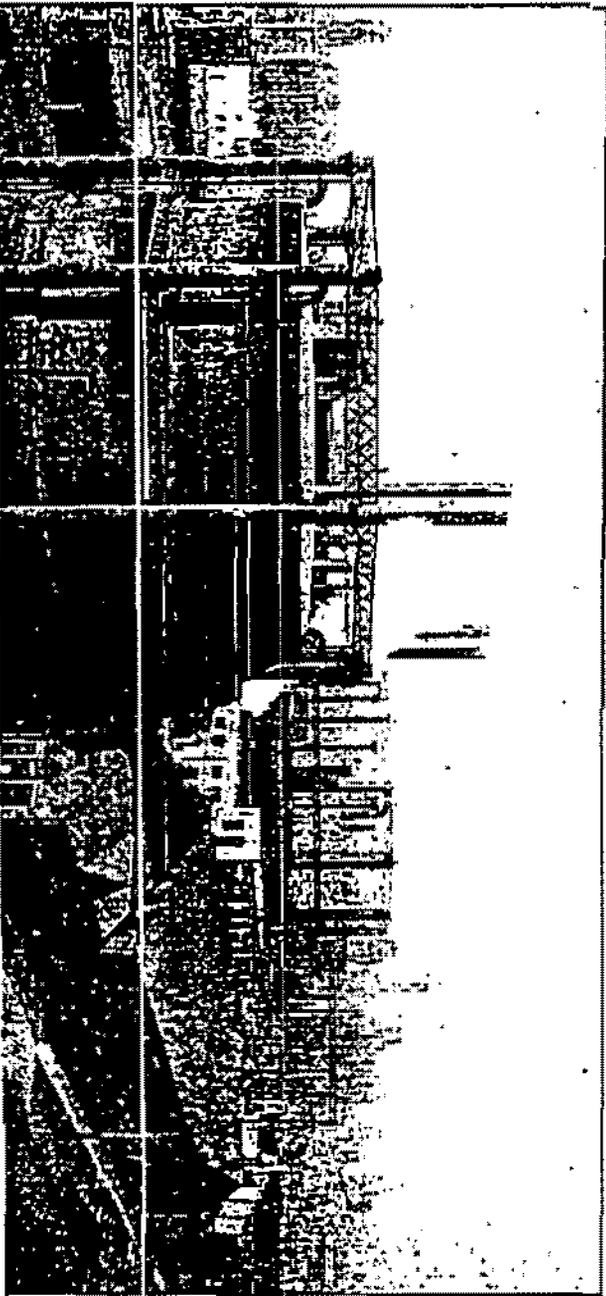
grams should be used to fund nee-
dle exchange programs, 55%
said yes, 40% said no, and 5%
were undecided.

"The people of Milwaukee are
far ahead of the politicians on
needle exchange," said Doug
Nelson, executive director of the
local AIDS agency.

Nelson said the survey "takes
away the excuse" that U.S.

Health and Human Services
Secretary Donna Shalala and
Milwaukee Mayor John Norquist
have used — that the public
doesn't support it — to justify
their opposition to allowing tax
money to be used for needle ex-
change.

Shalala is reexamining her po-
sition on the issue. **Please see NEEDLE page 2.**



New Lazich ad strikes back at Senate foe

Commercial accuses TV
spot supporting Marthey
of mistaking her vote

By ROBERT R. LAZICH
in the Journal Sentinel and
elsewhere

A new television commercial
for state Rep. Mary Lazich (R-
New Berlin) will go on the air

next week, accusing Sen. Marthey
of mistaking her vote.

Lazich's on-air adviser, Todd
Robert Murphy, said Sunday
that the new Lazich ad would
take the place of two other Lazich
commercials that had been
swiping for about two weeks.
The new Lazich ad says,
"Friends of Brian Marthey are
lying about Mary Lazich's re-

Needle/Groups claim support from public for exchange

From page 1

sition because the ban on using federal funds for such programs expires Tuesday. Nelson called on Norquist to do the same, and to allow some of the city's \$340,000 annual grant to the AIDS agency for prevention programs to be shifted to needle exchange.

Norquist's chief of staff, Bill Christofferson, said Sunday, "we'll certainly look at that," referring to the poll, but said results may have been skewed by the way the questions were asked — "current government AIDS prevention dollars" rather than "property tax money," for instance.

Norquist's position is that "providing free needles to drug users is not a use of property tax money that Milwaukee taxpayers would support," Christofferson said.

HIV, the virus that causes AIDS, is spread when drug users share needles contaminated with blood. Using clean needles prevents the infection of other drug users, and the condoms and counseling dispensed by needle exchange programs prevents the spread of HIV through unprotected sex.

More than 55 cities now have needle exchange programs. The first such program began nearly a decade ago in Tacoma, Wash.

