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001, memo	Sandra Thurman to Reed re: Senate Democrats Up in 1998 (2 pages)	ca. 1998	P5
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COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Bruce Reed (Subject File)
QA/Box Number: 21207

FOLDER TITLE:

Needle Exchange [1]

rs63

RESTRICTION CODES

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

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
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- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

*Needle Exchange*4/12
May 26, 1998

Ms. Kate Shindle
Miss America
The Miss America Organization
Post Office Box 119
Atlantic City, New Jersey 08404

Dear Kate:

Thank you for your letter regarding needle exchange programs and prevention of new HIV cases in the fight to end the AIDS epidemic.

I am taking the concerns you have raised very seriously. We all know that the rising incidence of HIV infection among those who use injected drugs, and among their partners and children, is a major factor in the continued growth of this epidemic. Therefore, I will continue to support retention of the HHS Secretary's authority to decide whether to allow local communities to use federal funds for needle exchange programs.

Recently, the Secretary released a report indicating that needle exchange programs can help reduce HIV transmission without encouraging the use of illegal drugs. This scientific analysis should be of great use to local and state officials who are considering the implementation of needle exchanges as part of their comprehensive HIV prevention strategies.

At the same time, the Administration tried to prevent the politicization of the needle exchange program by keeping decision-making at the local level. Therefore, we are not at this time allowing federal funds to be used for such programs. More must be done to help the general public and those in Congress understand the role of needle exchange programs in our efforts to fight both HIV and illegal drug use.

I appreciate the passion that you and so many others bring to this very important debate. Be assured that my commitment to ending this epidemic -- and to responding to the needs of those already living with HIV and AIDS -- remains firm. We must all work together to stop this deadly disease, and I will take all measures within my authority to achieve that end.

Sincerely,

BILL CLINTON

BC/TFS/RSM/RLM/efr-bws-emu
(S.shindle.k)

(Corres. #3967771)

cc: W. Wondwossen, 83 OEOB
cc: ~~Dan Burkhardt/BMC~~, 94 OEOB



Kate Shindle
MISS AMERICA 1998

April 6, 1998

The Honorable William J. Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington D.C. 20500

Dear President Clinton:

I am aware that your administration is once again reviewing the issue of federal funding for needle exchange programs, which affects the lives and futures of thousands of American men, women, and children each year. Once again, organizations across the country have been discouraged and frustrated at the outcome of one of these reviews. I am asking you to use federal funds to support needle exchange programs and prevent the spread of the HIV/AIDS epidemic.

It has been eighteen years since AIDS began to decimate American families, and the epidemic shows no sign of slowing. Despite recent breakthroughs in AIDS treatment, the number of new infections continues to explode. Every day, 16,000 people, somewhere, contract HIV. And as you know, the epidemic is undergoing a dramatic demographic shift. Women, minorities, and the young are being infected at unprecedented rates. Every hour of every day, two American teenagers contract HIV. And heterosexual women account for the fastest-rising group of new infections. AIDS is no longer restricted to any one social group. It's happening to all of us.

But a unique phenomenon continues to sweep our nation. It is the dynamic created by a desire to end the AIDS epidemic and a hesitance to implement the programs which will eradicate it. *We know exactly how to stop the spread of HIV.* In the absence of a cure, scientists, educators, and public health officials agree upon the need for strong and proactive programs which empower individuals to protect themselves from this virus.

Statistics regarding the prevalence of HIV infection among IV drug users are astounding: 63% of all AIDS cases among women are related to the sharing of needles—these women contract HIV either through IV drug use or through sex with an IV drug user. Similarly, 58% of pediatric AIDS cases are attributable to a parent's drug use. Clearly, drugs are killing Americans in more ways than one.

But needle-exchange programs are overwhelmingly effective in combating HIV infection. By providing clean syringes in exchange for used ones, we can easily prevent the sharing of contaminated drug paraphernalia. *Needle exchange programs prevent HIV from being spread.*

But needle-exchange programs are overwhelmingly effective in combating HIV infection. By providing clean syringes in exchange for used ones, we can easily prevent the sharing of contaminated drug paraphernalia. *Needle exchange programs prevent HIV from being spread.* In Baltimore, the HIV seropositivity rate was reduced by 40% during the program's three-year trial period. And the community benefits as well. The lifetime cost of treating *just one* person with AIDS is estimated to be \$119,000; while the median cost of running an exchange is just \$169,000—eliminating a significant financial burden on taxpayers. And by providing the opportunity for a one-to-one syringe exchange, we can all but ensure that there are no contaminated needles lying around in streets, on playgrounds, or in other places where children can find them and hurt themselves.

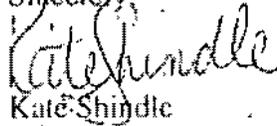
President Clinton, we are all familiar with the so-called arguments against needle exchange. Quite frankly, the idea that these programs promote drug abuse is unreasonable, and outdated, and has already been categorically disproven. Seven different independent agencies, including the Centers for Disease Control and the University of California at San Francisco, have shown unquestionably that there is no increase in the incidence of drug use in communities where needle-exchange programs have taken hold. In fact, the rate of use can actually decline when staff are able to counsel drug users into treatment. *No one wants more drugs on our streets.*

It's time to take action. Every 5.4 seconds, someone contracts HIV. While we bide our time and weigh our options, people are still dying. There seems to be a lot of "morality" talk surrounding HIV/AIDS prevention. Ironically, we have forgotten our moral obligation to save lives. We need to provide the information and tools which will empower all Americans to protect themselves. I am twenty-one years old, and my generation is dying.

It's time for us, finally, to have an intelligent and substantive dialogue about needle exchange. No more stalling. No more "looking into the issue." We no longer have the luxury of time. The facts are on the table. The AIDS-services community has done what you asked by providing these findings. Approximately 60% of Americans approve of needle exchange, and are watching. *Mainstream America cares about this.* Now you need to hold up your end of the deal.

There is still a lot of fear when it comes to talking about this issue, and dozens of warring factions. No one ever said ending a global pandemic would be easy. America needs money for needle exchange. We need to let scientists and public health officials determine the need for such programs on a community-by-community basis, and then we need funding to support their efforts. At this point, there is no more room for excuses. Americans are still dying, and we are to blame unless we protect them.

Sincerely,



Kate Shindle

Miss America 1998

Brian Franklin
Apartment 917
1401 North Taft Street
Arlington VA 22201

Bruce Reed
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. Reed:

I am writing you to express my sadness and disgust over the Administration's decision to withhold federal funding for needle exchange programs.

I recently graduated from college and made a choice to dedicate the rest of my life to helping people with AIDS. Today I work at an AIDS organization that helps people living with HIV and AIDS and can not recall a period as dark and damaging for the epidemic as this.

I am outraged that the Administration placed politics above science and showed that it did not want to wage a tough battle on the Hill. The mixed messages sent by the Administration led to a Republican Bill, H.R. 3717 that permanently prohibits federal funding of Needle Exchange Programs. Everyone knows the science is there. Study after study shows that Needle Exchange Programs work, they reduce the spread of HIV while not increasing drug use. The programs do not increase the risk of children and drugs and they even lead injection drug users to treatment and better lives. We know that- it is fact studies conducted by the GAO, NIH and other bipartisan organizations have proven it. We also know that over half of all new cases are as a result of dirty needles.

The President is enjoying tremendous popularity over 60% in the polls. He is obsessed with leaving his legacy. He could have made a difference in this epidemic, he could have been the President that helped end it. However in the end he showed that he had no courage to fight a difficult battle in the Congress. Even if he approved federal funding and the bill lost in Congress, we would be a lot better off than we are now.

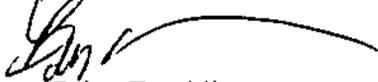
I am angered that you did not use science and compassion to make this decision. Instead you used politics and malicious arguments by General McCaffrey to come up with this irresponsible decision. Your decision will result in 33 people a day becoming infected with HIV.

I beg you to persuade the President to veto any legislation from the Hill that prohibits federal funding of Needle Exchange Programs. These programs work. Dozens of studies have proven it; the programs reduce the spread of HIV while not increasing drug use. Do not listen to General McCaffrey or the Republicans, listen to what your heart says. You can save lives and help end this epidemic.

I am angry because I feel that we were close to ending this epidemic. I thought that we were making progress. Instead, you have prolonged my job, and now I and everyone else that works with people living with HIV will have to work harder. I will not give up in this fight. There are lives at stake and I will do everything I can to save them. I hope you will do the same.

I would appreciate if you could take the time to write me back.

Sincerely,

A handwritten signature in black ink, appearing to read 'Brian Franklin', with a long, sweeping horizontal line extending to the right.

Brian Franklin



HUMAN
RIGHTS
CAMPAIGN

1101 14th Street NW
Washington, DC 20005
phone 202 628 4160
fax 202 347 5323

FAX TRANSMISSION

DATE: April 28, 1998

TO:

Needle Exchange

FAX #:

Rahm Emanuel	456 - 2530
John Podesta	456 - 1907
Sylvia Mathews	456 - 2883
Bruce Reed	456 - 2878
Chris Jennings	456 - 5557
Sandra Thurman	456 - 2348
Maria Echaveste	456 - 6218
Richard Socarides	456 - 6218
Ron Klain	456 - 6212
Elena Kagan	456 - 2878
Kevin Thurm	690 - 7755
Marsha Martin	690 - 7098
Eric Goosby	690 - 7560
Monica Dixon	456 - 6212
Bob Dreier	456 - 6231
Toby Donenfeld	456 - 6231

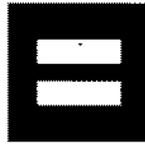
NUMBER OF PAGES: 6
(including cover)

FROM: Seth Kilbourn: Senior Health Policy Advocate
Direct Dial: (202) 216 - 1526
E-Mail: seth.kilbourn@hrc.org

If you have any problem with this transmission, please call (202) 628-4160.
HRC is sending out this letter and attachments today to all members of the House who voted no on the Hasert amendment.

CONFIDENTIALITY NOTICE

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HUMAN
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April 28, 1998

Via Facsimile

Dear Member of Congress:

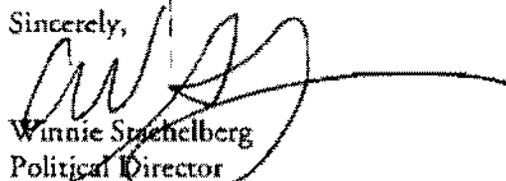
On behalf of the Human Rights Campaign, I am writing to ask you to oppose H.R. 3717, a bill which would permanently ban the use of any federal funds for needle exchange programs. The bill is scheduled to be considered by the House on Wednesday. As you know, on Monday, April 20th, Secretary Shalala announced that there is unequivocal support from the scientific literature that needle exchange programs reduce HIV infection and do not contribute to illegal drug use. Nevertheless, the Administration clearly stated its commitment to maintain the current prohibition on federal funding for needle exchange programs. H.R. 3717 is redundant and unnecessary, given the Administration's clear position.

As the attached article reports, AIDS deaths have declined significantly in the last two years primarily due to the success of new drug treatments which help keep people with HIV disease alive and healthy for longer periods of time. New HIV infections, however, continue to occur at an unacceptable rate. The article highlights that injection drug use is increasingly fueling this epidemic. In fact, over 50% of new HIV infections can be attributed to injection drug use and recent data indicate that 74% of all AIDS cases among women and over 50% of all AIDS cases among children are connected directly or indirectly to injection drug use. In the African American community, 48% of AIDS cases are related to injection drug use.

As the HIV epidemic continues to grow, it is vital that public health considerations drive the debate on funding and policy decisions. Instead of legislating a ban on federal funding for needle exchange programs, Congress should be taking affirmative and bold actions to reduce the numbers of new infections by increasing HIV prevention funding and expanding the options communities have to address their growing infection rates. Legislation banning federal funding for needle exchange programs would only serve to further politicize an issue that should appropriately be addressed by scientists and state and local public health officials.

Please do not politicize HIV prevention and take public health determinations out of the hands of scientists and public health experts. Amending the Public Health Service Act is a serious matter and should not be done hastily on the House floor without careful consideration from the Committee with jurisdiction. Please vote no on the rule and return this issue to Committee for the appropriate attention it deserves and vote no on H.R. 3717. Thank you for your attention to this urgent matter.

Sincerely,



Winnie Stichelberg
Political Director

WORKING FOR LESBIAN AND GAY EQUAL RIGHTS.

1101 14th Street NW, Suite 200 Washington, D.C. 20005
phone (202) 628 4160 fax (202) 347 5323 e-mail hrc@hrc.org

HIV's Spread Is Unchecked

AIDS-Slowing Treatments Eclipse Rising Infection Rate, Study Says

By Rick Weiss
Washington Post Staff Writer

Although the number of new AIDS cases in the United States has declined substantially in recent years, HIV continues to spread through the population essentially unabated, according to data released yesterday by the Centers for Disease Control and Prevention.

The first direct assessment of HIV infection trends shows that the recent decline in U.S. AIDS cases is not due to a notable drop in new infections. Rather, improved medical treatments are allowing infected people to stay healthy longer before coming down with AIDS, overshadowing the reality of an increasingly infected populace.

"The findings of this report give us a very strong message, that mortality may be going down—therapy is working—but HIV continues its relentless march into and through our population," said Thomas C. Quinn, an AIDS specialist at the National Institute of Allergy and Infectious Diseases. "These data tell us we have a lot of work to do."

The findings also confirm previously identified trends showing that women and minorities are increasingly at risk. Especially worrisome, officials said, is that the annual number of new infections in young men and women 13 to 24 years old—a group that has been heavily targeted for prevention efforts—is virtually unchanged in recent years.

HIV Spread Not Slowed in U.S.

AIDS. From A1

"It certainly documents that we have ongoing new infections in young people," said Patricia L. Fleming, chief of HIV/AIDS reporting and analysis at the CDC in Atlanta.

The report also shows continuing high numbers of new infections among intravenous drug users, a population that has recently been the focus of a political debate over the value of needle exchange programs that offer drug users clean syringes to prevent the spread of HIV, the virus that causes AIDS. [International financier George Soros yesterday offered \$1 million in matching funds to support needle exchange programs around the country, the Associated Press reported.]

CDC officials would not comment directly on President Clinton's decision this week to extend a ban on federal funding of needle exchanges. But both Fleming and Quinn said that AIDS prevention programs in this population need to be improved.

"It's clear that something stronger is needed to slow this epidemic," Quinn said.

The new figures, in today's issue of the CDC's Morbidity and Mortality Weekly Report, are based on HIV test results compiled by 25 states from January 1994 to June 1997. They indicate that the number of new infections during that period remained "stable," with just a "slight" decline of 2 percent from 1995 to 1996, the most recent full year included in the new analysis. By contrast, deaths from AIDS declined 21 percent in 1996 and dropped an addi-

tional 44 percent in the first six months of last year.

From 1995 to 1996, the number of HIV infections increased by 3 percent among women. And it jumped 10 percent among Hispanics, although officials said that figure was imprecise. Infections declined by 2 percent in the white and 3 percent in the African American populations.

All told, the study tallied 72,905 infections during the survey period. The number nationwide is much higher, since participating states account for only about 25 percent of U.S. infections.

The single biggest risk category was men having sex with other men, but heterosexual transmission continued its steady increase. Most of those cases involved women contracting the virus through sex with male drug users, Fleming said.

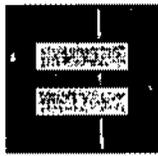
The survey is the first to track infection trends by looking directly at HIV test results in people coming to clinics and other health care outlets. That's a major change from the previous system, in which officials simply estimated the number of new infections by counting the number of people newly diagnosed with AIDS.

The old "back calculation" method worked fine during the first 15 years of the epidemic, when HIV infection progressed predictably to disease over a period that averaged about 10 years. With drug therapies now slowing disease progression, however, the number of new AIDS cases no longer reflects the number of new infections, and public health officials were becoming uncertain about how they were doing in prevention efforts.

The new reporting system, now spreading to other states, has helped officials regain those bearings, Fleming said. And although everyone wishes the numbers were more encouraging, she said, at least officials now have a clearer picture of the task at hand.

FOR MORE INFORMATION

To read Post coverage about the AIDS academic, click on the above symbol on the front page of The Post's Web site at www.washingtonpost.com



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SYRINGE EXCHANGE

Needle Exchange Does Not Divert Resources

- Needle exchange programs are in no way meant to divert resources away from drug treatment. They cannot be seen as a low cost substitute for such treatment. They can and should be seen as a part of an overall strategy to connect people to systems of care. Needle exchange programs provide a linkage to drug treatment in addition to other health care, counseling, and psychosocial services. Needle exchange programs are a component of a drug treatment and outreach strategy, they are not a substitute.
- No one doubts the effectiveness of drug treatment. The long term solution for injection drug users to reduce their HIV risk and put their lives back on track is to get off drugs. No policy or funding decisions should contradict that message. Because drug treatment on demand is not available in this country, it is imperative that we keep people alive until they can get into treatment. Needle exchange programs not only help people stay alive (through avoiding HIV infection), they also help many drug users start their long journey toward a drug free life.
 - In Tacoma, WA the needle exchange program was the source of 43% of new recruits into methadone treatment
 - Seattle's treatment slots have increased by 350 since needle exchange began.
 - The 90 treatment slots reserved for participants in the Baltimore needle exchange program were rapidly filled.
- No one is advocating for the use of drug treatment funds to support needle exchange programs. The money at issue is in the CDC HIV prevention budget. These funds flow through a community planning process which would have to support needle exchange as a component of the community's HIV prevention plan.

Support for Needle Exchange Is Not A Double Message

- It is not a double message to advocate for drug abstinence, drug treatment programs, and needle exchange. All of those efforts are directed at keeping people, old and young, alive and healthy.
 - Studies show that the mean age of injection drug users rises over time even in places where needle exchange programs operate.

Needle Exchange Should Be Continually Monitored

- The language in the FY 1998 Labor/HHS Appropriations bill requires any federally supported needle exchange programs to cooperate with federal efforts to evaluate and monitor the programs.
- Contrary findings to the general scientific consensus that needle exchange programs reduce HIV transmission and do not increase drug use should be examined carefully. One study in Montreal found an increase in seroconversion rates in the study population. Some have questioned whether those increases were related needle sharing as opposed to unsafe sexual behavior on the part of study participants, many of whom were prostitutes.

Alternative Approaches

- Data from Connecticut, which recently relaxed its laws restricting access to syringes, suggest that access to clean needles reduces HIV transmission. Whether that access comes through an exchange program or a pharmacy, the data show that when people can use clean needles, they reduce their risk for HIV. Pharmacy access and other means of obtaining clean needles may not, however, also provide referrals to drug treatment and support services, as do most needle exchange programs.

Impact of Drug Use on Treatment Regimens and Risk Behavior

- Drug use absolutely is detrimental to one's ability to maintain complicated treatment regimens and reduce risky behavior. The best long term solution is to free one's self from drug use. The linkage that needle exchange programs provide to drug treatment and support services helps, not hinders, the ability of people to maintain their health and reduce their risk.

Impact on Women and Children

- 74% of all AIDS cases among women are connected directly or indirectly to injection drug use (34% of the cases are those who inject drugs; 40% of the cases are among those who had sexual contact with an injection drug user).
- More than 50% of the cases of AIDS among children can be traced back to injection drug use.

Americans Support Needle Exchange and Local Control

- A poll commissioned by the Human Rights Campaign found that 55% of the American public favors needle exchange programs. (Source: The Tarrance Group and Lake, Sosin, Snell and Associates, April 1997)
- A Kaiser Family Foundation poll found that 61% of Americans favor changing federal law to allow state and local governments to decide for themselves whether to use their federal funds for needle exchange programs. (Source: Kaiser Family Foundation Omnibus Survey, November 1997)



HUMAN
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VOTE NO ON H.R. 3717

A VOTE IN THE HOUSE TO PERMANENTLY BAN FEDERAL FUNDING FOR NEEDLE EXCHANGE PROGRAMS MAY OCCUR AS EARLY AS WEDNESDAY APRIL 29

- On Monday, April 20th, Secretary Shalala announced that there is unequivocal support from the scientific literature that needle exchange programs reduce HIV infection and do not contribute to illegal drug use. Nevertheless, the Administration clearly stated its commitment to maintain the current prohibition on federal funding for needle exchange programs.
- On Thursday, April 23rd, the federal Centers for Disease Control and Prevention reported that there has been no measurable decrease in the rate of new HIV infections, over half of which are directly or indirectly related to intravenous drug use.
- Legislation banning federal funding for needle exchange programs is unnecessary and redundant given the clear position prohibiting funding taken by the Clinton Administration. It would only serve to further politicize an issue that should appropriately be addressed by scientists and state and local public health officials.
- Legislation banning federal funding for needle exchange programs does nothing to respond to the AIDS epidemic which continues to disproportionately strike young people, women and communities of color. Instead of legislating a ban on federal funding for needle exchange programs - already prohibited by the Clinton Administration, Congress should be taking affirmative and bold actions to reduce the numbers of new infections by increasing HIV prevention funding and expanding the options communities have to address their growing infection rates.
- Regardless of your individual beliefs about the appropriateness of federal funding for needle exchange, we encourage you to resist affirming a vote that has everything to do with politics and nothing to do with public health.
- Amending the Public Health Service Act is a serious matter and should not be done hastily on the House floor without careful consideration from the Committee with jurisdiction. Vote no and return this issue to Committee for the appropriate attention it deserves.

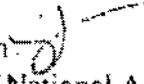
4/28/98

WORKING FOR LESBIAN AND GAY EQUAL RIGHTS.

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THE WHITE HOUSE
WASHINGTON

MEMORANDUM FOR SYLVIA MATHEWS AND BRUCE REED

From: Sandra L. Thurman 
Director, Office of National AIDS Policy
(202) 632-1090

Cc: Elena Kagan
Chris Jennings

Date: April 29, 1998

Re: Needle exchange debate and ONDCP

Attached is a press statement released by the authors of legislation that makes permanent the ban on federal support for needle exchange programs. You will note that Barry McCaffrey is cited as a supporting source. Also attached is a letter from Mr. McCaffrey to me, and my response outlining some of the errors and distortions it includes.

I am concerned about the damage that is done when someone from this Administration so publicly contradicts established policy. It is certainly making it rather difficult to manage the issue. The publication today by *The Washington Times* of a "study" done by ONDCP staff of a needle exchange program in Vancouver is yet one more example of this kind of public bashing of our own decision.

Anything you can do to insure that ONDCP's public statements are consistent with this Administration's policy (and are factually accurate) would be greatly appreciated!



Congress of the United States

House of Representatives

Washington, DC 20515

April 27, 1998

Federal Funds for Drug Needles?

Dear Colleague:

As you know, the Clinton Administration recently endorsed needle exchange programs for drug addicts. This is an outrage and that is why we have just introduced legislation, H.R. 3717, to permanently ban the use of federal funds for needle distribution.

Numerous studies -- including those done by General McCaffrey's Office of National Drug Control Policy -- have concluded that needle exchange programs increase illegal drug use. In addition, they do not reduce the spread of HIV. A recent study published in the prestigious *American Journal of Epidemiology* confirmed this: drug addicts who participate in needle exchange programs are 2.2 times more likely to contract HIV than addicts who do not participate.

We have led the fight against illegal drug use and we are not going to allow the pro-drug contingent in this Administration to reverse the progress we have made.

Please support our legislation when it comes to the floor this week.

Sincerely,


GERALD B. H. SOLOMON
Member of Congress


TOM DELAY
Member of Congress


DENNIS HASTERT
Member of Congress


BOB BARR
Member of Congress


ROGER WICKER
Member of Congress



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

Resdona

April 23, 1998

The Honorable Sandra L. Thurman
Director
White House Office of National AIDS Policy
808 17th St., N.W., 8th Floor
Washington, D.C., 20503

Dear Ms. Thurman:

Sorry -

The President's courageous decision not to authorize federal funding for needle exchange programs (NEPs) reflected both the continuing controversy over the efficacy of NEPs as a means to prevent the transmission of HIV and widespread concern that such programs encourage illegal drug use.

While all of us at ONDCP are encouraged by CDC studies showing that the number of new HIV cases in the U.S. appears to be declining, we share your commitment to policies that would help accelerate this decline. As you know, injecting drug use was an exposure category for 15 percent of new HIV cases reported between July 1996 and June 1997. Clearly, this problem needs to be addressed. However, NEPs are an inappropriate tactic that would undermine the President's multi-faceted, balanced *National Drug Control Strategy*.

We look forward to supporting future efforts against HIV/AIDS. Surely, our shared commitment to protecting all Americans from drug abuse and its consequences can result in mutually supportive public-health and law-enforcement strategies.

Sincerely,

Barry R. McCaffrey
Director

A sensible, prudent decision by the Administration which maintains focus of Federal efforts on supporting effective drug treatment.

THE WHITE HOUSE

WASHINGTON

April 28, 1998

Barry R. McCaffrey
Director
Office of National Drug Control Policy
Washington, DC 20503

Dear Mr. McCaffrey:

Barry

Thank you for your letter of April 23, 1998 regarding needle exchange programs (NEPs). Unfortunately, its perpetuation of factual errors and statements that directly contradict scientific determinations just made by HHS is troubling. The President is not well served when policy positions are predicated on misinformation.

The letter refers to the "continuing controversy over the efficacy of NEPs." As you well know, the Secretary of Health and Human Services with the support of the President, resolved that issue only last Monday. The position of this Administration is that needle exchange programs reduce HIV transmissions without encouraging the use of illegal drugs. We have both committed publicly to following the science on this issue, and now that the scientific determination has been made, I believe we have an obligation to respect it. I have certainly defended the Administration's decision not to fund needle exchange, despite the fact that it wouldn't have been my choice.

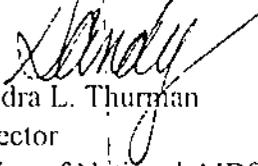
Also included in the letter are statements relative to the spread of HIV in this country, and particularly among injection drug users, that are erroneous. Unfortunately, we do not know, as is stated, that the number of new HIV infections in the U.S. are declining. Similarly, it is said that "injecting drug use was an exposure category for 15 percent of new HIV cases." Both errors come from the use of HIV infection data published by the Centers for Disease Control and Prevention but only available for the 29 states that collect such data. As we have explained in the past, these are almost entirely low-incidence and prevalence states and using their data to characterize the spread of HIV in our country as a whole is deceptive.

Finally, continued distortions of the implications of studies completed on needle exchange programs in Montreal and Vancouver are also of great concern to me. The scientists who directed these studies, in an op-ed published in the *New York Times* (see attached), directly refuted the misinterpretation of their studies that has been used to argue that NEPs are ineffective in reducing HIV transmissions. Not only have these distortions continued but the pretext of an objective review of those programs by ONDCP staff was done to substantiate those misinterpretations.

If there is a misunderstanding about the facts that you and I have discussed at length in person, or the discussions between our staff, I am more than willing to work to clarify them. Our work together can only be effective when we adhere to our commitments to follow the science and stick to the facts.

I appreciate and admire your passionate dedication to reducing the use of drugs in this country and look forward to continuing to work with you to address the both the AIDS and drug epidemics.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Sandra", written over a horizontal line.

Sandra L. Thurman
Director
Office of National AIDS Policy

Clinton: Yes to needle exchange, no on funding

by Lou Chibbare Jr.

The Clinton administration angered Gay civil rights and AIDS activists this week when the U.S. Department of Health and Human Services announced its support for needle exchange efforts to prevent HIV transmission but will not lift a longstanding ban on federal funds for such programs.