Numerous scientific studies have shown such programs reduce the spread of AIDS among drug users and to their partners and children and don't encourage new drug use.

The American Medical Association, the American Public Health Association, the National Academy of Sciences, the American Bar Association, the U.S. Conference of Mayors and a host of other groups have endorsed needle exchange, Nelson said.

Milwaukee's program started in March 1994, was expanded into Racine about two years ago, and has exchanged more than 1 million needles since it began. A \$30,000 grant from the Milwaukee Foundation composed a large share of its \$100,000 annual budget that year.

Users must bring in dirty needles to obtain clean ones; it's a one-for-one exchange. Needles aren't exchanged with juveniles.

Workers also offer HIV testing, drug counseling, and condoms to needle exchangers, and the program recently won national recognition for its success — only 2% of participants are HIV-positive, Nelson said.

But it only reaches about one-third of Milwaukee's estimated 4,000 to 5,000 intravenous drug users, he said. More could be reached if the program could use some of the \$500,000 in federal prevention money and some of the city money the agency already gets, he said.

Milwaukee Health Commissioner Paul Nannis, who will leave April 7 for a job in Washington, D.C., with Shalala's department, said Sunday, "This is an issue where science intersects with politics."

Nannis noted the scientific support for needle exchange. For instance, a September 1995 report by the National Research Council and the Institute of Medicine concluded that needle exchange "remains the safest, most effective approach for limiting HIV transmission" among drug users who cannot or will not stop injecting drugs.

Such programs do not increase either the amount of drugs used or the number of users, the report also found.

In New Haven, Conn., researchers found a 33% drop in the rate of new HIV cases originating from dirty needles.

A poll in December by the Kaiser Family Foundation, one of the largest private health foundations in the country, found that 64% of the public favors needle exchange programs and 61% think the current law should be changed to allow funding for them.

Earlier this month, President Clinton's AIDS advisers demanded that the administration immediately allow local communities to spend federal money on needle exchange programs. The Presidential Advisory Council on HIV/AIDS said 33 people every day catch the AIDS virus directly from a dirty needle.

Attitudes on needle exchange

Most Milwaukeeans support needle exchange programs to stem the spread of AIDS, and most say existing government money should help fund them, a survey shows.

In a poll conducted in December, 409 Milwaukee residents were asked:

■ Do you favor needle exchange programs to prevent AIDS?

UNDECIDED

7%

YES 57%
NO 36%

■ Should current government AIDS prevention dollars go to such programs?

UNDECIDED

5%

YES 55%
NO 40%

Milwaukee's needle exchange program:

- Started in March 1994
- Has exchanged 1 million needles
- Has a \$100,000 annual budget from private donations and non-government sources

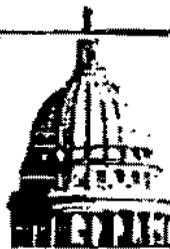
Source: University of Wisconsin-Milwaukee Institute for Survey and Policy Research poll and the AIDS Resource Center of Wisconsin.

See HLP Journal Section

"Lack of political will can no longer justify ignoring the science," the council wrote to Shalala.

Congress in 1988 specifically prohibited federal funds for needle exchange programs, but it left ways for the policy to be reversed in the future.

WISCONSIN STATE JOURNAL



THURSDAY/APRIL 2, 1998

MADISON, WISCONSIN

AIDS prevention workers begin needle exchange

By Dean Mosiman
City government reporter

AIDS prevention workers will take a van to Madison's South Side today and distribute the first of tens of thousands of free needles to drug abusers.

The most ambitious needle exchange effort ever is intended to slow HIV infection among an estimated 1,500 injection drug users in greater Madison and their sexual partners.

The AIDS Network of Madison contracted with the AIDS Resource Center of Wisconsin to deliver the Lifepoint program. It will provide 70,000 clean needles

the first year and 100,000 annually afterward, center director Doug Nelson said.

"Our purpose is to save lives," Nelson said. "We will reduce the HIV infection rate and help hundreds of people remain HIV free."

National data show half of new HIV infections are traced to injection drug use, experts said.

"Needle exchange is an absolutely essential part of a comprehensive AIDS strategy in Madison," AIDS network director Mary Turnquist said.

In addition to one-for-one needle exchanges, the program offers counseling,

treatment referrals, and HIV care and support. It has operated for four years in Milwaukee and Racine, where a million needles have been swapped.

Madison Mayor Sue Bauman applauds the effort, which requires no formal city approval because needle exchanges are exempt from drug paraphernalia laws.

"Anything we can do to rid society of AIDS, the better off we are," Bauman said.

The city has a limited needle exchange program run from clinics, Bauman said.

The Lifepoint van, staffed by two AIDS prevention counselors, will be accessible to drug users throughout the city.

"We go out where the drug users are,"

Nelson said.

The van will initially operate twice weekly, and start at unidentified spot on the South Side, Nelson said. It will eventually visit other parts of the city and make regular stops, he said.

Lifepoint chooses spots that won't trouble residents and that are away from schools, churches and public facilities, Nelson stressed.

And it's not a drug enforcement trap, Bauman said.

The privately funded effort will initially cost about \$30,000 a year and should reach about 400 of the region's 1,500 users, Nelson said.

Cigarette

Autos 10

Bridges

DARKNESS

[TX/RX NO 8393]

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MAKING APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1998, AND FOR OTHER PURPOSES

NOVEMBER 7, 1997.—Ordered to be printed

Mr. LIVINGSTON, from the committee on conference,
submitted the following

CONFERENCE REPORT

(To accompany H.R. 2264)

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2264) "making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 1998, and for other purposes", having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate, and agree to the same with an amendment, as follows:

In lieu of the matter stricken and inserted by said amendment, insert:

That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 1998, and for other purposes, namely:

TITLE I—DEPARTMENT OF LABOR

EMPLOYMENT AND TRAINING ADMINISTRATION

TRAINING AND EMPLOYMENT SERVICES

bills allowing the Social Security Administration to use unexpended fiscal year 1997 funds for fiscal year 1998 activities.

The conference agreement includes a provision proposed by the House and not included in the Senate bill requiring the Secretary of the Treasury to reimburse the trust funds from general revenues for expenditures related to union activities performed on official time. The conferees request that Social Security coordinate with the government-wide reporting effort which will be undertaken by the Office of Personnel Management in consultation with the Office of Management and Budget as required by Public Law 105-61.

The conferees support the Social Security Administration's unique, cooperative training program for Administrative Law Judges which is recognized by State Bar Associations for continuing legal education credits. The conferees encourage the Office of Hearings and Appeals to continue this training program and to expand financial support to enable greater ALJ participation.

OFFICE OF INSPECTOR GENERAL

(INCLUDING TRANSFER OF FUNDS)

The conference agreement provides \$48,424,000 for the Office of Inspector General through a combination of general revenues and limitations on trust fund transfers instead of \$52,424,000 as proposed by the House and \$37,354,000 as proposed by the Senate.

TITLE V—GENERAL PROVISIONS

DISTRIBUTION OF STERILE NEEDLES

Both the House and Senate bills contained restrictions on the use of federal funds for the distribution of sterile needles for the injection of any illegal drug (section 505). The Senate bill repeated language from previous appropriations bills allowing the Secretary to waive the prohibition if she determined that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs. The House bill removed the Secretary's authority over this issue.

The conference agreement includes the House language prohibiting the use of federal funds for carrying out any program for the distribution of sterile needles or syringes for the injection of any illegal drug. This provision is consistent with the goal of discouraging illegal drug use and not increasing the number of needles and syringes in communities.

The conference agreement also includes bill language limiting the use of federal funds for sterile needle and syringe exchange projects until March 31, 1998. After that date such projects may proceed if (1) the Secretary of Health and Human Services determines that exchange projects are effective in preventing the spread of HIV and do not encourage the use of illegal drugs; and (2) the project is operated in accordance with criteria established by the Secretary for preventing the spread of HIV and for ensuring that the project does not encourage the use of illegal drugs. This provision is consistent with the goal of allowing the Secretary maximum authority to protect public health while not increasing the overall number of needles and syringes in communities.

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

It is hoped that the delay in implementation of the provision with regard to exchange projects will allow the authorizing committees sufficient time to conduct a complete review and evaluation of the scientific evidence, as well as any conditions proposed by the Secretary, and consider the need for legislation with regard to these programs. It is the intent of the conferees that the Appropriations Committees refrain from further restrictions on the Secretary's authority over exchange after March 31, 1998.

TECHNICAL

The conference agreement inserts the word "the" before the word "Departments" in section 516 as proposed by the House.

SALARIES AND EXPENSES REDUCTION

The conference agreement deletes section 517 of the Senate bill that would have reduced salaries and expenses appropriations for all agencies in the bill by a total of \$75,500,000 to be allocated by the Office of Management and Budget. The House had no similar provision.

TEAMSTERS ELECTION

The conference agreement includes a general provision (section 518) proposed by the House that prohibits the use of funds in this Act for the election of officers of the International Brotherhood of Teamsters. The conference agreement deletes section 106 of the Senate bill which included a related provision. The conferees are aware that the U.S. District Court is currently supervising the election of IBT officers pursuant to a consent decree between the IBT and the Department of Justice. This consent decree provided, in part, a Federal government option to order supervision of the 1996 election at government expense. While the Department of Labor contributed a portion of the funding to assist the Department of Justice in financing the 1996 election supervision expenses, it is the understanding of the conferees that the cost to rerun this election is expected to be significantly less than the original elec-