HHS angered conservative political groups, too, by declaring that "extensive scientific research" shows that needle exchange programs curtail HIV transmission among injection drug users, do not encourage the use of illegal drugs, and that local health departments should consider using them as one of several options for fighting AIDS.



On Wednesday, protesters formed a picket line in front of HHS headquarters and demanded an end to the ban on needle exchange program funding.

HHS Secretary Donna Shalala announced the seemingly contradictory position at a press conference in Washington, D.C., on Monday.

AIDS advocacy groups have said needle exchange programs are needed because more than half of all new HIV infections in the United States have been linked to injection drug use or to those who have sexual contact with people who inject illegal drugs.

With government scientists standing at her side, Shalala said that, based on scientific research findings, she had invoked an existing law giving her authority to formally certify that needle exchange programs can be used as an effective tool for fighting AIDS. Shalala said top scientists with the National Institutes of Health, the Centers for Disease Control and Prevention, and the U.S. surgeon general each support her decision to certify needle exchanging programs as a proven AIDS-fighting practice that does not lead to more use of illegal drugs.

But Shalala stunned activists when she said the administration had decided to leave the ban on such funds in place and to require state and local governments to pay for the programs themselves.

"The administration has decided that the best course at this time is to have local communities which choose to implement their own programs use their own dollars to fund needle exchange programs," Shalala's office said in a statement

released Monday.

The federal law that gives Shalala authority to "certify" needle exchange programs also gives her authority to approve the use of federal funds to support such programs run by states and local governments. Gay civil rights and AIDS advocacy groups had expected the funding approval to go hand-in-hand with the scientific certification.

"Today's action is like acknowledging the earth is not flat but refusing to fund Columbus's voyage," said Daniel Zingale, executive director of the AIDS Action Council, a national group representing AIDS service providers. "Having life-saving science without allowing life-saving funding is morally indefensible."

On Wednesday, about 50 protesters from groups in Washington, D.C., and Philadelphia formed a picket line in front of HHS headquarters on Independence Avenue, SW, chanting, "Needle exchange saves lives, stop the ban now."

One of the protesters, Vernon Batts, a volunteer with D.C.'s HIV Community Coalition, said he has seen first-hand how a needle exchange program in D.C., operated by the Whitman-Walker Clinic, has helped people who inject illegal drugs avoid HIV infection while encouraging them to seek treatment for their addictions. Batts, who noted that he has HIV infection, said he is a recovered intravenous drug addict. He said that he may have been saved from contracting HIV if needle exchange programs had been available in past years, when he became infected.

"We can't understand why the government has taken this position," he said, referring to the decision not to lift the funding ban on needle exchange programs.

Republican leaders in Congress, including House Speaker Newt Gingrich (R-Ga.), expressed support for the administration's decision to retain the funding ban but criticized the White House for allowing Shalala to certify the practice of clean needle exchanges.

"What's a little heroin or cocaine among friends," the Reuters News Service quoted Gingrich as saying, sarcastically, at a press conference on Tuesday. According to the Reuters account, both Gingrich and Rep. Tom DeLay (R-Texas), the third-ranking House Republican, accused Clinton of being hypocritical for claiming to be against teen smoking while supporting clean needle exchange programs which Gingrich and DeLay say give tacit support for drug use.

"He's trying to take away cigarettes and give them needles to stick in their arms," said DeLay, according to Reuters.

Gingrich said he is considering introducing legislation restricting or banning needle exchange programs.

Administration sources said both Shalala and Sandra Thurman, director of the White House Office on AIDS Policy, urged President Clinton to approve funding for needle exchange programs. As of late last week, the sources said, the White House was expected to approve a scaled back program calling for funding of such programs in several cities as a preliminary step before expanding the funding additional programs.

However, two sources familiar with the White House said top White House political advisers persuaded the president to change his mind over the weekend after determining that strong opposition to needle exchange programs in Congress would almost certainly lead to legislation banning such programs. The strongest opponent to needle exchange programs



HHS Secretary Donna Shalala stunned activists with the announcement that the Clinton Administration would leave the ban in place.

within the administration is said to be retired Gen. Barry McCaffrey, director of the White House Office of National Drug Control Policy.

Another administration source, speaking on grounds of anonymity, said it was the fear of hostile reactions by key Republicans in Congress that prompted Clinton to support certification of needle exchange programs while rejecting funding for them. The source said that high-level White House advisers, after carefully weighing the funding question, persuaded the president that approving funding for needle exchange programs would likely lead to a worse situation politically.

"They were convinced that Congress would overturn the funding at the very least," said the source. The source said White House officials also believed Congress might go one step further by banning all federal AIDS funds for AIDS service groups that use private, state, or local funds to pay for needle exchange programs.

But officials with Gay civil rights and AIDS advocacy groups took strong exception to the notion that Congress was poised to overturn funding for needle exchange programs.

"We feel we would win a fight [in Congress] on needle exchange," said Winnie Stachelberg, an official with the Human Rights Campaign, a national Gay political group. Stachelberg noted that a proposal by House Republicans to ban needle exchange funding died last year in a House-Senate conference committee.

Rep. Richard Gephardt (D-Mo.), the House Democratic leader, agreed with Stachelberg's assessment. In an interview Wednesday with the *Blade*, Gephardt said Republicans would have a tough time pushing through legislation banning funding for needle exchange programs.

Gephardt, said he believes a coalition of Democrats and Republicans could be persuaded to oppose such a ban. He also said he did not believe Republicans could secure enough votes to overturn a presidential veto of a bill banning funding for needle exchange programs.

Officials with virtually all the national, mainline AIDS organizations issued strongly worded statements condemning the administration's decision to retain the funding ban on needle exchange. Some of them noted that, at the same time and the same hour Shalala announced the funding ban at an April 20 press conference, Clinton told reporters at an event in the White House Rose Garden that he was placing "health over politics" by remaining firm on his support for controversial legislation regulating the tobacco industry.

Activists, including Whitman-Walker Clinic director Jim Graham, said they were troubled that Clinton appeared to reject political considerations on the tobacco dispute but put those same political considerations over public health on the needle exchange question.

Wayne Turner, spokesperson for the AIDS protest group ACT UP/Washington, D.C., said he considers the reactions by the mainline AIDS groups to be a vindication of ACT UP's long-stated view that Clinton has failed to fulfill his campaign promises on AIDS. Turner noted that Clinton told AIDS groups during his 1992 presidential campaign he would support funding for needle exchange programs.

"This is quintessential Clinton," said Turner. "He supports you in principle but refuses to act."

Scott Hitt, chair of Clinton's Presidential Advisory Council on HIV, called the administration's decision to retain the ban on needle exchange "immoral" and "hypocritical."

"This is the number one cause of HIV transmission," Hitt said, referring to injection drug use. "What we have is a federal government that doesn't want to do what it should do to slow down this epidemic."

One of the few administration officials willing to speak on the record regarding the needle exchange flap, other than Shalala and White House political adviser Rahm Emanuel, was openly Gay Interior Department official Bob Hattoy. Hattoy, considered the administration's most outspoken and impassioned advocate for Gay civil rights and AIDS issues, called the administration's action "an amoral political decision... that will kill people."

Hitt, who serves with Hattoy on the presidential HIV advisory council, said he knows of no members of advisory council who plan to resign in protest over the administration's action. Some members of the council had talked about a possible mass resignation earlier this year if the White House did not lift the ban on needle exchange programs. Hitt said that, despite its refusal to lift the funding ban, the administration's decision to certify the effectiveness of needle exchange marks an important advancement.

"As long as you feel you're being heard and things are moving ahead, you feel you should stick around and try to keep things moving," he said. ▽

FAX

DATE: Saturday, May 30, 1998

TO: Bruce Reed, White House, Domestic Policy
Council Director

FAX: 456-2878

FROM: 1775 "T" Street, NW Washington, DC

PAGES: 4

MEMO

•• FYI and files in case you have not seen this. Similar letters regarding ADAP (AIDS Drug Assistance Program) funding are expected from other States and various other parties. • Bill Arnold, The ADAP Working Group, Washington, DC (202) 588-1775

APR 1 1998 2:04PM

NO 0000 5 3

Congress of the United States

Washington, DC 20515

The Honorable John Edward Porter
Chairman, House Appropriations
Subcommittee on Labor, Health and
Human Services, and Education
2358 Rayburn H.O.B.
Washington, DC 20515

Dear Mr. Chairman:

We are writing to express the deep appreciation of the hundreds of thousands of people living with HIV/AIDS who have benefited directly from Congress' longstanding support for the Ryan White CARE Act. As Representatives of New York, the state which has been hardest hit by this epidemic, we are especially supportive of everything that you have done to vigorously fund the CARE Act. As you know, newly developed treatment regimens have placed increasing burdens on the CARE Act and on the AIDS Drug Assistance Program (ADAP) which is funded under Title II of the CARE Act. We are asking for your support for an additional \$75 million above the President's FY 1999 budget request for the ADAP program.

Budget projections based on data from the ADAP survey by the AIDS Treatment Data Network (ATDN) and the National Alliance of State and Territorial AIDS Directors (NASTAD) conclude that state ADAPs will suffer a budget shortfall of at least \$21,431,779 in FY '98, which is expected to close access to ADAP in many states. An additional increase of at least \$175,146,551 in federal funding for FY '99 is needed to meet conservative estimates of growing need for medications to treat HIV disease and related opportunistic infections.

The need projections are based on a number of complex factors including:

- * A well-documented and steadily increasing growth rate in patients using ADAP for their prescription drugs--centering on the use of new anti-viral drugs. ADAP utilization continues to grow by a minimum of 1,000 new patients a month;

- * 90% of those ADAP clients, according to assumptions based on the *PHS Guidelines for the Use of Antiretroviral Agents*, will be prescribed multi-drug combination therapy with three or four antiretrovirals, usually including a protease inhibitor.

- * The CDC's reports that death rates from AIDS continue to fall dramatically for the first time in the American epidemic. Their reports suggest that this decrease is

Page Two

concentrated in populations with the best access to medical care and prescription drugs;

* Abstracts presented at recent medical conferences which illustrated that the appropriate use of combination therapy with protease inhibitors could lead to dramatic decreases in hospitalizations, nursing care days and home health service use--thus reducing overall costs of caring for patients.

Pressures on State ADAP programs have led at least twenty-six states to implement emergency measures to limit patient access in the last year:

* Ten states have closed to any new enrollment. Of these, Alabama, Florida and Mississippi have all been closed to new enrollees since May, 1997.

* Seven states are unable to provide access to protease inhibitors for any new clients, even if they are already enrolled in the ADAP to receive other drugs. Two states remain without protease inhibitor coverage.

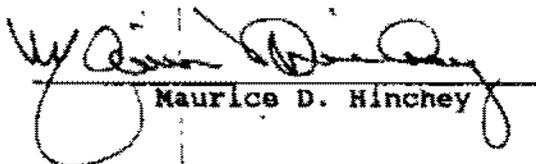
* Fourteen states have yet to cover all eleven approved antiretroviral (anti-HIV) drugs.

* The number of states providing all of the fourteen drugs recommended by the PHS Guidelines on the Prevention of Opportunistic Infections is now just 3 out of 52 ADAPs nationally.

* Thirteen states have reported that they will exhaust their ADAP budgets before the next round of federal funds is available on April 1, 1998. These states are: Alabama, Alaska, Arizona, Colorado, Idaho, Kansas, Kentucky, Maine, North Carolina, Puerto Rico, Texas, West Virginia and Wyoming. Temporary transfer of ADAP clients to pharmaceutical company patient assistance programs has been necessary in at least two of these states.

Once again, we commend your support of the ADAP program and urge you to support the additional \$175 million for the ADAP program. Through your efforts we can all continue to work together to keep people healthy and alive and provide access to these life-prolonging treatments to those who do not yet have access to them.

Sincerely,


Maurice D. Hinchey


Rick Lazio

MAY 21 1998 4:50 PM

NO. 0438 P. 4-4

Page Three

Sue Kelly
Sue W. Kelly

Sherry Boehlert
Sherry L. Boehlert

Mike Forbes
Michael F. Forbes

Carolyn McCarthy
Carolyn McCarthy

Edolphus Towns
Edolphus Towns

Jerrold Nadler
Jerrold Nadler

Michael R. McNulty
Michael R. McNulty

Jack Quinn
Jack Quinn

Peter T. King
Peter T. King

Benjamin A. Gilman
Benjamin A. Gilman

Gary L. Ackerman
Gary L. Ackerman

Eliot L. Engel
Eliot L. Engel

Major R. Owens
Major R. Owens

José E. Serrano
Jose E. Serrano

Thomas J. Harkin
Thomas J. Harkin

Charles B. Rangel
Charles B. Rangel

Louise M. Slaughter
Louise M. Slaughter

John J. LaFalce
John J. LaFalce

Charles E. Schumer
Charles E. Schumer

Hydia M. Velazquez
Hydia M. Velazquez



DEPARTMENT OF HEALTH & HUMAN SERVICES

Melissa T. Skolfield

Assistant Secretary for Public Affairs

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To: Bruce Reed

Fax: 456-2878 Phone: 456-6515

Date: 4/20 Total number of pages sent: 12

Comments:

Attached is the press release, Q+As (internal) and the fact sheet.
-m.

Needle Exchange

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

April 20, 1998

Contact: HHS Press Office
(202) 690-6343

NEEDLE EXCHANGE PROGRAMS: PART OF A COMPREHENSIVE HIV PREVENTION STRATEGY

***Overview:** Since 1981, injection drug use has played an increasing role in the spread of HIV and AIDS, accounting for more than 60% of AIDS cases in certain areas in 1995. To date, nearly 40% of the 652,000 cases of AIDS reported in the U.S. have been linked to injection drug use. More than 70% of HIV infections among women of childbearing age are related either directly or indirectly to injection drug use. And more than 75 percent of babies diagnosed with HIV/AIDS were infected as a direct or indirect result of injection drug use by a parent.*

To protect individuals from infection with HIV and other blood-borne infections, several communities have established needle or syringe exchange programs. In communities that choose to use them, needle exchange programs are a form of public health intervention to reduce the transmission of the human immunodeficiency virus (HIV) among drug users, their sex partners, and their children. They provide new, sterile syringes in exchange for used, contaminated syringes. Many needle exchange programs also provide drug users with a referral to drug counseling and treatment, medical services, and provide risk reduction information.

Under the terms of Public Law 105-78, federal funds to support needle exchange programs were conditioned on a determination by the Secretary of Health and Human Services that such programs reduce the transmission of the human immunodeficiency virus (HIV) and do not encourage the use of illegal drugs. The Secretary has made that determination. The Act's restriction on federal funding, however, has not been lifted.

The Administration has decided that the best course at this time is to have local communities which choose to implement their own programs use their own dollars to fund needle exchange programs, and to communicate what has been learned from the science so that communities can construct the most successful programs possible to reduce the transmission of HIV, while not encouraging illegal drug use.

In a February 1997 report to Congress, Health and Human Services Secretary Donna E. Shalala reported that a review of the findings of scientific research indicated 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."

On April 20, 1998, Secretary Shalala announced that a review of research findings indicated that needle exchange programs also "do not encourage the use of illegal drugs."

FEDERAL RESEARCH ON NEEDLE EXCHANGE

While Congress has restricted the use of federal funds for needle exchange programs since 1989, lawmakers have authorized funding for research into the efficacy of needle exchange programs as a public health intervention to reduce the transmission of HIV and to examine the impact of such programs on drug use. The federal government has supported and will continue to support research into the effectiveness of needle exchange programs.

Effect of Needle Exchange Programs on HIV Transmission

Three major expert reviews of the scientific literature on needle exchange programs conclude that such programs can be an effective component of a comprehensive community-based HIV prevention effort. Additionally, needle exchange programs can provide a pathway for linking injection drug users to other important services such as risk reduction counseling, drug treatment, and support services. The reviews include:

- *Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy*, United States General Accounting Office, March 1993, is an extensive review of U.S. and international data looking at the effects of needle exchange programs. It estimated that a needle exchange program in New Haven, Connecticut, had led to a 33% reduction in HIV infection rates among drug users in that city.
- *The Public-Health Impact of Needle Exchange Programs in the United States and Abroad*, prepared by the University of California, San Francisco, September 1993, reported that needle exchange programs served as an important bridge to other health services, particularly drug counseling and treatment. It also found that needle exchange programs reached a group of injecting drug users with long histories of drug use and limited exposure to drug treatment.
- *Preventing HIV Transmission: The Role of Sterile Needles and Bleach*, National Research Council and Institute of Medicine, September 1995, concluded that needle exchange programs have beneficial effects on reducing behaviors such as multi-person reuse of syringes. It estimated a reduction in risk behaviors of 80% and reductions in HIV transmission of 30% or greater.

Based on that scientific evidence, in February 1997, Secretary Shalala reported to Congress that a review of scientific findings indicated 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." She also directed the Department's scientific agencies to continue to review research findings regarding the effect of needle exchange programs on illegal drug use.

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Impact of Needle Exchange Programs on Drug Use

Extensive research indicates that needle exchange programs do not encourage illegal drug use and can, in fact, reduce drug use through effective referrals to drug treatment and counseling. Several recent studies strengthen the conclusion that needle exchange programs do not encourage the use of illegal drugs. They include:

- In March, 1997, the National Institutes of Health published the Consensus Development Statement on Interventions to Prevent HIV Risk Behaviors. That report concluded that needle exchange programs "show a reduction in risk behaviors as high as 80% in injecting drug users, with estimates of a 30% or greater reduction of HIV." 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 drug use.
- An October 1997, study of needle exchange programs in Baltimore, Maryland, (Brooner et al., Abstract presented to the American Public Health Association, October 1997) reported that needle exchange programs that are closely linked to or integrated with drug treatment programs actually reduce the incidence of drug use with high levels of retention in drug treatment. A 1998 NIH Consensus Conference report on the effectiveness of treatment for heroin addiction found that drug treatment programs can assist heroin users in halting their drug use.

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HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
April 20, 1998

Contact: HHS Press Office
(202) 690-6343

RESEARCH SHOWS NEEDLE EXCHANGE PROGRAMS REDUCE HIV INFECTIONS WITHOUT INCREASING DRUG USE

Health and Human Services Secretary Donna E. Shalala announced today that based on the findings of extensive scientific research, she has determined that needle exchange programs can be an effective part of a comprehensive strategy to reduce the incidence of HIV transmission and do not encourage the use of illegal drugs.

Under the terms of Public Law 105-78, the Secretary of HHS is authorized to determine that such programs reduce the transmission of the human immunodeficiency virus (HIV) and do not encourage the use of illegal drugs. The act's restriction on federal funding, however, has not been lifted.

"This nation is fighting two deadly epidemics – AIDS and drug abuse. They are robbing us of far too many of our citizens and weakening our future," said Secretary Shalala. "A meticulous scientific review has now proven that needle exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs. It offers communities that decide to pursue needle exchange programs yet another weapon in their fight against AIDS."

While the use of federal funds continues to be restricted, and criteria for their use have not been established, Secretary Shalala emphasized that needle exchange programs that have been successful have had the strong support of their communities, including appropriate State and local public health officials. The science reveals that successful needle exchange programs refer participants to drug counseling and treatment as well as necessary medical services, and make needles available on a replacement basis only.

The Administration has decided that the best course at this time is to have local communities which choose to implement their own programs use their own dollars to fund needle exchange programs, and to communicate what has been learned from the science so that communities can construct the most successful programs possible to reduce the transmission of HIV, while not encouraging illegal drug use.

Since the AIDS epidemic began in 1981, injection drug use has played an increasing role in the spread of HIV and AIDS, accounting for more than 60% of AIDS cases in certain areas in 1995. To date, nearly 40% of the 652,000 cases of AIDS reported in the U.S. have been linked to injection drug use. More than 70% of HIV infections among women of childbearing age are related either directly or indirectly to injection drug use. And more than 75% of babies diagnosed with HIV/AIDS were infected as a direct or indirect result of injection drug use by a parent.

- 2 -

Communities' use of needle exchange programs has increased throughout the epidemic. According to data reported to the Centers for Disease Control and Prevention, communities in 28 states and one U.S. territory currently operate needle exchange programs, supported by State, local, or private funds. Many of these programs provide a direct linkage to drug treatment and counseling as well as needed medical services.

Since 1989, the use of federal funds for needle exchange programs has been restricted by the Congress. Funding has, however, been authorized by the Congress to conduct research into the efficacy of such programs as a public health intervention to reduce transmission of HIV and to examine the impact of such programs on drug use. The federal government has supported numerous studies of the effectiveness of needle exchange programs in reducing the transmission of HIV among injection drug users, their spouses or sexual partners, and their children. Many of these studies also examined whether or not needle exchange programs encourage the use of illegal drugs.

In February 1997, Secretary Shalala reported to Congress that a review of scientific studies indicated 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." She also directed the Department's scientific agencies to continue to review research findings regarding the effect of needle exchange programs on illegal drug use. The scientific evidence indicates that needle exchange programs do not encourage illegal drug use and can, in fact, be part of a comprehensive public health strategy to reduce drug use through effective referrals to drug treatment and counseling.

"An exhaustive review of the science in this area indicates that needle exchange programs can be an effective component of the global effort to end the epidemic of HIV disease," said Harold Varmus, MD, Director of the National Institutes of Health. NIH has funded much of the research into the effectiveness of needle exchange programs and their impact on drug use. "Recent findings have strengthened the scientific evidence that needle exchange programs do not encourage the use of illegal drugs," Dr. Varmus said. Specifically, he cited:

- In March 1997, the National Institutes of Health published the Consensus Development Statement on Interventions to Prevent HIV Risk Behaviors. That report concluded that needle exchange programs "show a reduction in risk behaviors as high as 80% in injecting drug users, with estimates of a 30% or greater reduction of HIV." 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 drug use.
- An October 1997, study of needle exchange programs in Baltimore, Maryland, indicated that needle exchange programs that are closely linked to or integrated with drug treatment programs have high levels of retention in drug treatment. A 1998 NIH Consensus Conference report on the effectiveness of treatment for heroin addiction found that drug treatment programs can assist heroin users in halting their drug use.

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FOR INTERNAL USE ONLY—NOT FOR ATTRIBUTION OR QUOTATION**Needle Exchange Questions and Answers
Draft – April 18, 1998, 7:49 p.m.**

Q: What are you announcing today?

A: That the Secretary of Health and Human Services, after consulting with her scientific advisers, has determined that the scientific evidence exists to show that needle exchange programs reduce the risk of HIV infection, and do not encourage the use of illegal drugs.

Q: If the science is there, why aren't you releasing federal funds for needle exchange programs?

A: The Administration has decided that the best course at this time is to have local communities use their own dollars to fund needle exchange programs, and to communicate what has been learned from the science so that communities can construct the most successful programs possible to reduce the transmission of HIV, while not encouraging illegal drug use.

Q: The Administration has made this decision. Was it the President's decision? You're part of the Administration – do you agree with the decision?

A: It was an Administration decision.

Q: Do the scientific results you're announcing today meet the test Congress set up on the release of funds?

A: Yes.

Q: Does Congress need to act, either to release funds or to ban the use of them for needle exchange programs?

A: We will work with Congress to present the strong scientific evidence which demonstrates that needle exchange programs, when part of a comprehensive HIV prevention strategy, can reduce the incidence of HIV transmission and not encourage the use of illegal drugs. As I have previously said, local communities will not be permitted to use federal funds for needle exchange programs, so I do not expect this is an issue on which Congress must act.

Q: Why did it take so long?

A: It was imperative that we be exceedingly careful in our analysis of the science. And that is what we have done. Congress established a very stringent test in this area, and appropriately so. This is not an easy issue. It involves two major epidemics and we need to be certain of the evidence. I am very proud of this team of scientists standing behind me. In the last few months, they have gone over the scientific research with a fine toothed comb and they have reached a very clear determination: Needle exchange programs can be an effective public health intervention to reduce the spread of HIV without increasing drug use.

Q: Why are you taking this action?

A: Because the science is there. Communities around the country need to know that under certain conditions needle exchange programs can reduce HIV transmission and do not encourage illegal drug use. The report from the government's senior scientific advisers affirms those findings.

Second, injection drug use has played an increasing role in the spread of HIV and AIDS, accounting for more than 60% of AIDS cases in certain areas in 1995. To date, nearly 40% of the 652,000 cases of AIDS reported in the U.S. have been linked to injection drug use. More than 70% of HIV infections among women of childbearing age are related either directly or indirectly to injection drug use. And more than 75 percent of babies diagnosed with HIV/AIDS were infected as a direct or indirect result of injection drug use by a parent.

Q: Did political concerns delay this decision?

A: Absolutely not. From the beginning of this effort, it has been about three things: science, science, and science. The charge I gave my Department's scientists was to make sure the data were there and that they were accurate. They and I are very confident with these results.

Q: Did political pressure from AIDS groups force this decision?

A: Absolutely not. It is the job of scientists to examine the science. It is the job of public leaders to follow the science. It is the job of advocates to push us all to do our jobs, do them well, and, whenever possible, do them quickly. I understand the urgency of this issue but it was our job to make sure the science was there before we acted.

Q: What effect did the threat by the President's Advisory Council to seek your resignation have on your decision?

A: None at all. It is the job of scientists to examine the science. It is the job of public leaders to follow the science. It is the job of advocates to push us all to do our jobs, do them well, and, whenever possible, do them quickly. I understand the urgency of this issue but it was our job to make sure the science was there before we acted.

Q: Does General McCaffrey agree with your decision?

A: [I have spoken with General McCaffrey about the results of this scientific review, and he is aware of the Department's findings.] I will let him speak for himself. But let me say, very clearly, General McCaffrey and I are in absolute agreement on the necessity to reduce drug use in this country, especially among teenagers. No one should doubt that illegal drugs are wrong and that they can kill you. He and I also agree that we need to maintain and increase the funding available for drug treatment. Those concerns were important to me as I considered these issues.

Under the law passed by Congress, it is the responsibility of the Secretary of Health and Human Services to determine whether the scientific research findings meet the standard established by the Congress. All of the senior scientific advisers of the Department agree that the science-based standards have been met.

Q: General McCaffrey has made his opposition to needle exchange programs very clear. Does this mean the Administration is divided?

A: This is not a political decision. The Congress asked us to apply a very stringent scientific test and to answer two questions. First, do needle exchange programs reduce the transmission of HIV? Second, do such programs encourage the use of illegal drugs? Some of the best scientific minds in the country have pored over the data and have concluded that both of these tests have been met. That is the basis for our decision today.

Q: But General McCaffrey says that needle exchange programs will attract drug users and other undesirables to areas that implement needle exchange programs. Is this true?

A: Congress has made clear that needle exchange programs must not encourage drug use, and, after studying this issue thoroughly, we have determined that needle exchanges meet this test whether and, if so, local communities have their own needle exchange programs and how they operate them is a local decision.

Q: Won't this send a message to young people that drugs -- especially dangerous injectible drugs like heroin -- are okay?

A: Absolutely not. Injectible drug use is illegal, unhealthy and wrong. It is clearly a major health problem as well as a law enforcement concern. That's why the entire Federal government is sending a unified message to young people and to people of any age. Drugs put your future at risk. They can kill you. And they can infect you with HIV.

I am very proud of this Administration's record on fighting the drug epidemic. We have sharply increased the availability of drug treatment. We have worked in partnership with communities to fight drugs in and around schools. We have worked with state and local governments to put 100,000 more police officers on the streets and we have doubled the number of border guards. We will continue to fight drug use in this country and to offer drug treatment to those who are addicted so that they can stop using drugs.

The goal of needle exchange programs is to be part of a comprehensive HIV prevention strategy that can provide an entry into drug treatment programs.

Q: Do you expect there to be a needle exchange program in every community?

A: Absolutely not. The AIDS epidemic is different in every community and the response to the epidemic must vary to meet local needs. And the most important component of any prevention effort is community support.

Q: Why did you restrict yourself to studies of U.S. programs? Is there any evidence that other studies showed different results?

A: While our primary focus was on the evaluation of U.S.-based programs, we did examine relevant findings in studies performed in other countries (i.e., Canada). The NIH Consensus Conference Report issued last April included several studies conducted in several other countries. It's important to recognize, however, that the AIDS epidemic is different in every country. We were asked by the Congress to evaluate the effectiveness of needle exchange programs to fight the epidemic in this country.

Q: What is your response to the new study by the Office of National Drug Control Policy of the needle exchange program in Vancouver, Canada?

A. We have examined the research on both the Vancouver and Montreal needle exchange programs very carefully. There are several important factors to take into account. First, the drug epidemic in both of those cities is very different from those in American cities. It is dominated by the frequent injection of cocaine. Users of injectible cocaine average 10 to 15 injections every day compared with 3 to 5 times a day for heroin users. Cocaine users are more sexually active during drug use and have more sexually transmitted diseases. Nevertheless, more recent data from both cities indicate that the rate of HIV transmission among drug users who remain in needle exchange programs is two-thirds lower (4.9% versus 18.6%) than those who drop out of needle exchange programs.

Also, in a recent Op-Ed in the New York Times, the authors of the Canadian studies said that the rise in drug use experienced in Vancouver and Montreal was caused by an epidemic of injecting of cocaine in those two cities and a failure to link the programs to drug treatment. The science shows that successful needle exchange programs are linked to drug treatment through mandatory referrals.

Q: What is new since February of 1997 that leads you to certify that needle exchange programs are effective and don't encourage drug use?

A. Several recent findings have strengthened the conclusion that needle exchange programs do not encourage the use of illegal drugs. They include:

- In March, 1997, the National Institutes of Health published the Consensus Development Statement on Interventions to Prevent HIV Risk Behaviors. That report concluded that needle exchange programs "show a reduction in risk behaviors as high as 80% in injecting drug users, with estimates of a 30% or greater reduction of HIV." 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 drug use.
- An October 1997, study of needle exchange programs in Baltimore, Maryland, (Brooner et al., Abstract presented to the American Public Health Association, October 1997) reported that needle exchange programs that are closely linked to or integrated with drug treatment programs actually reduce the incidence of drug use with high levels of retention in drug treatment. A 1998 NIH Consensus Conference report on the effectiveness of treatment for heroin addiction found that drug treatment programs can assist heroin users in halting their drug use.

Q: How many needle exchange programs are operating in the United States?

A. According to the latest data reported to the CDC, needle exchange programs are operating in 28 states and one U.S. territory.

Q: Will the government continue to fund research into the effectiveness of needle exchange programs?

A. Scientific agencies regularly review their research portfolio to determine which studies need to be continued or extended and which studies can or should be terminated. All of the federally-funded evaluations of needle exchange programs will be evaluated as part of that process and decisions will be made on a case-by-case basis.

Q: Will the Alaska needle exchange program evaluation be terminated?

A. The Alaska program looks at a very specific question - whether over the counter sales of needles is more or less effective than a needle exchange program. There are two kinds of interventions and they need to be evaluated. NIH has built in specific safeguards to make sure this demonstration is conducted in an ethical manner.



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Comments:

Attached is the press release, Q+As (internal) and the fact sheet.

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HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

April 20, 1998

Contact: HHS Press Office
(202) 690-6343

NEEDLE EXCHANGE PROGRAMS: PART OF A COMPREHENSIVE HIV PREVENTION STRATEGY

Overview: Since 1981, injection drug use has played an increasing role in the spread of HIV and AIDS, accounting for more than 60% of AIDS cases in certain areas in 1995. To date, nearly 40% of the 652,000 cases of AIDS reported in the U.S. have been linked to injection drug use. More than 70% of HIV infections among women of childbearing age are related either directly or indirectly to injection drug use. And more than 75 percent of babies diagnosed with HIV/AIDS were infected as a direct or indirect result of injection drug use by a parent.

To protect individuals from infection with HIV and other blood-borne infections, several communities have established needle or syringe exchange programs. In communities that choose to use them, needle exchange programs are a form of public health intervention to reduce the transmission of the human immunodeficiency virus (HIV) among drug users, their sex partners, and their children. They provide new, sterile syringes in exchange for used, contaminated syringes. Many needle exchange programs also provide drug users with a referral to drug counseling and treatment, medical services, and provide risk reduction information.

Under the terms of Public Law 105-78, federal funds to support needle exchange programs were conditioned on a determination by the Secretary of Health and Human Services that such programs reduce the transmission of the human immunodeficiency virus (HIV) and do not encourage the use of illegal drugs. The Secretary has made that determination. The Act's restriction on federal funding, however, has not been lifted.

The Administration has decided that the best course at this time is to have local communities which choose to implement their own programs use their own dollars to fund needle exchange programs, and to communicate what has been learned from the science so that communities can construct the most successful programs possible to reduce the transmission of HIV, while not encouraging illegal drug use.

In a February 1997 report to Congress, Health and Human Services Secretary Donna E. Shalala reported that a review of the findings of scientific research indicated 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."

On April 20, 1998, Secretary Shalala announced that a review of research findings indicated that needle exchange programs also "do not encourage the use of illegal drugs."

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FEDERAL RESEARCH ON NEEDLE EXCHANGE

While Congress has restricted the use of federal funds for needle exchange programs since 1989, lawmakers have authorized funding for research into the efficacy of needle exchange programs as a public health intervention to reduce the transmission of HIV and to examine the impact of such programs on drug use. The federal government has supported and will continue to support research into the effectiveness of needle exchange programs.

Effect of Needle Exchange Programs on HIV Transmission

Three major expert reviews of the scientific literature on needle exchange programs conclude that such programs can be an effective component of a comprehensive community-based HIV prevention effort. Additionally, needle exchange programs can provide a pathway for linking injection drug users to other important services such as risk reduction counseling, drug treatment, and support services. The reviews include:

- *Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy*, United States General Accounting Office, March 1993, is an extensive review of U.S. and international data looking at the effects of needle exchange programs. It estimated that a needle exchange program in New Haven, Connecticut, had led to a 33% reduction in HIV infection rates among drug users in that city.
- *The Public-Health Impact of Needle Exchange Programs in the United States and Abroad*, prepared by the University of California, San Francisco, September 1993, reported that needle exchange programs served as an important bridge to other health services, particularly drug counseling and treatment. It also found that needle exchange programs reached a group of injecting drug users with long histories of drug use and limited exposure to drug treatment.
- *Preventing HIV Transmission: The Role of Sterile Needles and Bleach*, National Research Council and Institute of Medicine, September 1995, concluded that needle exchange programs have beneficial effects on reducing behaviors such as multi-person reuse of syringes. It estimated a reduction in risk behaviors of 80% and reductions in HIV transmission of 30% or greater.

Based on that scientific evidence, in February 1997, Secretary Shalala reported to Congress that a review of scientific findings indicated 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." She also directed the Department's scientific agencies to continue to review research findings regarding the effect of needle exchange programs on illegal drug use.

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Impact of Needle Exchange Programs on Drug Use

Extensive research indicates that needle exchange programs do not encourage illegal drug use and can, in fact, reduce drug use through effective referrals to drug treatment and counseling. Several recent studies strengthen the conclusion that needle exchange programs do not encourage the use of illegal drugs. They include:

- In March, 1997, the National Institutes of Health published the Consensus Development Statement on Interventions to Prevent HIV Risk Behaviors. That report concluded that needle exchange programs "show a reduction in risk behaviors as high as 80% in injecting drug users, with estimates of a 30% or greater reduction of HIV." 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 drug use.
- An October 1997, study of needle exchange programs in Baltimore, Maryland, (Brooner et al., Abstract presented to the American Public Health Association, October 1997) reported that needle exchange programs that are closely linked to or integrated with drug treatment programs actually reduce the incidence of drug use with high levels of retention in drug treatment. A 1998 NIH Consensus Conference report on the effectiveness of treatment for heroin addiction found that drug treatment programs can assist heroin users in halting their drug use.

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HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE

April 20, 1998

Contact: HHS Press Office
(202) 690-6343

RESEARCH SHOWS NEEDLE EXCHANGE PROGRAMS REDUCE HIV INFECTIONS WITHOUT INCREASING DRUG USE

Health and Human Services Secretary Donna E. Shalala announced today that based on the findings of extensive scientific research, she has determined that needle exchange programs can be an effective part of a comprehensive strategy to reduce the incidence of HIV transmission and do not encourage the use of illegal drugs.

Under the terms of Public Law 105-78, the Secretary of HHS is authorized to determine that such programs reduce the transmission of the human immunodeficiency virus (HIV) and do not encourage the use of illegal drugs. The act's restriction on federal funding, however, has not been lifted.

"This nation is fighting two deadly epidemics -- AIDS and drug abuse. They are robbing us of far too many of our citizens and weakening our future," said Secretary Shalala. "A meticulous scientific review has now proven that needle exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs. It offers communities that decide to pursue needle exchange programs yet another weapon in their fight against AIDS."

While the use of federal funds continues to be restricted, and criteria for their use have not been established, Secretary Shalala emphasized that needle exchange programs that have been successful have had the strong support of their communities, including appropriate State and local public health officials. The science reveals that successful needle exchange programs refer participants to drug counseling and treatment as well as necessary medical services, and make needles available on a replacement basis only.

The Administration has decided that the best course at this time is to have local communities which choose to implement their own programs use their own dollars to fund needle exchange programs, and to communicate what has been learned from the science so that communities can construct the most successful programs possible to reduce the transmission of HIV, while not encouraging illegal drug use.

Since the AIDS epidemic began in 1981, injection drug use has played an increasing role in the spread of HIV and AIDS, accounting for more than 60% of AIDS cases in certain areas in 1995. To date, nearly 40% of the 652,000 cases of AIDS reported in the U.S. have been linked to injection drug use. More than 70% of HIV infections among women of childbearing age are related either directly or indirectly to injection drug use. And more than 75% of babies diagnosed with HIV/AIDS were infected as a direct or indirect result of injection drug use by a parent.

- 2 -

Communities' use of needle exchange programs has increased throughout the epidemic. According to data reported to the Centers for Disease Control and Prevention, communities in 28 states and one U.S. territory currently operate needle exchange programs, supported by State, local, or private funds. Many of these programs provide a direct linkage to drug treatment and counseling as well as needed medical services.

Since 1989, the use of federal funds for needle exchange programs has been restricted by the Congress. Funding has, however, been authorized by the Congress to conduct research into the efficacy of such programs as a public health intervention to reduce transmission of HIV and to examine the impact of such programs on drug use. The federal government has supported numerous studies of the effectiveness of needle exchange programs in reducing the transmission of HIV among injection drug users, their spouses or sexual partners, and their children. Many of these studies also examined whether or not needle exchange programs encourage the use of illegal drugs.

In February 1997, Secretary Shalala reported to Congress that a review of scientific studies indicated 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." She also directed the Department's scientific agencies to continue to review research findings regarding the effect of needle exchange programs on illegal drug use. The scientific evidence indicates that needle exchange programs do not encourage illegal drug use and can, in fact, be part of a comprehensive public health strategy to reduce drug use through effective referrals to drug treatment and counseling.

"An exhaustive review of the science in this area indicates that needle exchange programs can be an effective component of the global effort to end the epidemic of HIV disease," said Harold Varmus, MD, Director of the National Institutes of Health. NIH has funded much of the research into the effectiveness of needle exchange programs and their impact on drug use. "Recent findings have strengthened the scientific evidence that needle exchange programs do not encourage the use of illegal drugs," Dr. Varmus said. Specifically, he cited:

- In March 1997, the National Institutes of Health published the Consensus Development Statement on Interventions to Prevent HIV Risk Behaviors. That report concluded that needle exchange programs "show a reduction in risk behaviors as high as 80% in injecting drug users, with estimates of a 30% or greater reduction of HIV." 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 drug use.
- An October 1997, study of needle exchange programs in Baltimore, Maryland, indicated that needle exchange programs that are closely linked to or integrated with drug treatment programs have high levels of retention in drug treatment. A 1998 NIH Consensus Conference report on the effectiveness of treatment for heroin addiction found that drug treatment programs can assist heroin users in halting their drug use.

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FOR INTERNAL USE ONLY—NOT FOR ATTRIBUTION OR QUOTATION**Needle Exchange Questions and Answers
Draft – April 18, 1998, 7:49 p.m.**

Q: What are you announcing today?

A: That the Secretary of Health and Human Services, after consulting with her scientific advisers, has determined that the scientific evidence exists to show that needle exchange programs reduce the risk of HIV infection, and do not encourage the use of illegal drugs.

Q: If the science is there, why aren't you releasing federal funds for needle exchange programs?

A: The Administration has decided that the best course at this time is to have local communities use their own dollars to fund needle exchange programs, and to communicate what has been learned from the science so that communities can construct the most successful programs possible to reduce the transmission of HIV, while not encouraging illegal drug use.

Q: The Administration has made this decision. Was it the President's decision? You're part of the Administration – do you agree with the decision?

A: It was an Administration decision.

Q: Do the scientific results you're announcing today meet the test Congress set up on the release of funds?

A: Yes.

Q: Does Congress need to act, either to release funds or to ban the use of them for needle exchange programs?

A: We will work with Congress to present the strong scientific evidence which demonstrates that needle exchange programs, when part of a comprehensive HIV prevention strategy, can reduce the incidence of HIV transmission and not encourage the use of illegal drugs. As I have previously said, local communities will not be permitted to use federal funds for needle exchange programs, so I do not expect this is an issue on which Congress must act.

Q: Why did it take so long?

A: It was imperative that we be exceedingly careful in our analysis of the science. And that is what we have done. Congress established a very stringent test in this area, and appropriately so. This is not an easy issue. It involves two major epidemics and we need to be certain of the evidence. I am very proud of this team of scientists standing behind me. In the last few months, they have gone over the scientific research with a fine toothed comb and they have reached a very clear determination: Needle exchange programs can be an effective public health intervention to reduce the spread of HIV without increasing drug use.

Q: Why are you taking this action?

A: Because the science is there. Communities around the country need to know that under certain conditions needle exchange programs can reduce HIV transmission and do not encourage illegal drug use. The report from the government's senior scientific advisers affirms those findings.

Second, injection drug use has played an increasing role in the spread of HIV and AIDS, accounting for more than 60% of AIDS cases in certain areas in 1995. To date, nearly 40% of the 652,000 cases of AIDS reported in the U.S. have been linked to injection drug use. More than 70% of HIV infections among women of childbearing age are related either directly or indirectly to injection drug use. And more than 75 percent of babies diagnosed with HIV/AIDS were infected as a direct or indirect result of injection drug use by a parent.

Q: Did political concerns delay this decision?

A: Absolutely not. From the beginning of this effort, it has been about three things: science, science, and science. The charge I gave my Department's scientists was to make sure the data were there and that they were accurate. They and I are very confident with these results.

Q: Did political pressure from AIDS groups force this decision?

A: Absolutely not. It is the job of scientists to examine the science. It is the job of public leaders to follow the science. It is the job of advocates to push us all to do our jobs, do them well, and, whenever possible, do them quickly. I understand the urgency of this issue but it was our job to make sure the science was there before we acted.

Q: What effect did the threat by the President's Advisory Council to seek your resignation have on your decision?

A: None at all. It is the job of scientists to examine the science. It is the job of public leaders to follow the science. It is the job of advocates to push us all to do our jobs, do them well, and, whenever possible, do them quickly. I understand the urgency of this issue but it was our job to make sure the science was there before we acted.

Q: Does General McCaffrey agree with your decision?

A: [I have spoken with General McCaffrey about the results of this scientific review, and he is aware of the Department's findings.] I will let him speak for himself. But let me say, very clearly, General McCaffrey and I are in absolute agreement on the necessity to reduce drug use in this country, especially among teenagers. No one should doubt that illegal drugs are wrong and that they can kill you. He and I also agree that we need to maintain and increase the funding available for drug treatment. Those concerns were important to me as I considered these issues.

Under the law passed by Congress, it is the responsibility of the Secretary of Health and Human Services to determine whether the scientific research findings meet the standard established by the Congress. All of the senior scientific advisers of the Department agree that the science-based standards have been met.

Q: General McCaffrey has made his opposition to needle exchange programs very clear. Does this mean the Administration is divided?

A: This is not a political decision. The Congress asked us to apply a very stringent scientific test and to answer two questions. First, do needle exchange programs reduce the transmission of HIV? Second, do such programs encourage the use of illegal drugs? Some of the best scientific minds in the country have pored over the data and have concluded that both of these tests have been met. That is the basis for our decision today.

Q: But General McCaffrey says that needle exchange programs will attract drug users and other undesirables to areas that implement needle exchange programs. Is this true?

A: Congress has made clear that needle exchange programs must not encourage drug use, and, after studying this issue thoroughly, we have determined that needle exchanges meet this test whether and, if so, local communities have their own needle exchange programs and how they operate them is a local decision.

Q: Won't this send a message to young people that drugs -- especially dangerous injectible drugs like heroin -- are okay?

A: Absolutely not. Injectible drug use is illegal, unhealthy and wrong. It is clearly a major health problem as well as a law enforcement concern. That's why the entire Federal government is sending a unified message to young people and to people of any age. Drugs put your future at risk. They can kill you. And they can infect you with HIV.

I am very proud of this Administration's record on fighting the drug epidemic. We have sharply increased the availability of drug treatment. We have worked in partnership with communities to fight drugs in and around schools. We have worked with state and local governments to put 100,000 more police officers on the streets and we have doubled the number of border guards. We will continue to fight drug use in this country and to offer drug treatment to those who are addicted so that they can stop using drugs.

The goal of needle exchange programs is to be part of a comprehensive HIV prevention strategy that can provide an entry into drug treatment programs.

Q: Do you expect there to be a needle exchange program in every community?

A: Absolutely not. The AIDS epidemic is different in every community and the response to the epidemic must vary to meet local needs. And the most important component of any prevention effort is community support.

Q: Why did you restrict yourself to studies of U.S. programs? Is there any evidence that other studies showed different results?

A: While our primary focus was on the evaluation of U.S.-based programs, we did examine relevant findings in studies performed in other countries (i.e., Canada). The NIH Consensus Conference Report issued last April included several studies conducted in several other countries. It's important to recognize, however, that the AIDS epidemic is different in every country. We were asked by the Congress to evaluate the effectiveness of needle exchange programs to fight the epidemic in this country.

Q: What is your response to the new study by the Office of National Drug Control Policy of the needle exchange program in Vancouver, Canada?

A. We have examined the research on both the Vancouver and Montreal needle exchange programs very carefully. There are several important factors to take into account. First, the drug epidemic in both of those cities is very different from those in American cities. It is dominated by the frequent injection of cocaine. Users of injectible cocaine average 10 to 15 injections every day compared with 3 to 5 times a day for heroin users. Cocaine users are more sexually active during drug use and have more sexually transmitted diseases. Nevertheless, more recent data from both cities indicate that the rate of HIV transmission among drug users who remain in needle exchange programs is two-thirds lower (4.9% versus 18.6%) than those who drop out of needle exchange programs.

Also, in a recent Op-Ed in the New York Times, the authors of the Canadian studies said that the rise in drug use experienced in Vancouver and Montreal was caused by an epidemic of injecting of cocaine in those two cities and a failure to link the programs to drug treatment. The science shows that successful needle exchange programs are linked to drug treatment through mandatory referrals.

Q: What is new since February of 1997 that leads you to certify that needle exchange programs are effective and don't encourage drug use?

A. Several recent findings have strengthened the conclusion that needle exchange programs do not encourage the use of illegal drugs. They include:

- In March, 1997, the National Institutes of Health published the Consensus Development Statement on Interventions to Prevent HIV Risk Behaviors. That report concluded that needle exchange programs "show a reduction in risk behaviors as high as 80% in injecting drug users, with estimates of a 30% or greater reduction of HIV." 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 drug use.
- An October 1997, study of needle exchange programs in Baltimore, Maryland, (Brooner et al., Abstract presented to the American Public Health Association, October 1997) reported that needle exchange programs that are closely linked to or integrated with drug treatment programs actually reduce the incidence of drug use with high levels of retention in drug treatment. A 1998 NIH Consensus Conference report on the effectiveness of treatment for heroin addiction found that drug treatment programs can assist heroin users in halting their drug use.

Q: How many needle exchange programs are operating in the United States?

A. According to the latest data reported to the CDC, needle exchange programs are operating in 28 states and one U.S. territory.

Q: Will the government continue to fund research into the effectiveness of needle exchange programs?

A. Scientific agencies regularly review their research portfolio to determine which studies need to be continued or extended and which studies can or should be terminated. All of the federally-funded evaluations of needle exchange programs will be evaluated as part of that process and decisions will be made on a case-by-case basis.

Q: Will the Alaska needle exchange program evaluation be terminated?

A. The Alaska program looks at a very specific question – whether over the counter sales of needles is more or less effective than a needle exchange program. There are two kinds of interventions and they need to be evaluated. NIH has built in specific safeguards to make sure this demonstration is conducted in an ethical manner.

THE WHITE HOUSE
WASHINGTON

April 19, 1998

MEMORANDUM FOR THE PRESIDENT

FROM: Bruce Reed

SUBJECT: Needle Exchange

You should try to make a final decision on needle exchange today. If you decide to go forward with the "demonstration" option, Shalala would like to announce it tomorrow to ward off a press conference AIDS groups have called for tomorrow morning to demand her resignation. If you decide to certify the science but rule out federal funds, we should announce that soon to stop Republican attacks over the issue.

Under the demonstration proposal, HHS would certify that needle exchange programs reduce HIV transmission without increasing drug use, and allow federal prevention funds to be used for those programs in up to 8 communities hardest hit by drug-related HIV. Communities that ranked among the highest in the overall rate or number of drug-related HIV cases or drug-related HIV cases among women of childbearing age would be eligible, but only 8 would be permitted to use federal funds. Over the next year, CDC would evaluate these 8 communities to determine whether their programs were working and whether they were making an effective link to drug treatment before deciding whether to expand the number of eligible communities.

A program would also have to 1) be legal in that state and community; 2) make referrals to drug treatment; 3) comply with hazardous waste disposal standards; 4) replace syringes on a one-for-one basis; and 5) agree to research and evaluation. HHS estimates that only about 27 communities have the capacity to meet these requirements.

You still have the option to certify the science but rule out the use of federal funds on the grounds that this should be a local decision, not a national political debate. Contrary to her earlier statement to Erskine, Shalala opposes this option, as would the AIDS community. (We do not know how much the AIDS and scientific communities will criticize the demonstration option.)

Several Republican members of Congress and the RNC have already issued statements attacking the Administration over needle exchange. They will almost certainly attach a ban on federal funds to the supplemental bill, to tobacco legislation, and to the Labor/HHS appropriations bill in the fall. The AIDS community would want you to veto legislation over this issue, but we have always refused to do so in the past.

Whatever you decide, we will inform Shalala and McCaffrey, and roll out the decision to key members and groups.

EMBARGOED MATERIAL

Contact: HHS PRESS OFFICE
(202) 690-6343**RESEARCH SHOWS NEEDLE EXCHANGE PROGRAMS REDUCE HIV INFECTIONS
WITHOUT INCREASING DRUG USE**

Health and Human Services Secretary Donna E. Shalala announced today that based on the findings of extensive scientific research, she has determined that needle exchange programs can be an effective part of a comprehensive strategy to reduce the incidence of HIV transmission and do not encourage the use of illegal drugs.

Under the terms of Public Law 105-78 passed by Congress last year, state and local governments will now be permitted to seek to use Federal HIV prevention funds to support the development and operation of needle exchange programs. Congress had restricted the use of federal funds for needle exchange programs until the Secretary of HHS has determined that such programs reduce the transmission of the human immunodeficiency virus (HIV) and do not encourage the use of illegal drugs.

In the next 12 months, HHS will approve up to eight areas hardest hit and most severely impacted by HIV transmission related to illegal drug use, particularly those that demonstrate the role that injection drug use plays in the community and the role of injection drug use in transmitting HIV to women of childbearing age.

"This nation is fighting two deadly epidemics -- AIDS and drug abuse. They are robbing us of far too many of our citizens and weakening our future," said Secretary Shalala. "A meticulous scientific review has now proven that needle exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs. It offers communities that decide to pursue needle exchange programs yet another weapon in their fight against AIDS."

Secretary Shalala also announced several conditions to assure that the use of federal funds will be consistent with community standards. No program may use federal funds unless it has the strong support of the community and the approval of the appropriate State or Local public health official. All programs will be required to refer participants to drug counseling and treatment as well as necessary medical services. And all programs will be required to certify that they are consistent with all State and local legal requirements, including the disposal of hazardous waste.

Since the AIDS epidemic began in 1981, injection drug use has played an increasing role in the spread of HIV and AIDS, accounting for more than 60% of AIDS cases in certain areas in 1995. To date, nearly 40% of the 652,000 cases of AIDS reported in the U.S. have been linked to injection drug use. More than 70% of HIV infections among women of childbearing age are related either directly or

- 2 -

indirectly to injection drug use. And more than 75% of babies diagnosed with HIV/AIDS were infected as a direct or indirect result of injection drug use by a parent.

Communities' use of needle exchange programs has increased throughout the epidemic. According to data reported to the Centers for Disease Control and Prevention, communities in 28 states and one U.S. territory currently operate needle exchange programs, supported by State, local, or private funds. Many of these programs provide a direct linkage to drug treatment and counseling as well as needed medical services.

Since 1989, the use of federal funds for needle exchange programs has been restricted by the Congress. Funding has, however, been authorized by the Congress to conduct research into the efficacy of such programs as a public health intervention to reduce transmission of HIV and to examine the impact of such programs on drug use. The federal government has supported numerous studies of the effectiveness of needle exchange programs in reducing the transmission of HIV among injection drug users, their spouses or sexual partners, and their children. Many of these studies also examined whether or not needle exchange programs encourage the use of illegal drugs.

In February 1997, Secretary Shalala reported to Congress that a review of scientific studies indicated 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." She also directed the Department's scientific agencies to continue to review research findings regarding the effect of needle exchange programs on illegal drug use. The scientific evidence indicates that needle exchange programs do not encourage illegal drug use and can, in fact, be part of a comprehensive public health strategy to reduce drug use through effective referrals to drug treatment and counseling.

"An exhaustive review of the science in this area indicates that needle exchange programs can be an effective component of the global effort to end the epidemic of HIV disease," said Harold Varmus, MD, Director of the National Institutes of Health. NIH has funded much of the research into the effectiveness of needle exchange programs and their impact on drug use. "Recent findings have strengthened the scientific evidence that needle exchange programs do not encourage the use of illegal drugs," Dr. Varmus said. Specifically, he cited:

- In March 1997, the National Institutes of Health published the Consensus Development Statement on Interventions to Prevent HIV Risk Behaviors. That report concluded that needle exchange programs "show a reduction in risk behaviors as high as 80% in injecting drug users, with estimates of a 30% or greater reduction of HIV." 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 drug use.

2291 [An October 1997, study of needle exchange programs in Baltimore, Maryland, indicated that needle exchange programs that are closely linked to or integrated with drug treatment programs have high levels of retention in drug treatment. A 1998 NIH Consensus Conference report on the effectiveness of treatment for heroin addiction found that drug treatment programs can assist heroin users in halting their drug use.

- more -

- 3 -

Under the conditions announced today by Secretary Shalala, the use of federal funds will be restricted to only those funds appropriated by the Congress to the Centers for Disease Control and Prevention to prevent the transmission of HIV. No funds appropriated to the Substance Abuse and Mental Health Services Administration to reduce illegal drug use, or to provide drug treatment and counseling, can be used to support needle exchange programs. In addition, no funds from the Ryan White CARE Act can be used to support needle exchange programs. Programs receiving federal funds must certify that they are making needles and syringes available on a replacement basis only; that they comply with established standards for hazardous waste disposal; and, that they agree to collaborate with federally-supported research and evaluation efforts.

"For these efforts to succeed, there must be strong community support and full compliance with all state and local laws and regulations. No federal funds will be available for any project that does not have the express support of the community involved," said Dr. Claire Broome, Acting Director of the Centers for Disease Control and Prevention.

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April 20, 1998

CONTACT: HHS PRESS OFFICE
(202) 690-6343**NEEDLE EXCHANGE PROGRAMS:
PART OF A COMPREHENSIVE HIV PREVENTION STRATEGY**

Overview: Since 1981, injection drug use has played an increasing role in the spread of HIV and AIDS, accounting for more than 60% of AIDS cases in certain areas in 1995. To date, nearly 40% of the 652,000 cases of AIDS reported in the U.S. have been linked to injection drug use. More than 70% of HIV infections among women of childbearing age are related either directly or indirectly to injection drug use. And more than 75 percent of babies diagnosed with HIV/AIDS were infected as a direct or indirect result of injection drug use by a parent.

To protect individuals from infection with HIV and other blood-borne infections, several communities have established needle or syringe exchange programs. In communities that choose to use them, needle exchange programs are a form of public health intervention to reduce the transmission of the human immunodeficiency virus (HIV) among drug users, their sex partners, and their children. They provide new, sterile syringes in exchange for used, contaminated syringes. Many needle exchange programs also provide drug users with a referral to drug counseling and treatment, medical services, and provide risk reduction information.

The first U.S. needle exchange program was begun in 1988. According to the data reported to the Centers for Disease Control and Prevention, needle exchange programs operate in 28 states and one U.S. territory. Beginning in fiscal year 1989, the U.S. Congress has prohibited the use of Federal AIDS prevention funds to support needle exchange programs until certain conditions are met. Under Public Law 105-78, the Secretary of Health and Human Services is required to certify that needle exchange programs reduce the transmission of HIV and do not encourage the use of illegal drugs.

In a February 1997 report to Congress, Health and Human Services Secretary Donna E. Shalala reported that a review of the findings of scientific research indicated 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."

On April 20, 1998, Secretary Shalala announced that a review of research findings indicated that needle exchange programs also "do not encourage the use of illegal drugs." Having met the Congressional standard, HHS has determined that a limited number of states and local governments will now be permitted to use certain federal funds to support the development and operation of needle exchange programs.

In the next 12 months, HHS will approve up to eight areas hardest hit and most severely impacted by HIV transmission related to illegal drug use, particularly those that demonstrate the role that injection drug use plays in the community and the role of injection drug use in transmitting HIV to women of childbearing age. Secretary Shalala also announced steps to assure that such use of federal funds will be consistent with community standards and targeted at those areas most affected by AIDS and HIV transmission related to injectible drug use.

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CONDITIONS FOR ACCESSING FEDERAL FUNDING

The use of federal funds to support needle exchange programs will be restricted to only those funds appropriated by the Congress to the Centers for Disease Control and Prevention to prevent the transmission of HIV. No funds appropriated to the Substance Abuse and Mental Health Services Administration to reduce illegal drug use or to provide drug treatment and counseling can be used to support needle exchange programs. And no funds appropriated to the Health Resources and Services Administration under the Ryan White CARE Act can be used to support needle exchange programs.

To use federal funding for needle exchange programs, communities must submit a comprehensive plan for the approval of state and local public health officers. These officials must then forward the application to the CDC, which evaluates whether or not the community has met the conditions for using funding. The CDC also will provide technical assistance to help bring interested communities into compliance with the requirements.

The Department of Health and Human Services will approve the eight applicants hardest hit and most severely impacted by HIV transmission related to illegal drug use, particularly those that demonstrate the role that injection drug use plays in the community and the role of injection drug use in transmitting HIV to women of childbearing age. Other conditions are:

- No program will be permitted to use funds unless it requires participants to be referred to drug counseling and treatment as well as needed medical services.
- No program will be permitted to use funds unless it certifies that it is using syringes on a one-for-one replacement basis only.
- No program will be permitted to use funds unless it complies with established standards for hazardous waste disposal.
- No program will be permitted to use funds unless it guarantees it will operate in a manner consistent with all State and Local legal requirements.
- No program will be permitted to use funds unless it agrees to participate in relevant research and evaluation efforts.

FEDERAL RESEARCH ON NEEDLE EXCHANGE

While Congress has restricted the use of federal funds for needle exchange programs since 1989, lawmakers have authorized funding for research into the efficacy of needle exchange programs as a public health intervention to reduce the transmission of HIV and to examine the impact of such programs on drug use. The federal government has supported and will continue to support research into the effectiveness of needle exchange programs.

Effect of Needle Exchange Programs on HIV Transmission

Three major expert reviews of the scientific literature on needle exchange programs conclude that such programs can be an effective component of a comprehensive community-based HIV prevention effort.

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Additionally, needle exchange programs can provide a pathway for linking injection drug users to other important services such as risk reduction counseling, drug treatment, and support services. The reviews include:

- *Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy*, United States General Accounting Office, March 1993, is an extensive review of U.S. and international data looking at the effects of needle exchange programs. It estimated that a needle exchange program in New Haven, Connecticut, had led to a 33% reduction in HIV infection rates among drug users in that city.
- *The Public-Health Impact of Needle Exchange Programs in the United States and Abroad*, prepared by the University of California, San Francisco, September 1993, reported that needle exchange programs served as an important bridge to other health services, particularly drug counseling and treatment. It also found that needle exchange programs reached a group of injecting drug users with long histories of drug use and limited exposure to drug treatment.
- *Preventing HIV Transmission: The Role of Sterile Needles and Bleach*, National Research Council and Institute of Medicine, September 1995, concluded that needle exchange programs have beneficial effects on reducing behaviors such as multi-person reuse of syringes. It estimated a reduction in risk behaviors of 80% and reductions in HIV transmission of 30% or greater.

Based on that scientific evidence, in February 1997, Secretary Shalala reported to Congress that a review of scientific findings indicated 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." She also directed the Department's scientific agencies to continue to review research findings regarding the effect of needle exchange programs on illegal drug use.

Impact of Needle Exchange Programs on Drug Use

Extensive research indicates that needle exchange programs do not encourage illegal drug use and can, in fact, reduce drug use through effective referrals to drug treatment and counseling. Several recent studies strengthen the conclusion that needle exchange programs do not encourage the use of illegal drugs. They include:

- In March, 1997, the National Institutes of Health published the Consensus Development Statement on Interventions to Prevent HIV Risk Behaviors. That report concluded that needle exchange programs "show a reduction in risk behaviors as high as 80% in injecting drug users, with estimates of a 30% or greater reduction of HIV." 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 drug use.

new [An October 1997, study of needle exchange programs in Baltimore, Maryland, (Brooner et al., Abstract presented to the American Public Health Association, October 1997) reported that needle exchange programs that are closely linked to or integrated with drug treatment programs actually reduce the incidence of drug use with high levels of retention in drug treatment. A 1998 NIH Consensus Conference report on the effectiveness of treatment for heroin addiction found that drug treatment programs can assist heroin users in halting their drug use.

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Wary of Taxes, House GOP Weighs Alternate Teen Smoking Measure

By JULIET EILPERIN
Washington Post Staff Writer

Amid mounting criticism of Sen. John McCain's (R-Ariz.) tobacco proposal, the House Republican leadership is considering a wholly different alternative that would fold an anti-teenage smoking initiative into a broader anti-drug package.

Though House Speaker Newt Gingrich (R-Ga.) and other lawmakers have raised this prospect in the past, recent support for the plan appears to have grown as key Republicans are focusing on the tax and spending aspects of the McCain bill. Gingrich, House Majority Leader Richard K. Arney (R-Tex.), House Majority Whip Tom DeLay (R-Tex.) and National Republican Congressional Committee Chairman John Linder (Ga.) have all questioned the idea of using new taxes on tobacco to finance government programs.

While McCain managed to marshal support in the Senate Commerce Committee for collecting \$500 billion in revenue from the tobacco industry, House Republicans are far more skeptical about imposing new taxes. In an interview to be aired today on CNBC's "Tim Russert" program, Gingrich called McCain's proposal "a bad bill."

"I am opposed to a liberal tobacco bill, which would raise taxes to create bigger government," he said. "I think we ought to give back to the taxpayers every penny of new revenue from tobacco."

Linder noted that teenage purchases make up only 2 percent of annual tobacco sales, and families earning "an average of \$30,000 a year" would bear the brunt of any new tobacco taxes.

Rather than launching a comprehensive reform of the nation's smoking habits, the House bill would be narrowly tailored to combat the problem of teenage smoking. Republican

Vice Chair Deborah Pryce (Ohio), who is coordinating the leadership's position on tobacco, argued that this strategy reflected the overarching aim of any tobacco legislation.

"That's the national objective, to reduce the number of young people that smoke," Pryce said in an interview Thursday.

The move also would allow House Republicans to attack President Clinton's record on fighting drugs, which Gingrich has identified as one of his top four priorities. When the speaker announced the creation of a congressional task force on drugs last month, the press release indicated that Gingrich hoped to design "a World War II-style victory plan to save America's children from illegal drugs."

"Because of the Clinton administration's lack of seriousness and commitment to winning the drug war, they are attempting to hide behind tobacco in the hopes that people will forget their lack of focus," said Gingrich spokeswoman Christina Martin. "Our intention is to hold their feet to the fire and protect our teens from multiple evils."

Pryce said it made sense to combine the work of the two speaker-appointed task forces. While one group has focused on tobacco legislation, the other has explored curbing both demand and supply in the drug trade.

"We have a perfect opportunity to take this anti-tobacco momentum and kill two birds with one stone," Pryce said, adding that Clinton had done little to address the nation's drug problem. "It certainly defines the difference between the Republicans and the White House. There's just no doubt."

Several Republicans argued that while teenage smoking posed health risks, illegal drugs presented a more serious problem.

"My sense is, since President Clinton became president, cocaine use has increased 153 percent and smok-

ing by teens has increased by 25 percent," Linder said. "If we're really looking at what's threatening America, we should be looking at drug use."

White House domestic policy adviser Bruce Reed cautioned Republicans against presenting anything less than "a comprehensive tobacco bill."

"We're happy to have a debate about how best to use any revenue raised by a tobacco bill," Reed said. "We're not interested in any stripped-down bill that only pays lip service to reducing youth smoking."

In contrast to the Senate, the House has yet to unveil tobacco legislation. The House bill that the leadership is considering could include options such as banning vending machine sales or restricting advertising aimed at teenagers.

Pryce, who declined to identify specific provisions in the House version, emphasized that in addition to drafting a teenage smoking bill, the House could push for broader legislation in another vehicle. "That's the very least that you will see," she said of the youth-oriented bill.

Republicans said their anti-drug legislation could include increased penalties for drugs in schools and on college campuses, lower insurance premiums for workplaces with tough anti-drug policies and increased patrols along the southern U.S. border.

Rep. Bill McCollum (R-Fla.), a co-chair of the task force, said Republicans hope to take advantage of a "window of opportunity" that exists in Latin America to curtail drug trafficking. He said Republicans are talking about spending "hundreds of millions" more than the Clinton administration for more surveillance equipment, patrol planes and other interdiction efforts.

Staff writer John F. Harris contributed to this report.

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Q: When will these regulations become effective? How will these regulations affect this juice season?

A: It is proposed that the HACCP regulation become effective one year after publication of the final rule with a two or three year phase-in period for small and very small businesses. FDA is asking for comment on the appropriate length of the phase-in period. Under the proposal, these businesses would be required to label until they implement HACCP. Implementing a HACCP program requires planning, training of personnel, and possibly the purchase of new equipment by producers. For these reasons, it is not feasible to make the rules effective for the next cider season.

FDA plans to have the labeling regulation in place by September of this year, in time for the 1999 cider season. Because of the short effective date, FDA has proposed allowing flexibility as to how the warning statement appears. While FDA intends to require that the warning statement appear on the label of the product itself, we are proposing a phase-in period starting January 1, 2000 (January 1, 2001 for small businesses) during which the statement may appear on placards, signs, or other point-of-purchase materials so long as the labeling is prominent enough to effectively inform consumers.

Q: What is HACCP?

A: HACCP stands for Hazard Analysis and Critical Control Point system. It is a systematic approach to the identification, assessment, and prevention of all types of risk -- biological, chemical, and physical -- that may occur in a food production process or practice. When implementing a HACCP system, a food producer develops a plan that anticipates and identifies the points in the production process where a failure to control the process would likely result in contamination of the food. HACCP is regarded as the state-of-the-art means to ensure the safety and integrity of the food supply.

Q: Has HACCP been successfully implemented for other foods?

A: Yes, HACCP is currently being implemented in the seafood, meat and poultry production industries. Also FDA's low-acid canned food regulations, which have been in place since the 1970s, are HACCP-based regulations.

Q: Are juices safe?

A: Juice products, in general, are safe and nutritious foods. Currently, about 98 percent of juice sold in the United States is pasteurized. However, the growing record of consumer illness in recent years demonstrates that a problem exists that must be dealt with, particularly in unpasteurized products. FDA's proposals are developed to reduce the potential for foodborne illness and assure that consumers can continue to rely on safe juice products. Unfortunately, we do not know the actual number of juice-related

illnesses because these types of illness are underreported. Individuals may not experience all of the symptoms or have severe enough symptoms to seek medical attention. Additionally, medical personnel may simply treat the symptoms without determining the underlying cause. Factoring in this underreporting, it is possible to estimate that the combined effect of these 2 proposals will prevent between 16,000 and 48,000 illnesses annually.

Q: What are the problems with juices that are being addressed in the proposed regulations?

A: The proposed regulations will cover a wide range of hazards that may result in foodborne illness, including microbial, chemical, and physical contamination. During the past several years, outbreaks of foodborne illness have been associated with the consumption of juice and beverages containing juice that have not been pasteurized or otherwise treated to destroy pathogens. In the Fall of 1996, an outbreak of *E. coli* O157:H7 from fresh apple juice resulted in 66 illnesses and the death of one child in the western United States and Canada. Other pathogens have also been associated with outbreaks. These include *Salmonella* and *Cryptosporidium* in apple cider, *Bacillus* in orange juice, *Salmonella* in unpasteurized orange juice and in orange drink, and *Vibrio cholerae* in coconut milk.

Illnesses have also been caused by other substances present in juices. Examples include tin leached from the can lining, use of poisonous parts of plants to make the juice, the undeclared presence of food ingredients such as sulfites and FD&C Yellow No. 5, residues from improper sanitation procedures, and the presence of glass, or other hazardous materials. Other types of chemical and physical hazards have the potential to cause illness, such as patulin, a toxin that can occur in juice when excessive levels of moldy apples are used in processing, and toxic elements (e.g., lead). The HACCP proposal will cover these types of hazards, as well as microbial contamination.

Q: Have the problems with juice increased in recent years?

A: Yes, the incidence of illness associated with consumption of fresh juice products has increased in recent years. Some of the microorganisms involved are newly emerging strains such as *E. coli* O157:H7 which has adapted to acidic conditions in foods such as juices and *Cryptosporidium*.

Q: How risky is juice compared to other foods?

A: All foods have the potential to be contaminated with a microbial, chemical, or physical hazard that can cause illness or injury, so, it is impossible to make this comparison. Food producers and manufacturers are aware of this and take steps to minimize the opportunity for contamination to occur. Juices, particularly those not treated to destroy

pathogens, provide a potentially favorable environment for supporting the growth of pathogens. However, juices treated to destroy pathogens are generally safe and nutritious.

Q: Should children drink unpasteurized juice?

A: FDA advises consumers that, due to the increased risk of illness from pathogens, unpasteurized juice not be given to children, the elderly, or anyone who has a significantly weakened immune system.

Q: How much juice is consumed in the United States?

A: Americans consume approximately 2.3 billion gallons of juice every year. Juice consumption at both ends of the age spectrum is high. Children under 6 years of age drink 16% of the juice consumed and this amount accounts for 50% of their fruit intake. Adults over 59 consume 20% of the juice. Orange juice is by far the most-consumed juice at 1.4 billion gallons annually. Other popular juices with American consumers are apple juice (1.66 billion gallons), grapefruit juice (166 million), pineapple juice (91 million), tomato and other vegetable juices (78 million), and grape juice (75 million).

Q: How many juice processors are there?

A: There are approximately 3,000 juice processors in the U.S.

Q: Are all juices covered by the regulations?

A: The labeling proposal affects only those juices that have not been pasteurized or otherwise treated to eliminate pathogens. In other words, only fresh, untreated juices will have to bear a warning statement. Juices processed, sold, and consumed in restaurants and similar retail establishments do not require this labeling. These juices are less than 3% of all juice on the market. Retailers of packaged juice, including those who sell less than 40,000 gallons of fresh juice per year, would be exempt from HACCP but would instead be required to place warning labels on their products.

Q: Would the proposed rules apply to imported juice products?

A: The rules would apply to all juice products sold in interstate commerce, including all imported juice products.

Q: How do the juice regulations fit into the President's Food Safety Initiative?

A: When President Clinton announced the Food Safety Initiative, HACCP rules for seafood and for meat and poultry were highlighted as an important part of improving the food safety system in this country. Expanding HACCP to other appropriate foods, particularly

	Labeling	HACCP
Large processor of fresh juice	only until HACCP implemented	yes
roadside stand selling less than 40,000 gallons per year	yes	no
retailers who package untreated juice for consumption off-site, including grocery stores	yes	no
retailers who sell for consumption on-site including restaurants, juice bars, and children's lemonade stands	no	no

**PRESIDENT CLINTON ANNOUNCES NEW MEASURES
TO INCREASE SAFETY OF FRESH JUICES**

April 20, 1998

Today President Clinton will announce the publication of two new proposed rules to increase the safety of fruit and vegetable juices. The new regulations would effect all juices, but have special provisions to help control illnesses that may come from fresh, unpasteurized juices, and require labels to alert those most at risk of food-borne illness such as children and the elderly. The rules would require most juice processors to implement a Hazard Analysis and Critical Control Point (HACCP) program, and require processors of fresh juices to greatly reduce the number of microbes in their products. HACCP is a state of the art, science-based method in which food producers develop plans that identify and control potentially dangerous points in the production process. The proposed rules also would require that all packaged fresh juice be labeled with a warning advising consumers of the potential risks of juice that has not been processed to eliminate harmful bacteria. The Food and Drug Administration estimates that there are up to 48,000 cases of juice-related illness each year.

The application of the HACCP rules to juices is part of the President's Food Safety Initiative. HACCP rules have already been promulgated by the Administration for meat, poultry, and seafood.

Reducing Hazards and Increasing Safety for Fresh Juices. The new HACCP rule would require processors that sell fresh, unpasteurized fruit and vegetable juices to take extra steps to reduce the number of microbes in their products to an amount roughly equivalent to that achieved by pasteurization. Juice processors would be free to implement any method that achieves a targeted 100,000-fold reduction in the numbers of microbes in the finished product including pasteurization, washing, scrubbing, antimicrobial solutions, alternative technologies, or a combination of these techniques. The HACCP proposed rule also would require processors to develop standard operating procedures under HACCP for monitoring plant and equipment sanitation and to keep records to ensure product safety. Retailers of packaged juice such as grocery stores and very small processors would not be subject to the HACCP requirement, but would be required to have warning labels on their products. Locations where juice is consumed on premises, such as a child's lemonade stand, juice bar, or restaurant would not be affected by the HACCP or labeling requirements.

Providing Warning Label for Consumers. The President will announce additional proposed rules that would require warning labels on juice products that have not been processed to reduce microbial risk. These labels would state that the product has not been treated to eliminate microbes; that the product may contain pathogens known to cause serious illness; and that the risk is greatest for children, the elderly, and people with weakened immune systems. These labels would be required for all packages of untreated, fresh juices but not for juice sold for on-site consumption such as in restaurants. The Administration expects to finalize this rule in time for the apple harvest this September.

Q: Why are you just limiting to 10 grantees the first year?

A: Permitting local communities to use CDC dollars to support needle exchange programs is a new activity for the federal government and raises a complex set of issues to be addressed at the federal and local levels if the maximum public health potential of needle exchange programs is to be realized. This includes developing a technical assistance capacity so that grantees can successfully integrate comprehensive HIV prevention programs with substance abuse prevention, treatment, and education efforts. This initial period would be used to understand how to make implementation of needle exchange programs funded with CDC dollars most successful, particularly among areas targeted because of the significant role of intravenous drug use in the spread of HIV. As well, we want to start efforts in those areas hardest hit and severely impacted by AIDS and HIV transmission related to illegal drug abuse.

Q: Why is HHS creating restrictive criteria when it says the science support the effectiveness of needle exchange programs in preventing HIV?

A: The majority of people served by needle exchange programs are hard-core, older drug users that require a complex array of services. We need to learn with the States and localities that choose to utilize needle exchange programs just how best to appropriately use federal funds to serve this population. With that knowledge, we will help other communities that seek assistance in maximizing the effectiveness of needle exchange programs in preventing HIV transmission and in getting addicts into treatment. These programs are appropriate only as part of a larger package of service, and we want to make sure that federal funds are used only for those programs that are appropriately integrated.

Q: How will you decide which ten to fund if you receive more applications?

A: In reviewing a grantee's request to modify its existing plan and redirect HIV prevention dollars, we will prioritize those areas hardest hit and severely impacted by AIDS and HIV transmission related to illegal drug abuse, that demonstrate the role that intravenous drug use plays in the spread of HIV in the grantee community, including the role of intravenous drug use in the spread of HIV in women of childbearing age (e.g., high incidence or rate of new cases of HIV/AIDS related to intravenous drug use, high incidence or rate of new cases of HIV/AIDS infection in women of childbearing age). In addition, we will assess the grantees' capacity to successfully implement the program consistent with the requirements and conditions established by the Secretary (e.g., local choice/support, mandatory referral to drug treatment services, needles provided on a replacement basis only, programs must be part of a comprehensive HIV prevention program, etc.).

Q: When will you be willing to expand the number of grantees?

A: Over the next year, we will monitor the grantees' implementation of needle exchange programs to assess their success in integrating comprehensive HIV prevention programs with substance abuse prevention, treatment, and education efforts, and access to medical care. We will also assure CDC's ability to provide the necessary technical assistance to grantees. This will help us determine the potential expansion of the number of eligible programs.

Q: Does HHS have the legal authority to limit the number of grantees which can use the dollars for needle exchange programs?

A: Yes.

Q: Isn't it unusual to limit the number of eligible grantees?

A: No. Available funds are often limited to a set number of applicants. But remember, these are programs that are already receiving federal funds, and this won't change the amount of money any community receives. It will simply allow some interested grantees to redirect available funds to another HIV/AIDS prevention activity if they choose to.

Q: What's the nature of this technical assistance from the CDC?

A: The technical assistance will be targeted to integration of comprehensive HIV prevention programs with substance abuse prevention, treatment and education efforts, and medical services; development of a cadre of peer technical experts; and outreach efforts to high risk populations to facilitate entry into a network of services.

APR 17 1998

NOTE TO BRUCE REED:

As we discussed, the following Qs and As reflect our suggested eligibility criteria for limiting the number of grantees that would be able to use their existing allotment of federal CDC HIV/AIDS prevention funds for needle exchange programs in the next year. Although fewer than 10 eligible grantees may request to redirect prevention dollars, if more grantees apply, we believe these criteria would appropriately start federal funding of needle exchange programs in those areas hardest hit by AIDS and HIV transmission related to illegal drug use. These eligibility criteria would be in addition to the conditions and requirements established by the Secretary (e.g., local choice/support, needle replacement only, mandatory drug referral, etc.)

Let's make sure we speak tomorrow. I can be reached through my pager at 1-800-800-7759.

Thanks --



Kevin Thurn

- ① 2nd time - new activity for Federal (complex)
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1) The Department intends to make available CDC HIV prevention funds to up to ten grantees which submit requests for modifying their existing plans and redirect their funds to support needle exchange programs consistent with the criteria laid out by the Secretary.

Q: Once the Secretary certifies, does HHS have the legal authority to limit the number of grantees which can use the dollars for needle exchange programs?

A: Yes.

Q: Why is HHS limiting the number of eligible grantees to up to ten?

A: Permitting local communities to use CDC dollars to support needle exchange programs is a new activity for the federal government and raises a complex set of issues to be addressed at the federal and local levels if the maximum public health potential of needle exchange programs is to be realized. This includes developing a technical assistance capacity so that grantees can successfully integrate comprehensive HIV prevention programs with substance abuse prevention, treatment, and education efforts. This initial period would be used to understand how to make implementation of needle exchange programs funded with CDC dollars most successful.

Q: How will you choose which ten grantees can proceed?

A: All grantees which meet the rigorous criteria established by the Secretary are eligible to apply. In reviewing a grantee's request to modify its existing plan and redirect HIV prevention dollars, we will assess the grantee's capacity to successfully implement the program consistent with the criteria; if so determined, we will approve up to ten.

Q: How will you determine when, if ever, to permit other grantees to use funds to support needle exchange programs?

A: Over the next year, we will (1) monitor the implementation of these needle exchange programs to assess their success in integrating comprehensive HIV prevention programs with substance abuse prevention, treatment, and education efforts, and access to medical care; and (2) assure CDC's ability to provide the necessary technical assistance to grantees.

This will help us determine the potential expansion of the number of eligible programs.

CITIES SORTED BY NUMBER OF NEW CASES

Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported July 1995 through June 1996, July 1996 through June 1997; and cumulative totals, by area and age group, through June 1997, United States

Metropolitan area	July 1995- June 1996		July 1996- June 1997		Cumulative Totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children 13 years old	Total
New York, N.Y.	11,303	131.0	10,129	117.2	85,375	1,628	97,003
Los Angeles, Calif.	8,089	41.8	8,231	35.4	35,753	271	36,024
Washington, D.C.	2,066	45.4	2,319	44.2	17,426	152	17,578
Houston, TX	1,332	35.0	1,806	47.6	14,988	126	16,114
Miami, Fla.	2,356	115.1	1,799	66.6	18,757	448	19,205
Philadelphia, Pa.	1,697	54.3	1,589	62.1	13,908	211	14,119
Newark, NJ	1,525	78.7	1,552	80.0	13,723	237	14,036
Baltimore, Md.	1,516	61.4	1,329	61.8	10,583	186	10,769
Chicago, Ill.	1,309	23.5	1,437	18.6	16,544	199	16,743
Atlanta, Ga.	1,768	51.4	1,416	40.0	12,734	93	12,827
San Juan, P.R.	1,300	66.3	1,381	70.2	12,048	228	12,276
San Francisco, Calif.	1,785	108.5	1,376	83.1	24,748	37	24,785
Fort Lauderdale, Fla.	1,221	86.4	1,127	78.4	9,711	224	9,937
Boston, MA	1,129	19.6	952	16.4	10,895	168	11,063
Dallas, TX	1,007	33.8	904	29.7	10,017	35	10,052
San Diego, Calif.	1,140	43.4	810	30.5	8,689	49	8,738
West Palm Beach, Fla.	833	85.3	725	73.0	5,594	186	5,880
New Haven, Conn.	855	52.6	570	41.1	5,160	120	5,280
Nassau-Suffolk, N.Y.	639	24.1	564	25.0	5,395	83	5,478
Tampa-Saint Petersburg, F	752	34.5	656	29.8	6,485	85	6,570
New Orleans, La.	730	55.5	640	48.7	5,461	56	5,517
Jersey City, N.J.	631	114.5	605	109.8	5,528	113	5,641
Detroit, MI	724	16.8	578	13.4	5,984	64	6,048
Riverside-San Bernardino,	658	32.2	562	18.6	5,423	47	5,470
Oakland, CA	663	30.2	548	24.8	6,787	39	6,826
Bergen-Passaic, N.J.	490	37.5	520	39.7	4,489	69	4,558
Seattle, WA	540	24.5	496	22.2	5,689	18	5,707
Orlando, FL	589	42.5	495	34.9	4,307	68	4,375
Norfolk, VA	545	35.5	492	31.9	2,676	57	2,733
Saint Louis, Mo.	436	17.2	418	16.4	3,766	31	3,797
Hartford, Conn.	511	46.0	412	37.1	3,065	46	3,111
Buffalo, NY	46	3.9	385	32.8	1,273	15	1,289
Las Vegas, Nev.	374	32.7	382	31.8	2,597	24	2,621
San Antonio, Tex.	374	25.6	369	24.8	3,166	26	3,192
Jacksonville, Fla.	386	39.3	367	36.4	3,458	65	3,523
Orange County, Calif.	514	19.8	358	13.6	4,636	27	4,663
Phoenix, AZ	462	17.4	333	12.1	3,698	12	3,710
Denver, CO	447	24.4	327	17.5	4,767	19	4,786
Fort Worth, Tex.	199	13.3	310	20.5	2,580	25	2,605
Rochester, N.Y.	323	29.7	302	27.8	1,741	11	1,752
Memphis, TN	302	28.3	290	26.9	2,103	15	2,118
Cleveland, Ohio	246	11.0	277	12.4	2,613	36	2,649
Austin, TX	293	29.1	276	26.5	3,041	19	3,060
Baton Rouge, La.	221	39.2	273	48.1	1,279	18	1,297
Nashville, Tenn.	293	26.8	272	24.3	1,867	16	1,883
Portland, Oreg.	354	20.6	269	15.3	3,270	8	3,278
Middlesex, N.J.	330	30.6	261	23.9	2,652	65	2,717
Louisville, Ky.	150	15.2	248	25.0	1,128	14	1,142
Richmond, Va.	279	30.1	246	26.3	1,946	25	1,971
Monmouth-Ocean, N.J.	288	27.4	236	22.2	2,380	59	2,439
Indianapolis, Ind.	332	22.5	229	15.3	2,285	13	2,298
Kansas City, Mo.	342	20.4	228	13.5	3,302	12	3,314
Minneapolis-Saint Paul, M	278	10.2	220	8.0	2,720	15	2,735

San Jose, Calif.	296	18.8	217	13.6	2,662	13	2,675
Wilmington, Del.	272	49.8	216	39.2	1,526	9	1,535
Sacramento, Calif.	277	19.0	213	14.4	2,611	24	2,635
Albany-Schenectady, N.Y.	210	23.8	193	22.0	1,340	20	1,360
Syracuse, N.Y.	78	10.4	182	24.4	952	7	959
Pittsburgh, Pa.	227	9.5	179	7.5	1,996	16	2,012
Columbus, Ohio	192	12.4	176	12.2	1,857	12	1,869
Springfield, Mass.	169	28.5	157	26.5	1,288	23	1,311
Birmingham, Ala.	211	23.7	156	17.4	1,385	19	1,404
Charlotte, N.C.	198	15.3	156	11.8	1,538	19	1,557
Providence, R.I.	167	18.4	154	17.0	1,548	15	1,563
Oklahoma City, Okla.	117	11.5	153	14.9	1,331	7	1,338
Raleigh-Durham, N.C.	173	17.4	152	14.8	1,528	21	1,549
Milwaukee, Wis.	162	11.1	151	10.4	1,573	14	1,587
Salt Lake City, Utah	175	14.6	141	11.6	1,257	14	1,271
Tucson, AZ	144	19.1	141	18.4	1,149	6	1,151
Albuquerque, N.Mex.	53	0.0	135	20.1	818	2	840
Greenville, S.C.	138	15.6	124	13.0	1,081	2	1,083
Cincinnati, Ohio	272	17.1	117	7.3	1,532	14	1,546
El Paso, TX	120	17.7	114	16.7	715	2	717
Sarasota, Fla.	122	21.2	108	20.4	1,102	21	1,123
Harrisburg, Pa.	93	15.2	104	16.9	603	5	608
Greensboro, N.C.	177	15.7	102	9.9	1,246	19	1,265
Little Rock, Ark.	86	15.8	96	17.5	821	10	831
Honolulu, Hawaii	141	16.2	95	10.9	1,459	11	1,479
Dayton, OH	116	12.2	91	9.6	808	15	823
Fresno, CA	145	17.1	89	10.3	953	13	966
Gary, Ind.	67	10.8	87	14.0	553	3	556
Mobile, AL	109	21.2	84	16.2	855	11	866
Tulsa, Okla.	90	12.0	83	11.0	872	8	880
Allentown, Pa.	105	17.1	78	12.7	629	8	637
Akron, Ohio	33	4.9	75	11.0	418	-	418
Omaha, Nebr.	64	9.5	72	10.6	588	3	591
Grand Rapids, Mich.	85	8.5	69	6.8	608	3	611
Ventura, CA	89	12.6	68	9.5	665	2	667
Bakersfield, Calif.	167	27.1	56	10.6	738	4	742
Knoxville, Tenn.	65	10.1	55	10.0	529	6	535
Stockton, Calif.	81	15.4	54	12.0	392	13	405
Tacoma, WA	69	10.6	62	9.4	636	8	644
Wichita, KS	78	15.3	61	11.9	562	2	564
Toledo, OH	65	10.6	56	9.2	468	10	478
Scranton, Pa.	32	5.1	39	6.2	337	4	341
Youngstown, Ohio	29	4.8	27	4.5	264	-	264
Ann Arbor, Mich.	38	7.3	24	4.5	304	7	311
Total	59,669	36.0	52,989	32.0	506,700	6,680	513,380

**CITIES SORTED BY
CUMULATIVE NUMBER OF ADULT/ADOLESCENT ONLY CASES**

Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported July 1995 through June 1996, July 1996 through June 1997; and cumulative totals, by area and age group, through June 1997, United States

Metropolitan area	July 1995- June 1996		July 1996- June 1997		Cumulative Totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children 13 years old	Total
New York, N.Y.	11,303	131.0	10,129	117.2	25,275	1,620	27,103
Los Angeles, Calif.	8,609	42.3	3,232	35.4	15,753	221	16,004
San Francisco, Calif.	1,785	108.6	1,376	83.1	24,749	97	24,785
Miami, Fla.	2,356	115.1	1,799	86.6	18,657	148	19,205
Washington, D.C.	2,056	45.8	2,619	44.2	17,426	252	17,678
Chicago, Ill.	1,809	23.5	2,437	18.6	16,544	199	16,743
Houston, Tex.	1,332	35.8	2,308	47.6	14,988	136	15,124
Philadelphia, Pa.	1,697	34.3	1,589	32.1	13,908	211	14,119
Newark, N.J.	1,525	70.7	1,552	80.0	13,739	297	14,026
Atlanta, Ga.	1,768	51.4	1,416	40.0	12,734	93	12,827
San Juan, P.R.	1,300	66.3	1,381	70.2	12,048	228	12,276
Boston, MA	1,129	19.6	952	16.4	10,895	168	11,063
Baltimore, Md.	1,516	61.4	1,529	61.8	10,583	186	10,769
Dallas, TX	1,007	13.8	904	29.7	10,017	35	10,052
Fort Lauderdale, Fla.	1,221	86.4	1,127	78.4	9,713	224	9,937
San Diego, Calif.	1,140	43.4	810	30.5	8,689	49	8,738
Oakland, CA	663	30.2	548	24.0	6,787	39	6,826
Tampa-Saint Petersburg, F	752	34.5	656	29.8	6,425	95	6,570
Detroit, MI	724	16.8	578	13.4	5,984	64	6,048
West Palm Beach, Fla.	833	85.3	735	73.0	5,694	186	5,880
Seattle, WA	540	24.5	496	23.2	5,689	18	5,707
Jersey City, N.J.	631	114.5	605	109.8	5,528	113	5,641
New Orleans, La.	730	55.8	640	48.7	5,461	56	5,517
Riverside-San Bernardino,	658	22.2	562	18.6	5,423	47	5,470
Nassau-Suffolk, N.Y.	639	24.1	664	25.0	5,395	53	5,478
New Haven, Conn.	855	52.6	670	41.1	5,160	120	5,280
Denver, CO	447	24.4	327	17.5	4,787	19	4,786
Orange County, Calif.	514	19.8	359	13.6	4,636	27	4,663
Bergen-Passaic, N.J.	490	37.5	520	39.7	4,489	69	4,558
Orlando, FL	589	42.5	495	34.9	4,387	68	4,455
Saint Louis, Mo.	436	17.2	418	16.4	3,766	31	3,797
Phoenix, AZ	462	17.4	333	12.1	3,698	12	3,710
Jacksonville, Fla.	386	39.3	367	36.4	3,458	66	3,523
Kansas City, Mo.	342	20.4	228	13.5	3,362	12	3,314
Portland, Oreg.	354	20.6	269	15.3	3,270	8	3,278
San Antonio, Tex.	374	25.6	369	24.8	3,166	26	3,192
Hartford, Conn.	511	46.0	412	37.1	3,065	46	3,111
Austin, TX	293	29.1	276	26.5	3,041	19	3,060
Minneapolis-Saint Paul, M	278	18.2	220	8.0	2,720	16	2,736
Norfolk, VA	545	35.5	452	31.9	2,676	57	2,733
San Jose, Calif.	296	18.8	217	13.6	2,662	13	2,675
Middlesex, N.J.	310	30.6	261	23.9	2,552	66	2,718
Cleveland, Ohio	246	11.0	277	12.4	2,613	36	2,649
Sacramento, Calif.	277	19.0	213	14.4	2,611	24	2,635
Las Vegas, Nev.	374	32.7	382	31.8	2,597	24	2,621
Fort Worth, Tex.	199	13.3	310	20.3	2,580	25	2,605
Monmouth-Ocean, N.J.	208	27.4	236	32.2	2,380	59	2,439
Indianapolis, Ind.	332	22.5	229	15.3	2,285	11	2,298
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Wilmington, Del.	272	49.8	216	39.2	1,526	9	1,535
Honolulu, Hawaii	141	16.2	95	10.9	1,468	11	1,479
Birmingham, Ala.	211	23.7	156	17.4	1,385	19	1,404
Albany-Schenectady, N.Y.	210	23.8	193	22.0	1,340	20	1,360
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Louisville, Ky.	150	15.2	248	25.0	1,128	14	1,142
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Greenville, S.C.	138	15.6	124	13.8	1,081	2	1,083
Fresno, CA	145	17.1	89	10.3	953	13	966
Syracuse, N.Y.	78	10.4	182	24.4	952	7	959
Tulsa, Okla.	90	12.0	83	11.0	872	8	880
Mobile, AL	109	21.2	84	16.2	855	11	866
Albuquerque, N.Mex.	53	8.0	115	20.1	838	2	840
Little Rock, Ark.	85	15.8	96	17.5	821	10	831
Dayton, OH	116	12.2	91	9.6	808	15	823
Bakersfield, Calif.	167	27.1	66	10.6	738	4	742
El Paso, TX	120	17.7	114	16.7	715	2	717
Harrisburg, Pa.	93	15.2	104	16.9	683	5	688
Ventura, CA	69	12.6	58	9.5	665	2	667
Tacoma, WA	69	10.6	62	9.4	638	8	644
Allentown, Pa.	105	17.1	78	12.7	629	6	637
Grand Rapids, Mich.	65	8.5	69	6.8	608	3	611
Stockton, Calif.	81	15.4	64	12.0	592	13	605
Omaha, Nebr.	64	9.5	72	10.6	588	3	591
Wichita, KS	78	15.3	61	11.9	562	2	564
Gary, Ind.	67	10.8	87	14.8	553	3	556
Knoxville, Tenn.	65	10.1	65	10.0	529	6	535
Colorado, OH	65	10.6	56	9.2	468	10	478
Akron, Ohio	33	4.9	75	11.0	418		418
Scranton, Pa.	32	5.1	39	6.2	337	4	341
Ann Arbor, Mich.	38	7.3	24	4.5	304	7	311
Youngstown, Ohio	29	4.8	27	4.5	264		264
Total	59,069	36.0	52,989	32.0	506,700	6,680	513,380

TOP METRO AREAS FOR PEDIATRIC AIDS CASES REPORTED IN 1997

New York City
Houston
Philadelphia
Fort Lauderdale
Washington, DC
Chicago
San Juan
Boston
Miami
Baltimore

TOP TEN NEEDLE EXCHANGE PROGRAMS

New York City
Bridgeport
Chicago
Oakland
Los Angeles
San Francisco
Philadelphia
Seattle
Tacoma
Baltimore

Strongly encourage

* Targeting is less sustainable > a #

* Addit. baggage

Look closely at integration of drug treatment ←

- encourage wide array of places to apply

- High HIV - high-impact

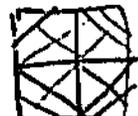
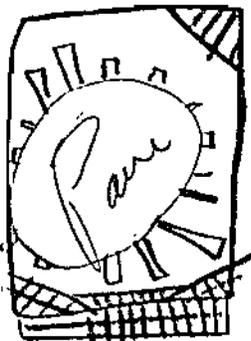
- Worst-hit -

1st come, 1st served

8 →

Worst HIV, worst pediatric AIDS ^{worst} ^{cases}, ^{worst} ^{most at-risk} IV drug use or

9. of ~~the~~ drug users among childbearing women of pediatric AIDS



301-907

0291





SIEWERT_J @ A1
04/17/98 03:29:00 PM

Record Type: Record

To: Bruce N. Reed

cc:

Subject: RNC'S NICHOLSON 'OUTRAGED' OVER CLINTON-GORE NEEDLE ...

Date: 04/17/98 Time: 15:23

bRNC's Nicholson 'Outraged' Over Clinton-Gore Needle Exchange Plan

To: National Desk, Political Writer

Contact: Mike Collins of the Republican National Committee,
202-863-8550

WASHINGTON, April 17 /U.S. Newswire/ -- Republican National Committee Chairman Jim Nicholson this morning charged that a Clinton administration effort to allow taxpayer-funded needle exchanges for heroin addicts "is giving aid and comfort to the enemy in the war on drugs."

"As Gen. Barry McCaffrey has rightly and courageously said, our message on drug use ought to be clear and unambiguous -- not a wink and a nod and 'I would have inhaled if I could have,'" Nicholson charged.

Published reports indicate that the White House is about to lift the congressional ban on needle exchanges, following a report by Health and Human Services Secretary Donna Shalala arguing that the program could blunt the spread of AIDS without encouraging drug use.

Contrary to Shalala's report, a study conducted by the Office of National Drug Control Policy, headed by Gen. McCaffrey, indicates that HIV infections were actually higher among users of free needles than among those who didn't have access to them. The McCaffrey study also indicates that the death rate from drugs soared after a free needle exchange program was instituted in Vancouver, British Columbia, in 1988, and that drug use soared as well. Moreover, the highest rates of property crime in the city occurred within two blocks of the needle-exchange site.

"It no longer comes as a surprise that the Clinton-Gore administration is willing to engage in reckless, counterproductive experiments just to pander to the extreme left-wing of the Democrat party," Nicholson charged, adding that "it shows how out-of-touch this administration really is."

-0-

/U.S. Newswire 202-347-2770/
APNP-04-17-98 1522EDT

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Sandra Thurman to Reed re: Senate Democrats Up in 1998 (2 pages)	ca. 1998	P5

**This marker identifies the original location of the withdrawn item listed above.
For a complete list of items withdrawn from this folder, see the
Withdrawal/Redaction Sheet at the front of the folder.**

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Bruce Reed (Subject File)
OA/Box Number: 21207

FOLDER TITLE:

Needle Exchange | 1 |

rs63

RESTRICTION CODES

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

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

**Attachment
Congressional Outreach**

House

Leadership -- **Gephardt, Gingrich**
Appropriations/L-HHS -- *Porter, Young, Obey, Pelosi*
Commerce/Health -- **Bilirakis, Ganske, Brown, Waxman**
Caucuses -- **Waters, Becerra, Norton, Johnson**

* Republicans who voted NO on Hastert and who could potentially be organized to send a "Dear Colleague" accompanied by the science and position statements by the AMA, etc.

Campbell (San Jose, CA)
Cooksey (Alexandria, LA)
Foley (Palm Beach, FL)
Frelinghuysen (Morristown, NJ) -- Appropriations
Ganske (Des Moines, IO) -- Commerce, Health
Greenwood (Bucks City, PA) -- Commerce, Health
Horn (Long Beach, CA)
Houghton (Jamestown, NY)
Johnson (New Britain, CN)
Kolbe (Tucson, AZ) -- Appropriations
Leach (Cedar Rapids, IO)
McCrery (Shreveport, LA)
Morella (Rockville, MD)
Shays (Bridgeport, CN)
Thomas (Bakersfield, CA)
Young (St. Petersburg, FL) -- Appropriations (L/HHS)

Senate

Appropriations -- **Specter, Harkin**
Labor -- **Jeffords, Frist, Kennedy**
Others -- *Hatch, Gorton*

Key

bold = supporters of needle exchange
italics = likely supporters of needle exchange

THE WHITE HOUSE
WASHINGTON

MEMORANDUM FOR BRUCE REED

FROM: Sandra L. Thurman /s
Director, Office of National AIDS Policy
(202)456-2437 /s

Date: April 15, 1998

Re: Needle Exchange

Attached please find a one pager on the importance of needle exchange for women and children, and a proposed roll out strategy. If there is anything else I can do, please do not hesitate to call. Thanks for hanging in there!

The Important Role of Needle Exchange in Saving the Lives of Children and Families

Background:

AZT has led to a 43% reduction in new cases of pediatric AIDS. The combination of needle exchange and appropriate medical services could help to bring this rate to zero. Needle exchange programs have been proven to reduce HIV transmission. This is particularly important for women and children. 61% of new HIV infection among women are related to IV drugs, 80% of new HIV infections in children are related to IV drugs.

Needle exchange programs provide an opportunity to help keep children from being born with HIV by reaching out to women of childbearing age and pregnant women, and linking them to essential services and support. Most of the most successful needle exchange programs have been developed in cities with large number of infection among women and children (i.e. NYC, Chicago, Los Angeles, and Philadelphia).

Suggested policy changes designed to target women, children, and families:

The Administration's needle exchange policy should ensure that programs make a special effort to reach out to women, children and families. This can be accomplished by:

- requiring all funded programs to serve those most in need, determined by local demographics of the target population; this means that areas with high rates of HIV among women and children will be required to make services for this population a priority; this is the language used in Ryan White to make sure that children and families receive proper attention.

- all funded programs will already be required to provide referrals for drug treatment and other health and support services; language could be added to ensure that, where appropriate, services are targeted to the needs of women and children; and

- the ongoing research and evaluation of the overall needle exchange program could be required to include information regarding participation in needle exchange programs by women and their families, and the role of needle exchange in reducing HIV transmission among children.

* This approach would place an appropriate emphasis on putting children first (600 last year) without sending the message that the Administration is not concerned with others that became HIV infected (40,000-60,000 last year). In addition, we know that to serve children, we must reach out to their parents. This is especially true in this context given that the children we are trying to save are yet unborn.

Suggested roll-out strategy designed to highlight the importance of this strategy for women, children, and families:

The Administration's needle exchange announcement should include the participation of the President of the Academy of Pediatrics -- either live or through press release. The AAP strongly supports needle exchange because of its importance in reducing pediatric AIDS by caring for women of childbearing age and pregnant women.

**Scientific Certification of the
Effectiveness of Needle Exchange Programs
Roll-Out Strategy**

Overall Roll-Out Goals

- To maximize positive exposure for the Administration as the guardians of public health and sound science; and
- To minimize the risk of negative exposure through appropriate planning and management of the roll-out, and through the inclusion of a broad array of mainstream supporters.

Summary of Basic Components

- Press Event/s
 - Press briefing on the science
 - Press conference on the Secretary's certification
- Supplemental Press Strategy/ Community Coordination
 - Major National Media -- print and electronic
 - Major Local/Regional Media Markets
 - Specialty Press (medicine/health, gay, black constituencies)
 - Editorial Boards
- Congressional Outreach
- Timing

Press Events

Scientific Press Briefing:

This 30-45 minute briefing would be designed to present and highlight the scientific evidence that has accumulated demonstrating that needle exchange programs reduce HIV transmission and do not encourage drug use. In addition, data demonstrating that needle exchange can be an effective bridge to treatment would also be presented.

Drs. Varmus, Leshner, Fauci, and Gayle could be present to show an impressive and united scientific front from HHS and to answer any scientific questions the press may have, including those related to the Montreal and Vancouver data. We might also include the authors of those studies.

The press would receive two handouts:

1. document summarizing the science and signed by all of the above described HHS docs. This has been completed and accompanied the Secretary's memo to the President.
2. an epidemiological profile showing the more than 50% and growing number of men, women, and children directly or indirectly HIV infected through IV drug use.

Press Conference:

This 30-45 minute press conference would be designed to highlight the broad based mainstream support for the Secretary in her certification of the scientific data on the effectiveness of needle

exchange. The photo is a "we are the world" shot with two or three recognizable individuals or organizations standing with her and speaking in support of her action. Following her statement and two or three other thematic statements, questions would be in order. Given that the scientific briefing would have preceded the press conference, questions would likely be limited to political realities.

Other possible speakers include:

American Medical Association or Academy of Pediatrics -- AMA could speak on behalf of the vast army of other medical and health organizations in support of needle exchange. Nancy Dickie is their new Board Chair and is an articulate Texas Republican with strong ties to Gov. Bush. In the alternative, Lonnie Bristow, their past Chair and emeritus, is African-American, and is now working closely with a new group called "Physician Leadership on Substance Abuse." Finally, Reed Tuckson, also African-American, is the AMA Vice President and former President of the March of Dimes. He is a pediatrician and could also talk about the relationship of IV drug use to pediatric AIDS (80% of cases).

Association of State and Territorial Health Officers -- ASHTO could speak on behalf of state and local health officials who are charged with the development and implementation of HIV prevention programs. It may be useful to have the Connecticut Health Officer represent ASHTO as a state with a Republican governor who funds a needle exchange program which is showing very promising results (New Haven). She could talk about the importance of states rights, local control, and needle exchange as part of a broadly supported comprehensive strategy that has saved lives in her state.

NAACP -- Kuwasi Mfume could speak for a range of organizations representing the African-American community including the NAACP, National Medical Association, National Urban League, National Black Police Association, and others to dispel the myth that the black community opposes this strategy. He could highlight the disproportionate impact of HIV on communities of color and explain why this action is consistent with, and an integral part of, the Administration's race initiative. Finally, as a former Member of the Congressional Black Caucus and the representative from Baltimore (which has a great needle exchange program), he has a few extras he can bring as well.

Former Administration Health Official -- It may be worth checking on an appearance by Lou Sullivan or Bill Roper. Throughout the Bush Administration, HHS often articulated the policy that when it came to HIV prevention, the federal government should neither force communities to take action they were not comfortable with or prevent them from taking action they thought was necessary to slow the spread of HIV. An appearance by either of these officials would provide significant cover with the Congress. Roper, former director of the CDC, is now Dean of the School of Public Health at the University of North Carolina. Collectively, the Schools of Public Health have passed a resolution in support of needle exchange. He could represent the group.

Other representatives could be present to show broad support for the Secretary's action. They would not be asked to speak but could be available as a resource to the Secretary (at her option) during the Q and A. These individuals and organizations might include:

- National Black Mayors' Conference
- US Conference of Mayors
- American Bar Association
- National Black Police Association: a member, Melvin Wearing, the Chief of Police for New Haven, is an extremely strong supporter of the needle exchange, and would probably be willing to attend. He has written to the Secretary asking her to move forward with this important action. He attended the White House Conference on 0-3 and sat on the panel with the President.
- AIDS organizations: AIDS Action, HRC, NAPWA, AMFAR, NORA
- Dr. Varmus (to show support on the science)
- Sandy Thurman (to show support from the White House)

Note: If there was a desire to streamline this press event, the press briefing-conference could be consolidated by adding Dr. Varmus to the speaking line-up at the press conference. He could present the science and then be available for the Q & A. Further, if the desire was to simply make this announcement on paper, without an event, we could work with friends at the Post and the NYT, who have shown an active interest in this issue, to produce a positive story. This could be supplemented by a written statement from each of the organizations applauding the Administration for its leadership.

Supplemental Press Strategy/Community Coordination

Major National Media: Beyond those in attendance at the press event, we would want to reach out to the national media to ensure that they have science and the Secretary's statement. In addition, our "friends" among the weekend "talking heads" should receive our information so that they can push the science during political round-table discussions. Finally, the Department will have to decide if spokes people.

Major Local/Regional Markets: To ensure positive stories in each of the major media markets, we would put together a list of health and AIDS point people on the ground in each of the markets who would be available to applaud the Administration's leadership and to help manage the story locally.

Specialty Press: Materials would be made available to the specialty press with a constituency interest in this issue including the gay press, the black community press, and the medical-health journals and newsletters. In each case, we would work with the appropriate constituency to ensure that materials from the Department were supplemented by press releases from the most relevant and influential organizations.

Editorial Boards: The Department should consider an editorial board mailing to the major papers. Again, we would talk with health and AIDS point people on the ground to follow up and to provide city specific epidemiological data and any information from needle exchange programs that are currently operating. It would certainly not hurt to have papers like the Philadelphia Inquirer and the Chicago Tribune do editorials in support of the Secretary's leadership and the soundness of this policy.

Congressional Outreach: To maximize positive relations with the Congress, the document summarizing the science and the Secretary's certification should be delivered to Capitol Hill leaders with special attention given to Labor-HHS Appropriators and authorizers. A call to Porter and Specter from the Secretary or Rich Tarplin would also help. In addition, caucus chairs (Black, Hispanic, and Women's) and friendly Republicans who may be inclined to support the Secretary's action (Johnson, Foley, Gansky) should be brought into the loop before they hear it through the media. Briefings by Dr. Varnus, et. al. should be offered to all of the above. We will actively follow-up with our moderate Republicans to produce a "Dear Colleague" letter in favor of the Administration's action.

How to Appropriately Limit the Number of Cities Authorized to Implement Needle Exchange Programs

- Limiting the number of cities authorized to use federal funds for needle exchange **in FY98** can be justified. After all, we are more than half way through the fiscal year and federal HIV prevention funds have already been obligated. To avoid disruption of existing services and to allow for adequate planning of new needle exchange programs, the number of cities authorized to re-program FY98 funds could be limited.

- FY98 eligibility could be limited to no more than 10 cities with a "demonstrated serious need", a currently operating program, and the ability to meet the 7 criteria required by the Congress and the Administration.

- Beginning in FY99, all states (50), localities (8), and territories (7) that receive federal HIV prevention funds should be authorized to use these funds for needle exchange if they so chose, and if they meet the required criteria.

- However, only cities directly funded by the CDC (8 - SF, LA, NY, Chicago, Houston, Philadelphia, DC, San Juan) would be authorized make this decision on their own, all other cities seeking to use federal funds for needle exchange programs would be required to get the support and approval of their state health department.

- While needle exchange programs are currently operating in 27 states, it is unclear how many cities will be able to convince their state health departments to dedicate federal funding for this purpose. For example, programs in CN, MA, MD, WA will have state support -- programs in AZ, LA and MI may not. While it is important to note that there will never be more than 65 maximum grantees authorized to implement needle exchange programs, it is likely that less than 25-30 grantees will opt into this demonstration. This is a small pool of grantees for any demonstration project.

- In addition, the criteria delineated by the Congress and the Administration are themselves designed to limit federal funding of needle exchange to only those programs that are "responsibly" implemented. These criteria includes approval from the state or local health official, links to drug treatment and other services, consistency with state and local laws, participation in ongoing research and evaluation, and more. It is anticipated that less than half (55-60) of existing needle exchange programs (110-120) would qualify.

- In the end, it is impossible to say that the Administration is "following the science" if we certify that these programs save lives, and then do not allow state or local health departments to implement them if they so chose.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Melissa T. Skolfield

Assistant Secretary for Public Affairs

Phone: (202) 690-7850

Fax: (202) 690-5673

To: Bruce Lead

URGENT

Fax: 456-5542 Phone: _____

Date: 4/17/98 Total number of pages sent: 2

Comments:

FMI

**Questions and Answers on Washington Times Story on Needle Exchange
April 17, 1998**

Q: Has General McCaffrey been left out of the needle exchange decision?

A: No, because a decision has not been made. It's important to note, however, that Congress has specifically placed authority for making this decision with the Secretary of Health and Human Services. Congress has prohibited the use of Federal AIDS prevention funds to support needle exchange programs unless the Secretary of Health and Human Services certifies that needle exchange programs reduce the transmission of HIV and do not encourage the use of illegal drugs.

In February 1997, Secretary Shalala reported to Congress that a review of scientific studies indicated 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 while HHS continues to look at this issue, Secretary Shalala has not yet concluded that needle exchange programs do not encourage drug use -- the standard set by Congress if the ban on federal funds is to be lifted.

Q: But the Washington Times reported that Secretary Shalala could announce a decision as early as Monday. Is this true?

A: Secretary Shalala will make an announcement when she feels that the science is there.

Q: Is the Administration split on this issue?

A: No. We all share the view that the Administration should not take any action that might send young people conflicting signals about the use of illegal drugs. The intravenous use of drugs is illegal, unhealthy and wrong. It is clearly a major health problem as well as a law enforcement concern. And while HHS continues to look at this issue, Secretary Shalala has not yet concluded that needle exchange programs do not encourage drug use -- the standard set by Congress if the ban on federal funds is to be lifted.

Q: But General McCaffrey says that needle exchange programs will have a "nutball effect" attracting drug users and other undesirables to areas that implement needle exchange programs. Is this true?

A: Congress has made clear that needle exchange programs must not encourage drug use, and Secretary Shalala shares that concern. That's why she has been studying this issue so thoroughly for so long. And while HHS continues to look at this issue, Secretary Shalala has not yet concluded that needle exchange programs do not encourage drug use -- the standard set by Congress if the ban on federal funds is to be lifted.

*** TX REPORT ***

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FAX TRANSMISSION

WHITE HOUSE
2 FLOOR/WEST WING
WASHINGTON, DC 20502
(202) 456-6515
FAX: (202) 456-2978

To: Rich Tarplin
Fax #: 690-7380
From: Bruce Reed
Subject Tobacco
:

Date: April 17, 1998
Pages: 11, including this cover sheet.

COMMENTS:

Following is a 10-page fax from Matt Meyers -- FYI.

THE WHITE HOUSE

WASHINGTON

April 13, 1998

James R. McDonough
Director, Strategy
Office of National Drug Control Policy
750 17th Street NW
Washington, DC 20503

RE: Needle Exchange Correspondence Dated April 10, 1998

Dear Mr. McDonough:

I very much appreciate your sharing the perspective of ONDCP regarding the issue of needle exchange (letter dated April 10, 1998), and your impressions of the program in Vancouver. However, many of the conclusions and statements that were made perpetuate erroneous and incorrect interpretations of scientific studies.

The science is clear and convincing.

It is stated that, "the science is uncertain" and "insufficient." I strongly disagree. In fact, Dr. Varnus, the Director of the NIH, recently reconfirmed before Congress that the science was adequate to support a certification by the Secretary that needle exchange programs reduce HIV infection without encouraging illegal drug use. Nevertheless, I thought we had agreed to let the Secretary of HHS, with support from the public health experts, make these "scientific determinations."

ONDCP continues to cite studies of NEPs done in Montreal and Vancouver as evidence that they don't work. We have expressed our concern regarding the manner in which those studies have been cited, and have been subsequently joined (in an op-ed in the *New York Times*) by the authors of those studies. While both initially show a higher incidence of HIV infection among participants in the NEPs than the general population, it is because these programs specifically target those at highest risk for HIV infection. Even among this hard-to-reach population, the Vancouver NEP now shows a reduction in HIV infection. Arguing the adequacy of the science in opposition to virtually every major medical and public health organization and journal weakens the credibility of this Administration.

Public health benefits outweigh the risks.

There is no evidence that HIV transmission rates are declining, as is stated. We do know that injection drug users, their partners, and their children are increasingly impacted by this epidemic--as many as 55 to 82 new infections every day. According to the scientists, NEPs reduce HIV infections without encouraging illegal drug use. Therefore, the public health benefits clearly outweigh any theoretical risks. Clearly, an effective HIV prevention strategy with no encouraging effect on illegal drug use should be an option for those health officials who deem it to be appropriate. As for drug prevention, I wholeheartedly agree that much more needs to be done and welcome the leadership of ONDCP in this area.

Needle exchange and drug treatment are wholly compatible and mutually supportive.

I agree that "needle exchange programs should not be funded instead of treatment." This has never been under consideration by this Administration. Quite the contrary, we have joined ONDCP in emphasizing the critical importance of increasing drug treatment services. The Congressional funding restriction currently under review by this Administration pertains to funds currently available to states and localities for HIV prevention, not drug treatment.

We will continue to work with HHS and ONDCP to support more drug treatment funding. It is worth noting that several cities with successful needle exchange programs such as Philadelphia, Baltimore, and San Francisco have been able to double their drug treatment budgets since their NEPs began.

Federal funding, and the federal imprimatur on the science, are absolutely critical.

While some state and local governments are demanding the option to use their federal HIV prevention funds for needle exchange programs, others are awaiting a public health determination by the Federal government before proceeding. Certifying that needle exchange programs are efficacious in reducing the spread of HIV without encouraging illegal drug use is a critical message to those state and local communities struggling with this issue. They are simply looking for leadership on this issue, and it is our responsibility to provide that leadership.

Congress will not abandon its investment in AIDS care, research, and prevention because needle exchange programs are funded.

We are not aware of any Member of Congress that has even suggested that AIDS funding for care, research, and prevention be reduced or abandoned in order to fund needle exchange programs. In establishing the criteria under which it felt needle exchange programs could be funded, Members of Congress indicated that they understood that needle exchange is an important but single strategy that must be seen as part of a comprehensive plan designed to deal with two complex epidemics.

What Congress has demanded is that this Administration provide direction and leadership on reducing the number of new infections so that the human and financial hemorrhaging can be stemmed.

Allowing state and local communities the option to use their HIV prevention funds for needle exchange programs in no way undermines our drug-control program.

Hypodermic syringes are not the cause of illegal injection drug use any more than matches are the cause of illegal marijuana use. However, the sharing of hypodermic syringes is directly contributing to the spread of deadly blood-borne diseases in this country. Needle exchange programs quite simply allow for the exchange of used syringes for clean ones, not handing them out on the street corner. Moreover, the scientific studies clearly show that NEPs are reaching hard-core drug users that are otherwise unreachable and offer our best and perhaps only chance of encouraging their acceptance of drug treatment.

Supporting NEPs sends a message to America that we care about our children.

The sharing of needles is the largest factor in the spread of HIV among children. NEPs offer the best hope of significantly reducing the number of babies born with HIV. That is why the Academy of Pediatrics is such a strong supporter of NEPs. Giving local communities the option to use their funds for needle exchange programs sends the message that we care about these children and their mothers. It is also a statement that we believe treatment works, and that we want drug users to stay alive so that they can avail themselves of the benefits of treatment.

NEPs are an integral component of programs that serve disadvantaged neighborhoods drowning in illegal drug use.

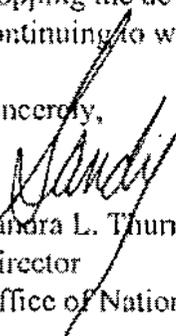
These communities are already in crisis not because of NEPs, but because of drugs, crime, poverty, violence, and AIDS. In these communities, NEPs are often the only link people have to a way out of this pernicious cycle of addiction and despair. Again, needle exchange programs increase the need for drug treatment services, health care, housing, jobs, and other services. In many cases, they have proven to be a tremendous opportunity for a range of successful interventions with a population that has heretofore remained extremely difficult to reach.

To argue that NEPs "attract addicts from surrounding areas" supports their expansion, not their restriction. Only because the programs are scarce are drug users forced to travel to different communities to get clean needles. It is certainly also true, as your staff observed in Vancouver, that it is the ready availability of illegal drugs that attracts addicts, not needles.

The bottom line is that the science is there to support the Secretary's determination. This Administration has a moral obligation to do everything it can to stop the spread of this terrible disease. Giving states and local communities the option to use their federal HIV prevention funds for needle exchange programs is an essential step if we are ever to stop this epidemic.

While on occasion we might struggle to find common ground, I greatly appreciate your dedication to stopping the devastating impact that drug use and HIV/AIDS have on our nation. I look forward to continuing to work with ONDCP to address these difficult issues.

Sincerely,


Sandra L. Thurman
Director
Office of National AIDS Policy

cc: Erskine Bowles
Rahn Emanuel
Bruce Reed



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

April 10, 1998

The Honorable Sandy Thurman
Director
White House Office of National AIDS Policy
808 17th St., NW, 8th Floor
Washington, DC 20503

Dear Ms. Thurman:

Sandy
Wanted to let you know of a meeting yesterday between Director McCaffrey and Brskine Bowles to discuss needle exchange policy. Other participants included Rahm Emanuel and Bruce Reed. Mr. Bowles stated that he was keeping the President abreast of the ongoing discussion of this issue, to include providing him copies of recent correspondence between ONDCP and the AIDS Policy Office.

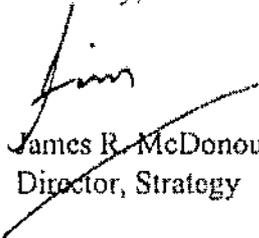
In summary, the concerns the Director has with moving forward on needle exchange at this time are as follows:

- **The science is uncertain.** It would be imprudent to take a key policy step on the basis of yet uncertain and insufficient evidence.
- **The public health risks outweigh benefits.** Each day, over 8,000 young people will try an illegal drug for the first time. Heroin use rates are up among youth. While perhaps eight persons contract HIV directly or indirectly from dirty needles, 352 start using heroin each day, and more than 4,000 die each year from heroin/morphine-related causes (the number one drug-related cause of death). Even assuming that needle exchange programs can further accelerate the already declining rate of HIV transmission, the risk that such programs might encourage a higher rate of heroin use clearly outweighs any potential benefit.
- **Treatment should be our priority.** Our fundamental moral obligation is to provide treatment for those addicted to drugs. Needle exchange programs should not be funded instead of treatment.
- **Federal dollars are not required.** State and local governments and the private sector can already fund NEPs.
- **Federal support of NEPs may undercut AIDS research, prevention and treatment.** If federal funds are allocated to NEPs, those who oppose AIDS research, treatment and prevention programs may argue why provide millions of federal dollars for these HIV/AIDS programs when the answer lies in a twenty-cents needle?

- **Federal support of NEPs may undermine other drug-control programs.** The use of taxpayer dollars to support needle exchange programs is a lightning rod issue. The President's *National Drug Control Strategy* is increasingly gaining support and making a difference. An Administration decision to alter course on NEPs and spend federal monies to buy drug paraphernalia could seriously undermine our ability to continue to carry out effective drug policies that enjoy bipartisan support.
- **Supporting NEPs will send the wrong message to our children.** By handing out needles we encourage drug use. Such a message would be inconsistent with the tenor of our national youth-oriented anti-drug campaign.
- **NEPs place disadvantaged neighborhoods at greater risk.** NEPs are normally located in impoverished neighborhoods. These programs attract addicts from surrounding areas and result in a concentration of criminal activity.

The bottom line is that General McCaffrey believes we should provide the President the opportunity to listen to the considered viewpoints of his Drug Policy Council before a decision is made to support needle exchange programs with federal funds.

Sincerely,



James R. McDonough
Director, Strategy

Enclosure
Vancouver Needle Exchange
Trip Report

THE WHITE HOUSE
WASHINGTON

April 14, 1998

MEMORANDUM FOR THE PRESIDENT

FROM: Bruce Reed
SUBJECT: Needle Exchange Options

As we discussed last night, we have a couple of alternatives to Secretary Shalala's recommendation on needle exchange. You should try to make a decision on this issue before you leave for South America.

Under all these options, the government's top scientists would certify that needle exchange decreases HIV transmission and does not increase drug use. The central question is whether (and under what conditions) to release federal funds. The three possibilities are:

1. Release funds with HHS criteria (Shalala recommendation). Shalala recommended letting any community with a needle exchange program that meets specified criteria -- i.e., program cannot violate state paraphernalia laws, must refer participants to drug treatment, etc. -- exercise a local option to use federal AIDS prevention funds for that purpose. The HHS criteria would cut the number of eligible communities in half, because only 50-60 of the 110-120 programs nationwide operate legally. (Moreover, only six cities -- San Francisco, Los Angeles, New York, Chicago, Houston, and Philadelphia -- receive direct funding from CDC for HIV prevention. All other funds go to state health departments, so other cities would need the approval of the chief health official in the state.) Shalala and Sandy Thurman support this option because it will help the most communities. Most White House advisors oppose it because opening the door this wide will be easy for Congress to demagogue and quickly overturn.

2. Limit funds to areas where HIV transmission is at emergency levels. We could reduce the universe of needle exchange programs still further by only allowing a set number of communities with the most severe drug-related HIV problems to qualify -- for example, areas with 25-30% of total AIDS cases directly or indirectly related to injection drug use. (There probably aren't enough cases of infected babies born to drug addicts -- perhaps 500 a year nationwide -- to make that a separate criterion.) HHS estimates that only 10-15 programs (mostly in the largest cities) would meet these conditions in FY98. HHS could live with this option if the limitations only apply to FY98 funds. We could characterize it as a demonstration project and an emergency measure, not necessarily a moral endorsement of needle exchange. Some in the AIDS community believe this option is unethical, because it withholds a known

treatment from people in need. On the other hand, it might be easier to defend in the public arena and perhaps hold onto in Congress. This option would make it somewhat harder for Congressional leaders to force a tough vote for Democrats, although the far right might succeed in demanding a needle exchange ban anyway.

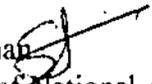
3. Withhold federal funds on the grounds that needle exchange is a local decision. The best way to prevent Congress from banning the use of federal funds is to take that issue off the table from the outset. Under this option, Shalala and government scientists would make a strong case for why communities with an HIV problem should consider needle exchange programs as a way to protect the public health. But we would make clear that because this is a contentious issue with nowhere near a national consensus, that decision and the money to pay for it must come at the local level. We would tell the AIDS community that this effort will do better over the long haul if we don't give Congress an opportunity to make political hay, and that the amount of federal money involved isn't worth the damage the right wing could do. Shalala, Thurman, and the AIDS community believe this option would make us look like cowards, because we'll never know whether we can win the Congressional battle unless we try. A number of White House advisors believe that battle is extraordinarily difficult to win in the short or long term, and this option is the only one that can withstand the Republicans' assault on the drug issue.

Obviously, there is no clear consensus on this issue. Shalala, Thurman, and others in the Administration closest to the AIDS community favor option 1 and could live with option 2, but oppose option 3. McCaffrey, Rahm, and others closest to the anti-drug community favor option 3 and oppose options 1 and 2. Most others in the White House oppose option 1 but could live with either option 2 or 3. If you believe we can hold onto a demonstration in Congress, you should probably go with option 2. If you believe Congress will ban this no matter what, needle exchange programs around the country would probably be better off if we went with option 3.

Erskine strongly recommends that you make up your mind before you leave tomorrow. The AIDS Council has another conference call tomorrow to decide whether to call for Shalala's resignation. No matter what you decide, it probably makes more sense to roll it out before Congress returns from recess.

THE WHITE HOUSE
WASHINGTON

MEMORANDUM FOR BRUCE REED

From: Sandra L. Thurman 
Director, Office of National AIDS Policy
(202) 632-1090

Date: April 14, 1998

Re: Needle exchange

Attached please find an outline of the compromise that we discussed this morning. In addition, there is a chart showing the narrowing of scope of eligibility. We have discussed the criteria on this chart with Kevin; the Secretary has also reviewed it and had only minimal comments. She believes, as do we, that we should be focusing on narrowing the scope of eligibility for FY98 funds because by FY99, we'll know where we stand with Congress.

Please call or page me if you need anything else. I am available!

Read

Needle Exchange

THE WHITE HOUSE
WASHINGTON

April 9, 1998

MR. PRESIDENT:

Tomorrow morning you are scheduled to meet with your senior advisers to discuss needle exchange. DPC has prepared a short summary/options memo describing the issues that remain for decision. We recommend you read the DPC memo.

In addition, both Secretary Shalala and General McCaffrey have sent you new memos on the issue. Sec. Shalala provides a detailed summary of the scientific arguments and research supporting needle exchange, and includes with her memo a number of detailed attachments (which we have in our office). McCaffrey argues the science is uncertain and offers a summary of arguments against needle exchange programs. We attach both their memos for your information.

Sean Maloney 

THE WHITE HOUSE
WASHINGTON

April 9, 1998

MEMORANDUM FOR THE PRESIDENT

FROM: Bruce Reed

SUBJECT: Needle Exchange

This memo presents you with several options on needle exchange, based on our prior discussions with you. It also provides further information on the positions of constituency groups and policy experts.

As you know elite opinion runs strongly in favor of needle exchange. Most scientists and public health experts who have studied the question also agree with HHS's conclusion that needle exchange decreases HIV transmission while not increasing drug use. (It is impossible to prove whether needle exchange programs actually reduce drug use, because it would be unethical to run a controlled experiment that compares addicts who have access to clean needles with addicts who do not.) Dr. Koop has a more complicated view. As Surgeon General, he visited a number of programs in Europe and concluded that (1) needle programs are not uniformly effective, but there is no evidence that they attract non-addicts to drugs; and (2) needle programs will not be very effective here, because most addicts are so far outside the mainstream that they will not show up reliably to exchange needles.

The AIDS community and the anti-drug community are miles apart. We might be able to muster half-hearted support from the Human Rights Campaign for the compromise options listed below, but most groups will be very disappointed if we do not accept Secretary Shalala's recommendation. (Of course, if we do accept this recommendation and Congress reverses the action, we will have to veto the bill in order to retain the groups' support.) Conversely, anti-drug advocates are likely to oppose needle exchange as strongly as they do drug legalization.

The options are:

1. Let Shalala certify and release funds. After certifying that needle exchange decreases HIV transmission and does not increase drug use, HHS could release the funds in any of three ways: (a) by publishing an interim final regulation, which would allow federal funds to flow to a community as soon as that community meets the qualifying criteria specified in the regulation; (b) by publishing a notice of proposed rulemaking, which would require a public comment period and would not take effect for two or three months; and c) by publishing program guidance, which would be accompanied by a similar comment period. The lagtime in options (b) and c) would give Congress time to overturn the decision to fund needle exchange programs prior to the distribution of any monies.

You had asked whether HHS could require, as a condition of funding, that communities confine their needle exchange programs to individuals actually participating in drug treatment. As a legal matter, HHS could take this action. HHS argues, however, that doing so would be bad public health policy, because it would discourage the most at-risk addicts from taking part in needle exchange programs. The AIDS groups are likely to share this view.

In addition, Elizabeth Birch from HRC has suggested that you could allow HHS to certify and then say nothing, one way or the other, about releasing federal funds. This approach, however, is difficult to understand. Nothing can be done quietly with respect to this issue. Either the Administration will release federal funds, in which case the approach is the same as Shalala's recommendation -- or the Administration will not release funds, in which case it begins to look much like option (3) below.

2. Let Shalala certify, but limit federal funds to a few demonstration cities. After certifying that needle exchange decreases HIV transmission and does not increase drug use, HHS would pick a number of communities (say, 5 or 10) for needle exchange "demonstrations." You would ask Shalala (perhaps with General McCaffrey) to study and report whether these demonstration programs work before releasing funding to any other communities. Members of Congress will find it harder to attack this approach than Option (1), because it does not constitute an endorsement of needle programs -- just a commitment to testing them. But HHS argues that (a) we do not need "demonstrations," because we already know that needle exchange works, and (b) all federally funded needle exchange programs are in some sense demonstrations, because all communities will have to submit evaluations of their programs to the Secretary. In addition, the AIDS community may give us scant credit for this limited release of funds, although Richard Socarides believes that the community would prefer this compromise approach to the one detailed below.

3. Let Shalala certify, but withhold federal funds. After HHS certifies that needle exchange decreases HIV transmission and does not increase drug use, you would announce the withholding of federal funds until Shalala and McCaffrey have had time to build a national consensus on the issue or to study the best ways of reconciling public health and drug control policies. Of all the options described in this memo, this approach is the least likely to provoke a Congressional response, because you have not actually released any funds for needle exchange programs. For the exact same reason, however, the AIDS community will like this approach the least. And as you heard at your meeting with her, Shalala also strongly opposes this option.

Koos

Amie Dundee
Glas

- can't do anything that goes against grain of local society.
- in Dundee, DOA
- Glasgow: Rx for needles
- Edinburgh: where should we take the dirty ones?
- no evidence that non-addicts shut up
- our drug addicts are in mainstream. In Scotland they have jobs
- diff kind of people here.
- * if drs. say no



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.

A handwritten signature in cursive script that reads "Donna E. Shalala".

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.

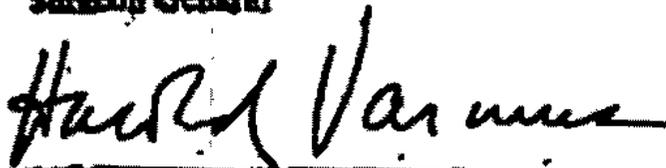
Therefore, based on the scientific data, we strongly recommend that you certify that needle exchange programs are effective in reducing the transmission of HIV and do not encourage the use of illegal drugs, and that the Congressional test regarding the use of Federal HIV prevention funds for needle exchange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



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



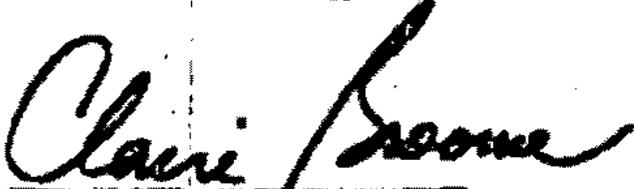
Margaret Hamburg, M.D.
Assistant Secretary for
Planning and Evaluation



Harold Varma, M.D.
Director
National Institutes of Health



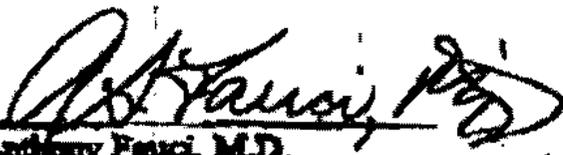
Nelsa Chavez, Ph.D.
Administrator
Substance Abuse and Mental Health
Services Administration



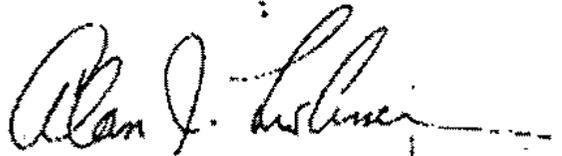
Claire Hecox, M.D.
Acting Director
Centers for Disease Control and Prevention



Eric P. Goody, M.D.
Director
Office of HIV/AIDS Policy



Anthony Fauci, M.D.
Director
National Institute of Allergy and
Infectious Diseases



Alan I. 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

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 (Brooner 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



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY

Washington, D.C. 20503

April 9, 1998

Rosen

Dear Mr. President:

'98 APR 9 PM 9:36

Met last Monday with Erskine, Rahm and others to discuss drug-related issues in regard to needle exchange. We all share a common concern about the devastating impact of AIDS. As your principal advisor on counter-drug policies, felt we owed you a direct explanation of the risks involved in lifting the ban on federal funding for needle exchange programs.

- **The science is uncertain:** Have personally, and with great care, reviewed the studies that proponents of needle exchange rely upon to support their cause. In every instance, supporters of needle exchange simply gloss over what are gaping holes in the data -- holes, which if filled would leave significant doubt that needle exchanges not only exacerbate drug use, but may not uniformly lead to a decrease in HIV transmission. We note that proponents of needle exchange are quick to seize upon the limits of studies that reflect the negative impacts of needle exchange, but quickly embrace even clearly flawed studies that support their position. One wonders if the science in this debate is as objective as it should be. Bottom line, it would be imprudent to take a major policy step on the basis of yet uncertain and insufficient evidence.
- **The public health risks outweigh benefits:** In the face of scientific uncertainty, the weighing of the potential risks and benefits of the decision to fund needle exchange programs takes on a far greater importance. Each day, over 8,000 young people will try an illegal drug for the first time. Heroin continues to exert a strong "counter-culture" pull on our young people, and the rate of heroin use is up among youth. In overwhelming numbers, the lives of these heroin users will be ruined; their families will be devastated. Many will die from the drug -- whether the death certificate says overdose, suicide, AIDS, tuberculosis, wound botulism, exposure, or violent crime. The ultimate cause of death is their addiction. We are concerned about the roughly 8 people per day who contract HIV through drug-related means. However, on balance, we are more disturbed by the 352 people per day who begin using heroin, and the roughly 4,178 people who die each year from heroin/morphine-related causes (the number one drug-related cause of death). Even assuming that needle exchange programs can further bring down the already declining rate of HIV transmission, the risk that such programs will encourage a higher rate of heroin use clearly outweighs any potential benefit.
- **Treatment should be our priority:** Our fundamental moral obligation is to provide treatment for those addicted to drugs. Unfortunately, the vast majority of needle exchange programs take the inexpensive route, passing out low cost needles without any follow on treatment. This, indeed, is not a solution. Rather, such programs are, at best, short-term controls on HIV transmission, which leave totally unchecked the ravages of drug addiction. These programs primarily serve to swap causes of death, not reduce numbers of deaths. Until such time as we can put federal dollars fully behind treatment, we are on morally indefensible grounds putting them behind needles.

- **Federal support of needle exchange programs will undermine all our other good efforts to fight drugs:** The use of taxpayer dollars to support needle exchange programs is a lightning rod issue. Your *National Drug Control Strategy* is increasingly gaining support and making a difference. An Administration decision to alter course on needle exchange and spend federal monies to buy drug paraphernalia could seriously undermine our ability to continue to carry out balanced, smart, and effective drug policies. There is little doubt that there is a staunch, organized resistance to needle exchange programs as sound government policy. Indeed, proponents of needle exchange must recognize that even if the Administration were to try to change this policy, the "victory" would be short-lived; the likelihood is that Congress would act swiftly to reverse this decision.
- **Federal support of needle exchange programs puts the most disadvantaged neighborhoods and people at greater risk:** The sad reality is that needle exchange programs are located in impoverished inner-city neighborhoods not wealthy suburbs. These programs become magnets pulling in addicts from surrounding areas (the first time many of these suburbanites will ever see these streets) and crime, making it that much harder for these communities and their residents to survive, let alone get ahead. The pervasiveness of drug culture in these areas puts children who are already at risk in greater jeopardy. The Vancouver study of the largest needle exchange program in North America failed to mention that drug-related deaths in the city skyrocketed from just 18 in 1988, to 200 in 1993. The current 1998 forecast is for 600 drug-related deaths in the province, the vast majority of which will occur in Vancouver. (My Deputy, Dr. Hoover Adger, just returned from a fact-finding trip to Vancouver; a copy of his trip report is attached.)
- **Opposition is passionate and widespread:** Since the March 31, 1998 sunset of the flat Congressional ban on Federal funding, numerous individuals and groups have written in opposition to needle exchange. The list includes: law enforcement organizations, such as the Fraternal Order of Police; physicians and treatment providers, especially those serving low income neighborhoods; parent groups; education groups; state and local prevention organizations; community anti-drug coalitions; inner-city community activist groups; rescue missions; and Evangelical Christian groups.
- **Facilitating drug use sends the wrong message to our children:** By giving drug users needles we facilitate drug use -- just as giving a drunk the keys to a car facilitates drunken driving. Presently, we are spending over \$195 million to wage a national campaign aimed at educating kids that "drugs are wrong, and they can kill you." The dramatic inconsistency between, on the one hand, telling our children that drugs are wrong, and, on the other hand, facilitating drug use, imperils our ability to reach our children.
- **The need for federal support of needle exchange programs is dubious:** A heavy heroin user will spend roughly \$100 a day on heroin. If the user can afford even half that amount for his or her habit, logic suggests that a twenty-cents needle is affordable.

Moreover, states, communities, and other interests remain free to use local or private monies to support needle exchange programs -- support which given the low costs of needles is not a hardship on them. The fiscal burdens of needle exchange programs on both the drug user and subfederal governments both, are not so burdensome as to justify the use of federal funds here.

- **Putting federal funds into needle exchange programs undercuts AIDS research, prevention and treatment:** The solution to AIDS is not to ameliorate the symptoms, but to find a cure. By allowing federal funds to go to needle exchange programs, we provide those who oppose AIDS research, treatment and prevention programs an easy, inexpensive out. Why, they will argue, support millions of federal dollars for these HIV/AIDS programs, when the answer lies in a twenty-cents needle? Rather than focus on the promising medical and scientific gains being made with new drug treatments, so called "altruist vaccines," and the like, we are diverted by a narrow side issue that for the vast majority of those both already infected and at risk will have no impact whatsoever on their lives.

Mr. President, a decision as important as this one must consider every possible outcome, positive as well as negative. Before moving ahead with so substantial a change in policy, strongly suggest that you charge the federal government with developing a more reliable, complete and objective understanding as to all the risks and benefits at issue here. Additionally, suggest that once the necessary information is developed, that the matter be referred by you to the PDPC for review and to prepare a recommendation to you.

Would welcome the opportunity to discuss this matter personally with you at your earliest convenience. Will continue to work closely with the members of your staff and the rest of the Cabinet to ensure that we continue to win the fight against drugs.

Very respectfully,


Barry R. McCaffrey

The President of the United States
The White House
Washington, D.C.



Reed |

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY

Washington, D.C. 20503

April 10, 1998

Bruce -

Dear Mr. Reed:

Wanted to share with you some of the deluge of letters we are receiving on needle exchange.

The groups represented here include some of the most important supporters of this Administration, for example police associations, community groups, and the medical community. Continue to believe that caution is the best course of action here.

Welcome your thoughts on the matter.

Very respectfully,

Barry R. McCaffrey
Director

Mr. Bruce Reed
Assistant to the President
The White House
Washington, D.C.



EXECUTIVE OFFICE OF THE PRESIDENT

OFFICE OF NATIONAL DRUG CONTROL POLICY

Washington, D.C. 20503

NEEDLE EXCHANGE LETTERS

Letters received as of 4/10/98 at 1600 hours

DRUG/SOCIAL POLICY GROUPS

1. Eagle Forum/Sheila Moloney, Executive Director
2. The Committees of Correspondence, Inc., Otto and Connie Moulton
3. Europe Against Drugs (EURAD), Renee Wikesjo, International Secretary
4. Concerned Citizens for Drug Prevention, Inc., Lea Palleria Cox, President
5. Statistical Assessment Service (STATS), David Murray, Bryan Kim
6. America Cares, Inc., Joyce Nalepka
7. Save our Society from Drugs (SOS), Betty S. Sembler
8. Drug Watch Colorado, Beverly J. Kinard
9. FORUM, Yesse B. Yehudah, Executive Director
10. Drug Free America Foundation, Inc., Terry Hensley, Executive Director
11. Drug Watch International, Omaha, Nebraska, Janet D. Lapey, MD, President
12. Letter to the Editor, New York Times from Drug Watch International, Omaha, Nebraska, Janet D. Lapey, MD, President
13. Drug Watch International, Arizona, Alex J. Romero, Executive Director
14. Empower America, William J. Bennett, Co-Director

RELIGIOUS GROUPS

1. Christian Coalition of Massachusetts, Evelyn Reilly, Executive Director
2. Central Union Mission, David O. Treadwell, Executive Director
3. Christian Drug Education Center, Beverly Kinard, President
4. Christian Coalition, Capitol Hill Office, Jeffrey K. Taylor, Acting Director of Government Relations
5. Focus on the Family, John Livoni, MD, Bradley G. Beck, MD
6. Family Research Council, Gary L. Bauer, President
7. Gospel Rescue Ministries, Edward J. Eyring, MD, PhD, President and Executive Director

COMMUNITY COALITIONS

1. Main South Alliance for Public Safety, William T. Breault, Chair
2. Community Awareness Action Team, Eleanor Scott, Vice Chairman
3. President of Northern Virginia Association, Parents' association to Neutralize Drug and Alcohol Abuse (PANDAA), Deborah Fosberg Nelson, President
4. Maryland Alliance for Drug Free Youth, Inc., Beverly S. Preston, Director
5. Connecticut Communities for Drug-Free Youth, Inc., Karin R. Kyles, President
6. New Jersey Federation for Drug-Free Communities, Linda B. Ledger, Vice President
7. PRIDE-Omaha, Inc., Susie Dugan, Executive Director
8. Drug-Free Workplace, Elizabeth Edwards, Board of Directors
9. Houston's Drug-Free Business Initiative, Calvina L. Fay, Executive Director

PRIVATE CITIZENS

1. Sally L. Satel, MD
2. James L. Curtis, MD, Director, Department of Psychiatry, Harlem Hospital Center and Clinical Professor, College of Physicians and Surgeons of Columbia University
3. Mr. Kevin L. Kiss
4. Jim and Carol Weber
5. Jean Schram, MA, CADC, CSADP
6. Margaret L. Petito
7. Mary L. Smith
8. Ambassador William T. Pryce, Council of the Americas

TREATMENT PROVIDERS

1. Human Service Center, John F. Gilligan, PhD, President
2. Phoenix House, Mitchell S. Rosenthal, MD

PARENTS/YOUTH PREVENTION ADVOCATES

1. Dare Unit, Michael D. Castrodale, Springfield Police Department
2. Illinois Drug Education Alliance (IDEA), Pat Sutarik, Managing Editor
3. Illinois Drug Education Alliance (IDEA), Judy Kremer, President
4. Sparta Township Public Schools, Charles E. Leach, Director of Curriculum and Staff Development
5. STATUS (Students are the ultimate solution), John W. Hewett, Founder
6. The Institute for Youth Development, Shepherd Smith, President
7. Parents' Pipeline, Inc., Sheila Fuller, Author and Publisher
8. National Families in Action, Sue Rusche, Executive Director
9. National Family Partnership, Judy Cushing, President



PHYLLIS SCHLAFLY
PRESIDENT
58 FAIRMOUNT
ALTON, ILLINOIS 62002
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EAGLE FORUM

LEADING THE PRO-FAMILY MOVEMENT SINCE 1972

316 PENNSYLVANIA AVE. S.E., SUITE 203 WASHINGTON, D.C. 20003, (202) 544-0353

April 9, 1998

General Barry R. McCaffrey
Director, ONDCP
750 17th St., NW
Washington, D.C. 20006
via fax: 202-395-6744

Dear General McCaffrey:

On behalf of Eagle Forum, I would like to thank you for your strong opposition to federally funded Needle Exchange Programs (NEPs).

The United States Government has no business taking American tax dollars and buying free needles for drug addicts. Congress recently affirmed this idea when it passed a ban on federally funded NEPs. Although this ban has expired, concern with and opposition to NEPs continues.

I realize that you have come under pressure recently from activists for your principled stand against NEPs. General McCaffrey, rest assured, these activists do not stand for the majority of the American people.

Americans are concerned about drugs and they are concerned about AIDS. But giving free needles to drug addicts is not the right way to address either of these problems plaguing our nation. General McCaffrey, please continue your fight against federally funded NEPs and know that you will have the support of Eagle Forum in your effort.

Sincerely,

Sheila A. Moloney
Executive Director

The Committees of Correspondence, Inc.

Drug Prevention Education

Connie & Otto Moulton

24 Adams Street, Denver, MA 01923-2718

Phone: 978-774-3626 Fax: 978-774-2641

April 9, 1998

FAX: 202-395-6744

General Barry McCaffrey
ONDCP
750 17th Street, NW
Washington, DC 20503

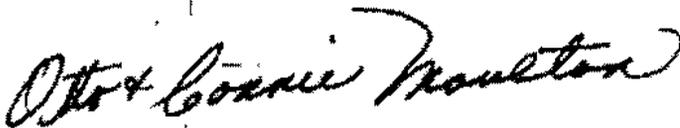
Dear General McCaffrey,

Our organization has been in existence since 1980 and was one of the founding members of the National Federation of Parents for Drug-Free Youth, Pride, and Drug Watch International. The Committees of Correspondence, Inc. represents over fifteen hundred supporters involved in strong drug prevention issues. We all support your courageous stand against the funding of needles to drug addicts.

The drug culture has been successful influencing high level government officials. The issue of Needle Exchange Programs should not be controlled by mob rule such as the Act Up organization and addicts who want no control over their drug use.

Stand firm against subsidizing drug use.

Sincerely,



Otto & Connie Moulton



From the desk of the Secretary

Renée Wikesjö
 P.O. Box 139
 254 23 Lomma, Sweden
 Phone +46 40 414559
 e-mail: w@sw.pnet.se
<http://www.inf.ie/~eurad>

Lomma, 8-4-'98

General Barry McCaffrey, Director

Office of National Drug Control Policy
 750 Seventeenth Street NW
 Washington, DC 20006

fax | 202-395-6744

We, the members of EURAD, Europe Against Drugs, support your resistance against the Needle Exchange Program.

With our experiences from Europe, we have seen how the N.E.P leads to a more permissive outlook on the drug-issue. It does not help the abuser, nor does it help society. It is very important for Europe, as for the rest of the world, that the USA stays firm in this issue.

Sincerely

Renée Wikesjö
 International secretary of EURAD

EURAD Foundation is not politically or religiously affiliated. EURAD works on all levels of society, specially the grass root organisation and closely with scientists and experts in the field of drug abuse for a drug free life style. EURAD is a non profit organisation. EURAD advocates a humane restrictive drug policy of prevention and early intervention called The Third Way. EURAD totally reject any kind of acceptance, medicalisation, integration, regulation, normalisation, decriminalisation and legalisation of dangerous drugs. EURAD respect the UN Conventions from 1963 (amended in 1972), from 1971 and 1988 for current and future drug control.

CONCERNED CITIZENS FOR DRUG PREVENTION, INC.
P. O. Box 2078
Hanover, Massachusetts 02339
Phone & Fax: *781-826-5598
*** Formerly 617 area code.**

TO: General Barry McCaffrey
Fax: 202-395-6744
Pages: 3

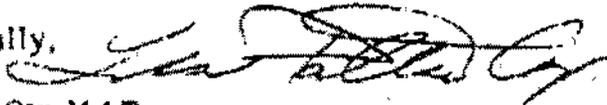
THE INFORMATION CONTAINED HEREIN IS SOLELY FOR THE ADDRESSEE AND REVIEW OR USE BY ANYONE OTHER THAN THE ADDRESSEE IS A VIOLATION OF CONFIDENTIALITY STATUTES. IF FAX IS INCOMPLETE OR ILLEGIBLE, PLEASE CONTACT SENDER.

Dear General McCaffrey:

On behalf of parents across the nation, we urge you to stand firm against free needles to addicts and continue to uphold and maintain the ban on federal funds for such programs. To facilitate the use of potentially lethal drugs - often leading to death and enslavement - under government auspices, is inhumane and unconscionable.

Just as there has been a strong, deceitful tobacco lobby, so too, is there a strong pro-drug lobby using marijuana as "medicine," "harm reduction," "free needles to addicts" and reduction of mandatory minimum sentencing as their vehicles toward the eventual legalization of drugs. They have courted and wooed many into believing that such concepts have validity, when there is no such proof. Heroin use has escalated across the country with NEP's serving as magnets for drug dealers. As one recovering addict in Boston has said: "Give me a needle, you give me death."

DPH's have long been apologizing for the Tuskegee experiment, so too, will they be apologizing for enabling users to inject poison, endangering the addict, his loved ones, and society in general. We implore you, do not allow federal funds to be used to enslave users into a life of addiction and risk collateral damage to neighborhoods:

Respectfully, 

Lea Pallera Cox, M.A.T.
President, Concerned Citizens for Drug Prevention, Inc.
Massachusetts Delegate, Drug Watch International

Our Goal - Drug-Free Youth

STATS

STATISTICAL ASSESSMENT SERVICE

Letters Editor
The Washington Post
1150 15th Street NW
Washington, DC
20071

Dear Editor,

Your claim ("Pr. George's Needle Plan Wins Vote" March 25) that "numerous federally funded studies have shown that needle exchange programs (NEP) nationwide have helped reduce new HIV infections..." overstates the scientific status of NEP effectiveness. The difficulty of conducting careful epidemiology with heroin addicts has been underestimated. Though some scientific bodies have offered endorsement of NEPs, all of the studies to date suffer from serious methodological limitations, including self-selection and self-reporting biases, inadequate samples, improper controls, and limited proxy measures.

In fact, the most recent and large-scale study conducted in Montreal, using a sophisticated observational design utilizing prospective and case-control methods, found a consistent and independent *positive* association between NEP attendance and risk of HIV infection.

Moreover, the promising figures you cite from Baltimore may not be reliable. The data are non-published and ignore the fact that surrounding counties, with which the Baltimore 20% putative decline in new HIV infection is contrasted, have a dramatically smaller level of HIV prevalence.

Health and Human Services Secretary Shalala is correct to insist that support for NEP must await more convincing science. To err on this issue, without strong evidence that dispensing needles to the addicted will neither place them at greater risk for HIV nor enhance the legitimacy of hard drug use, would be to perpetrate a public health tragedy.

Sincerely,

David Murray
Statistical Assessment Service
Washington, DC
202-223-3193

Bryan Kim
Statistical Assessment Service



April 9, 1998

General Barry McCaffrey
Office of Drug Control Policy
The White House

Dear General McCaffrey:

I am writing to convey my strong support for your opposition to federal funding for needle distribution/exchange to heroin addicts. Spend my tax dollars for prevention and treatment.

This, to me, is one of those "commonsense" issues that we are tempted to say, "Ask your grandmother." It's not that we don't appreciate research, General McCaffrey, it's just that it makes no sense to allow our government to expedite addiction.

Programs in Switzerland failed (See following article from The Washington Post, February 29, 1992.) Canadian studies show an increase rather than a decrease of HIV positives after needle distribution programs are implemented.

Finally, we did a survey of 1,400 citizens a few years ago when Maryland was considering needle distribution. 98.6% of all respondents were opposed. 21% of our sample was African American. 100% of African Americans were instantly opposed. The most memorable of the responses was from an African American man of approximately age 35 who responded, "What? Are they crazy? My mother is a diabetic. She raised five children. We went barefoot in the summer so she could save money to buy needles the rest of the year. And 'they're' going to give free needles to heroin addicts?"

We defeated needle distribution by one vote in the Maryland legislature against a very strong lobby effort by Mayor Schmoke. We were delighted. However, the following day a recall vote was held because the margin was not large enough to prevent it. Two Montgomery County representatives had "taken a walk" during the first vote. The vote was recalled and we lost by one or two.

However, a more recent vote during this session that would have established a needle distribution program in Prince George's County failed.

We would be happy to do the survey again with a staff member from your office to supervise it—if there's any doubt about how the public feels. We know we speak for citizens across the nation, and most certainly for and with the African American community, when we say, "Let's work harder to get addicts off needles and appropriate more money for prevention and treatment." We have never been a nation of drug users.

Joyce Nalepka
Joyce Nalepka
301-681-7861



April 9, 1998

The Honorable Barry McCaffrey
Director, Office of National Drug Control Policy
750 Seventeenth Street NW
Washington, D.C. 20006

Dear General McCaffrey:

Save Our Society From Drugs (S.O.S.) applauds your opposition to needle exchange programs. This type of "harm reduction" is absurd. These programs send a misleading message to our nation's youth. That message says using drugs is ok as long as your needles are clean. It is time for our country's leaders to realize that this is merely another guise to legalize dangerous drugs.

Once again, thank you General McCaffrey for taking the lead on this issue. We support your opposition to the fullest.

Sincerely,

A handwritten signature in cursive script that reads 'Betty S. Sembler'.

Betty S. Sembler
President

DRUG WATCH COLORADO

P. O. Box 740308
Arvada, Colorado 80006-0308

Phone: 303-423-2053
Fax: 303-403-9379

General Barry McCaffrey, Director
Office of National Drug Control Policy
750 Seventeenth Street NW
Washington, DC 20006

Fax No. 202-395-6744

Subject: Needle Exchange Funding

Dear General McCaffrey,

I met you in Denver when you did the kick-off for the media campaign against illegal drugs. I appreciate so much your firm stand against the drug legalization movement in this country and other nations.

As a Drug Watch International Delegate from Colorado, I'm sure you are aware of the work that we do confronting the illegal drug scene.

I just want to take this opportunity to tell you to **KEEP UP THE STRONG STAND AGAINST NEEDLE EXCHANGE PROGRAMS**. Thank you for doing the right thing in prohibiting our tax dollars from being used to fund such programs.

We realize the pressure from the other side is great but Ezekiel said in the Bible that we must confront what is wrong or the blood is on our hands.

We pray for your continued strength in fighting the legalization movement and also pray our Congress and HHS will stand strong against the NEPs.

Sincerely,

DRUG WATCH COLORADO



Beverly J. Kinard
Colorado Delegate to
Drug Watch International

Fulfilling

Our

Responsibility

U.L.T.

Mentor

April 8, 1998

General Barry McCaffrey
Director
Office of National Drug Control Policy
750 Seventeenth Street NW
Washington, DC 20006

Dear General:

For over 20 years FORUM has been on the front lines working to end the cycle of drug use and its effects on the development of inner cities throughout America. We have also worked with many of our nations constitutional representatives on the local, state, national and international level to implement drug prevention education initiatives. Therefore, we are in full agreement with your position not to support needle exchange programs.

Policies that involve our government in sanctioning needle exchange programs violate the constitutional interest of every citizen by contributing to a problem that has already destroyed too many American lives, families and communities. To develop the inner cities of America, we need policies that are constitutional, correct and courageous enough to solve the problem of drug use, crime, violence and other related behaviors. As you know, these types of problems have devastated communities throughout America and continue to cripple this nation and its citizens.

Your leadership on this very important issue is vital and strongly support your position against needle exchange programs. If you would like any information on the work that FORUM is doing, or if there is anything we can do to support you in this effort, please feel free to call on us at (773) 933-5700.

Sincerely,

Yesse B. Yehudah

Yesse B. Yehudah
Executive Director

Executive Director

Yesse Yehudah

Director

Phillip Bradley

Programs

Project C.R.A.N.G.E.

(Creating Healthy
Initiatives thru
Non-violence,
Guidance and
Education)

Maternal and Child
Health

Urban Effort

Housing Initiative

Job Opportunities

(Housing, Community
and Economic
Development for
families)

Health Education
and Outreach

Community Literacy
and GED Initiatives

Life Education

Center Library
Initiative

Serving the health
and needs of people
and institutions
everywhere



**Drug Free
AMERICA**
Foundation, Inc.

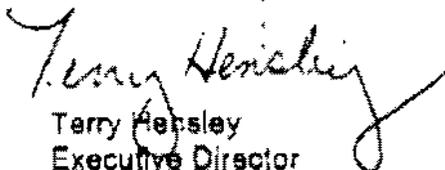
April 9, 1998

The Honorable Barry McCaffrey
Director, Office of National Drug Control Policy
Executive Office of the President
Washington, D.C. 20503

Dear General McCaffrey:

The Drug Free America Foundation, Inc. strongly encourages your effort to oppose needle exchange programs. This so-called "harm reduction" is what is influencing our nation's youth. Our citizens must be educated that this is merely another guise to legalize dangerous drugs. We do not support needle exchange programs or any other form of "harm reduction" or the confusing messages they convey.

Sincerely,


Terry Hensley
Executive Director

TH/alm

DRUG WATCH INTERNATIONAL
P.O. Box 45218
Omaha, Nebraska 68145-0218
(402) 384-9212
(402) 397-9924 Fax

April 9, 1998

The Honorable Barry R. McCaffrey
 Director
 Office of National Drug Control Policy
 Washington, DC 20503

Dear General McCaffrey:

Thank you very much for your stand against needle exchange programs (NEPs). In today's *New York Times*, Bruneau and Schecter, two of the authors of the Vancouver and Montreal studies, confirm that intravenous drug users (IDUs) who take part in NEPs in Montreal and Vancouver have higher HIV infection rate than non-NEP users. They then incorrectly state that this is because NEP users represent a higher risk group. It should be pointed out that 92% of Vancouver IDUs use the NEP! HIV/AIDS prevalence has increased from 1-2% to 23% during the 10 years the Vancouver needle program has operated (Strathdee SA et al, *AIDS* 11:F59-F65, 1997). Furthermore, Montreal study authors, Bruneau, Franco, and Lemothe, postulated that actually the reason for this increase of HIV in NEP-users could be because "the NEPs may facilitate the formation of new sharing groups, gathering together isolated IDUs" (*American Journal of Epidemiology* 146: 107-110, December 15, 1997). Needle programs give a green light to drugs

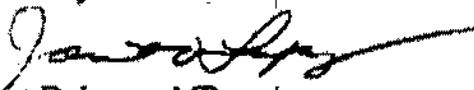
Indeed, NEPs may even function as buyers' clubs. Donald Grove, (*Harm Reduction Communication*, Spring 1996) has written that most NEPs "serve as sites of informal (and increasingly formal) organizing and coming together. A user might be able to do the networking needed to find good drugs in the half an hour he spends at the street-based needle exchange site-- networking that might otherwise have taken half a day." Many believe that the facilitation of drug use by NEPs is responsible for the increase in drug use which has accompanied the proliferation of NEPs.

Promoters of NEPs ignore the rising rate of drug use. In Vancouver, deaths from drug overdoses have increased over five-fold since 1988 when the Vancouver NEP started. Now Vancouver has the highest heroin death rate in North America, and is referred to as Canada's "drug and crime capital" (*The Washington Post* 4/2/97). Furthermore, Bruneau and Schecter note that in Montreal and Vancouver, cocaine is now injected 40 times a day, requiring virtually mountains of needles as the drug epidemic escalates.

Montreal study authors Bruneau, Franco, and Lemothe (*American Journal of Epidemiology* 146: 107-110, December 15, 1997) also noted that "evaluating the effect of NEPs per se without accounting for other interventions and changes over time may prove to be a perilous exercise." They conclude by stating that there is still no unequivocal evidence of benefit of NEPs. An example of this failure to control for variables is *The Lancet* NEP report highlighted by Bruneau and Schecter which compared HIV prevalence in different cities but did not compare differences in outreach/education and/or treatment facilities. In fact, a Chicago study (Weibel WW et al, *J. AIDS and Human Retrovirology* 12:282-289, 1996) showed that HIV incidence in IDUs dropped 71% through outreach/education alone without provision of needles.

Since NEPs have not been shown unequivocally to prevent HIV and since there is evidence that they increase drug use, our funds are better spent on outreach/education and treatment.

Sincerely,


 Janet D. Lapey, MD
 President, Drug Watch International

DRUG WATCH INTERNATIONAL**P.O. Box 45218****Omaha, Nebraska 68145-0218****(402) 384-9212****(402) 397-9924 Fax**

April 9, 1998

Editor

New York Times
229 W. 43rd Street
New York, NY 10016-3959

To the Editor

Bruneau and Schechter "The Politics of Needles and AIDS" (*NY Times* 4/9/98) state that intravenous drug users (IDUs) who take part in needle exchange programs (NEPs) in Montreal and Vancouver have higher HIV infection rate than non-NEP users. They claim that this is because NEP users represent a higher risk group. Yet, the Montreal study authors Bruneau, Franco, and Lemothe postulated that actually the reason for this increase could be because "the NEPs may facilitate the formation of new sharing groups, gathering together isolated IDUs" (*American Journal of Epidemiology* 146: 107-110, December 15, 1997).

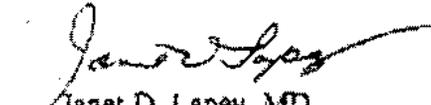
Indeed, NEPs may serve as buyers' clubs. Donald Grove, (*Harm Reduction Communication*, Spring 1996) has written that most NEPs "serve as sites of informal (and increasingly formal) organizing and coming together. A user might be able to do the networking needed to find good drugs in the half an hour he spends at the street-based needle exchange site-- networking that might otherwise have taken half a day." Many believe that the facilitation of drug use by NEPs is responsible for the increase in drug use which has accompanied the proliferation of NEPs.

In Vancouver, heroin use has risen sharply: deaths from drug overdoses have increased over five-fold since 1988 when the Vancouver NEP started. Now Vancouver has the highest heroin death rate in North America, and is referred to as Canada's "drug and crime capital" (*The Washington Post* 4/24/97). Furthermore, Bruneau and Schechter note that in Montreal and Vancouver, cocaine is now injected 40 times a day, requiring virtually mountains of needles as the drug epidemic escalates.

Montreal study authors Bruneau, Franco, and Lemothe also noted that "evaluating the effect of NEPs per se without accounting for other interventions and changes over time may prove to be a perilous exercise." They conclude by stating that there is still no unequivocal evidence of benefit of NEPs. An example of this failure to control for variables is *The Lancet* NEP report highlighted by Bruneau and Schechter which compared HIV prevalence in different cities but did not compare differences in outreach/education and/or treatment facilities. In fact, a Chicago study (Weibel WW et al, *J. AIDS and Human Retrovirology* 12:282-289, 1996) showed that HIV incidence in IDUs dropped 71% through outreach/education alone without provision of needles.

Since NEPs have not been shown unequivocally to prevent HIV and since there is evidence that they increase drug use, our funds are better spent on outreach/education and treatment.

Sincerely,



Janet D. Lapey, MD
President

Drug Watch International

Alex J. Romero, Arizona Delegate

Arizonans for Drug Free Youth

Executive Director

P.O. Box 83685

Phoenix, AZ 85071-3685

Ph: (602) 563-9469 Fax: (602) 942-6366

FAX*FAX*FAX*FAX

TO: General Barry McCaffrey, Director
Office of National Drug Control Policy
750 Seventeenth Street NW
Washington, DC 20006

FROM: Alex J. Romero, Executive Director
DATE: APRIL 8, 1998

REF: NEEDLE EXCHANGE POLICY

I am sending this brief note in support of the Office of National Drug Control Policy regarding Needle Exchange programs.

As the Founding President of Arizonans for Drug Free Youth and Communities, Inc., Chairman of the Community Partnership of Phoenix, Co-Chairman of the Governor's Alliance Against Drugs, and a member of the Executive Committee of Drug Watch International, I speak for many in the prevention community in Arizona who share our opposition to clean needle exchange programs and applaud your stand against those who promote the ill advised clean needle programs.

FROM EMPLOYER AMERICA
EMPOWER

AMERICA

(WED) 4 8 98 17:27:27 17-21 NO 4261672692 3

1776 I Street, NW, Suite 970
Washington, DC 20006
(202) 452-6200

Founding Chairman
Theodore J. Forstmann

Co-Directors
Lamar Alexander
William J. Bennett
Jack Kemp
Jeanne J. Kirkpatrick
Vin Weber

Chairman
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Vice Chairman
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Senator Trent Lott
Michael Novak
Dennis Prager
Julian H. Robertson, Jr.
Donald H. Rumsfeld
Judy Sheiton
John Skeen
Ward W. Woods

President and CEO
Jocette Shiner

April 8, 1998

General Barry McCaffrey
Director
Office of National Drug Control Policy
Executive Office of the President
Washington, D.C. 20500

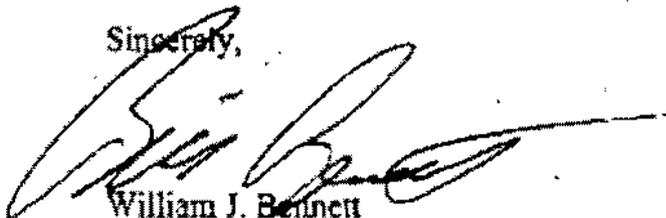
Dear Barry:

I strongly believe that the Administration must not reverse its position toward federal funding of needle exchange programs. As you have rightly pointed out, the problem isn't dirty needles; the problem is heroin [and crack] addiction.

Needle exchange is bad policy. It extends drug addiction among those who most need treatment; it sends the exact wrong message to children; it defies law enforcement and attracts drug abusers and dealers into neighborhoods; and -- despite claims to the contrary -- it is not proven to reduce the spread of AIDS. In fact, the reliably scientific study by McGill and Montreal Universities found a *positive* association between participation in needle exchange programs and risk of HIV infection.

I agree with Representative Charles Rangel, who has said, "I believe government has an obligation to do more than just help people use drugs more safely." The current federal policy is the right one. I support that policy and urge the administration to stand firm.

Sincerely,



William J. Bennett



CHRISTIAN COALITION OF MASSACHUSETTS

P. O. Box 1611, Waltham, MA 02254-1611 - Phone: 781-398-CCMA Fax: 781-398-1776

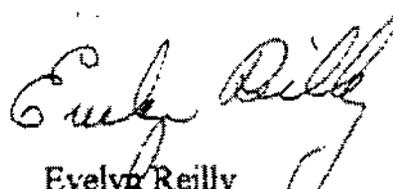
URGENT

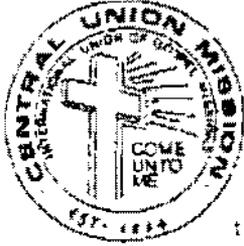
April 8, 1998

General Barry R. McCaffrey
Director, Office of National Drug
Control Policy

Fax: 202-395-6744

We have been informed that reversal of government policy prohibiting federal funds for needle exchange programs will be considered on Good Friday, April 10. We strongly oppose any change in the policy. We are aware of the Canadian studies that indicate that needle exchange programs only increase the number of addicts. Please stand firm against any change in this policy. Thank you.


Evelyn Reilly
Executive Director



CENTRAL UNION MISSION

"The Mission With A Heart . . . In The Heart Of The City"

1330 A Street, N.W. • Washington, D.C. 20004 • Phone (202) 745-2113 • FAX (202) 232-7072



April 9, 1998

GEN Barry R. McCaffrey
 Director, ONDCP
 750 17th St., NW
 Washington, DC 20006
 FAX: (202) 395-6744

Dear GEN McCaffrey:

I have received word from friends who are concerned about federal funding of The Needle Exchange Program that you are opposed to such funding. As one who has devoted much of his retirement years to serving disadvantaged men, women and families in The District of Columbia, I strongly support you in this effort.

My interest and concern in this area is based on first hand information from the men and women in our recovery programs and those who counsel them. Issuing free needles simply makes life that much easier for the addict and encourages his or her habit. In dealing with hundreds of men each week and a smaller number of women, we rarely encounter anyone whose health problems are related to a dirty needle.

As I believe you are aware, the high success rate of recovery enjoyed in the programs and ministries of Rescue Missions is the result of total lifestyle changes supported by our emphasis on genuine spiritual change of heart and soul in our clients. Free needles are just one more distraction for those who would otherwise turn to us for life-saving help.

Thank you for your efforts to place the Needle Exchange Program under the close scrutiny it deserves. Free needles is a bad idea that does not work.

Sincerely,

David O. Treadwell
 LTC, USA, Retired
 Executive Director

MINISTRIES

Overnight Shelter • Spiritual Recovery/Rehabilitation Program • Gospel Services • Holmes House • Family Services Program
 Teen Ministry • Literacy Training • Christmas Bag Program • Camp Bennett • Emergency Food Pantry
 Food/Clothing Distribution • Bible Study • Community Service • Radio Broadcast & Tape Ministry • Mothers Program

CHRISTIAN DRUG EDUCATION CENTER

P.O. Box 740308
Arvada, Colorado 80006
USA

Phone (303)423-2053
Fax (303)403-9379
Email cdec@integrityonline9.com

April 9, 1998

General Barry McCaffrey, Director
Office of National Drug Control Policy
750 Seventeenth Street NW
Washington, DC 2006

Fax No. 202-395-6744

Subject: Needle Exchange Programs

Dear General McCaffrey,

The Christian Drug Education Center is a center organized to educate people of all faiths across this nation and other countries about the harmful effects of illegal drugs.

Our supporters come from Colorado, Arizona, Tennessee, Massachusetts, Oregon, Washington State, Florida, the Phillipines and the Netherlands. The financial support comes from a variety of faiths.

My mailing lists total well over 5,000 people. This list includes all those who attended our Christian Conference on Addiction.

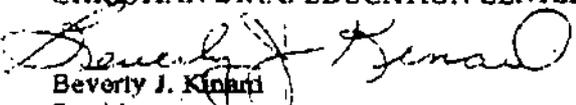
We also are in a national group that will have a "Pray for the Children Weekend" October 23, 24, and 25, 1998. This weekend will be dedicated to praying that children and their families will be drug-free and safe.

WE SUPPORT YOUR STRONG STAND AGAINST NEEDLE EXCHANGE PROGRAMS! We thank you for doing everything in your power to prohibit government funding of such programs that do nothing more than encourage new use and additional abuse of illegal drugs.

Testimony given in Denver this last month when Colorado defeated a NEP bill, indicated you didn't have to worry about people contracting AIDS from dirty needles because with the 80% pure black tar heroin, their hearts explode in minutes after shooting up. One treatment program testified that the director sees five deaths a week from this. One liberal legislator said he didn't care how many died of heroin. Why does one segment of society have the right to forfeit the lives of drug users?

Sincerely,

CHRISTIAN DRUG EDUCATION CENTER


Beverly J. Kinard
President

**Christian Coalition**

Capitol Hill Office

April 9, 1998

General Barry McCaffrey
Director, Office of National Drug Control Policy
750 17th St., NW
Washington, DC 20006

Dear General McCaffrey:

On behalf of the Christian Coalition, I urge you to remain steadfast in your commitment to deny the use of federal funds for needle-exchange programs (NEPs) in the United States. Contrary to what some advocacy groups have claimed, NEPs have not been scientifically proven to be safe and effective medical interventions for the prevention of HIV/AIDS.

In fact, recent studies of NEPs have shown a marked increase in AIDS. A Vancouver study published in 1997 reported that when their NEP started in 1988, HIV prevalence in IV drug addicts was only 1-2%, but now it is 23%. Vancouver, with a population of 450,000, has the largest NEP in North America, providing over 2 million needles per year. However, a very high rate of needle sharing still occurs. The study found that 40% of HIV-positive addicts had lent their used syringe in the previous 6 months, and 39% of HIV-negative addicts had borrowed a used syringe in the previous 6 months. Additionally, heroin use has increased dramatically during the NEP. The results of the Vancouver study have also been mirrored in studies conducted in Chicago and Montreal.

By providing needles to addicts, NEPs enable the addict to continue self-destructive illegal behavior. NEPs keep addicts on the needle, which increases the difficulty of providing aggressive, successful treatment for the addict. In contrast, outreach/education programs and mandatory treatment programs are safe and effective in preventing both drug use and HIV/AIDS. These are the programs that should be encouraged at the state and federal levels.

Furthermore, the establishment of NEPs creates "drug-use" zones in which law enforcement officers are prevented from enforcing state and federal drug laws. Consequently, drug dealing and drug use is de facto legalized in NEP areas. The federal government must oppose any efforts to weaken our existing laws against the use of illegal drugs. The Christian Coalition urges you to oppose any use of federal funds for needle exchange programs.

Sincerely,



Jeffrey Taylor
Acting Director of Government Relations



April 8, 1998

Gen. Barry R. McCaffrey
Director, ONDCP
750 17th St. N.W.
Washington, D.C. 20006

via fax - 202-395-6744

Dear General McCaffrey:

On behalf of our 55,000 physician constituents, the Physicians Resource Council of Focus on the Family wholeheartedly supports your position strongly opposing the federal funding of needle exchange programs.

The evidence concludes that injecting drug users are at high risk of contracting the HIV virus. These programs prolong the danger by helping to continue the addiction.

Most Americans oppose federally funded needle giveaway programs. Six in ten Americans have said that they want their members of Congress to stop needle exchange programs and to return the focus to drug abstinence and rehabilitation. Voters are also concerned about the additional effects of needle exchange programs on public health. They indicate a clear anxiety over increased crime and drug use in their own neighborhoods.

Thank you for your strong opposition to this deadly idea.

Sincerely,

John Livoni, M.D.
Chairman, Physicians Resource Council

Bradley G. Beck, M.D.
Medical Issues Advisor
Focus on the Family



April 9, 1998

Gen. Barry R. McCaffrey
Director, ONDCP
750 17th St. N.W.
Washington, D.C. 20006
via fax: 202-395-6744

Dear Gen. McCaffrey:

The Family Research Council wholeheartedly supports your strong opposition to federally funded Needle Exchange Programs (NEPs). Free needle programs are an insidious public danger.

The evidence concludes that injecting drug users are at high risk of contracting the HIV virus. NEPs prolong the danger by supporting and encouraging the addiction. Yet, there is a national and well-financed pro-free needle lobby pushing for federal funding of NEP programs.

The pro-free needle lobby misrepresents Americans since six out of ten oppose federally funded needle giveaway programs. Voters are concerned about the collateral effects of local NEPs on public health and indicate a clear anxiety over increased crime and drug use in their own neighborhoods.

Thank you so much for your strong opposition to this deadly idea. Our country cannot afford to continue to enslave the victims of drug addiction.

Sincerely,


Gary L. Bauer
President

Family Research Council



Gospel Mission + Haven + Fulton House of Hope/Haven + Barnabus House
Samaritans + Change Points + Zacchoens + School of Tomorrow

GOSPEL RESCUE MINISTRIES

of Washington, D.C.

April 8, 1998

General Barry R. McCaffrey
Director, ONDCP
750 17th St., NW
Washington, DC 20006
Fax 202-395-6744

Dear General McCaffrey

Your opposition to the concept of federal funding for Needle Exchange Programs has been brought to my attention. As a person intimately involved with the lives of addicts, both as a physician and as director of a rescue ministry, I hasten to support your action.

My concerns are several:

First, the issue of drug abuse is a moral one, and condoning abuse by supplying needles is morally wrong.

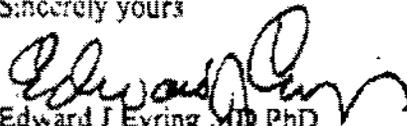
Second, "clean" needles are more likely to be shared, actually increasing the very risks they are intended to reduce.

Third, why spend money helping to support drug addiction, when we are also spending money (and not enough) to prevent it?

Fourth, the very notion of providing needles is that of allowing people to do what they want to do regardless of the consequences. This type of choice is inimical to the public good, which it is the government's duty to protect.

Thank you for your opposition to this illogical, expensive and incorrect idea.

Sincerely yours


Edward J. Eyring, MD PhD
President and Executive Director

Fax Transmittal		Date <u>4-8</u>
		# of pages <u> </u>
To <u>Gen McCaffrey</u>	From <u>Dr. E. J. Eyring</u>	
Co. <u> </u>	Co. <u> </u>	
Dept. <u> </u>	Phone# <u> </u>	
Fax# <u>305-6744</u>	Fax# <u>898 0285</u>	

MAIN SOUTH ALLIANCE FOR PUBLIC SAFETY



CHAIRMAN
William T. Breault

DIRECTOR OF AFFAIRS
Debra M. Lockwood

ASSOCIATE DIRECTOR
Wendy Lucier

SECRETARY - TREASURER
James W. Lockwood

4 Hathaway Street

Worcester, MA 01610

Tel. (508) 754-3867

General Barry McCaffrey, Director
Office of National Drug Control Policy
750 Seventeenth Street NW
Washington, DC 20006

April 9, 1998

Dear General McCaffrey:

We of the Main South Alliance for Public Safety of Worcester Massachusetts offer you the strongest possible support in your efforts to prohibit federal funding of "Needle Exchange" programs.

Our organization has been fighting against these programs for eight years. Proponents have tried twice in the past to have a program approved for Worcester and it has been defeated twice - overwhelmingly. (Worcester is the second largest city in New England).

Now, not able to accept these two overwhelming "no" votes; the needle-exchange crowd is at it again in Worcester. And we will defeat them again - overwhelmingly.

In other Massachusetts cities and towns, the tide has been running strongly AGAINST needle exchange. In New Bedford, a city-wide referendum defeated needle exchange by a 2 - 1 margin, after the city council had tried to sneak it in. Other defeats occurred in Springfield (the third largest city in Massachusetts) and several other cities. Only in extreme liberal strongholds such as Provincetown and Northampton have advocates managed to achieve any recent success.

We believe that needle exchange programs are: morally unacceptable, scientifically ambiguous, and a direct threat to neighborhood public safety.

Our grassroots efforts need federal validation of the kind you are giving us. Drug trafficking and distribution are inexorably entwined with use and addiction. You are fighting the good fight and we want you to know that the support of most people in the country is with you.

Sincerely,

A handwritten signature in black ink that reads "William T. Breault". The signature is written in a cursive style and is positioned above the typed name and title.

William T. Breault
Chair

Community Awareness Action Team

"Building a Community Without Drugs"

April 9, 1998

General Barry McCaffrey, Director
Office of National Drug Control Policy
750 Seventeenth Street NW
Washington, DC 20006

Dear General Barry McCaffrey:

We have actively opposed needle exchange legislation in Colorado for the past two years. This approach will only send the wrong message to our young people. Treatment options should be provided but not through needle exchange programs.

Thank you for your support on this matter. We encourage you to continue your position against needle exchange programs. And we will continue to actively support this position.

Sincerely,



Eleanor Scott
Vice Chairman

6515 Bellarmine Ct.
McLean, Va. 22101
April 9, 1998

General Barry McCaffrey, Director
Office of National Drug Control Policy
750 Seventeenth Street NW
Washington, D.C. 20006

Dear General McCaffrey:

I am writing you as President of a Northern Virginia Association, PANDAA (Parents' Association to Neutralize Drug and Alcohol Abuse) to strongly encourage your position against clean needles.

I believe Needle Exchange programs enable drug users to continue their self-destructive pattern of drug use and do more harm than good. Although these programs aim to cut down on HIV infections, no convincing study has proven conclusively that they do so; meanwhile, drug use soars in areas like Vancouver where NEPs are in effect.

Our organization has recently fought against Safe Rides programs in the high schools for similar reasons; they enable users to keep using. Designated Drivers support Designated Drinkers. Needle Exchange Programs support Needle Use and Drug Habits. A "No-Use" message is the only responsible and life enhancing stand to take.

Deborah Fosberg Nelson

Deborah Fosberg Nelson
President, PANDAA

ATT: Dan Schecter

Maryland Alliance for Drug Free Youth, Inc.

P.O. BOX 423 • LINTHICUM, MARYLAND 21090 • (410) 859-4320

General Barry McCaffery
Office of National Drug Control Policy
White House
Washington D.C.

Dear General McCaffery,

We urgently request that you do not fund needle exchange programs.

There is no valid scientific evidence that Needle Exchange Programs have resulted in reducing the prevalence of HIV/AIDS, Needle Exchange Programs have not been shown to have any advantage over drug treatment programs.

There is considerable evidence that there is a significant increase in HIV/AIDS in injecting drug users that participate in Needle Exchange Programs. (ie. the study of the NEP in Vancouver British Columbia.)

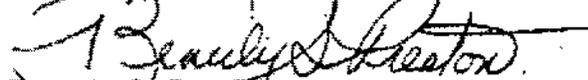
There is also evidence that there is an increase in heroin use in areas that have Needle Exchange Programs, especially among young people.

Aggressive outreach/education efforts have resulted in decreased seroconversion rates for HIV/AIDS without providing needles to the population.

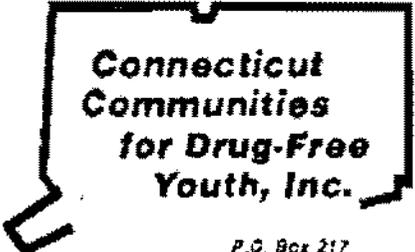
The most humanitarian approach for the addict, the drug user, and society is prevention, intervention and treatment.

THERE ARE NO QUICK FIXES

Sincerely,



Beverly S. Preston
Director MADFY



**Connecticut
Communities
for Drug-Free
Youth, Inc.**

P.O. Box 217
New Canaan, CT 06840-0217
203-977-3234 1-800-422-3234

April 10, 1998

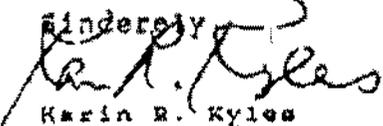
General Barry R. McCaffrey
Director
Office of National Drug Control Policy
750 Seventeenth Street, NW
Washington, DC 20006

Dear General McCaffrey:

Connecticut Communities for Drug-Free Youth, Inc. (CCDFY) is a statewide alliance of task forces, parent groups, agencies, and concerned individuals that supports and promotes parent and community action in the area of alcohol, tobacco, and other drugs awareness and prevention. Since 1983 through advocacy, education, and leadership, CCDFY has provided a variety of resources and programs that supports primary prevention efforts for young people and parents within each community. Since its inception, the mailing list of CCDFY has grown to reach 8,000 people in Connecticut.

In August 1997, ONDCP released comments in connection with survey results announced by the Family Research Council regarding needle exchange programs which stated that "Federal treatment funds should not be diverted to short term 'harm reduction' efforts like needle exchange programs." We support that statement and urge you to maintain your position against "clean needles" and in favor of intervention and drug treatment for addicts.

Sincerely,



Karin R. Kyle
President

New Jersey Federation for Drug Free Communities

TO: General Barry McCaffrey, Director
Office of National Drug Control Policy
750 Seventeenth Street, NW
Washington, D.C. 20006
Post Office Box #702 Livingston, New Jersey 07039

FROM: Linda B. Ledger, Vice President
New Jersey Federation for Drug Free Communities
85 Woodlawn Road, Sparta, New Jersey 07871

RE: (position AGAINST clean needles)

DATE: April 9, 1998

The New Jersey Federation for Drug Free Communities, an all volunteer organization who has been providing drug prevention programs to high school students for 16 years and responsible for training over 7,000 students, supports General McCaffrey's position AGAINST clean needles. Needle exchange programs have Not been successful in reducing aids or drug abuse. One only has to look at the problems of Zurich, Switzerland to see the overwhelming evidence against any state or nation thinking of adopting needle exchange programs.

Linda B. Ledger



SAFE FROM DRUGS

SAFE FROM ALCOHOL

SAFE FOR TEENAGE PARTIES



From: Susie Dugan, Executive Director
Phone: 402-397-5308 (M) 402-392-1893 (H)
Fax: 402-397-5924 (M) 402-392-8928 (H)

FAX SHEET # of pages: 1 Date: 4-8-98
To: 202-395-6744

ATTN: DAN Scheeter

General Barry McCaffrey, Director
Office of National Drug Control Policy
750 Seventeenth Street NW
Washington, DC 20006

Dear General McCaffrey:

On behalf of the volunteers and staff of PRIDE-Omaha, Inc., I urge you not to support clean needle exchange programs.

PRIDE-Omaha, Inc. is a grassroots parent/community organization of over 5,000 members and is dedicated to preventing the use of alcohol, tobacco or other drugs by young people.

Needle Exchange programs encourage drug use, and much research has shown that such clean needle programs do not reduce the incidence of HIV prevalence.

Needle exchange programs send the wrong message to our young people. Please do not waiver in your opposition to them.

Sincerely yours,

A handwritten signature in cursive script that reads "Susie Dugan".
Susie Dugan
Executive Director



Serving the Business Community

April 9, 1998

Barry McCaffrey
 Director
 Office of National Drug Control Policy
 750 Seventeenth Street, N.W.
 Washington, D.C. 20006

**ARIZONANS FOR A
 DRUG-FREE WORKPLACE**

Transmitted by Facsimile
 202/395-6744

PO Box 13223
 Tucson, AZ 85732-3223
 (520) 740-5063 / (800) 392-3359
 Fax (520) 740-2969
 e-mail: afdfw@azstarnet.com

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General McCaffrey:

It is our understanding that the federal ban on Needle Exchange Programs (NEPs) expired March 31st and that the ban has not been reinstated as of this date.

Please remain firm in your position against NEPs. We support you in this effort and **DO NOT WANT** our tax dollars going to support and facilitate drug addiction! NEPs have not been shown to be a successful approach to addiction and diseases spread through shared-needle use.

You have stood firm in your dedication to fighting substance abuse in this country, and you have not stood alone. It is so important for you to **REMAIN RESOLUTE** against ALL efforts to erode this country's barriers to illicit drug use as is being done not only with the NEPs, but the various state initiatives to decriminalize and medicalize dangerous drugs. We cannot condone illicit drug use in any manner, be it NEPs or "medicalization".

Organizations such as ours, and individuals such as myself are just small voices, barely heard - but you are able to be heard and speak for the vast majority of people in this country who do not condone illicit drug use. Please do not allow further erosion, leading to tolerance, of substance abuse. We must rely upon you to remain strong.

Sincerely,

Elizabeth Edwards



Houston's Drug-Free Business Initiative

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March 23, 1998

The Honorable Barry McCaffrey
Director
Office of National Drug Control Policy
750 Seventeenth Street NW
Washington, DC 20006

Dear General McCaffrey:

It is our understanding that an announcement will be made tomorrow regarding needle exchange programs.

We want to encourage you to continue your previously stated position in opposition to these programs. As you know, there is no clear, convincing evidence that giving free needles to drug addicts decreases the incidence of AIDS. These programs cannot possibly reduce drug use and, in our opinion, sends a mixed message to the addicts that their drug taking is okay. We believe the programs are a disincentive for addicts to seek abstinence-based treatment which could save their lives.

Houston's Drug-Free Business Initiative serves over 3,000 employers in the Texas Gulf Coast Area who are concerned about drug abusers in the workplace and the potential negative impact from their drug use on safety and productivity. Through our drug-free workplace programs and our zero tolerance policies to substance abuse, we have successfully rehabilitated many, many employees and saved their lives. We did not achieve these successes by "enabling" them to continue to use their drugs. To give free needles to drug addicts and condone their habits, sends the wrong message to our workers - a message that we as employers cannot afford.

Please stand your ground and oppose needle exchange programs. They are not the answer to the problem.

Best regards,

Calvin Fay
Calvin L. Fay
Executive Director

Serving Gulf Coast Area Employers

SALLY L. SATEL MD
801 Pennsylvania Ave. NW #1203
Washington DC 20004

(202) 638-8911 ph

(202) 638-1505 fax

General Barry McCaffrey
Director, Office of National Drug Control Policy
Executive Office of the White House
Washington DC

Dear General McCaffrey:

April 9, 1998

I am writing to express my view on federal funding for needle exchange programs (NEPs). In short, I do not support federal ear-marking for NEPS. The first reason is scientific: we do not yet have consistent evidence that NEP's decrease HIV transmission rates. The second is political: funding for specific elective health programs should be a local, not a federal, responsibility.

From a scientific standpoint we know three facts: (1) NEPS do not recruit new users; (2) virtually all studies to date have been plagued by methodological problems (e.g., self-reporting, self-selection, suboptimal control groups, etc.); (3) two recent, carefully executed Canadian studies actually found an increase in transmission.

Oddly, today's New York Times carries an Op-Ed by Julie Bruneau and Martin Schechter (principal investigators of the Canadian research) in which the authors seem to discount their own findings. They claim that HIV rates weren't so much increased in the NEP group as they were *decreased* in the comparison group since the latter contained individuals who happened to buy clean needles and engaged in less risky behavior overall. If the authors are correct, then their study is, at best, uninterpretable (that is, it needed a third comparison group of individuals who used dirty needles routinely and engaged in unprotected sex).

Thus, carefully controlled, prospective studies are still needed. I think it is reasonable for federal funds to be used in the service of obtaining good data. But, as mentioned before, I think it is the domain of locales to make choices about whether to implement NEPS if they can be demonstrated to be effective.

From a political standpoint, locales will have to weigh the intangibles: the symbolic impact of needle give-aways (my personal view is that harm reduction is a posture of defeat); the alternatives (data suggest that there are better ways to reduce drug and needle use using treatment, coercion and contingency management) and the feasibility (many locales find that needle exchanges are sordid affairs with needles strewn about outside and addicts congregating and loitering).

One final note: my colleague, Dr. Herbert Kleber, argues for revising the paraphernalia laws so that addicts can purchase needles without fear of punishment. This suggestion is worth serious consideration.

In summary:

- we need more solid data on the effectiveness of NEPS;
- funding NEP research is an appropriate role for the federal gov't
- implementation and financing of NEPS should be done at local level with local resources*

Thank you for your consideration.

Sincerely,



Sally L. Satel MD
Lecturer, Yale University School of Medicine

* - some of these funds may be block grant dollars